

**AN ETHNOGRAPHIC EXPLORATION OF
AGRICULTURAL PSYCHIATRIC REHABILITATION
VILLAGES IN TANZANIA**

by

Nadia Roberts
Bachelor of Arts, University of British Columbia, 2004

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

In the
Department of
Anthropology

© Nadia Roberts 2007

SIMON FRASER UNIVERSITY

Spring 2007

All rights reserved. This work may not be
reproduced in whole or in part, by photocopy
or other means, without permission of the author.

APPROVAL

Name: Nadia Roberts
Degree: Master of Arts
Title of Thesis: An Ethnographic Exploration of Agricultural
Psychiatric Rehabilitation Villages in Tanzania

Examining Committee:

Chair: Dr. Dara Culhane
Associate Professor of Anthropology

Dr. Parin Dossa
Senior Supervisor
Professor of Anthropology

Dr. Michael Kenny
Supervisor
Professor of Anthropology

Dr. Marina Morrow
External Examiner
Assistant Professor/Faculty of Health Sciences

Date Defended/Approved: March 28, 2007



DECLARATION OF PARTIAL COPYRIGHT LICENCE

The author, whose copyright is declared on the title page of this work, has granted to Simon Fraser University the right to lend this thesis, project or extended essay to users of the Simon Fraser University Library, and to make partial or single copies only for such users or in response to a request from the library of any other university, or other educational institution, on its own behalf or for one of its users.

The author has further granted permission to Simon Fraser University to keep or make a digital copy for use in its circulating collection (currently available to the public at the "Institutional Repository" link of the SFU Library website <www.lib.sfu.ca> at: <<http://ir.lib.sfu.ca/handle/1892/112>>) and, without changing the content, to translate the thesis/project or extended essays, if technically possible, to any medium or format for the purpose of preservation of the digital work.

The author has further agreed that permission for multiple copying of this work for scholarly purposes may be granted by either the author or the Dean of Graduate Studies.

It is understood that copying or publication of this work for financial gain shall not be allowed without the author's written permission.

Permission for public performance, or limited permission for private scholarly use, of any multimedia materials forming part of this work, may have been granted by the author. This information may be found on the separately catalogued multimedia material and in the signed Partial Copyright Licence.

The original Partial Copyright Licence attesting to these terms, and signed by this author, may be found in the original bound copy of this work, retained in the Simon Fraser University Archive.

Simon Fraser University Library
Burnaby, BC, Canada



STATEMENT OF ETHICS APPROVAL

The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

(a) Human research ethics approval from the Simon Fraser University Office of Research Ethics,

or

(b) Advance approval of the animal care protocol from the University Animal Care Committee of Simon Fraser University;

or has conducted the research

(c) as a co-investigator, in a research project approved in advance,

or

(d) as a member of a course approved in advance for minimal risk human research, by the Office of Research Ethics.

A copy of the approval letter has been filed at the Theses Office of the University Library at the time of submission of this thesis or project.

The original application for approval and letter of approval are filed with the relevant offices. Inquiries may be directed to those authorities.

Simon Fraser University Library
Burnaby, BC, Canada

ABSTRACT

This thesis examines patients' experiences of living with mental illness and addiction in the context of agricultural psychiatric rehabilitation villages. It focuses on community and family roles, treatment, work, and use of local healing. The thesis explores some of the complexities and tensions that exist within the village, and their Tanzanian context as a site of healing. It highlights the importance of relationships within this healing. It is based on three months of ethnographic fieldwork conducted in Tanzania, and thirty interviews with patients and health care workers. The focus is on the importance of social relationships in healing, and on the impact of mental illness on the patients' narratives. By allowing patients' stories to act as the basis of the thesis, their voices are honoured and a new perspective emerges on mental health. This research contributes to anthropological literature on narrative as well as cross-cultural understandings of illness.

Keywords: mental health; Tanzania; healing; narratives

Subject Terms: medical anthropology; transcultural psychiatry

*For Baba, who was always loving, kind and ready to cook a plate of
perogies for anyone who walked through her door.*

ACKNOWLEDGEMENTS

I would like to thank my committee for their time, attention and encouragement over the past three years: Dr. Parin Dossa, my Senior Supervisor, and Dr. Michael Kenny, my Supervisor. I would also like to thank Dr. Marina Morrow, my External Examiner, for her thought-provoking questions at my defence.

Dr. Kilonzo's assistance and expertise during my fieldwork was invaluable. The insights of all the health care professionals I talked to were extremely helpful in understanding the mental health care system in Tanzania.

I would like to thank Michelle Walks for taking the time to read drafts of various chapters and give me helpful feedback throughout the process of writing.

My parents, John and Charlene, have given me unconditional support (financial, emotional and otherwise!) over the past three years, and I would particularly like to thank my mom for taking the time to edit this thesis in its entirety. I would also like to thank Kevin for helping me understand on a more personal level the importance of relationships and love in healing.

Lastly, and most importantly, I would like to acknowledge my participants and their courage in the face of adversity. Their lives embody the meaning of hope and their stories inspire me to attempt to face my own challenges with the grace and dignity they exhibited.

TABLE OF CONTENTS

Approval	ii
Abstract.....	iii
Dedication	iv
Acknowledgements	v
Table of Contents	vi
Preface.....	1
My First Visit to the Village	1
Introduction.....	3
Interviews	5
Narratives	7
An Outline	9
Chapter One: Literature	12
Literature on Mental Health and Anthropology	12
Mental Illness as Alienation and Stigma.....	18
Cultural Context of Illness	21
Chapter Two: Methodology	25
Ethnography	33
Ethics	34
Limitations	35
Chapter Three: Background.....	37
Ujamaa in Tanzania.....	38
Healthcare in Tanzania.....	42
Psychiatry in Tanzania	48
Agricultural Psychiatric Rehabilitation Villages.....	51
Chapter Four: Healing Paths.....	55
Onset of Symptoms	57
Seeking Treatment.....	62
Literature on Local Healing in Africa	65
Local Healing Among the Patients in Tanzania.....	69
Hospitalization and Psychiatric Care	78
Healthcare Professionals on Local Healing.....	81
Healthcare Professionals on Stigma.....	84
Chaos in Stories.....	86
Chapter Five: Daily Village Life.....	90

The Villages	90
Funding.....	93
Staffing.....	95
Daily Life and Work	96
Financial Compensation and Needs of Patients	97
Patients' Response to Work	99
Stories in Repair	105
Chapter Six: Relationships and Future Plans	107
Sense of Community	108
Staff	108
Patients	110
Family.....	114
Staff	114
Patients	117
Healing in the Village	120
Staff	120
Patients	121
Future Goals of the Patients	124
Healing Through Stories	127
Conclusion	129
Resistance.....	129
Relationships	132
Contributions.....	136
Appendices.....	138
Appendix A: List of Patients Interviewed.....	138
Appendix B: List of Healthcare Professionals Interviewed	141
Appendix C: Demographic Profile of Patients.....	143
Reference List.....	144

PREFACE

My First Visit to the Village

When Dr. Kilonzo, the psychiatrist responsible for overseeing the patients in the village, drove me to Uhuru village for the first time, he introduced me to the staff. I met Grace, who is in charge of the administrative and agricultural aspects of the village, and her assistant Talib, who is in charge of animal husbandry. Grace has been working there for sixteen years and Talib for seventeen years. I was then introduced to James, one of the nurses, who has been working there for several years, and who took me on a tour of the village with Dr. Kilonzo. We walked to the rooms where patients slept, very simple concrete rooms with two beds in each one, with mosquito nets. Dr. Kilonzo talked and joked with some of the patients, asking why they weren't working. James then showed us the area with the livestock. There were several cows roaming around freely, a pen with about a dozen pigs in it, and a few long, concrete buildings full of thousands of chickens. We walked to the coconut grove situated behind the village, which has hundreds of coconut trees. Several patients were sitting under a tree, resting, and James introduced me to Tuyu, the occupational therapist, who was standing with them, holding a clipboard. Her job is to engage the patients in activities such as tie-dyeing, basket-making, stitching, and weaving – to teach them new skills and keep them active.

Being in the village was often a quiet and slow experience. When Vincent, my research assistant, and I got off of the rickety mini van busses each day, known as a *dala dalas* in Tanzania, across the street from the village, there were no people in sight. We walked along the dirt road leading into the village and saw a patient or two at work in the kitchen or sitting around. We headed over

to say hi to Grace in the office that she shared with Talib. I approached whichever nurse was working, Jamila or James for the first several weeks, and then Joseph who returned from being on leave. I arrived at the times of day when patients were not working if I wanted to do interviews, or a few times I watched them work and participated in the work a little (usually to the amusement of the patients). I should mention that Grace informed me that they are not called patients, but villagers. This is to make them feel included in the community and not separated by their illness. I attempted to use that phrasing while writing, but found it confusing to keep track of who I was referring to – as technically the labourers who live in the village nearby are also villagers, as are the staff members who live at Uhuru. I therefore decided to retain the use of the term “patient¹” in my thesis for the purpose of clarity.

¹ The author is aware that using the word “patient” instead of the term “villager” is reinforcing a biomedical perspective of mental illness and relegating villagers to a biomedical status, despite an explicit attempt in Tanzania to do otherwise. However, for simplicity’s sake it was clearer to use the word “patient” as it is a term that for most readers will immediately identify who is being discussed: those in the village for rehabilitation. The “patients” are then distinguished from the labourers, staff members and their family members who also live in the village and hence are also “villagers”. The use of the word “patient” is a limitation of this work due to its biomedical connotations.

INTRODUCTION

The World Health Organization has identified mental illness as deserving particular attention and action in the 1990s and the twenty first century because of observed trends, such as urbanization, which are likely to increase the extent of the problem. (Harpham 1995:167)

Mental health care is a topic that is frequently in the news and which is debated and discussed by politicians, scholars, health care workers and consumers alike. Mental health is an important topic as it is consistently reported that rates of various mental illnesses are on the rise around the world. Stigma and mystery still surround mental health in most parts of the world, despite education campaigns and public awareness outreach efforts by those working in the field.

Understanding how other cultures treat mental health can be of assistance in reflecting on how we, in Canada, treat mental health. With this in mind, I knew when I began graduate school that I wanted to study mental health in Tanzania. This decision was informed by my experience of living in Tanzania for five years during high school and being diagnosed with depression while living there.

In October 2004, I read an academic article on psychiatry in Tanzania, in which agricultural psychiatric rehabilitation villages were mentioned. The article, co-written by Dr. Gad Kilonzo, a Tanzanian psychiatrist who was instrumental in my research in Tanzania, included a few paragraphs about the villages. The paragraphs suggested that local healing and biomedicine were both used by patients in the villages and that families were instrumental in treating the patients in the villages. The article focused on the holistic treatment offered, the use of work, and on the social aspect of the villages. This intrigued me. I wanted to find out more.

My goal was to explore the mental health care system (or a portion of it) in a country with an extremely different economic, historical and cultural context than we have in Canada. Tanzania is one of the poorest countries in the world, in terms of Gross Domestic Product, and its history involves colonization by first the Germans and then the British. I wanted to explore how some of these factors influence the mental health care offered in Tanzania, to find out if agricultural psychiatric rehabilitation villages are specific to the context within which they exist in Tanzania, or if aspects of them can be applied in different contexts in other countries.

My first plan was to investigate the use of local healing in convergence with biomedicine in the villages. I also planned on focusing solely on patients suffering from depression. Upon arrival in Tanzania, however, my focus broadened and shifted as I became more interested in the sense of communal and familial relationships as a survival strategy. Such a simple and essential means of treating mental health patients (focusing on relationships) has implications for the direction of mental health treatment on a global scale. I hope that the reader is able to see beyond the specific context of Tanzania and agricultural psychiatric rehabilitation villages to a more general theme of the need for connection and social relationships that exists globally. At a time when industrialization and technology are leading to increased individualization around the world, my research identifies a simple and common need across cultures for socialization, both to prevent mental illness but also to help in treating it.

I also focus on the patients' narratives; their life stories, and the contexts of their suffering. I wanted a fuller picture of these individuals' lives. By understanding the lives of patients, I was able to gain insight into the impact of mental illness and addictions on narrative and story-telling. By allowing patients to speak for themselves, this research challenges the psychiatric model which often insists that patients are somehow incapable of doing so. The patient-perspective is of growing interest in anthropological literature on mental health and narrative, and contributes to

understanding the cultural context of illness, a fundamental goal of Medical Anthropology. I also focus on the cultural, historical and political context of mental health treatment in Tanzania, contributing insight into cross-cultural modes of treatment.

Interviews

In psychiatry, patients don't produce information as easily as they do in other medical settings. Most patients with physical disorders are frightened by their pain and eager to give information about it. Psychiatric patients have a very different relationship to their symptoms and don't always want to answer questions. (Luhrman 2000:33)

When I began conducting interviews with Tanzanian mental health patients in an agricultural psychiatric rehabilitation village, I was armed with a Eurocentric model of thinking about mental health which I soon found did not fit in the local context. I was unable to elicit the types of responses I had hoped for or anticipated. When I asked patients about their diagnoses, they stared at me blankly. When I tried to ask them why they were in the village, they told me a story of how they ended up there, which often was long and complicated. They did not identify a particular mental illness as the reason. When I asked them what type of medication they were on, they did not know – they said that took the “blue pill” or “red pill”, whatever their doctor gave them.

Coming from Canada, I am used to talking to people about their depression or bipolar illness with a degree of awareness and reflexivity; how it has impacted their life, how they cope with it, how they feel about it. The patients in Tanzania, however, did not talk about their situation in the terms I am familiar with; biomedical terms. They made little reference to the stigma surrounding mental health and how it is perceived in Tanzania. Rather, they were silent about these things. They talked around them. My questions did not seem to resonate with them in the sense that I

hoped they would. I anticipated that I would be able to talk to the villagers about being patients and how that has affected their self-perception and how others perceive them.

What emerged instead were pieces and threads of the individuals' stories. A patchwork of snippets and glimpses into their lives evolved. They spoke of their lives both past and present, often as if past and present existed simultaneously. I found myself struggling to listen "openly" to what was being said, not focusing on the words or the questions, but on the context, the body language, and the tone they used. I found myself wanting to piece together a clear, linear history and to understand their presence in the village as a chapter in the story of their life. I wanted their lives to be neat and tidy so I could make sense of them. Yet, they weren't neat and tidy. Their lives were a culmination of experiences and events, and often times it was hard to tell which event preceded which.

The villagers told me stories that involved people in their lives – family members, friends, authority figures. It was as if people identified themselves through their relationships with others and as if they used others as a reference point for their own life history. While I was asking questions that were directed towards them as individuals, wanting to know how they felt, what they wanted in life, how being "ill" had impacted their self-perception, the villagers' responses contained very little focus on them as individuals. Rather, they responded to me by describing various social interactions or relationships which often did not seem related to their present situation. It became clear rather quickly that relationships are the most important aspect of the villagers' lives. Relationships between the staff and patients, relationships between patients, relationships with family members, and relationships to the broader community, all came out repeatedly in the interviews.

Narratives

If stories, lives and journeys are so entwined, what happens to our capacity to tell stories when our lives are torn apart? (Jackson 2002:33)

Michael Jackson, in *The Politics of Storytelling*, writes about the use of story telling as it relates to the lives of refugees primarily. Much of what he writes about trauma and the social disruption that accompanies being a refugee can be applied to those who experience mental illness as well:

Both natural disasters and social upheavals destroy the balance of power between a person's immediate lifeworld and the wider world. At such times, not only do questions of choice and freedom become desperately acute, but the very possibility of storytelling is thrown into radical doubt. (Jackson 2002:34)

This can be seen in the interviews I conducted with patients in Tanzania; their stories reveal the degree to which their lives have been disrupted by the impact of experiencing mental illness or addiction. They do not talk about their lives linearly or fluidly, but in pieces and fragments. Their narratives reflect the fragmentation they have experienced as a result of mental illness or addiction. The ways that the patients reflect on their own lives and the silences and things they choose not to reflect on are a product of their experiences, and the context – cultural, historical, political and economic – within which they live. The patients I talked to in Tanzania captured the fact that,

The idea that any human life moves serially and progressively from a determinate beginning, via a middle passage, towards an ethically or aesthetically satisfying conclusion, is as artificial as the idea of a river running straightforwardly to the sea. (Jackson 2002:22)

The interviews I conducted with patients living in agricultural psychiatric rehabilitation villages in Tanzania reflect the lives that the patients have lived. That the interviews were often disjointed, that answers were abrupt or non-existent, or that certain questions were avoided and others elicited lengthy replies, does not suggest that there was nothing to be said or that certain

questions had no meaning for patients. It does not suggest that as mental health patients, my interviewees were incoherent. Rather it reflects larger social issues and processes. The disruption caused by addiction or the confusion caused by schizophrenia are mirrored in the way that the patients talked about their lives. The fact that the patients have largely grown up in poverty without many material resources to support them is captured in some of their resignation to their state and also in the agency they exhibit in trying to imagine a life for themselves beyond being ill or addicted. That each interview was unique is to be expected. That there are commonalities in what was said and not said reflects the context that the patients share as Tanzanians living with mental illness or addiction.

Laurence Kirmayer writes that,

When stories deviate from our expectations for plausibility, intelligibility, order and coherence, we have several options: we can expand our vision of the possible; we can interpret the narratives as defective, indicating cognitive dysfunction or some other form of psychopathology; or we can question the motives and credibility of the narrator. (2003:167)

I have chosen to 'expand my vision of the possible' when analyzing the transcriptions of the interviews I conducted. Rather than become discouraged by scant replies or at times incoherent narratives, I have chosen to see my interview transcripts and the narratives they represent as revealing larger social and personal issues for the patients. The fact that my interviewees were mental health patients and have been through a serious amount of disruption in their moods, thought processes and social functioning, not to mention their daily lives, is reflected in some of the pauses and silences in their interviews. That they are mostly from working class Tanzanian families with little in the way of economic support in a country where poverty and the struggle to survive are the norm is captured in the movement from hope to despair that they exhibit in their narratives.

Jackson identifies the concept of “reempowerment” (Jackson 2002:78) in storytelling, as it “enables the regeneration and celebration of social existence, without which we are nothing” (Jackson 2002:58). He suggests that storytelling is a chance “to clarify and bear witness to what one has salvaged and retrieved” (Jackson 2002:104), and that in doing this, one “reaffirms, in the face of dispersal, defeat, and death, the *social* bonds that bind one to a community of kindred spirits” (Jackson 2002:133). The theme of social bonds emerges in my research; the importance of being connected to others is perhaps more important for mental health patients in Tanzania than any other factor. This is presumably not a uniquely Tanzanian phenomenon, but represents a more universal need for social relationships and networks which is integral to mental well being.

My hope is that my thesis captures for the reader some of the salvaging and retrieval that these patients have done to cope with and survive their mental illness or addiction and some of the agency they have exhibited in doing so.

An Outline

Seriously ill people are wounded not just in body but in voice. They need to become storytellers in order to recover the voices that illness and its treatment often take away. (Frank 1995:xii)

I have chosen to use the patients’ stories, lives and words, as guides for this thesis as a way of honouring their voices and autonomy. I hope that this method of writing captures their experience of the village and gives the reader a glimpse into their lives and the role the village plays in those lives, within the wider context of Tanzania.

In the first chapter, I outline the literature on mental health and anthropology, which addresses and contextualizes some of the themes in my research. In the following chapter, I discuss the methodology I used in my research. I then, in Chapter 3, elaborate on the cultural context within

which agricultural psychiatric rehabilitation villages exist. I first discuss Tanzania's history of 'ujamaa', or community living, and then I talk about the history of the health care system in Tanzania, followed by a brief discussion of psychiatry in Tanzania and agricultural psychiatric rehabilitation villages. Chapter 3 is meant to set the stage for the reader to develop a deeper understanding of the villages and the economic, political and social context within which they exist.

Following this background chapter, I tell the stories of the patients. I recount their narratives, which I have divided into three sections, corresponding with chapters. The first section, Chapter 4, deals with how the patients came to arrive in the village. I write about their life history to the extent that they shared it with me, and their experiences with both biomedicine and local healing. In Chapter 5, I go on to talk about life in the village for the patients. This section includes a description of daily life in the village, the roles of staff in the village, the role of work in the village, and an analysis of the patients' responses to working. In Chapter 6, I discuss social relationships and I wrap up the patients' narratives by discussing their hopes and goals for the future. I end the thesis in this way to acknowledge the complexity of mental health and to emphasize that although the people I interviewed were mental health patients living in a rehabilitation village at the time I met them, they are far more than mental health patients. Their stories are contextualized by living in Tanzania and their relationships with their families, friends, and each other. This is the reality they will return to once they leave the village – reintegrating into their communities and with their families.

At the end of each of Chapters 4, 5 and 6, I return to the theme of narratives, using excerpts from Arthur Frank's *The Wounded Storyteller* to elaborate on issues of voice and agency.

I hope that my thesis does some justice to the patients' stories and at the same time offers some insight into a form of mental health treatment that is fairly unique and particularly so in a country that is struggling economically and in which the majority of people live in poverty. It is my hope that this insight can be used to reflect on mental health treatment here in Canada and lessons we may be able to learn from practices used elsewhere. In Tanzania, where resources may not be available, there is nonetheless an emphasis on holism, community and healing. Mental health patients living in rehabilitation villages are encouraged to piece their lives together after experiencing mental illness. This is essentially the goal of all mental health treatment: to allow individuals to return to some semblance of a regular, routine-filled life with a support network in place.

CHAPTER ONE: LITERATURE

Literature on Mental Health and Anthropology

The stories my participants told were proof that the reason their voices have not been heard was not because they had no perspective to offer or because they were inarticulate. One wonders, therefore, to what extent this “invisibility” and “silence” is an outcome and expression of cultural attitudes about the nature of mental illness. Does it suggest that we consider mental illness somehow renders the subjective experience invalid along with the experiencing subject? Does the subject internalize these ideas about him or herself? Or is the suffering in the experience simply too painful for any of us except in a form that is “once removed”, whereby it is less likely to remind us of our own vulnerability. (Appleton 2000:28)

When I applied to the Simon Fraser University (SFU) Ethics Board for permission to conduct research with mental health patients in Tanzania, members of the board expressed concern and hesitation about my research. It was implied that mental health patients are too vulnerable to be interviewed. I was asked whether I could do my research without interviewing mental health patients. This attitude reflected to me the exact reason I was intent on doing the interviews in the first place: mental health patients are perceived as being somehow incapable of speaking for themselves. The underlying assumption is that mental health patients are too sensitive or fragile to be asked questions about their health, their histories, their thoughts and their feelings. This paternalistic attitude is pervasive and serves to reinforce stereotypes around mental illness and the stigma attached to it. I was determined, in my research, to dispel some of these stereotypes and some of the stigma by allowing mental health patients to tell me their stories in their own words and to contextualize their experience with mental illness through their narratives.

The attitude that the SFU Ethics Board expressed is one that mental health patients are faced with constantly and one which they end up internalizing: that they are too vulnerable, sensitive and frail to make decisions about their own treatment or to speak for themselves. They are instead conditioned to believe that they must rely on the expertise of physicians and other health care professionals to become better. They essentially hand over their autonomy and power to their health care providers in hopes of restoring their mental health. This process is fundamentally alienating and only adds to the stress and havoc that mental illness creates in a person's life.

I managed to convince the SFU Ethics Board that I would be extremely careful not to "harm" any patients with my questions, and I expressed quite adamantly to them my thoughts on the importance of allowing patients to speak for themselves. I explained that a large part of the motivation behind my research was to dispel the idea that mental illness renders patients incoherent and/or unable to have a strong voice of their own. They granted me permission to carry out my research, with some conditions attached.

I hoped to look beyond the stereotypes and stigma. I planned to engage in thoughtful and meaningful discussions with mental health patients in Tanzania about their experiences in the health care system, their perceptions of agriculture psychiatric rehabilitation villages, and the life experiences that had brought them to the village. Through these discussions I anticipated revealing the social context within which patients' illnesses are located and to discover their perception of the treatment options in Tanzania; which range from local healing to inpatient psychiatric hospital care to living in one of the few agricultural psychiatric rehabilitation villages that exist in the country. I wanted to hear the patients' perspectives and stories.

I interviewed 12 patients in Tanzania: 11 from Uhuru village near Dar Es Salaam and 1 from Amani village near Moshi, in the North of Tanzania. Some of the patients were in the village for

mental illness and some for addictions. Each patient had a unique story to tell. The first set of questions I asked dealt with their current situation in the village and their treatment history, feelings about being in the village and their use of local healing and biomedicine. The second set were more in depth questions related to their history, their background, their life story, the impact of illness or addiction in their life and their hopes for their future. The goal of these questions was to, “Empathetically witness the existential experience of suffering.” (Kleinman 1988:10)

Kleinman suggests that illness meaning is culturally determined and a process of creation by the patient (1988:31). He emphasizes the need to listen to the patient and their family; to their complaints, explanations and experiences, and then to, “interpret it in light of the different modes of illness meanings – symptom symbols, culturally salient illnesses, personal and social contexts.” (Kleinman 1988:49) He further suggests that, “The story of sickness may even function as a political commentary, pointing a finger of condemnation at perceived injustice and the personal experience of oppression.” (Kleinman 1988:51) He talks about empathetic witnessing as “the existential commitment to be with the sick person and to facilitate his or her building of an illness narrative that will make sense of and give value to the experience.” (Kleinman 1988:55)

Ann Appleton argues that, “A phenomenological study of mental illness constructed from first-person subjective narratives can make a substantial contribution to our understanding of illness in terms of ordinary human experience.” (2000:24) By allowing patients to speak for themselves it is possible to understand the context in which their illness emerged and how they perceive their illness. As Danielle Groleau phrases it, “Illness narratives are the outcome of both individual idiosyncratic experiences and larger cultural systems of meaning.” (2004:117) Appleton proposes that, “The anthropological perspective – seeing the person within his or her wider cultural context, including both temporal and spatial dimensions – has the potential to generate

new insights into how we might mitigate the alienating and depersonalizing effects of the mental illness experience.” (2000:24) Appleton’s research model is premised on “A commitment to wholeness... that life narratives, the “native point of view”, might add a further dimension of understanding to the human experience of mental illness.” (2000:26)

This was what I hoped to achieve through my interviews. I wanted to allow patients the opportunity to make sense of their lives and their stories, to contextualize their illness within the society and culture they live and to make connections between their past and their present situation. Much like Groleau’s analysis of narratives, I too felt that, “Narratives move the body through those spaces and times in ways that make sense of suffering, while striving to protect the individual from further injury.” (Groleau 2004:131)

However, the patients engaged less in telling their stories than I anticipated. I envisioned that they would open up to me over time and tell me about their lives and how they ended up in the village. The responses I got from patients were generally brief and unengaged. The patients were not used to being reflective about their lives in the way that I had expected. The responses my questions did elicit proved to be diverse and varied.

The stories and backgrounds of the patients were all different, as were their treatment paths, their responses to life in the village and also their hopes and dreams for the future. This is a natural result and is something I would like to maintain the integrity of in my thesis as it speaks to the intensely personal nature of illness experience. As Appleton phrases it, “Biomedical categorization tends to mask the great diversity of experience among individuals that might affect outcomes and even diagnoses.” (2000:26) These patients may all be “ill” or “addicted”, but they are also humans with unique stories to tell. I have therefore decided to use their stories as the threads that hold my thesis together. I will use the stories of the patients to discuss the larger

themes and concepts within my research – including the use of local healing and biomedicine, the use of work in the villages, and the importance of relationships.

I hope that by using the stories and words of patients as the thread that runs throughout the thesis, I am able to allow the patients to speak for themselves and honour their narratives and experiences. Their lives are unique in many ways, but there are commonalities that they experience within the context of life in Tanzania. Through their narratives, I hope to allow the reader “to see the way that social and cultural realities impact and interact with individual experience and identity.” (Appleton 2000:26)

Often times it was difficult for me to make sense, in a linear way, of what the patients told me about their lives. The story of a particular patient, Julianna, stands out as being the least linear or easy to follow; each time she talked to me her story seemed to shift and change. Appleton touches on this eloquently, suggesting that, “When the sense of continuity and temporal flow of experience is broken – as in mental illness – we might expect to see the continuity of the narrative also broken at that point.” (2000:29) This quote captures my response to Julianna’s narrative, which is not to negate it or ignore it simply because of inconsistencies or discontinuity within it. To me, the inconsistency and discontinuity are as revealing as the details of the story itself. The multiple layers of her story and the confusion with which she projects it reveal to me the depth of the rupture that she has experienced both socially and emotionally, and are as important as continuity and coherence.

Many of the patients spoke of their lives as if they were not whole somehow; it was as if parts of their stories were missing. The narratives were often disjointed and broken apart. There was a sense that the patients felt themselves inadequate and as if there was little to be gained by telling their stories. Appleton expresses a similar finding in her own research:

The feeling of having failed was frequently implied or expressed in the narratives. This was not just failure in terms of a single incident or context; the idea of failure in an existential sense was also mentioned – the perception of oneself as having failed as a human being. (2000:31)

Mental health and addictions patients are dealing with rupture in their lives – rupture in their emotional responses, thought processes, social relationships, and well being. Due to the sense of mystery that still surrounds mental health problems and their causes, this rupture is all the more alienating and scary for those experiencing it. This was clear in the interviews I conducted with patients. There was something missing, some answer, some thread; there was a sense of resignation to an altered reality and identity for patients; that of being incomplete somehow. As if they had internalized the stigma that surrounds mental illness and were reflecting it to me in their stories.

I found that giving the patients an opportunity to tell me their stories allowed them to piece together their lives to an extent. Although the narratives were not necessarily always coherent or linear, they “represent an opportunity to create significant order from the disorder caused by trauma or distress.” (Groleau 2004:121) Whether or not a narrative was clear to me, the act of telling it offered the patient the opportunity to reflect on their life and their illness and to attempt to make some sense of it.

It was extremely important to me not to discredit a patient’s story simply because it was hard for me to make sense of. Rather, I wanted to honour their reality as they were sharing it with me, and to be witness to their story (as simple or confusing as it might be). Appleton discusses the tendency of people,

To perceive the person who is ill only in terms of his or her “disordered” mind. In doing this, we exclude other aspects of experience, identity, and ways-of-seeing and knowing that might allow us to empathize and to recognize what we share in common as human beings. The result is that,

consciously or unconsciously, we act in ways that deny or ignore their validity as persons-in-the-world, we patronize, we assume control, we exclude. (Appleton 2000:42)

In my research, I refused to patronize, control or exclude. The result was a series of interview transcripts which were not necessarily clear or self-explanatory, but which reflect the thought processes and emotions of the patients who talked to me. The transcripts reflect the patients' life stories as they perceive them, which is more important to me than whether or not those stories are accurate or make sense. I wanted to use my interviews to initiate a "healing process when the subject weaves together strands that represent divergent aspects of experience." (Groleau 2004:132) To an extent this is what the interviews did. The patients began piecing their lives together through the stories they told me, and it is through these stories that I aim to describe the mental health system in Tanzania and in particular the agricultural psychiatric rehabilitation villages which were the site of the interviews and the "home" of the patients at the time they were interviewed.

Mental Illness as Alienation and Stigma

Mental illness can be extremely alienating and disorienting. When individuals are experiencing mental illness in any form, they are often struggling with issues around perception, confusion, thought processes, and emotional imbalance. To add to this, they are perceived by those around them to be somehow flawed or marked by their illness. This stigma is often attributed to a lack of knowledge and education about mental illness in society. Irving Goffman's work on stigma is the most-quoted source on the topic. He describes stigma as "a special kind of relationship between attribute and stereotype... there are important attributes that almost everywhere in our society are discrediting." (Goffman 1963:4) He explains that shame results from stigma, as "Shame becomes a central possibility arising from the individual's perception of one of his own attributes as being

a defiling thing to possess, and one he can readily see himself not possessing.” (Goffman 1963:7)
Goffman explains that, “The painfulness, then, of sudden stigmatization can come not from the individual’s confusion about his identity, but from his knowing too well what he has become.”
(1963:132)

This came across in the interviews I conducted with mental health and addictions patients in Tanzania, who were not sure how to talk about their problems, or the reason they were in the village. It was as if they were scarred somehow by their illness or addiction and were not sure how to address this fundamental flaw they perceived in themselves. The illness or addiction was undoubtedly an alienating experience because of the impact it had had on their lives, but also because of the way that others had responded to them. Most of the patients were taken to get treatment by family or friends who had recognized a problem in them and had encouraged, or in some cases forced, them to get treatment. They then went through the cycle of treatments – local healing in some cases, hospitalization in others, all of them having seen a psychiatrist at the hospital and been on medication of some type before they arrived in the village. Some of them had been on a series of medications and had experienced a series of hospitalizations. This process was fundamentally alienating and confusing for the patients, and I talked to them at a time when their lives still seemed to be “on hold”, while they were still going through treatment and they were identified as being ill or addicted.

It seemed to me that their hesitation in talking about their lives was a reflection of their inability to comprehend or make sense of how they had ended up in the village and the way that their lives had been impacted. It can be easier not to think or speak of such ruptures within a person’s life than to acknowledge them, particularly when they are still an ongoing part of a person’s identity and life. For the patients in the village, their illness or addiction was their central identifying feature. It was the reason they were in the village and it was the aspect of their life upon which

their future hinged – they were aware that they needed to become well in order to reintegrate into their communities of origin, return home and start their lives again. Their illness or addiction represented the fissure that had brought them to this place for a period of time and it was the part of themselves they most identified with while they were there. It was as if their lives were on hold while they lived at the village and there was uncertainty surrounding their futures once they left the village. Their illness or addiction, at the time I interviewed them, was their central identifying feature. They could not escape or avoid this aspect of themselves. Their narratives were centred on this aspect of themselves, and this thesis tries to capture the movement of these narratives from chaotic to being in repair to looking towards the future. Although this was not necessarily a linear progression for each of the patients, I have attempted to find common movement among the narratives for the sake of structuring my thesis.

Ann Appleton writes of the social attitudes toward mental illness “affirm[ing] the view that these ways of being are a threat to our idea of a well-functioning society.” (2000:33) When mental illness is not understood or talked about openly in society then to experience mental illness and to become aware of that experience as that of a mentally ill person is stigmatizing and can easily result in shame. The healing process for mentally ill patients necessarily involves some reintegration of their self-perception and the perception of those around the individual. Appleton argues that, “If we are to remove the stigma and alienation that adhere around the experience of mental illness, then we need to find a way of relating it to ordinary human experience, a way of seeing and acknowledging commonalities rather than difference.” (2000:39)

The labelling of mental illness can be perceived as positive, as in the case of diagnosis being a step towards cure and access to welfare and benefits, yet labelling can also be “profoundly alienating” for patients (Appleton 2000:40), as it connects them to a stigmatized identity. Nick Crossley addresses this in his research on patients who fight against the psychiatric system. He

writes that, “Much of the power of psychiatry is a symbolic power of definition and judgment, and its violence is the symbolic violence of stigmatization and disqualification.” (Crossley 2004:162) He addresses the fact that, “The power of the psychiatrists’ discourse relative to that of the survivor rests, to some degree, upon the fact that the psychiatrists’ discourse is sanctioned by the institution of psychiatry, the educational system, and the state.” (Crossley 2004:169)

This is a theme that was echoed in the interviews I conducted. Patients seemed both grateful to be in the village and yet also somewhat resigned to having to be there, as if they had nowhere else to go. Some of the patients expressed simultaneous gratitude and resentment. Mental health patients are caught in this tension between needing services, needing assistance, needing treatment, and yet at the same time that very need is alienating and contributes to the stigma of their condition. They are powerless to help themselves in a medical model which tells them that they need experts to treat them, and they are therefore dependent on the services and treatment that the medical system can offer them. Within this they often feel helpless. This can be linked back to the general knowledge and awareness of mental illness in society, or as Crossley expresses it, “Negative public perceptions lead directly to stigmatization and also put pressure on politicians and psychiatrists to sustain a paternalistic and coercive line.” (Crossley 2004:174)

Cultural Context of Illness

Only through biologically and culturally grounded investigation of somatic presentations of mental illness across cultures will we be able to uncover a more accurate picture of the mechanisms by which individuals come to experience and express distress. (Kohrt 2005:147)

In order to understand a person’s experience of illness, it is necessary to understand the context within which that illness occurred. Raquram describes his clinically depressed research participants in Bangalore, India: “The pains in their bodies are anchored in the contexts of their

local worlds. Though the pains are located inside the individual body, they reflect the events and constraints of the social space of which they are a part.” (2001:41) Similarly, the illness or addiction of the patients I talked to in Tanzania reflected the cultural and social context within which they lived. Poverty was one of the central themes in the interviews I conducted – it came up again and again when talking about patients’ backgrounds, their current situation, and their hopes for the future. The economic constraints they faced as Tanzanians living in rural areas without access to many resources surfaced as common to all the patients I talked to. They felt marginalized and as if existence itself was a struggle; the struggle to survive, eat, and provide for themselves and their loved ones. Poverty underlined their experiences. The patients I talked to were aware of the causes of their problems, whether or not they articulated that awareness.

It was as if mental illness or addiction were a layer of hardship that had emerged out of an already difficult life. This struggle to survive seemed to overshadow their mental illness or addiction, and put it into context. It also contextualized life in the village and the hardships they faced as patients (or “villagers” as they are called in Tanzania) living in agricultural psychiatric rehabilitation villages. Poverty and economic hardship are, if not always directly visible, then just beneath the surface for most Tanzanians. In a country where the majority of the population live on less than one dollar a day, poverty is impossible to ignore and Tanzanians live in the shadow of that poverty.

Raquram found that the patients he talked to, “were very perceptive about the nature of their problems, their origins and determinants in everyday life, and they are concerned about sharing them.” (2001:41) Although the patients I talked to seemed somewhat reluctant at times to open up, when they did they talked about the hardships they had faced. They were aware of the factors which had contributed to their illness or addiction. Yet, Raquram writes, “In routine medical encounters the social dimensions of the suffering body are often reified and abstracted as

disconnected events within the individual's biological body." (Raquram 2001:41) Patients' stories are not listened to by health care providers; the context of their suffering is ignored, and as a result so is much of the insight into the cause of their illness. Groleau is aware of this lost opportunity for insight in the clinical setting:

Unfortunately, the brevity and narrow focus of the usual clinical encounter in primary care does not allow clinicians to gain access to the larger stories evident in these illness narratives, nor does it give patients time to construct a meaningful narrative. Hence, patients' symptoms may appear medically unexplained while patients are well aware of social circumstances that provide coherent explanations within their community. (2004:131)

When physicians do not pay attention to the "cultural dimensions and social determinants of the patient's distress," (Raquram 2001:42) the result is that the illness, "becomes more distant from the experience and meaning for the patient." (Raquram 2001:42) A patient who is not asked about their life story, and their background, begins to lose their intuitive awareness of the connection between these factors and their illness. This was evident in the interviews I conducted with patients. They were reluctant to talk to me about their pasts; it was as if they did not at first see the connection between their present situation and the social and cultural context within which they had become ill or addicted. While it is evident that, "Social conditions, interpersonal problems, and cultural meanings figure prominently and play a major role in the experience and meaning of their illnesses" (Raquram, 2001:44), patients who are not encouraged to explore these factors are at risk of losing sight of their significance. This seemed to be the case for some of the patients who were hesitant to talk about their pasts and who seemed resigned instead to the treatment paths upon which their doctors had put them.

It is as if there is a constant struggle between the patients' own awareness of their situation and the factors which have contributed to their illness, and the message they receive via clinical encounters, which is generally that they have no control over their illness and that they need to

listen to the clinicians who know better than the patients themselves how to help them. The discrediting of the insights and experiences of mental health patients by clinical professionals (Raquram 2001; Jadhar 2001; Crossley 2004; Groleau 2004) runs the risk of taking away the patients' sense of autonomy and self-awareness, creating doubt in the patients' minds about their understanding of themselves, leading to a greater sense of dependency and powerlessness. For individuals whose lives have been ruptured, shattered or put on hold due to mental illness or addiction, the further loss of control and insight that occurs through their encounters with the biomedical system can be destructive and damaging. Yet, until the stigma surrounding mental illness is addressed, and until "a culturally sensitive inquiry helps in the development of treatment strategies that are congruent with the cultural concepts and needs of patients" (Raquram 2001:44), the wealth of insight and experience that patients themselves bring to the clinical encounter will be lost. There is a great deal of room within the biomedical model of health care for patients' narratives. As Jadhar writes in his article on depression among white Britons in London: "Recent literature in cultural psychiatry indicates the value of attending to patients' interpretations and that these can be successfully integrated into the practice of health care." (2001:48)

CHAPTER TWO: METHODOLOGY

Instead of working from the conventional formula in which an outside investigator initiates and controls the research, this model depends on ongoing collaboration between interviewer and interviewee. Such a model begins by taking seriously what people say about their lives rather than treating their words simply as an illustration of some other process. (Cruikshank 1990:1)

Much like the above quote by Julie Cruikshank on her research model, I wanted my research to be a representation of the lives of a group of mental health patients in Tanzania. I did not want to use their words “as an illustration of some other process”, but to start with their stories and through them, to gain insight into the experience of being a mental health patient in Tanzania. Above all else, I was concerned with staying true to their words and stories.

I spent three months in Dar Es Salaam, Tanzania from June to August 2005. I spent one month learning Swahili, two weeks securing research permits from the appropriate institutions in Tanzania, and the remaining six weeks conducting interviews and ethnographic fieldwork in an agricultural psychiatric rehabilitation village outside of Dar Es Salaam. I conducted a total of 30 interviews with 23 individuals. Of the 23, 12 were patients, 2 were psychiatrists, 2 were village administrators, 5 were nurses, and 2 were occupational therapists². The interviews ranged from twenty minutes to one hour. None were longer than an hour. I had a research assistant, Vincent, who conducted all of the interviews in Swahili and who translated and transcribed by hand those interviews. I conducted and transcribed all of the interviews in English. I used pseudonyms for all interviewees, except for the two psychiatrists, Dr. Kilonzo and Dr. Mbatia, who gave me permission to use their real names.

² See Appendix C: Demographic Profile of Patients.

Of the individuals I interviewed, 4 of the 12 patients were female, 1 of the 2 administrators was female, 2 of the 5 nurses were female, and 1 of the 2 occupational therapists was female. While I listened in the questions for areas where gender emerged as a factor, I did not ask questions directly related to gender. I was focussed on the marginality involved in being a mental health patient and all that is attached to that identity. As such, I did not pay close attention to gender, and the marginality involved in this aspect of identity, although it likely would have enriched my research if I had.

Having said this, there were a few themes that emerged in terms of gender throughout my fieldwork. The experience of being a female patient was somewhat different than that of being a male patient. Female patients tend to do the cooking and cleaning in the village. The males tend to work with the livestock. Of course I was only in the village for six weeks so it is possible that these trends changed after I left or were only in existence for the duration of my fieldwork.

There were definitely patterns among the female patients in regards to what they had done at home before coming to the village and their plans once they left the village. They tended to do domestic work (cleaning, cooking) or selling clothes. The males, on the other hand, tended to have done a variety of jobs, from working in a mine to front desk work at a hotel to agricultural work. There were other factors involving gender which emerged in interviews, such as the female patients' need for sanitary napkins, the fact that one patient thought she might be pregnant, and the fact that another patient talked about boys in the community surrounding the village spreading lies about sleeping with her. These are issues specific to the female patients and are described in more detail later in the thesis. If I had paid more attention to gender as a theme and incorporated it into my interview questions, my analysis would no doubt be more nuanced.

The range of ages of patients was from 18 to 60. There was a diversity of ages in the villages. This reflects the reality of mental illness, that it can affect anyone regardless of age. It seemed to

me that most patients were in their twenties and thirties, but there were a few older patients there as well. Due to the high turnover rate at the villages (there are only ever 12-15 patients at once and most stay for an average of six months) it is likely that the range of ages changes over time. There were no clear patterns in the interviews that emerged in terms of age. For instance, it might be expected that the older patients would have had more experience with, and faith in, local healing due to having a longer connection with traditions in Tanzania, but this was not the case. The patients who had used local healing represented a variety of ages. Similarly, family was equally important for the older patients and the younger patients, although it might seem that younger patients would depend on their families more for economic reasons.

The patients I talked to were, for the most part, working class Tanzanians from rural areas. They did not represent the middle or upper class of Tanzania. This was reflected in the levels of education they had attained and the jobs they had worked, as well as their hopes for the future. They face a pervasive sense of limitation. They know their options are limited and are resigned in many ways to this fate. Although this research was not intended to be about the causes of mental illness among Tanzanians, it was clear in conducting the interviews with patients that poverty and hardship were factors for several of the patients who talked about being tired, confused and run down. Patients talked about how hard they had worked before they became sick and how hard they would have to work after they left in order to survive

Although all the patients I talked to were working class and from rural areas, there have been doctors and engineers who have been patients at rehabilitation villages according to the psychiatrists and staff I talked to. A few staff members told me about a doctor with addiction issues who spent two years living at the village outside of Dar Es Salaam. During this time he reportedly took a leadership role among the patients in the village and after his two years, he went

back to work as a doctor. Dr. Gilonzo gave me this doctor's contact information and he had apparently agreed to talk to me, but I never heard back after leaving a phone message for him.

I conducted open-ended semi-structured interviews. I had lists of questions which I put together before hand and which I had to submit with my thesis prospectus in order to get my Tanzanian research permit. I asked a series of around twenty five questions to each patient I interviewed, and a series of approximately the same number of questions to each of the health care practitioners I talked to. For some patients, certain questions elicited extremely brief replies or no replies at all, which accounts for the variation in the lengths of the interviews. I also asked six of the patients a second set of interview questions at least two weeks after the initial interview. I began asking the second set of questions soon before I left Tanzania and did not have time to interview all twelve patients a second time. I therefore randomly chose six patients to interview a second time.

The first set of questions dealt with life in the village and the patients' history of mental illness, treatment, and use of local healing. The second set was directed towards their life history and how they ended up in the village as part of the continuum of their life experiences. I asked, in the second interviews, about childhood, family, work experience, and more detailed questions about the impact of mental illness on the interviewee's identity. The second set of questions emerged out of my interest in knowing more about the patients' lives prior to their arrival in the village. In each interview, the participants signed an informed consent form based on the SFU Ethics Board's informed consent form. This form, which addressed confidentiality and the purpose of the research, was read and explained to them in Swahili by Vincent before they signed it.

The interviews were conducted in a room within the village. When I first arrived in the village, the head administrator asked one of the nurses to help me with my research. She became my link

to the village and the patients who lived there. She introduced me to patients and asked patients to speak with me. At first this was problematic, as she would tell patients to speak to me, and then she proceeded to sit in on the interviews. She sat at the desk in the office and the patient, my research assistant, and I would sit on the chairs in the office. The seating structure and the presence of the nurse, I realized later, likely influenced the comfort level of the interviewees. Fortunately she only sat in on three interviews before deciding that I was capable of conducting interviews without her in the room. I noticed a difference in the demeanour of patients when she wasn't present. The first interviewee seemed particularly anxious, was sweating, and kept glancing at the nurse before answering questions. As several of the questions were about the patients' perceptions of life in the village, I soon realized that having the nurse present was not conducive to creating a comfortable environment or getting honest responses from the patients.

The English proficiency of my research assistant was, without doubt, a factor in the research I conducted. As I was somewhat pressed for time and did not have extended contacts in Dar Es Salaam, I relied on the recommendation of my Swahili teacher, who suggested a young (twenty year old) friend of his might be able to help me in my research. By the time I realized that Vincent did not have the level of English necessary to translate some of the nuances of the questions I was asking and the responses they were eliciting, I was already spending time in the village and wanted to get on with interviews and not lose time trying to find another research assistant. I therefore relied on Vincent for the majority of my translation work, despite the fact that the English translations he provided were often not as fluid or in depth as I knew the Swahili responses had been.

My Swahili, after my month of lessons, was conversational. I could communicate on a basic level what I wanted to say. I was able to understand fifty to sixty percent of what was said around me, as long as the speaker was speaking at a relatively slow pace. This level of

proficiency was extremely useful for following along with the interview questions and responses as Vincent asked them, as well as the patients' or health care workers' responses. However, as mentioned above, I did lose a lot in Vincent's translations, much of which only emerged after I had returned to Vancouver and it was too late, by then, to clarify translations.

I did not live in the village itself. This was not an option as there was nowhere for me to stay and no facilities existed to support my stay. I could have shared a room with one of the patients, but I preferred not to isolate myself to that extent. I was already rather isolated staying at the Salvation Army hostel five kilometres outside of Dar Es Salaam, and my Swahili was still a work in progress. I spent three or four days a week at the village for about six weeks. I usually arrived mid-morning and stayed for anywhere from two hours to six hours. I generally stayed for three or four hours. The reason for the relatively short days spent there was partly due to the nature of life in the village. There were only ten to twelve patients living there at any given time. It was often very quiet in the village and a sense of stillness pervaded the air. At any given time of day there were a few patients working (in the field, with the animals, in the coconut farm, cooking), a few patients in their rooms, and a few patients milling about seemingly randomly. The administrator in charge of the village and the nurse who was assisting me both suggested I come when the patients were not working. They felt this was a better use of my time. That way I could talk to them and, presumably, not distract them from their work. Although a few times I was there while patients worked, I tended to come between work sessions so as not to disrupt the schedule.

My presence in the village was definitely noticed. At various times, patients sat together in a line on a bench near the kitchen area and watched me. They approached me and asked me for money to help them with various needs (soap, toothpaste, tea, sugar, medicines). Although on a few occasions I did give money to patients for particular needs they articulated, I tended instead to bring supplies (such as soap, sugar, and tea) to the village for the nurses to distribute. This

seemed more equitable and fair. After talking to the administrator in charge of the village about whether or not to give money to patients to thank them for their time after interviews, I gave a 2,000 Tanzanian shillings (around four dollars Canadian) honorarium for each interview I conducted. One of the nurses collected this money and it was to be distributed among the patients after I completed my research. This way all patients would benefit equally from my presence in the village, rather than only the patients I interviewed.

When I was in the village, patients called me over to them to talk, they greeted me with handshakes and high-fives, and they wanted to tell me about themselves. Due to the fairly isolated location of the village (which was two rickety bus rides away from the hostel I stayed at), it was rare for anyone new to enter the village, let alone to see an “mzungu” (white person) walking around. My skin colour alone was enough to make me stand out. The fact that I had a research assistant with me and that word was spreading that I asked a lot of questions, no doubt added to the attention I was attracting from the patients. For these reasons, I preferred to keep a low profile in the village and not be a constant presence. Rather I went there three to four times a week and stayed for a few hours, walking around a bit, stopping to talk to and catch up with the staff and patients, and conducting interviews as it seemed appropriate.

Another reason I did not want to be at the village all of the time was because the patients were indeed working and I did not feel comfortable watching them work. I did pick up a hoe one day and try to help them in the field, but all the patients stopped working and were highly entertained by my feeble efforts. I felt that my presence was distracting and so I preferred to stay out of their way. Having said that, I saw the patients working at various times as I walked through the areas where they worked in or sat and talked for a minute to the staff person overseeing their work. One day I sat in the grass with Tuyu, the occupational therapist in the village, and talked to her as she made something out of macramé while watching the patients weed in the garden. James, one

of the nurses, sat with us as well. I was conscious of the fact that the patients were engaged in manual labour while the three of us sat around talking and watching them. I did not feel comfortable in this situation so I tended to avoid being around when the patients worked.

I was always conscious of the presence of Vincent, my research assistant. He is a very quiet and thoughtful person and was very good at keeping himself busy if I left him to go somewhere else in the village to talk to someone or just to explore on my own a bit. However, I was always aware of leaving him alone for too long without anything to do. He was empathetic towards the patients in the village, who asked him for money, and who approached him consistently to talk. Some of the younger male patients enjoyed his presence as they could relate to him and talk to him. Due to his age (twenty years) I felt a bit protective of him; I did not want him to feel overwhelmed or pressured into giving them money, so I tended to stay near him.

Incidentally, Vincent's presence ended up helping the interview process unfold. Aside from the fact that he spoke Swahili, he also has a laid back demeanour and was able to make the interviewees feel at ease. He was genuinely curious about the research and was not judgmental. This was important in my research – I did not want any patients to feel uncomfortable sharing their stories with us or opening up to us about personal matters. Vincent's personality helped a great deal in this regard. His young age also helped as patients seemed to warm up to him.

I also spent three days in Moshi (a town in the north of Tanzania, near the border with Kenya), visiting an agricultural psychiatric rehabilitation village just outside of the town. Dr. Kilonzo, the psychiatrist who helped facilitate all my research in Tanzania, suggested I spend a few days in another village to see some of the similarities and differences between them. I interviewed one patient (who happened to speak English), the head nurse, the occupational therapist and also a psychiatric nurse at the hospital in Moshi. These interviews were all conducted in English as I

travelled to Moshi alone and my Swahili was not fluent enough to conduct interviews. These four interviews, and the time spent in the village there, were helpful as they gave me a sense of some of the differences and similarities between the two villages.

Ethnography

The methodology used in this research is ethnography. Due to the fact that ethnographers inevitably influence their work, ethnography has been noted for its ambivalent status (Hammersley 1992:1). However, the rationale behind ethnography, that the nature of the social world has to be discovered and this can only be done by observation and participation in ‘natural’ settings (Hammersley 1992:2), remains a convincing argument for using this methodology as a way to focus on the social processes seen and the social meaning behind them. According to Hammersley, “Ethnography’s power as a descriptive medium draws strength from the fact that it is inductivist, that is focuses on the point of view of those who are being researched, and that it places research in context.” (Hammersley 1992:21) As this research deals with the narratives of individuals in some depth, and with understanding the experiences of individuals, as well as the social context surrounding those experiences, ethnography fits well with the goals of my research. Hammersley wisely differentiates between descriptions, which “tell us about the features of some phenomena”, and explanations, which “tell us why it has those features.” (Hammersley 1992:27) He also acknowledges the need to make explicit the values, purpose and relevancies on which ethnographic research is based and to provide supporting argument. Abu-Lughod reflects on her own ethnographic work among Bedouin women during which she, “sought to fashion from [her] field notes and tapes a representation of another community that did not turn people into something object-like.” (Abu-Lughod 2000:262) Hammersley furthers this by writing that, “Rather than a focus on universal laws, ethnography focuses on detailed accounts of the concrete experience of life within a particular culture and of the beliefs and social rules that are used as

resources within it.” (Hammersley 1995:10) He also warns of the need for ethnographers to be aware of their own orientations in regard to their socio-economic locations and the values that are part of these locations (Hammersley 1995:11), but writes that, “To say that our findings, and even our data, are constructed does not automatically imply that they do not or cannot represent social phenomena.” (Hammersley 1995:18)

Ethics

The largest ethical issue in this research was the fact that I interviewed mental health patients. Mental health patients are considered a vulnerable population for good reasons: they are struggling with a change in their perceptions, their moods, their personalities, and are working to piece their lives back together. However, from the outset I was clear in my mind that none of this detracted from their ability to be interviewed. On the contrary, I felt that interviewing patients, (as long as it was done with compassion sensitivity and caution), could offer them a chance to express themselves and be heard. It could offer a group of people who are often not listened to or deemed to have anything worthwhile to say, a chance to contribute to understanding their situation and shed some light on their experience. I saw it as an opportunity for me to learn from them, but also hopefully a chance for them to gain something from the experience. The SFU Ethics Board took some convincing on this issue, which I saw as perpetuating the stigma that exists around mental illness: the idea that those who are mentally ill are somehow unable to speak for themselves. The board was reluctant to allow me to interview patients. I made it very clear that I would not interview any patients without an awareness first of their state of mind, and without consulting with health care professionals in the village. I consulted closely with the people who worked in the village to ensure that I did not contribute to the disruption that mental illness brings to a person’s life. I was explicit with the SFU Ethics Board that were it to turn out

that none of the patients were deemed able to be interviewed, I would accept that. However, I knew that I would find patients eager to talk and share their stories.

The other ethical issue I had is one that all anthropologists doing fieldwork outside of their own community must inevitably experience: that of feeling like an outsider. In many ways, my five years in Tanzania as a youth as well as having been diagnosed with depression myself, helped with this dilemma. My familiarity and comfort with the culture in Tanzania, and also with mental illness and various treatment paths, became more apparent as my research progressed: they made it easier for me to connect with patients and health care workers. However, I am still an outsider. I am not Tanzanian and I have never lived in an agricultural psychiatric rehabilitation village. I was always aware of the limitations of my own frame of reference during my research and tried to be respectful of this fact as much as possible.

Limitations

The largest limitations in my research were that of time and language. As the research had to fit into my schedule of completing my MA coursework at SFU, I could not leave until May. I also had to be back by September to work as a teaching assistant. I therefore had only three months to learn Swahili, attain research permits within Tanzania, and conduct interviews at the village and with health care professionals. Had there been no time limitations I would have spent a great deal more time learning the language and in the village itself.

Language was a barrier for me in my research. Although my Swahili knowledge and skills increased exponentially over my five weeks of intensive lessons, I am still not fluent. I relied on a research assistant to do all the Swahili interviews and to transcribe and translate them. I felt this limitation most acutely when, during interviews, I was unaware of things being said, or could not

express myself fully. I was also aware of the limitations of Vincent's knowledge of English when I read through his transcripts and realized the depth and richness of language which had been lost in the process of translation. After I came back to Vancouver, and read some of the translations for the first time, I felt a sense of loss and frustration knowing that I could not go back and clarify responses with the interviewees.

Another limitation I faced was access. I relied on the generosity, graciousness and assistance of other people to help me make connections and access the individuals I interviewed. Mental illness is a very personal issue and one I take very seriously, so I was constantly aware of the need to respect the wishes and concerns of everyone I talked to in Tanzania in regards to my research.

CHAPTER THREE: BACKGROUND

To interpret an orally narrated life story, we need enough sense of the speaker's cultural background to provide context for hearing what is said. One obstacle hampering the analysis of autobiography is the very real human tendency to make implicit comparisons between the account heard or read and one's own life. (Cruikshank 1990:4)

In this chapter I put agricultural psychiatric rehabilitation villages into context. I first discuss Nyerere's concept of 'ujamaa' and give some history and background to this idea, as it laid the foundation for Tanzania's development and growth as a newly independent country in the 1960s. The sources of the information in this section are varied and several sources are extremely dated, but together they give a basic understanding of ujamaa. Agricultural psychiatric rehabilitation villages, started in the 1960s, were created due to the influence of this ideology; a focus on agriculture and rural communities. Agricultural psychiatric rehabilitation villages reflect the values embedded in the concept of ujamaa; they are meant as a place for mental health patients to continue to interact in a community, as villagers, and they are also meant to teach mental health patients about agriculture, which in the 1960s was Tanzania's predominant economic resource. Without understanding something of Nyerere's concept of ujamaa, it is impossible to understand the context of the villages.

I then go on to briefly discuss health care in Tanzania. This section is not meant to be comprehensive or holistic, but rather to give some insight into the health care system in terms of how it was formed, how it is structured, and how it is funded. This gives some understanding of the context within which the villages were formed.

I finally discuss psychiatry in Tanzania. As there is little published material on Tanzania's psychiatric health care system, I relied on the interviews I conducted with two psychiatrists in Tanzania for this information, one of whom is responsible for psychiatry in the Ministry of Health. This information is again not meant to be specific or thorough, but rather to give an introduction and some insight into the psychiatric health care system in Tanzania. A subsection of the discussion of psychiatry deals with agricultural psychiatric rehabilitation villages; a little bit of information about their history, formation and function. This leads into the start of my ethnographic description of life in the village, which in turn leads into the next chapter on patients' lives before they arrived in the villages.

It is hoped that this chapter provides the reader with the basic context needed to understand the function and purpose of the villages and their role for psychiatric patients in Tanzania.

Ujamaa in Tanzania

Nyerere will go down in history as the initiator of Tanzanian peasants' agricultural transformation. He began bridging the chasm between the logic of the peasant household and that of the nation state. (Bryceson 1988:47)

Julius Nyerere was the first president of Tanzania after its independence in 1967. Early on Nyerere emphasized that increased agricultural production was the key to development in Tanzania. He talked often about the individual farmer being responsible for this development. An integral part of Nyerere's plan for socialism to exist in Tanzania was to increase Tanzania's self-reliance. Not wanting to rely on outside aid or be dependent on foreign resources, he saw agriculture as Tanzania's biggest strength and industrialization as something for Tanzania to work gradually towards. He therefore focused on increasing the agricultural capacity of Tanzania's individual farmers with programs and policies such as 'villagization' and 'ujamaa'.

The premise of ujamaa is that, “The purpose of all social activity is on the human person” (Duggan 1976:181), and it is based on the notion that all people are equal. Nyerere “emphasized personal responsibility because, ultimately, the building up of Tanzania depends upon the people.” (Duggan 1976:185) Nyerere recognized that Tanzania’s strongest resource was its agriculture and therefore focused a lot of energy on strengthening that resource and making Tanzania and its citizens self-sufficient. At the time of independence over 95 percent of Tanzania’s population was rural farmers (Duggan 1976:195). Nyerere foresaw a country whose citizens wouldn’t need to depend on outside countries for economic growth and survival. He therefore wanted to focus on agriculture, Tanzania’s strength, rather than industrialization, which he saw as being something that Tanzania would work towards gradually (Duggan 1976:195). The concept of ujamaa centred on the idea that with technical and financial help from the government, people would be able to “increase their output and thereby raise their standard of living without sacrificing the goals of socialism.” (Duggan 1976:195)

According to Duggan, “Nyerere sees the program of ujamaa villages as a revival of traditional tribal life in which goods were held in common and no one went hungry while another had an abundance of food.” (1976:195) He envisioned groups of people moving their houses into a single village and starting communal plots to work together and to share in the proceeds (Duggan 1976:204). He foresaw community farms in which the harvest would be divided among the farmers according to how much work they put in, “thus preventing lazy people from exploiting the more industrious.” (Duggan 1976:204) Nyerere thought that the villagers in ujamaa villages would be autonomous, making decisions for themselves, and that this would help Tanzania’s goal of building socialism (Duggan 1976:205).

The concept of ujamaa is different from villagization, which is “no more than a relocation of rural populations by shifting peasant families out of their separate homesteads into villages, but

without affecting traditional practices of individual cultivation of land.” (Legum 1988:10)

Ujamaa villages, as Nyerere envisioned them, were places where groups of people worked and farmed together.

Deborah Bryceson argues that the peasant household is “Tanzania’s strongest and most pivotal institution.” (1988:37) She discusses the use of joint resources within peasant households and how that ensures survival of people living within those households. This is something that I found in most of the interviews I conducted; a reliance on family and household members for basic resources.

It was in the 1967 Arusha Declaration that Nyerere instituted the policy of ujamaa explicitly as part of his “intention to build socialism on the basis of self-reliance.” (Othman 1988:51) The Arusha Declaration was “considered the formal start of the state’s effort to build a socialist society.” (McHenry 1994:19) Nyerere equated ujamaa with African socialism, as the policy was “aiming to combine the traditional moral obligation of mutual support in peasant subsistence societies with the imperatives of nation-building.” (Bryceson 1988:41) Villagization, which (as stated above) was different from ujamaa villages, became mandatory in 1973 “through a series of state-conducted ‘operations’.” (Bryceson 1988:42) This was part of the process of the state taking control of peasant production in Tanzania, and was not, like ujamaa villages, about the peasants themselves taking control and ownership over their own production. As incentive for peasants to undertake the villagization process, they were “promised a state-provisioned social and productive infrastructure.” (Bryceson 1988:42) The government did build schools and dispensaries following these promises, but did not provide the supplies needed to keep them running.

Nyerere was adamant that ujamaa was an extension of a classless pre-colonial traditional African society and a step toward socialism (Othman 1988:53). He was concerned about the urban areas exploiting the rural areas for crops and therefore put a lot of energy and focus on the growth of Tanzania's agricultural capacity (Barker 1979:97). In a paper entitled 'Socialism and Rural Development', Nyerere wrote in 1967 of the need to "return to the traditional values of mutual respect, common ownership, and obligation to work." (Barker 1979:97) He wanted to move away from "the class system emerging in the rural areas out of the colonial connection and towards a 'nation of ujamaa villages'." (Barker 1979:97) Initially, in 1968, some Tanzanians were forced into forming ujamaa villages. Nyerere then published 'Freedom and Development' in which he made clear that no one could be forced into an ujamaa village (Barker 1979:97). He suggested instead that the Tanganyika African National Union (the only political party in mainland Tanzania) "was to provide education and leadership so that prospective members would know why they were forming an ujamaa village." (Barker 1979:97) Nyerere made it clear that the government would provide infrastructural support for ujamaa villages.

Boesen discusses how "in its theoretical formulation the ujamaa ideology stresses the importance of voluntaristic and participatory character." (Boesen 1979:129) In practice, however, ujamaa was to be achieved through education and mobilization of the peasants. Facing the lack of any "strategic framework for the content and direction of this mobilization" (Boesen 1979:129), local governments and leaders ended up using whatever means they wanted. Boesen is critical of the encouragement that government offered ujamaa villages beyond supporting their agricultural production (Boesen 1979:131). Eventually, according to Boesen, the government took a new approach of "encouraging ujamaa activities in existing villages." (Boesen 1979:134) Whether due to a lack of education about ujamaa, or because the political motivation behind it and its connection to socialism was not important to individual farmers, many Tanzanian farmers did not comprehend exactly what the concept of ujamaa meant and how it applied to their lives. Boesen

writes that, “Ujamaa cooperation was more easily comprehended by peasants as they saw it... as a new method to supplement the income of their individual family farms.” (Boesen 1979:134) In other words, they understood ujamaa in practical terms: how it impacted their economic reality.

Mascarenhas writes about the ideals behind ujamaa and how rural socialism is “based on a relation of mutual respect, communal ownership and sharing of basic goods, and the obligation of everyone to work.” (1979:150) He also writes about the three stages of transformation to an ujamaa village. First, groups of families would move to one village and then they would “get involved in collective enterprises, such as a school farm.” (Mascarenhas 1979:150) Finally, the farmers would put all their energy into the community farm. Although Nyerere talked a lot about ujamaa being close to traditional African living, it also “was a strategy to raise the quality of life of people in rural areas.” (Mascarenhas 1979:150)

Healthcare in Tanzania

As everywhere in Africa, there existed an extensive system of traditional medical care at the time of the coming of the first Europeans... More or less ‘modern’ medicine was introduced to East Africa by the first missionaries. (Gish 1975:14)

Tanzania saw 26 hospitals built during Germany’s 26 years of rule (Gish 1975:14). When Britain became the new colonial leader after World War I they built rural dispensaries which, although intended to focus on prevention, ended up being used for curative purposes (Gish 1975:14). In the first years of British rule, “The number of dispensaries grew from 35 in 1926, when they were first established, to 285 in 1931” and by 1960 there were almost 1000 dispensaries (Gish 1975:14). The colonial administration began, after World War II, to put more energy and emphasis on the health care system in Tanzania.

Tanzania's current health care system was largely created during the time Tanzania was a British colony and there was a racial hierarchy of who benefited from the system. Gottlieb writes that, "As part of the colonial situation, hospitals and other public, general-purpose health care facilities were carefully graded for service to three clientele groups: Europeans, Asians and Africans." (Gottlieb 1975:2) Peter Kopoka writes that the health service was geared for elite clientele who were generally not Africans (2000:2). African patients were generally only able to access medical practitioners for surgery and "Africans seeking outpatient attention had to wait their turn in long waiting lines and had initial access only to medical assistants or poorly schooled "dressers"; African patients were bedded in large open wards with few amenities and limited nursing care." (Gottlieb 1975:2) There was an attitude in the colonial government that it was important to move Africans away from traditional medical practices towards modern "sanitation and health" (Gottlieb 1975:2). Yet, as more and more Tanzanians turned toward Western medicine, the "limited financial base... became increasingly inadequate." (Gottlieb 1975:2)

In 1961, the newly independent government of Tanzania inherited a health system that relied heavily on traditional healers, a few clinics, and missionary health centres. (Morrison 2002:12)

Upon independence, the new government "was not interested in the imposition of health care charges and turned down proposals for health insurance applicable primarily to urban wage earners or plantation labourers." (Gottlieb 1975:5) The new government worked "to make health care comprehensive, universally accessible, and free of out of pocket payments to the general public." (Kopoka 2000:2) One of Nyerere's primary goals was to make health care accessible to the rural population, which in 1961 made up 80% of Tanzanians (Kopoka 2000:3). This was somewhat successful: "By 1978, 90% of Tanzanians lived within ten kilometres of a health facility, and 75% within five kilometres." (Morrison 2002:120) Health care services since independence have largely been paid for by Tanzanians – through their own resources and incomes. This could be through fees for services or through taxes. According to Morrison, "It

became apparent by the 1980s that the limited tax base meant that the government did not have the means to cover the recurrent costs of operating the public health network.” (2002:120) In the mid 1990s, the government “began encouraging private sector involvement as a partner in the provision of health services... in recognition of the fact that the state was unable to meet all the health needs of the population.” (Morrison 2002:120)

Gottlieb outlines the six medical sectors in Tanzania. The first, the Ministry of Health (AFYA), which is financed by the national government, organizes and administers the majority of health care services in Tanzania. In 1975 there were 64 hospitals in the country with 30 or more beds. The only revenue produced was through “so-called “amenity” patients in two grades (I and II formerly called “European” and “Asian” grades) who pay for a higher quality of hospital or outpatient services.” (Gottlieb 1975:9) Missions and religious organizations are the second most important health care sector as they have “launched many important training schemes and provide whatever high quality medical service is readily available in many rural areas of mainland Tanzania.” (Gottlieb 1975:10) Other than the Ministry of Health and Missionary Institutions, “a third important network of medical facilities has been organized by local governments,” (Gottlieb 1975:11) which deal with such issues as public health and sanitation activities. The fourth sector of health care services is “a network of clinics, dispensaries, and hospitals established by plantations and industrial firms primarily for their employees and related family dependents.” (Gottlieb, 1975:11) The fifth medical sector is composed of the private practices of a small number of doctors, dentists and rural medical aids. The sixth, and final, sector is the traditional healers and “is probably providing the largest share of health services to the people of Tanzania in number of practitioners, total revenue collected, and number of contacts with the Tanzanian population both urban and rural.” (Gottlieb 1975:16) These sectors are all mutually dependent, according to Gottlieb: “they draw upon a single pool of scarce domestic medical and nursing skills.” (1975:27)

According to Gottlieb, thousands of Tanzanians use traditional healers every day and “Frequently a “visit” is a major exorcism ritual or procedure extending over an entire 24 hour period with a large kinship attendance.” (1975:20) Gottlieb writes in 1975 that his survey showed that 50% of rural and 53% of urban households sampled were Christian. He suggests that Christian communities in Tanzania “waged a conscious and persistent war against traditional medicine with its reliance upon ritual and magic.” (Gottlieb 1975:20) Muslim communities, on the other hand, “seem to exhibit a close interweaving between traditional medical practice and religious ritual and facilities.” (Gottlieb 1975:20) As none of the patients I talked to identified themselves to me as Muslim, I cannot comment on the perspective of Muslim mental health patients. However, the patients who told me they were Christian did not all have the same views on traditional healing. A few patients had used traditional healing and Christian prayer in their attempts to get better. Others were vehemently against the use of local healing as it was associated with the “devil” as they phrased it. There was a lot of variation in the Christian patients’ responses.

Gottlieb elaborates on the quality and types of medical care provided by traditional healers in Tanzania. He writes that many “have developed skills both in diagnosis and treatment of hurts and illnesses” while “some of them are pure herbalists who searched for substances which they had come to believe had some kind of healing power.” (Gottlieb 1975:23) He writes that others are “bone-setters” or have “developed a skill at crude surgery” or are “specialized as midwives and presided over births.” (Gottlieb 1975:23) Gottlieb writes of the variety of levels of skills and services offered by traditional healers across Tanzania, pointing out that in some more remote areas there is less exposure to new ideas and developments in medicine and traditional healers are therefore not as likely to change and modernize as in other less secluded parts of the country (Gottlieb 1975:23). Gottlieb uses one particular example to make this point, writing that, “Among the Sukuma this skill was joined with a semblance of guild or professional organization

which has been persistently mentioned over the years and which even exerted an outreach influence over neighbouring peoples.” (1975:24)

Gottlieb mentions that there are “European illnesses” for which Tanzanians will seek out western medical practice, and “African illnesses” for which traditional medicines are sought. He suggests that the boundary between these two is real, but “shifting” and that “members of the African community seem to be experimenting with different forms and combinations of medical treatment from the different sectors.” (Gottlieb 1975:28)

In order to increase the pool of health care providers, training programs were instituted in the 1970s to “result in a major acceleration... in the annual supply of the junior grades of medical practitioner... who play a large role in providing health services in outpatient departments, dispensaries, clinics and maternity and hospital wards.” (Gottlieb 1975:37) It is harder to train the senior grades of medical practitioners in Tanzania, particularly when “brain drain” is taken into account (Gottlieb 1975:37).

Tanzania has faced a lot of problems with basic infrastructure which necessarily affect its health care system. There are problems with old and non-functional equipment in hospitals due to inadequate budgets. Due to low transportation budgets and inadequate vehicle repair facilities, rural health facilities are not mobile – they cannot reach the most marginalized populations in Tanzania. In addition to this,

...it would not be difficult to show that most of the hospitals built before WWII were designed for a primitive level of service, lack adequate sewage and waste disposal facilities, have deficient water intake lines, have cramped quarters for nursing stations in hospital wards, and have poor lighting. (Gottlieb 1975:43)

In order to alleviate some of the costs of health care, the government initiated user fees in 1993 and increased them in 1994. Young children, pregnant women and those affected by chronic diseases are exempt from these fees, in order to “guarantee general access to health care.”

(Morrison 2002:120)

Village health workers offer basic first aid, sanitation and nutrition education services.

Dispensaries are staffed by rural medical aides and provide basic care serving approximately four villages each. Rural health centres oversee about six dispensaries, offer certain facilities for in-patients, and are staffed by medical assistants (Morrison 2002:121). As of 2002, there were 104 district hospitals in Tanzania, designed to “offer both primary health care and basic surgical, medical and maternity facilities to those referred from lower level facilities.” (Morrison 2002:121) There were seventeen regional hospitals with more sophisticated equipment than the district hospitals, but offering similar services. Finally, “four consultant hospitals form the top layer of health coverage, with the best facilities located at Muhumbili Medical Centre, Dar Es Salaam.” (Morrison 2002:121) There is also a medical school at Muhumbili Medical Centre.

The population of Tanzania bears half the cost of its health care system. In 1994, seven dollars was spent per person for health care, when “at the same date, the estimated cost of providing the basic health package and essential clinical services in a low-income country was estimated to be twelve dollars.” (Morrison 2002:121) Government funding in Tanzania is less than 25% of the recommended government spending (Morrison 2002:121).

With liberalization and ongoing sectoral reforms, Tanzania is forced to cut down public expenditure on health and education and cannot employ more teachers or more doctors. But perhaps the greatest obstacle to sustainable development is increasing mass poverty. (Kopoka 2000:3)

Linked to mass poverty is the rapid urbanization that is occurring in Tanzania and its impact on health, as the influx of people seeking jobs in cities is “forcing many city dwellers to live in

overcrowded and unhygienic conditions, where lack of clean water and adequate sanitation are breeding grounds for infectious diseases and ill health.” (Kopoka 2000:3)

The political climate in Tanzania is also linked to economic difficulties, which in turn affect the health care system. As Tanzania has moved from socialism to multi-party democracy and a market economy, it has been costly in terms of the economy of the country, but also in terms of wages, crime rates and social welfare (Kopoka 2000:14). Between the “social spending cuts as a result of [Structural Adjustment Programs]” and “economic hardships as a result of slow economic growth” (Kopoka 2000:14), the health sector has experienced immense setbacks since the 1980s. In an attempt to rectify this, user fees have been introduced, even though this policy “goes so strongly against all that Tanzania has held so important.” (Kopoka 2000:15) Due to the instability of the public health sector, the private sector has grown since the 1990s, with the development of private hospitals, dispensaries and pharmacies (Kopoka 2000:15). These facilities tend to exclude the poorest members of the population as the prices charged continue to rise and there are no policies or guidelines to govern the private health sector. At the same time, the government is investing less in health care as it relies more on the controversial user fees, resulting in health facilities that are “in poor physical condition... buildings are decaying, water and electrical supplies are out of order, and sanitation measures are often non-functional.” (Kopoka 2000:18)

Psychiatry in Tanzania

Extreme financial constraints have made it difficult for Tanzania to accomplish what is even minimally required in the field of mental health.
(Gish 1975:147)

Before arriving in Tanzania, I was unable to find any material on its mental health system, except for one article co-written by Dr. Gad Kilonzo in which agricultural psychiatric rehabilitation

villages were mentioned. Dr. Kilonzo agreed to meet with me in Dar Es Salaam. He is a psychiatrist and a professor at the Health Sciences College in Dar Es Salaam, and also happens to be the psychiatrist in charge of Uhuru psychiatric rehabilitation village outside of Dar Es Salaam. He provided me with a basic history of the agricultural psychiatric rehabilitation villages in Tanzania and a general sense of the mental health system in place in Tanzania.

According to Dr. Kilonzo, there are eleven psychiatrists in Tanzania, and three of them are retired. Four of these psychiatrists practice at Muhumbili Hospital in Dar Es Salaam. There are an additional two psychiatrists training at the college currently. He mentioned that psychiatrists, like many other professionals, often leave Tanzania to work in other countries such as England. The eight practicing psychiatrists in Tanzania serve a population of more than thirty six million people.

According to Gish, "Throughout East Africa during the colonial period the pattern of care of the mentally ill was based upon the need to protect society from those who were violent or aggressive by keeping them in remand prisons or mental hospitals." (1975:147)

Mirembe, located in Dodoma (Tanzania's geographic centre) is the hospital for mentally ill patients in Tanzania. It had 2000 beds at its peak in the 1960s, but now holds only 300 patients. The Sanga Institution, a forensic psychiatric hospital, is next to it. This is also run by the Ministry of Health, although it used to be run by Prison Services. The first psychiatric unit apart from the National Mental Hospital was opened in Dar Es Salaam in 1965 (Gish 1975:147). There are currently psychiatric units in most general hospitals, although increasingly there is less of an emphasis placed on separate mental wards as more patients are treated in regular wards.

In 1968 the Ministry of Health adopted the policy of regionalization as far as mental health programming and psychiatric care was concerned. Five

units attached to the regional hospitals were opened between 1969 and 1973. (Gish 1975:147)

In the mid 1960s, there was a move away from institutions in Tanzania. This was when the first agricultural psychiatric rehabilitation villages were built. According to Gish, the goal of the villages was to help patients “leave the hospital more quickly and benefit by residence in the therapeutic community of the village.” (1975:148) He writes that the goal of the villages was to become self-sustaining, except for the salaries of the village staff (Gish 1975:148).

Ndosi, in his chapter on mood disorders in Tanzania, outlines some of the cultural beliefs and understandings around mental illness in Tanzania. He writes that, “Despite two generations of colonization of Tanzania and thirty years of rapid postindependent sociocultural changes, most Tanzanians still believe in the supernatural causes of disease, irrespective of their educational levels.” (Ndosi 1995:86) According to Ndosi, “Traditional views on causes of mental disorders vary widely. A mental disorder is considered a misfortune like a physical illness, a bad harvest, or floods.” (Ndosi 1995:86) Although research in 1984 suggested that, “7 percent of patients attending rural health facilities complained of psychiatric symptoms and 2 percent got psychiatric diagnoses,” Ndosi proposes that these numbers are likely lower than in actuality due to “fears of stigmatization or inadequate diagnostic criteria.” (Ndosi 1995:86) Elaborating on the stigma attached to mental illness, he writes that, “schizophrenia and psychotic states carry the social stigma of *kichaa* or *wasimu*.” (Ndosi 1995:86) As a way of avoiding stigmatization, in most Tanzanian patients, “Depression is predominated by somatic complaints, which are culturally more acceptable than the expression of emotional complaints.” (Ndosi 1995:87) He writes that drug therapy is becoming increasingly popular in treating psychiatric disorders in Tanzania.

Agricultural Psychiatric Rehabilitation Villages

Agricultural psychiatric rehabilitation villages are “creative African contributions to rehabilitative psychiatry” where patients are “treated by both traditional healers and western-trained doctors.” (Kilonzo and Simmons 1998:425) The villages “were designed to be microcosms of rural villages in terms of social milieu, productive activities and economic self-reliance” and they provide “agricultural plots where patients can be engaged according to their abilities and stages of motivation.” (Kilonzo and Simmons 1998:425) Research into the effectiveness of the villages has shown that, “patients appear to make swifter recoveries with regard to social responsiveness and normalization of behavior than in the hospital environment,” and that, “stable social networks are believed to contribute towards a positive outcome.” (Kilonzo and Simmons 1998:425)

The idea for a psychiatric agricultural rehabilitation village came from Aro village started by Dr. Lambo in Abekuta, Nigeria in the 1960s as a site to treat mental health patients. By 1969 there were two such villages in Tanga, a town in the North of Tanzania. Professor Swift, a government consultant from the United States, stationed in Dar Es Salaam, was inspired by the two villages in Tanga, and built the Hombolo Psychiatric Rehabilitation Village twelve kilometres from Dodoma, the capital of Tanzania. Swift then contacted Canadian University Services Overseas (CUSO), who offered to fund the building of Mwera psychiatric rehabilitation village outside of Dar Es Salaam. This village was 100 acres large and created in the middle of an existing village. Staff and patients from Hombolo went to Mwera.

In 1975 the World Health Organization (WHO) started an initiative to integrate mental health treatment into primary care and used Tanzania as a pilot project. The funding came from the WHO and DANIDA, a Danish non-profit organization. It ran from 1980 to 1983 and was concentrated in Morogoro and Kilimanjaro regions. Common mental conditions were defined using simple descriptions and case vignettes, and nurses, clinical assistants and primary care

workers were trained to recognize and treat mental conditions. This was done to avoid people being sent to Mirembe Psychiatric Hospital and so that they could instead be treated at or near their homes. Accessibility was the main focus of the pilot project and communities were mobilized through committees to bring awareness to mental illness. Traditional healers were included in this mobilization in an attempt to allow local healers and western medical practitioners to learn from one another. These efforts were supported by health centres. There was an attempt to create continuity among health care workers by designing steps to be followed and flow charts to be used for cases. This project proved effective as the psychiatric units in Morogoro and Moshi were emptied. DANIDA committed 100% of funding for the first year, and said they would take away 10% of funding each year. In the end DANIDA was unable to secure any of this funding. The training that had taken place and the coordination within regions were still effective without the funding. The number of beds at Mirembe Hospital went down to 300 and prison wards were emptied of patients who were sent to general hospitals.

There are currently psychiatric villages outside of Dar Es Salaam, Moshi, Mwanza, Tabora and Kilosa. As the majority of my fieldwork was conducted in Uhuru, outside of Dar Es Salaam, I will focus primarily on this village. I spent six weeks in the village, during the days, talking to numerous patients, staff, and workers. The majority of the material for my thesis came from these interviews. However, I also spent two days in Amani, outside of Moshi, interviewing the nurse in charge of the village, a patient, the occupational therapist and a psychiatric nurse who works in the psychiatric ward at the local hospital associated with the village. I therefore also use material from these interviews. Although the context and the village itself is slightly different from Uhuru, some similar themes prevailed in the interviews, and using both villages as points of reference allowed me to gain a much fuller picture of agricultural psychiatric rehabilitation villages in Tanzania. My time in Uhuru, though still less extensive than I would have liked due to bureaucratic difficulties and the limited amount of time I had in Tanzania, provided me with a

more holistic sense of the running of a village as I got to know the people who comprise the village from seeing them on a daily basis. This allowed me a glimpse, albeit a slight one, into the daily rhythms and interactions in the village, which was my main interest. To see if there was indeed a sense of community, and if so, how it unfolded and created and presented itself.

The two villages I saw ranged in size and the main agriculture emphasis varied from village to village. For instance, the village outside of Moshi has corn as its main source of income, while the village outside of Dar Es Salaam emphasizes poultry and egg production. Due to this variability, some villages are more sustainable than others. While the government pays for all staff and worker salaries, the maintenance of the village itself comes from the agriculture. Therefore the village outside of Dar Es Salaam, with its two thousand chickens and large production of eggs, makes more money than the village outside of Moshi where the corn was not as fruitful. This has had a serious impact on the quality of life in the village and was easy to see. The village outside of Moshi suffered from food shortages which was less common in the village outside of Dar Es Salaam. The food eaten was simple in both cases, however – usually beans and ugali, the local staple, made from corn flour which is heated with water and mixed into a thick paste until it is hard enough to pick up in small balls with the fingers.

The village outside of Dar, Uhuru, has no electricity or running water, although it does have a system of using methane gas from the cows to light the stove in the kitchen area. The lack of water and electricity were brought up repeatedly by patients and staff as constraints on life in the village. There is a generator which is turned on to pump water from the well on certain days of the week. One day as I was leaving Uhuru, I saw a group of eight or nine patients with buckets standing around the one water tap on the edge of the village collecting water. The ease and patience with which they waited for their turn to fill their bucket and the hum of conversation

occurring among them suggested that this had become part of their routine in the village. It had become one of the ways they connected with one another.

The lack of basic resources was a theme that emerged in several interviews, although often it was a mixed message, as if the patients did not want to be overtly critical. Right after telling me that conditions in the village were good, Doris informed me, in the same sentence, that there is no water, no kerosene and no equipment for collecting water from the one tap. Mixed feelings ran throughout the interviews. This likely reflects the reality that although the conditions in the village were less than ideal with no running water or electricity, the conditions in the village were, for many of the patients, better than the conditions they faced in their homes and the villages they had come from.

Both rehabilitation villages I visited have space for around thirty patients, although they were less than half full while I was in Tanzania. This was due to the criteria that have been established by psychiatrists in charge of villages regarding who will be admitted to the village and who will not. Due to the importance of family, which I will talk about in more detail in a later chapter, patients must have some social support in the form of family members if they are to live in the village. They must also choose to live in the village themselves and agree to stay there for a given amount of time.

In the following chapter I discuss the patients' lives before arriving in the village, exploring common and divergent aspects of their life histories and their encounters with the biomedical and local healing systems.

CHAPTER FOUR: HEALING PATHS

The medical anthropological subject can be understood only when placed in the context of local experience and perception of medicine and historical, political and cultural events transcending the medical that impinge upon health care treatment. (Rasmussen 2000:249)

This chapter introduces some of the patients in the village, addressing their initial awareness of their problems, how they ended up seeking treatment, and the types of treatment they tried before going to the village. It is meant to give insight into the lives of the patients: who they are, their world view, and how they ended up in the village. There were commonalities between several of the patients, and ways in which each story I heard was different from the next. There is an extended section within this chapter on the topic of local healing, as this was one of my original research interests before travelling to Tanzania, and a topic I discussed with patients during interviews.

Of the 12 patients I interviewed, most had not finished secondary school for financial reasons: they had to work and, therefore, leave school. They tended to come from families with at least three other siblings and they all came from towns or villages outside of Dar Es Salaam. All of the patients in the village had spent time in a hospital before going to the village. Almost all of them had lived at home or with family members before they had gone to the hospital. All of them had worked before going to the hospital, doing jobs that ranged from selling clothes to mining to agriculture to cleaning homes, to front desk hotel work, to driving, to fixing cars. All of them talked about poverty and the economic reality that they faced which limited their options in life. The following excerpt from an interview with Fayaz, a man in his mid-twenties, captures an

economic reality facing many of the patients: not being able to complete secondary school for financial reasons:

Interviewer Did you go to secondary school?

Fayaz No, because I had no money for school fees then my mother told me to leave so my brothers could continue. Then I helped my mother with cultivation and selling rice to gain money to pay for my brothers... I loved [school]... like to continue to acquire more ideas.

Mary said that she likes school because, “It helps because I know to read and write” and that she “like[s] to know many things and have more experience and knowledge.” She expressed regret at not being able to continue in school.

Several other patients talked about having to work from a young age to help support their families. The jobs they did ranged from helping their families cultivate their land to selling clothing to cleaning other peoples’ homes. There was a sense of regret expressed by many of the patients that they had been unable to continue their studies, and they all commented on enjoying learning.

Mapunda, the only patient I talked to in the village outside of Moshi, identified money as a contributing factor to mental illness:

I think financial problems contribute very much to the problems in the head. Even I don't have money. I don't feel well. For example, my wife told me that she is going to the bank and then she came out of the bank and had money in the house. Money contributes very much. If someone has money they can get something he wants, something he likes. He can get it.

Most of the patients I talked to had lived at home before arriving in the village. Hashim, although living at home, explained to me, “I was trying to spend my time out of home. I didn’t want to

disturb my family.” Julianna told me, “I lived at home with my aunts who took care of me because my father and mother died.” Faume said, “I lived only with my mother because my father was at Kigoma far away.” Simon said he lived with his father. Given that the majority of the population in Tanzania lives on less than one dollar a day, most young people live with their families until they are in their late twenties and often thirties. This economic reality was evident among the patients I interviewed.

Onset of Symptoms

Life is too tough. The life we are living is not good, so we have problems. If we think too much we break our minds. Too many problems. If you don't have a job, it's harder. If you are rich, you won't be sick in the head. Problems start slow and small. Get bigger. Vincent
(research assistant)

Nicholas, born in 1979, had five brothers and sisters and lived with his mother before coming to the village because he had nowhere else to live. His father lived far away. He attended school until his problem started. When I attempted to find out what kind of problem he had, what the reason was for his presence in the village, the vagueness of his replies was typical of the patients I talked to.

Interviewer *How did it start? What happened?*

Nicholas *I didn't know. Even now if you go to someone who have the same problem as me and ask about how he feels, he can say 'I am normal person, mentally fit when this problem started'. I didn't think there was a problem, I didn't know what was going on, but people who saw me noticed I had a problem.*

I – How did you feel?

N – I didn't know myself even I am trying to think but can't get an answer. There is no evidence I noticed that's why I don't remember. So I felt headache sometimes, difficult to say, but I was not normal to my head.

I – Did other people notice? What did they say?

N – Some people noticed. They said I am crazy and have mental problem, others said I was mad, but I couldn't understand how. But later I saw that it might be true.

Many of the patients made reference to others identifying their mental health or addictions problems, as if these were blind spots that the patients themselves were unable to see. Most of them seemed to acknowledge that there was something wrong in their heads, a problem in their minds and thoughts, but they articulated little insight about what the problem might be, why it might have started, how they were treating it. Often their families intervened and that is how they ended up seeking treatment.

For instance, when I asked Kumi why he was seeing a psychiatrist, he said, “Due to the knowledge changes, see things which relatives didn't see, sometimes experiencing things that are not there. My parents sent me to local healer when discovered no changes in the hospital.”

When I asked Fayaz, whose interview was conducted in English, why he was in the village, he replied:

F – I am in healing of mental illness.

I – What kind of mental illness?

F – Called mental illness.

This was typical of patients. At first I was disconcerted by their replies; I wanted to hear them articulate their diagnosis, what was wrong with them, why they were there. My discomfort with their responses perhaps reveals my own need to categorize the patients, to have some sense of why they were there, how they had come to live in the village. This is likely due to the fact that I come from a society where the medical model of mental illness is prevalent and pervasive.

After a few interviews, I realized that for the patients I talked to, diagnosis was irrelevant. I did not want to ask the nurses at the village about the patients, as I felt that this was disrespectful of their ability to speak for themselves, but also I noticed the nurses did not speak about the patients in terms of what was wrong with them, their illness. They spoke of them as “villagers”. This, I was told by the administrative head of the village, was intentional; a way of making them feel like part of the community and not like an illness. I therefore did not find out what the diagnosis of most of the patients was and why they were in the village. I was more concerned with the reasons they perceived that they were there. I wanted to hear their perceptions and explanations, regardless of how hard it was for me to understand those perceptions and explanations.

Margaret, who was adamant about not needing to be in the village, stood out in her interview as it was clear that she believed there was nothing wrong with her mental health. She was cognizant of the cause of her problems, and felt that they were not intrinsic to her, but triggered by an external event; the loss of her son, who was taken by her husband, and the confusion this caused in her.

I – When did you start to notice the problem in your head?

M – 1996

I – What happened?

M – My son was taken by his father to Mtwara without informing me. That’s why I became confused. When I was looking for him my brother told me I am crazy but I know I am not crazy. Then they sent me to hospital.

M – I just swallow the medication of mental illness so it’s like forcing. But I am not crazy. Problem was after losing my son but it’s only by looking for my son that they told me I am crazy. But after sent back my son I am okay now. Cause was just looking for my son but they thought I was crazy. Now I am okay.

Loss was the catalyst for the mental health problems of two other patients, as well, although for these patients it was the death of loved ones. One patient had lost her father before her problems started, and another had lost her sister. Both said that these family members were the people they were closest to in the world and articulated a sense of grief and confusion at the loss of their loved ones. Both also mentioned feeling taken care of by the person who had died and feeling abandoned upon their death. They talked about feeling as if the world stopped making sense for them and their problems were a direct result of the confusion they felt upon losing their family members. In a country where people tend to rely on their families for economic support and survival, and where mortality rates are higher and life expectancy is lower, it seems likely that it is common for familial deaths to cause intense disruptions in the lives of the many Tanzanians who depend on their families for survival.

Nyamizi's description of being left alone after her sister's death captures the degree of dependency many Tanzanians have on family members:

As I saw the death of someone who takes care of me I came here to Dar Es Salaam. I couldn't get anyone else to take care of me, even to be with me.

Hashim talked about loss in a different form; the loss of a relationship and its impact on him.

I – When did the drug problem start?

H – Started since 1996.

I – How did it start?

H – I was broken hearted.

I – What happened?

H – I was expecting something but it was not going as I wanted. So after this feel like my life had finished. Too much thinking.

Something like confusion and complication. Feel that when I am using drug it is going to help me forget my problems.

I – Which drugs did you do?

H – It was heroin.

Simon told me about his father dying and then having to rely on another family member for support: “After that my father died. My small brother took me again.” It seems from this short excerpt from his interview that, like the other patients mentioned above, he depended on the support of his family to survive, despite being fifty years old.

From the above interview excerpts, it becomes evident that family and relationships play a large part in both the cause of mental health complications and also in identifying them. This reflects the important role that social relationships play in Tanzania: people rely on family members to survive. This can be seen by Nyamizi’s saying, “I couldn’t get anyone else to take care of me.” She felt dependent on her sister and when her sister died, she was unable to take care of herself and ended up on a train to Dar Es Salaam where she eventually sought care at the hospital and has since spent ten years in the rehabilitation village. She had no other family to go to for assistance and as a result has been unable to leave the village as she has nowhere to go. Similarly, when Simon lost his father he had to rely on his younger brother to take care of him. Family is integral to survival in Tanzania.

All of the patients talked rather vaguely about the onset of their symptoms. It was difficult to pin down the exact sequence of when they noticed changes in themselves, what those changes were and the impact of those changes. Rather, they talked about their family members or friends noticing changes in them and taking them to get help, either with local healers or at the hospital. It was as if they referenced themselves through their relationships with others. The confusion and disorientation that accompanies mental illness and addiction make it difficult to put together a

linear story of the onset of symptoms. Instead, the patients referenced their story through their interactions with others. In this sense, other people become integral to their stories, acting as signs along the road of illness for the patient to identify where they have been and what they have experienced.

Seeking Treatment

As mentioned above, several patients were taken to either local healers or hospitals by their friends and family. Most commonly, it was family members who directed patients to treatment. Some patients, such as Nicholas, sought out care on their own.

Nicholas: I decided to be here according to the problems I was facing so that I could learn to develop self-reliance for the future because I am dependent on my relatives.

Despite mentioning his own reasons for being in the village, he then goes on to say that his family “sent” him to local healers first and then to the hospital. This was common as well; for patients to have first tried local healing and then to have gone to the hospital as a last resort. Some of the patients had been in and out of hospitals before they arrived in the village. The following excerpt from an interview with Nicholas is a good example of this:

Nicholas: First time I was going to psychiatrist of Muhumbili Hospital I was getting a medicine for a year. Then in April this year I have been sent back to hospital where they admitted me for four days then I escaped. They have turned me back to hospital. I had been there for a month after being discharged then I saw that it's better coming here [to the village] to learn and to be treated directly... I went to hospital to get healing to problems that faced me. Disturbance in the city, being mad at being dependent, staying at home so that basic needs like disturbance to my relatives... I feel happy when I see doctor because in him I am getting healed and getting instructions for how to learn and to continue with other process also, they give us medicine.

For Nicholas, it was unclear from the interviews I conducted with him whether he sought out treatment on his own or his family encouraged him to do so; it seemed like a combination of the two. Kumi, another young male patient in the village, when asked why he was in the village, replied, “I decided because I wanted to learn how to be self-dependent.” This echoes Nicholas’ sentiments and reflects the idea that many of the patients expressed; of being reliant on their families for survival and feeling a sense of frustration at their dependence while also expressing gratitude. Kumi then went on to say, in his interview, that his mom sent him to the village, “Because she saw me at home without any activities so she decided to send me here to learn how I can be self-dependent so that after I leave here I will have the knowledge to rely on myself.” Like Nicholas, Kumi is somewhat ambiguous about whose decision it was that he live in the village.

Doris, a patient who had spent 10 years living in the village, spent a year in the hospital before going to the village. She was taken to a local healer by her sister and then went to the hospital when the local healer was unable to help her. Similarly, Andrew, when I asked how he ended up in the village, replied, “My brother who lived with me at Tabata discussed with a doctor about my problem then the doctor advised that it was good for me to come to this village.” It was common for family members to encourage the patients to seek treatment or to take them directly to get help. Mary and Julianna both told me that their sisters took them to the hospital. Frank said his family sent him to the doctor for his drug addiction problem. Simon told me, “One day my parents took me to a local healer, but they didn’t get permission from the doctor at Muhumbili [hospital].”

Margaret’s treatment choices were largely dictated by her brother:

I - Who took you to Muhumbili hospital?

M - My brother.

I - Why didn't you go to a local healer?

M - My brother who sent me here doesn't like witchdoctors.

It is not surprising that family members directed patients to seek treatment. The villages cater mostly to patients with schizophrenia and psychosis, according to Dr. Mbatia. Schizophrenia and psychosis alter the way a person thinks, feels and relates to the world. Patients' perception is distorted and many times it is as if they are living in their own world. Those closest to the patients, their families, inevitably notice these changes and become concerned as it becomes clear that the person they know and love no longer seems like the same person. They want to see them improve and therefore take them to get help. For some patients their families first took them to local healers, for others they went directly to the hospital or a doctor. Either way, their family members are accessing services that they think will benefit the patient and get rid of the symptoms they are experiencing.

I hoped in my research to talk to patients more about when they first noticed changes in themselves and the impact this had on their perception and their relationships. The second set of interview questions I asked dealt primarily with these issues. However, patients did not have very much to say. In retrospect, it makes sense that they would not have a clear memory of the trauma and disruption caused by mental illness or addiction as it first presented itself in their lives. Like any trauma, it is difficult to think about it linearly or rationally. The patients were still at varying stages in the healing process when I talked to them. Part of healing is making sense of and absorbing the initial impact that the illness or addiction had on their life. Part of this absorption is likely an inability to articulate; a silence.

Literature on Local Healing in Africa

That the history of African medicine has received little attention is unsurprising. While anthropologists have not been uninterested in change over time, the overwhelming emphasis of work in this field remains on contemporary medical practices, including the social meanings of symbols and rituals and the ways in which illness and disease have been conceived as disrupting societal and cosmological order. (Wallace 2003:356)

Local healing is a catch phrase for all healing that is not biomedical healing, but is instead rooted in local culture or tradition. In Tanzania local healers practice many different forms of healing and vary from region to region, community to community, and individual to individual. There are two types of local healers in Tanzania that the people I talked to distinguished between. The first are local healers whose methods include a spiritual element. This could include divination or contacting spirits of ancestors. The second are those who use natural sources, such as plants, for medicine, and who have studied herbs and types of natural cures for illnesses. Even within these two extremely broad categories of healers there is a lot of variation and diversity. Each healer practices in their own style according to numerous factors including tribal background, geographic location, the training they received, the types of patients they see, the demand of their clientele.

My original plan before going to Tanzania was to talk to local healers as part of my fieldwork. However, this proved to be difficult as none of the patients I talked to were currently seeing a local healer and I had no way to access local healers. Also, due to the variety of local healers and the potentially diverse responses I could get from them, it seemed beyond the scope of my thesis to try to do any meaningful research with local healers themselves. The information I have on local healers comes from my interviews with patients and professionals, as well as the more informal conversations I had with numerous Tanzanians during my three months in Dar Es Salaam. I was interested in whether patients had consulted with local healers at any point and the

reasons behind their decision to use local healers or not. I wanted to know about their experience with local healers and whether they had a preference for local healers or biomedical practitioners. Among the health care professionals, I was curious about their perception of local healing, how many of their patients used local healing services, and whether they thought that the two systems were compatible.

Historically, before the arrival of missionaries in Tanzania, local healers were the primary form of health care for the majority of Tanzanians. It was the only form of health care available for most Tanzanians. Now that there is access to biomedical healthcare in most parts of Tanzania, albeit more reliable in some areas than others, local healers are no longer the primary form of health care. They are, however, still a popular choice of healing for many Tanzanians. This is evident from my interviews, which suggested that half of the patients had some experience with local healing in the course of their treatment history.

Often times, local healing is talked about in reference to biomedicine. Biomedicine, often referred to as Western medicine, according to Leith Mullings, “reflects its origins in the advanced capitalist societies of Europe and the US.” (Mullings 1984:192) This has implications for how it deals with treating individuals: “Along with the dominance of psychoanalytic approaches and their followers emerges the firm crystallization of the notion of the individual and individual responsibility in mental therapy.” (Mullings 1984:192) Local healing, on the other hand, is often discussed as focusing on social relationships. Olebjirn Rekdal describes an African traditional healer as being, “typically portrayed as a person who shares the same social and cultural environment as his patient, the patient is treated not primarily as an individual, but as an integral part of the social and cultural whole.” (1999:466)

Several anthropologists talk about the fact that local healers are much more cognizant of social, cultural and political context in their treatment of patients. For instance, Daniel Offiong writes that, "Traditional healers are aware that treatment of a patient begins by first appreciating the peoples' indigenous beliefs and worldviews, which is at the centre of psychological functioning and provides the basis of healing." (1999:128) Michael Mabunda writes in his 2001 article, that, "Modern methods of healthcare do not provide any services which even remotely resemble the divination and psychotherapy offered by the traditional healers." (2001:13) A growing consensus exists among anthropologists that local healers provide more personalized and culturally relevant care to patients.

Several of the patients I interviewed had used local healing at some point in their treatment history. This may seem surprising in a country where biomedicine is becoming increasingly available to even the most isolated rural populations. Rekdal comments on this in his article on the Iraqw people of Tanzania: "Widespread acceptance and extensive use of biomedical health services may not necessarily mean that people abandon traditional beliefs and practices." (1999:458) Rekdal writes about the "adaptive features" of local healers in Africa, in terms of how they deal with the changing society and culture. He suggests this adaptability, "account[s] for much of the continued popularity of African traditional medicine." (Rekdal 1999:472) Rekdal's article focuses on the incredible diversity of local healing services the Iraqw people access and the distance they go (outside of their own region/tribe) for local healing. In this context, he explains, "Biomedicine and the biomedical doctor constituted simply an addition to an already existing repertoire of exotic medical alternatives." (Rekdal 1999:472) Mabunda writes that the perception of the cause of illness is influenced by beliefs and values, and it determines the course of treatment a patient will seek. He explains that, "Most of the respondents wish to have access to both forms of healing in order to maximize their chances of recovery." (Mabunda 2001:13) He explains that certain illness, such as mental illness, are seen to be "best cured" by

local healers, rather than biomedicine, as their cause is seen as being rooted in social and cultural relationships and experiences, which local healers are more adept at dealing with (Mabunda 2001:13). In general, according to Mabunda, biomedical and local healing, “are seen to be complementary, thus offering the patient a better chance of recovery.” (2001:15)

Rekdal writes about the depiction of local healers by Europeans as, “primitive, irrational, and evil witchdoctor[s]” who were antagonistic of, “what Europeans saw as the best in the West: development, science and Christianity.” (1999:465) Specifically in Tanzania, he writes, some of the negative perceptions of local healers are a result of many local healers “playing a leading role in the multiethnic rebellion of 1905-1906 against the Germans, in which an estimated 250,000 – 300,000 Africans and 15 Europeans were killed, and were feared as potential instigators of anti-government feelings and activities.” (Rekdal 1999:462) This intersection in history between medicine and politics is an interesting one, which has impacted the European perception of local healers in Tanzania and coloured their depiction.

Things are changing globally in respect to the relationship between biomedicine and local healing. For instance, “[World Health Organization] has not only declared African traditional healers an important resource in health promotion, but has also encouraged research on their healing techniques and remedies.” (Rekdal 1999:465) In response, national governments have established research institutes for traditional medicine and started programs to attempt to integrate local healers into public healthcare. For instance, Offiong writes that Ghana has established the Institute for Herbal and Plant Medicine and that Tanzania has established a Traditional Medicine Unit at the University of Dar Es Salaam (1999:127).

In many parts of Africa, traditional or local healers are still used frequently by patients who also use the biomedical system. Mabunda writes that in Northern Province, South Africa, according

to one of his respondents, “As many as 80% of patients in hospitals visit traditional healers prior to coming to hospital.” (2001:15) In addition to this, “In some hospitals traditional healers are part of the multidisciplinary team who treat patients during critical times.” (Mabunda 2001:15) Marc Kahn’s research with Xhosa-speaking psychiatric nurses in South Africa examines the nurses’ views on traditional healing and its role in mental health care. He writes that the nurses were in favour of traditional healers working with the hospital and that they, “subscribe to a pluralistic system and draw on both cultural worlds in an adjunctive way without a single core set of principles of mental health.” (Kahn 2001:47) He did point out that the nurses, “tend to give priority to the psychiatric model” (Kahn 2001:47) and that, “The psychiatric model tends to be the centre around which they imagine various possible forms of association with traditional healing.” (Kahn 2001:47) While the nurses clearly saw value in traditional healing, they saw it as “ancillary to Western mental health care rather than as a parallel system.” (Kahn 2001:48) This can be seen in the views of the some of the health care professionals I talked to in Tanzania, which I discuss later in this chapter. While they openly talk about some of the reasons that local healers are an important asset for healing in Tanzania, they seem to favour biomedical healing as a health care choice. The patients I talked to felt the same way.

Local Healing Among the Patients in Tanzania

...most African people believe in local healers. It is our nature because before scientific medication reached Africa we still used local healers.
Simon (patient)

A few of the patients identified supernatural causes as part of the reason they were in the village. Julianna was one of these patients. In the following interview segment, she mentions a demon following her:

I – When did you start to have problems?

J – I felt badly, see my head expand. I told my mother I feel like my head expanding but she told me ‘you lie to me’. Sometimes felt cold, went to lie under the sun to gain warmth. She said ‘you are lazy and don’t want to work’. I told her I was ill.

I – How did you notice you were ill?

J – I felt badly then fainted that’s why they sent me to the hospital.

I – Did other people notice? What did they say?

J – Because I made noises, shouts that was due to sleeping time see what man followed me he say he loves me so much was demon because my master says I must have holding to marry him because he love me deeply.

J – It was like demon in my head made me do everything he wanted.

Julianna also explained to me that she went to a local healer in Dodoma because she wanted to make people love her. He gave her medicine for 1,400 Tanzanian shillings (\$1.50). She said he gave her plant medicine mixed with water. She had to wash with it and chant Islamic prayers (although she is Christian) and then, she was told, everyone would love her. She claimed that it worked. People used to hate her without reason, but after she was treated by the local healer, she was loved by everyone.

Local healing was a first line of defence for about one-half of the patients I interviewed. Most of them had been taken to local healers by family members or friends when they first became ill and their behaviour or mood changed. Some of them had been more than once. When local healing proved ineffective they then went to a hospital and received psychiatric care. About one-half of the patients had a negative perception of local healing or had never tried it. Even among patients who had tried local healing, the consensus seemed to be, like among the psychiatric nurses interviewed by Kahn, that biomedical health care is more reliable and effective than local healing. There was only one patient, Simon, who felt that local healing was more effective for treating his illness. He identified local healers as potentially helping him to make money. The following

extended excerpt from the interview I conducted (in English) with Simon captures some of his perceptions of local healers:

I – Have you ever seen a local healer?

S – One day my parents are taking me to a local healer. But they didn't get permission from the doctor at Muhumbili.

I – Why did they take you?

S – I don't know.

I – What did the local healer say?

S – One local healer said that you have word of God, the demon, the true demon in your head.

S – Local healers told me that you have got two demons in your head.

I – And then what did the local healer do?

S – So my father rejected to continue with the healing. Because he knew that I will be richer than he is..

I – So your father didn't like it?

S – He objected.

I - Because he doesn't believe in demons?

S – He believes only that I will be richer than him.

I – So you went again to a local healer or only one time?

S – I went again my small brother send me to the local healer.

I – And what did the local healer say?

S – There are demons.

I – It helped you?

S – Yeah

I – He gave you medicine?

S – Yeah

I – Do you like local healers?

S – Yeah I like them

I – Do you think they are helping?

S – According to them I can get rich.

I – The local healer told you that you will be rich?

S – He told me if I continue treatment I will be rich.

I – And you believe this?

S – I believe because the knowledge... local healers... because you cannot live in this world without their power.

I – You see them now, since coming to the village?

S – No.

I – Do you think you will return one day?

S – I think if I have money I will go

I – Is it expensive?

S – Some of them are 2... 3... 10,000/=.

I – 10,000/= ? That's a lot.

S – Even one million.

I – I think they must be very good for 10,000/=!!

S – 10,000/= is cheaper for simple things.

I – Do you prefer to see the doctor or the local healer?

S – The local healer is better.

I – Why?

S – Because I have seen in Africa it's not like in Europe because you cannot get rich without work or if someone gives you money.

I – So local healers they help?

S – Yes they help.

I – How?

S – If you follow their treatment, instructions, you will become rich. If you are rich, you don't have to worry.

It is interesting that Simon preferred local healers because they had the potential to make him rich. He does not say he prefers them because they are able to treat his problems more effectively. The fact that he talks about being rich as a cure highlights the role of poverty in mental health problems in Tanzania. In another excerpt from the interview with Simon, below, he touches on the use of both biomedicine and local healers and also on the treatment he received from a local healer:

I – Do you think you can go to the local healers and also the psychiatrist? Both?

S – I can not tell. Because the doctors do not like you to go to the witchdoctors.

I – Why?

S – They don't believe in it.

I – Do you believe it is possible to take medicine from here and also see local healer?

S – Yeah, both is good.

I – Does the local healer give you medicine?

S – The local healers have got some medicine. They sing.

I – What kind of medicine?

S – From trees. It grows off trees. Natural.

I – And you think it is good?

S – Yes it is good. If you don't respect witchdoctor, bad things can come.

Simon notes that, “The doctors do not like you to go to the witchdoctors”, suggesting that he is aware of a divide between local healing and biomedicine. In the excerpt from his interview earlier, he said that his parents did not have permission from the doctor to see the local healer. It is interesting that he assumes that the doctors have the authority to make that decision and that his parents would need permission from the doctor. This suggests that he perceives biomedical doctors as having more power and authority than local healers and likely reflects the fact that the majority of health care services in Tanzania are biomedical services. Biomedical services have taken over the dominant role that local healing played before colonization and now other forms of healing are measured against it.

Mapunda, a patient in the village outside of Moshi, also mentioned seeing a local healer, a herbalist, although he says it was not helpful:

M - Someone bewitched me. It would not be good for me to say who.

I – When did they bewitch you?

M – A long time ago. I was at medical school for laboratory technician in 1968. I was taking a course in medical technology and then I was bewitched. I was hurt in the stomach.

I – If you think you were bewitched, did you go to see a local healer?

M – Yes I have tried. A herbalist. I took medication.

I – And did it help?

M – Didn't help much.

Although Mapunda was open to the experience of seeing a local healer, he did not find it helpful. When I asked Kumi about the types of treatment he has sought out and received, his response suggested a degree of flexibility and openness in regards to what type of healing works for him:

K – Three times been treated at the hospital and only once treated by a local healer

I – Why do you see a psychiatrist or local healer?

K – Due to the knowledge changes, see things which relatives didn't see, sometimes experiencing things that are not there. My parents sent me to a local healer when discovered no changes in the hospital.

K – I go to local healers when problem is impossible for doctors so it needs spiritual faith.

I – Do you feel improved now?

K – I feel improved well because first time was seeing things which were not there, terrifying things but now I don't see them.

Interestingly, Kumi notes that he goes to local healers when biomedical doctors are unable to help him. Of the patients I talked to, half had tried some form of local healing and/or thought there were supernatural causes for their symptoms. They used local healers in conjunction with biomedical services, either as a first step in seeking help or as a last resort if other treatment did not work out. Local healing is another tool that Tanzanians can use in seeking treatment for mental illness or addiction, although not all patients choose to use it.

John, one of the patients, said that he doesn't trust witchdoctors because "you can't prove them." This attitude was reflected in other interviews as well – that it is impossible to know whether or not local healers are "real" or "effective" and so there is an element of distrust toward them. Tanzania is becoming increasingly urbanized and industrialized. More and more students are able to access education, and are therefore becoming removed from traditional ways of knowing and passing on knowledge. It is not surprising that there was scepticism towards local healing expressed in some interviews. My Swahili teacher told me several stories of 'testing' local healers in his youth. He said he would go to various local healers in market places and ask them to make him rich or to make personal changes in his life, knowing that they would be unable to

follow through on his request. In this sense, he felt that he was proving they were not real or effective as they were unable to deliver what he asked them for and he found this highly amusing.

While a few of the patients had tried local healing before approaching the biomedical healthcare system, Mary, like a couple of the other patients, had used prayer. When I asked her how her problem started and what she did about it, she said,

I told my sister there are people facing me and spreading lemon water on me. Then she sent me to church. They prayed for me as you know it is their faith. It didn't succeed. Then she sent me to Muhumbili [hospital] where I was admitted.

This is another example of family intervening, which was the case for almost all of the patients I talked to. Religion was mentioned by several of the patients who talked about using prayer or faith as part of their attempt to get better. None of the patients I talked to self-identified as Muslim, interestingly enough, despite the fact that approximately half of all Tanzanians are Muslim. The patients I talked to who identified being religious all self-identified as Christian.

Simon, who had seen local healers, also told me about using religious healing before he went to the hospital:

I – Did you try other forms of healing before you came here?

S – Local healers. Religious beliefs. Christian.

I – To help you?

S – And the people of religion just praying for me.

I – You think it helps when they are praying?

S – A little bit.

I – Do you think medicine and being here is helping you?

S – Of course.

My research assistant, Vincent, was vehemently against the use of local healers. His attitude was reflected in the interviews I conducted with some of the patients and was essentially that local healers are against Christianity and God, and it is therefore a sin to use them. Vincent is an extremely devoted Christian (who attempted on numerous occasions to convert me to Christianity and patiently asked me over and over again why I did not go to church) and he explained that local healers are the work of demons. A few other patients mentioned that they would never go to a local healer because it is anti-Christian. They implied that using local healers was something that only people living in rural areas did and not something that urban Christians did. It was interesting to see this reflection of missionary zeal and conversion in the voices of the patients.

Among the patients who had seen local healers there did not exist any tension or sense of dualism between local healing and biomedical services. The two existed in conjunction with one another and both were effective in their own ways, according to patients. They did not feel that using one or the other, or even faith healing as a third option, was contradictory in any way. They talked about them as possibilities within a spectrum of options for healing available to them. Family influence was a theme among those who had used local healing – the fact that family members often suggested using local healers or actually took the patient to see the local healer. In a country where local healing is still fairly common and pervasive, it makes sense that the families of mentally ill or addicted patients would attempt to use any means available to help their loved ones.

Access to psychiatric help in Tanzania is often limited. One needs to get to a larger urban centre to see a psychiatrist, of which only twelve currently practice in Tanzania. There has been little in terms of public education or awareness campaigns about mental health or addictions in Tanzania as the priority has been on some of the serious physical illnesses that Tanzanians face, such as HIV/AIDS and malaria. As a result, for many Tanzanians, particularly those living in rural and

more isolated areas, mental health is still somewhat of a mystery. The common rhetoric and knowledge that exists in some countries around various types of mental illness, the symptoms associated with them and how to best treat them and access services does not exist in Tanzania. Although biomedical care as a model for treating mental illness in Tanzania has been in use since the 1950s, it was originally used primarily to treat Europeans in Tanzania and was gradually expanded to include the local population. There is still a serious shortage of mental health care professionals in Tanzania, and of resources, both material and informational, for those experiencing mental health problems. As a result, there remains a great deal of mystery still around mental illness and many Tanzanians attribute it to supernatural causes, seeking treatment with local healers.

Hospitalization and Psychiatric Care

Psychiatric practice has long been dominated by the disease model: the idea that the recognition of a symptom or disease can be matched with the discovery of an underlying biological abnormality. (McCulloch 1995:9)

Several of the patients who tried local healing did not find it useful and said they preferred seeing doctors and using hospital services. Nicholas said he used local healers for “normal problems like fevers”, but that he likes to spend time with psychiatrists because he has improved and his feelings are more “normal” than he had hoped. Kumi said that he has been to the hospital three times and has only been once to a local healer. He was explicit about his feelings about psychiatrists: “First thing when I see a doctor is I feel grateful in my heart. I see the end of my problems, because he is the one who is professional to deal with my problems.” He went on to say, “I go to local healers when problem is impossible to doctors so it needs spiritual faith.” Doris said that after ten years in the village, she trusts psychiatrists and biomedical healing. She said that, “They bring me medicine whenever my mental confusion increases, changing

medications, I am improving... They have helped me for a long time, ten years! I have trusted them for ten years.”

Margaret, the patient who felt her “illness” was precipitated by her son being taken by her husband, was sent to the hospital by her brother even though, as she said, “I didn’t think I was crazy.” She said that her brother forced her to go to the hospital although she felt okay. She said she was being forced to take medication and when I asked her what type she replied: “I don’t know what it’s called... I don’t know the name, it’s available on the packet.”

Margaret’s response was indicative of a lack of awareness among the patients about the medication they were taking. Although most patients were on medication, only one patient out of twelve named the medication they were on when asked what they were taking. The rest did not know or referred to the medication as “the blue pill” or the “medication to help me sleep.” The following excerpt from my interview with Simon captures some of the ambiguity surrounding illness and medication.

I – Why did you come here?

S – I came for treatment.

I – Treatment for what?

S – I’m taking medicine.

I – What kind of medicine do you take?

S – Psychiatric.

I – What is the medicine for?

S – The medicine is for curing. For curing that psychiatric issues.

I – Do you know what the issue is? Schizophrenia? Depression?

S – I do not know because when I was in Muhumbili Hospital I did not know what happened.

Even the one patient, Fayaz, who knew the name of the medication he was taking, was not sure what the medication was for. When I asked him what the medication was for, he was silent. I then asked if the doctor explained to him about his treatment and he replied: “No, he doesn’t.” This silence and lack of knowledge about medication on the part of patients was surprising to me. Coming from Vancouver, where information is easily accessible via internet, where instruction pamphlets are given out with all medications, and where a growing emphasis is placed on consumer awareness, I was unaccustomed to the patients’ seeming disinterest in their medication.

When I asked Mary about her medication, her reply was typical of the patients’: “Yes I am taking medication. I don’t know what kind but is a small tablet with yellow colour I take everyday and two times per day. It helps.”

The patients seemed more concerned with the effect of the medication on their well being: whether or not the medication was helping them sleep or easing their confusion or decreasing the speed of their thoughts or ridding them of anxiety. They did not know what the medication was prescribed to them for, or what it was called, but they knew whether or not it was benefiting them. This connects with the patients’ disinterest in their diagnoses. They are more concerned with how they are feeling than with the technical terms for their illness or medication. This is a pragmatic way to deal with illness; rather than focusing on the diagnosis, they focus on the prognosis. They concern themselves with the act of healing and immerse themselves in that task. It suffices for them to know that they have a mental illness or addiction and that they are taking medication. What matters beyond this is how they are feeling, whether the medication is working, and when they might be able to return home. As they experience the disruption of illness, they focus on getting through the disruption and being able to earn money again and return to their families and communities. They are less concerned with understanding or analyzing the disruption itself and its cause.

Healthcare Professionals on Local Healing

Part of my original research plan was to investigate the interplay between local healing and biomedical care in Tanzania, and I asked the health care professionals I talked to about local healing. I wanted to know how prevalent the use of local healing among mental health patients was, and also what they thought about local healing and whether it was compatible with biomedical care.

Grace, the head of Uhuru village outside of Dar Es Salaam, had a strong opinion about local healers:

I think most of them they are wasting their time. Some of the healers they are tricking you. They are not doing anything. The place I am coming from we are not used to local healers so maybe I have different views from others. But for me I think they are wasting their time. But I think if they can work together with the doctors then psychologically they can save them because a lot of people they believe in witchdoctors. Some of the doctors in Moshi and Tanga they are working with local healers.

When I asked if Grace thought many Tanzanians believe in local healers, she replied,

Things are changing. You know we didn't have hospitals in the villages and local healers were closer. There's two types of local healers. There's one who uses magic, and ones who can give you anything, you know plants. That one is better. Some of them they know the roots and plants – that this one can heal people. Those people coming from the coast, they believe in magic.

Andrew, the occupational therapist in Amani village said that patients “are going to the local healers and different people seeking treatment because it depends on the way they believe, so if it believes in ancestral spirit they take them where they feel like going to get help.” When I asked him what he thought of local healers, he replied,

You know, there was a traditional healer using very nice medication. Like a certain plantation, certain roots and it's the healing people and this is what I complain to our community that when people came, the white people came to our country, this is what I can feel to say, that they feel whatever Africans are doing is not right. There was some types of fruits and most of the old people who have this knowledge they died already therefore our stage now, this, they don't have this knowledge, which types of medication they use to treat stomach ache or whatever. So this is washed away by white people when they came... A lot of people are sick and they go to the hospital and they are not getting better... once you believe, I think it works. If you don't believe, no effect at all. It happens like that.

Tizo, a psychiatric nurse who works at the hospital in Moshi and is also a leader with MEHATA (Mental Health Association of Tanzania), said that “usually before [patients] come to us they are starting from the local healers.” When I asked if a lot of patients see local healers, she replied, “most of them.” She saw the benefit in local healing as a way to treat certain mental health conditions:

Yes some conditions they can help like depression and anxieties because they have time to talk with the patient. And the patients they get relief. Maybe here in the psychiatric unit we can listen more but in the general care they just direct the patient... but the traditional healers have more time.

When I asked about the potential for collaboration between doctors and local healers, Tizo said:

That's what they were doing. We invited them in our workshops and we visited them and we continue to visit them to see how the information... but they shouldn't stay with the patient for a long time. If they are failing the first time, they should send the patient to us. We are working together... they have a role to play and they can help. They are accepted in the community so we should work with them.

Johnson, the nurse in charge of Amani village, told me that in Tanzania in the past most people thought that mental illness was caused by witches, but he said, “nowadays it is changing. Many of them know about psychiatry. Some are dealing with these local healers.”

Dr. Kilonzo, a psychiatrist, told me that it is sometimes possible for western medicine and local healing to see “eye to eye”, and that many people with depression go to local healers for treatment. He said that some doctors are sceptical, but that many doctors recognize the need to work together with local healers. He distinguished between what he called “genuine” local healing and local healing that is not genuine. He said that there is a lifelong process of learning to become a genuine local healer and that it involves an apprenticeship. He said that there needs to be a minimum period of training and apprenticeship established in order to validate the field of local healing more and increase the standard of care and consistency among, and between, local healers. On an individual level he said that he has made friends with many healers and that they would refer patients to each other and discuss how they have handled cases with one another. He said minor conditions in particular are handled well by local healers. He pointed out that local healers have more time to spend with patients and that many of the things they do are similar to what psychiatrists do, such as listening, helping the patient understand what is happening or has happened. He said that often the local healers try to get the family together and, in this sense, Dr. Kilonzo said that local healers “promote healing in terms of interpersonal relationships.” He also said that chants and dances, used by some local healers, can be cathartic.

In my interviews with Dr. Kilonzo, Tizo and Johnson, I was struck by the degree to which they were familiar with local healing and to which they had collaborated with local healers in the past. To me, this level of familiarity and collaboration by health care professionals speaks to how widespread and pervasive the use of local healing is and the fact that it is widely accepted as a valid means of treating mental health problems. It also reveals efforts, on the part of both local

healers and biomedical health care providers, to bridge the gap between local healing and biomedicine and an acknowledgment of the important role that local healers play in Tanzania's health care system. It speaks to the pluralism of the medical system in Tanzania.

Healthcare Professionals on Stigma

I wanted a sense of how the majority of Tanzanians perceive mental illness and asked the healthcare professionals I talked to about the issues of stigma. While most of them had very little to say about stigma, Andrew and Tizo both illuminated the topic somewhat for me.

Andrew told me that, "in the community they are running after these people and they don't know you can live with them. It's just because of ignorance. They are scared of them." When I asked him whether he thought most Tanzanians understand mental illness, he said,

There was a lot of beliefs and ideas. There was an area in Tanga where they feel it's ancestors or evil spirits or things like that... They thought it's evil or being bewitched... The community is troubled by these people. They don't know how to handle them. They don't know how to deal with them. Therefore what I can say is people fearing them a lot... Stigma maybe for themselves because of the perception of the community... they feel like they are not accepted, they are resisted... now, for that reason, they can feel stigma. They are stigmatizing themselves. Because the way they are perceived in the community that the community is resisting them. Other people don't have the ability to care for them... instead I think they feel like it's a burden and it's some sort of stress I think. It threatens them and is some sort of trouble to their life. Not to stigmatize them. Not to isolate them from the norm but instead it's just to fear them.

Tizo told me that, "Relatives don't want to take [patients] back home... because of the stigma".

She said that "Most [Tanzanians] think [mental illness] is genetic. Others think they are bewitched. Others think it is the devil." She said, "They are seeing that we are really caring for

the patient and they are starting to accept them, although a few are still not accepting them.”

Mary works with MEHATA, the Mental Health Association of Tanzania. When I asked here what MEHATA does to combat stigma, she told me they have community programs where they meet with classroom leaders and do outreach into schools. She said the stigma is decreasing and they will continue to focus on the community and family in Tanzania, “so they can help.” She also mentioned using local healers to help intervene with patients before their illness reaches a chronic state.

Dr. Kilonzo talked about the efforts to educate health workers in villages and rural communities about mental health problems and some of the symptoms associated with mental illness. He said that now more and more health workers are starting to see mental health patients and they are able to identify their problems as mental health related, and are better equipped with resources to deal with such patients. He said that on the whole, however, in Tanzania, health workers tend to not recognize and treat mental health problems. He also said that most patients tend to express mental health problems as physical symptoms as it is easier to communicate them this way. Health workers, therefore, need to be able to discern and pay attention to symptoms to identify potential mental health problems.

When I asked Grace if the patients in the village experience stigma and she replied, “Yes. That’s why they like the place when they come here, because they are accepted.”

She has identified one of the key reasons that patients, despite their complaints about the village, spoke positively about life in the village. They were for the most part grateful to be there and suggested that the experience was a positive one and that they were feeling better than when they had first arrived in the village. Perhaps this is largely because they are surrounded by peers and supportive professionals, whose job is to help people dealing with mental illness and addiction.

Consequently, they feel accepted for who they are, and do not have to explain themselves or feel ashamed of their illness or symptoms. They likely feel they are understood in an empathetic community. Empathy and understanding play key roles in the process of healing from mental illness.

Chaos in Stories

Serious illness is the loss of the “destination and map” that had previously guided the ill person’s life: ill people have to learn “to think differently”. They learn by hearing themselves tell their stories, absorbing others’ reactions, and experiencing their stories being shared.
(Frank 1995:1)

In this chapter I have described some of the patients who lived in the village and the circumstances surrounding their lives before they arrived in the village. I discussed different forms of healing sought out by patients and included a discussion of literature on local healing in Africa in order to frame the ethnographic data I gathered during interviews. I outlined patients’ experiences with local healing and the biomedical system and their responses to both. It became clear as my ethnographic research progressed that there was great diversity among the opinions of the patients regarding their illnesses: the causes, optimal treatments, and whether local healing had been tried. Each story was different and I have tried to capture that in this chapter in introducing the reader to the patients and their lives.

The narratives the patients told me were, as I wrote in the introduction, often fragmented and difficult to follow. Arthur Frank, in *The Wounded Storyteller*, calls these “chaos stories” (1995:97). He writes that,

Stories are chaotic in their absence of narrative order. Events are told as the storyteller experiences life: without sequence or discernable causality. The lack of any coherent sequence is an initial reason why chaos stories

are hard to hear; the teller is not understood as telling a “proper” story. But more significantly, the teller of the chaos story is not heard to be living a “proper” life, since in life as in story, one event is expected to lead to another. Chaos negates that expectation. (Frank 1995:97)

The patients told me stories that were sometimes difficult to make sense of in terms of this idea of a “proper” story. For instance, Julianna told me several shocking stories during our first interview: that she was raped, that she had been a prostitute, that her sister’s daughter was a prostitute. These stories all seemed to overlap in the way she told them. When I tried to get clarification on these stories, it was as if she had never mentioned them. I was never clear on the sequence of events in her life, or even of the reality of the events of her life. Frank captures my experience of listening to such stories in the following quote: “Chaos stories are also hard to hear because they are too threatening. The anxiety these stories provoke inhibits hearing.” (1995:97) It was a struggle for me to remain open and attentive to patients’ stories when they veered from a linear, somewhat predictable course. I wanted them to make sense, to fit into a box or category of some type. I wanted them to be whole and complete. By looking for these aspects of stories, I was likely missing the important parts. As Frank explains it, “Chaos is what can never be told; it is the hole in the telling.” (1995:101) By focusing on the completeness and coherence of the patients’ stories I tended to ignore the silences and gaps between the lines that perhaps indicated where the real story began. I had to learn to pay attention to these silences and gaps.

It is tempting, when presented with a narrative that makes little sense, to ignore or discard it; to attribute its incoherence to a flaw in the person telling the story. To delve into a chaos story is to witness its incoherence and to explore its roots. According to Frank, “The chaos story presupposes *lack* of control.” (1995:100) Patients living in the rehabilitation villages are removed from their everyday lives, their families and their communities, and are taking medications to treat symptoms which are alienating and unsettling to say the least. They are living in the midst of disruption and particularly near the onset of their illness, have little control over it. It is little

surprise that the patients' stories are often chaotic, and perhaps it is difficult to witness such stories because it is difficult to imagine ourselves lacking such control over our own lives.

Despite the chaos and the variety among the stories told by patients, there were common elements to them as well. All of the patients had been to the hospital before they were admitted to the village. All of the patients had families who had been involved, to some degree, with identifying and treating the patients' illnesses. Several of the patients had sought out and used local healers before they had tried biomedical treatment. Most of those who had seen local healers had been taken by family members. Similarly, most of the patients were taken to the hospital by family members. From the patients' narratives it became clear that their mental illness or addiction experience had not been in isolation; they were part of larger networks of people and their experience impacted the lives of those around them. Conversely, their lives were impacted by those around them; evident by the impact of loss (by death or in one case, romantic loss) on the patients. In this chapter I have tried to establish some of the social relationships that exist for the patients and the context within which they have sought treatment. I have outlined the options available to them and some of the reasons they have sought the care they have.

The patients I talked to seemed desperate to get better, to see some improvement in their mental health. Local healing is one way that they have been able to access help. The fluidity with which they are able to move between local healing, biomedicine and faith healing (or prayer) reflects a comfort and familiarity with these various forms of healing, but also a degree of necessity. They have tried whatever options are available to them in order to get better, in a pragmatic and functional way.

In the following chapter I discuss life in the village. I go into a bit more detail about the background of the villages and talk about how they function and the use of work as therapy. I then discuss patients' response to work.

CHAPTER FIVE: DAILY VILLAGE LIFE

In this chapter I outline how the villages operate and discuss the use of work in the villages as a model of therapy. I also discuss some of the aspects of community in the village and the patients' responses to life in the village, which are varied and diverse.

The Villages

Patients are referred to the village by psychiatrists or psychiatric nurses in the hospitals. The decision to move to the village seems to be one that is made in conjunction with family, health care professionals and the patients themselves. According to Dr. Kilonzo, a clinical team discusses the patients' objectives and goals, which are then discussed with the patient ("client") and they are referred to the rehabilitation team who then interviews the patient and decides whether or not the patient will be admitted to the village. It is completely voluntary for patients and they "have to want to go." The rehabilitation team then discusses how the village can best meet the patients' needs. Patients stay in the village anywhere from three to nine months.

Although one patient at Uhuru, Doris, has been there for ten years, housing people for extended periods of time is not the intended use of the village according to the staff I talked to, and is part of the reason that stricter criteria have been developed around which patients can live there. The staff attempt to ensure that patients have the optimal support to live there for less than a year and then transition back to the community. The villages are seen as places for rehabilitation and this rehabilitation involves teaching patients agricultural skills, social skills, and reintegrating them

into a small community within the village before they are ready to return to their homes and communities of origin.

The villages house people with mental health related problems as well as those with addiction issues. This was not something I was aware of upon arrival in Tanzania and somewhat changed the focus of my thesis. Originally I was interested in depression and its treatment in Tanzania using local healing and biomedicine. However, Dr. Kilonzo informed me that most depressed patients do not go to the village due to the fact that they do not want to socialize and also their illness is lower-impact and does not interrupt their lives as severely as schizophrenia or psychosis. They are therefore not the ideal candidates to benefit from living in an agricultural psychiatric rehabilitation village. The villages emphasize interaction and work and are fairly intensive in terms of the time spent there and the focus on rehabilitation. Therefore, depressed patients tend to benefit less than patients with other forms of mental illness, and, according to Dr. Kilonzo, are “inappropriate” for life in the village. Patients were a mix of those dealing with addiction and those dealing with mental health complications (mostly, according to Dr. Kilonzo, bipolar disorder and schizophrenia), and it was impossible to discern through dialogue with patients which one they were due to the way they talked about their problems.

Dr. Kilonzo told me that after the Second World War, therapeutic communities were started for veterans with mental health disorders. This was the first model for an agricultural psychiatric rehabilitation village. This model was applied to Africa when the first village, Aro Village, was built, as stated above, in Nigeria by Professor Lambo. (As a side note, I have heard of similar villages in Quebec and in Pakistan, although I have been unable to find much information on the villages in either location). Hombolo was the first village built in Tanzania and at the time it was built 95% of employment in Tanzania was based on farming in rural areas. It was therefore relevant to use agriculture to rehabilitate patients as the skills patients would learn could be

applied to make a living after leaving the village. This has since changed to some degree. As urbanization and industrialization have occurred over the past several decades, the relevance of teaching agricultural skills to mental health patients has been questioned. As Talib, the head of animal husbandry at Uhuru village, mentioned, it might be more useful for some patients now to learn computer skills than agricultural skills. However, in a country where it is a struggle to provide the basics such as water and electricity in these villages, the likelihood of accessing computer technology for the patients is slim.

Grace, the head of Uhuru Village, thought that agriculture was still a relevant way to engage patients:

You know the backbone of our country is agriculture and most of the people they come from the farms. You can't teach them computers and everything. When they go back home there's no computers.

She did mention that they needed a greater range of activities, “because we are getting different people, not only from the farming villages, but... we even stay with doctors here, engineers here.” Talib, Grace’s assistant, felt that the skills were relevant no matter what: “Professional patients like doctors and engineers they still proceed with what they acquire from here even if they still go back to their work. They can still do agriculture or keep poultry.” He also mentioned the affordability of continuing with agriculture for patients. It is feasible for patients to start small gardens or buy a few chickens when they return home, but it is not feasible for them to buy computers and it is difficult to get jobs in industries. Talib was convinced that agriculture, due to its simplicity and applicability, remained the most relevant tool for rehabilitating patients.

When the villages were first built in Tanzania, land was extremely cheap. This made it feasible for the Health Ministry to buy large plots of land to be used for agricultural purposes. In neighbouring countries Uganda and Kenya, Dr. Kilonzo explained that land has been expensive

and this has precluded the start of any agricultural psychiatric rehabilitation villages. The villages in Tanzania, therefore, were a result of a combination of inspiration from outside sources, economic opportunity to secure land, and a climate of deinstitutionalization of mental health patients in the country.

DANIDA provided the funds for Uhuru Village and in 1985 it officially opened, although patients moved in earlier than that. When it first opened the coconut grove was the crux of its activity. Artisans were brought in who were trained in mental health issues. They taught carpentry, bamboo work, woodcraft, dress-making, tie-dye, macramé and other skills. In the past seven years the government has reduced the workforce due to lack of funding and this has led to the artisans no longer working at the village. Now the occupational therapist who works at the village teaches tie-dye and other crafts, but agriculture is the main focus. There are labourers who work for the village (paid for by the government) who help teach the patients to work with the coconuts and animals.

Funding

Dr. Kilonzo informed me that Mapenzi, the agricultural psychiatric rehabilitation village that used to exist right next to Uhuru, and of which Uhuru was originally an extension, closed last year due to shortage of funding. Several of the patients and staff from Mapenzi now live and work in Uhuru, the only such village near Dar Es Salaam. It is located about ten kilometres from the nearest village, and is eighteen kilometres from Dar Es Salaam city centre.

Dr. Mbatia, another psychiatrist in Tanzania, and the head of the mental health and abuse section of the Ministry of Health, met with me in his office. In the hour we talked, he provided me with more of a sense of the background of the village and its purpose. From 1989 to 1997 he was the

psychiatrist responsible for Uhuru. He said that there is a balance in the goals of the village between therapeutic elements for healing and the expectations of the hospital, presumably meaning the use of medication and monitoring of progress. He said that when the villages were created, the hospitals expected that they would create more of an income than they have. Some of the villages, such as Amani, have fewer resources than Uhuru due to the variation in what the villages produce and how much money they can make on the goods they produce, and this creates problems. He had questions about the sustainability of the villages and reiterated the need for more resources to diversify, in order to meet the needs of a greater range of “clients.”

Dr. Mbatia felt that the villages have the potential to be very effective: they offer patients space to recover and reorganize, the chance to learn new skills, and to socialize. Self-worth is an issue he highlighted as being important for the patients and he said that given the chance to slowly integrate into the village, to be part of a system, to have routines provided and to live communally, benefits the self-esteem of patients. Because these benefits are often unquantifiable, however, it is hard for hospital managers to see patients’ progress and take the villages seriously, which partly explains the shortage of funding.

Andrew, the occupational therapist in Amani, explained the impact of the shortage of funding on the lives of patients in the villages:

They don't have enough food, sometimes the monitoring of mental patient, sometimes they don't have certain types of medication. Medication and food. And medication can have a very bad side effect so they don't eat enough food to compensate...there is not enough activities to stimulate them to reach where they are supposed to reach.

Staffing

At each village, Dr. Mbatia informed me, there are one to two nurses, support staff (or labourers), agriculture and animal husbandry experts, and an occupational therapist. There is variety between villages and the staff working at a village changes according to availability of resources and personnel. He said that because acute patient care is given priority in Tanzania, chronic patient care (such as is provided in the villages) is not given a lot of financial support. Dr. Mbatia's estimate for the number of psychiatrists in Tanzania was more optimistic than Dr. Kilonzo's. He told me there are fourteen psychiatrists, seven of whom are in the department at the college, and one of whom has a private practice in Zanzibar, but works one day each week in public service.

He said that there is a strong team environment within the villages; even the security people working at the villages (to keep strangers out of the village) know the patients. This familiarity is an important part of the functioning of the villages, he suggested. When I asked how it is decided when patients can go home, he said that the staff team meets and makes the decision together. He said some patients are ready to leave after a few weeks and don't want to stay. I found this was true with some patients I interviewed. They felt they were ready to go before the staff felt they were ready to go. This seemed to create some tension between staff and patients and led to and/or reflected a sense of lack of autonomy and agency on the part of some patients.

At Uhuru Village, there are twelve labourers, four nurses (usually one or two working at a time), one occupational therapist, one head of agriculture, and one person in charge of the running of the village. In addition there is a person who was in charge of finances who was around sometimes, but seemed largely based out of Muhumbili Hospital. The head of the village, the head of agriculture, and the nurses all go to Muhumbili Hospital one day a week and use this time to get supplies, medication, food, and presumably to discuss future intakes. One nurse, whose daughter

has cerebral palsy and lives with her in a small house in the village, remains in the village as she is the sole caretaker of her daughter and must be available to go home and feed her and take care of her.

One common theme I found among the staff, whether nurses, occupational therapists or the administrators, was that they did not have extensive training in the mental health field prior to working in the village. It seemed most of them learnt about mental health from working in the villages, although some did mention attending workshops or seminars about mental health. The two administrators, Grace and Talib, had agricultural training and background (Grace has a masters degree from Australia in Agriculture, and Talib specialized in dairy husbandry at agricultural school and attended a 10 month program in Japan on vegetable growth).

Daily Life and Work

We don't force them. If they are not able to do anything they don't work.
-Benson (psychiatric nurse)

In Uhuru village, which is on two hundred acres of land, there are forty five dairy cows, a dozen pigs, over two thousand chickens and a coconut plantation. The money from the production of agriculture is used to supplement the government funding for the village, which covers the staff costs. Agriculture is used in the villages, according to Dr. Kilonzo, to provide vocational skills, to build confidence and self-esteem, as a way to occupy the minds and bodies of patients, and to provide structure to their daily life. He emphasized the importance of staying active, claiming that “idleness is the enemy of mental health.”

At Uhuru village, patients wake up at 6am, clean themselves and their rooms and have breakfast, which is prepared by whoever is on kitchen/cooking duty and is usually porridge and tea. They

perform their agricultural duties from 8-10am, with paid labourers teaching and assisting them. They then have two hours of leisure time during which they tend to talk together or go to their rooms to rest. From 12pm-1pm they eat lunch, prepared by one of the patients, and then from 2pm-4pm they engage in activities with the occupational therapist, such as tie-dyeing and basket-making. As stated above, there used to be more activities available for patients to take part in, until funding was cut by the government. Now their options are limited. They eat dinner at 6pm and then go to bed around 8pm. As there is no electricity and only a few kerosene lamps, and it gets dark at 6pm, there is very little to do between dinner and going to bed.

Godfrey, the occupational therapist at Amani village near Moshi, outlined some of the goals of the village:

What I do here we are focusing more on self-care areas. Like washing yourself, washing clothes, making bed, cutting hair, self care. Dressing. Eating behaviors, sometimes they are isolating, sometimes they don't care even to wash their hands. You look this first then you come up with activities like cooking, anyone can cook, it is good for organizing good planning. In washing the pigs, even gardening. It needs some social organizing and brain...Encouraging people about self-care and productive activities.

Financial Compensation and Needs of Patients

There is a reward system for the work patients do. Money is given to patients according to how much work they have been assessed to have done. This is a token amount given at the end of each month. I witnessed a meeting one day in the communal dining area where the money was given out. All the patients gathered with Grace (the person in charge of the village) and Jamila (a nurse), who used a logbook to distribute money among everyone. The patients receive 150 shillings (or 15 cents) per day for working with the livestock and 100 shillings (10 cents) per day

for other work. Dr. Kilonzo informed me that there are a variety of social classes represented in the village and that the amount given is not considered enough by some patients. It seemed to me, from interviews with patients, that all the patients wanted more money. Several of them asked me for money outright. They complained that they were unable to buy basics like tea, sugar, toothpaste and soap – things they are expected to provide for themselves, and which their families often provide them if their families are able to and visit.

One of the patients, Julianna, to whom I became the closest in my time there, asked me one day for money for sanitary napkins. Until she asked me this, I had not considered what the women do when they menstruate. Due to the sensitivity of talking about such personal matters (it was clearly awkward for Julianna to ask me for the money in the first place as she had to ask through Vincent, my research assistant) I am still unsure as to what they use for sanitary napkins, which can cost up to \$1 for a package, when they have so little money. Julianna also complained each time I saw her that she couldn't dress "sharp" like I did, because she had no money. Her clothes were torn and she said she had no soap. Another patient, Simon, at the end of our second interview, informed me he needed glasses and asked if I could give him money to buy them.

As mentioned in the methodology section of this thesis, I tended not to give money to patients individually; instead I gave money (approximately \$2 Canadian) to Jamila, the nurse who facilitated my research, for each interview I conducted which she then distributed among all the patients equally when I finished my research in the village. I also took basic supplies, such as tea, sugar, and soap, to Grace, the head of the village, to be distributed among all of the patients. I felt overwhelmed by the requests for assistance by patients. I did, however, give Julianna money for sanitary napkins. I could not say no to such a personal and basic request.

Patients' Response to Work

Most of the staff members were clear about the benefits of work. James, one of the nurses at Uhuru, said,

...my role is to be together with patients supervising them to ensure the problem which brought them here is over. Return to normal. Also to treat them because some come with bad conditions and can't understand work, even how to cook, but we train them so that they become good workers when they return home.

He also told me that the village was good for patients because at the hospital the patients are “lazy”, and not talking to other patients, but at the village they are busy and engaged with one another.

There was a mixed response to work from patients. As Tuyu, the occupational therapist at Uhuru, phrased it when I asked how the patients feel about working: “Some feel good, others don't. If you tell them to go to the garden some feel like you are scorning or harassing them, but some feel it is healing.”

It seemed that there was some degree of flexibility regarding which duties were performed, but not a lot. James, the assistant head of the village, said that patients “have to work somewhere. Not only sleeping”, and explained that patients,

...get some introduction from the nurse so maybe first, second week they introduce the patient to all types of work. After some time we can learn what the interest of the patient is and they can do it.

One patient, Frank, told me he likes shamba (gardening) work and that it keeps him busy, not thinking about his past. He was told that he would rotate to other jobs, but after 1.5 months in the

village he is still in the shamba program. Julianna, however, said that she changes jobs often and enjoys all the jobs equally. She then went on to tell me that her favourite job is cooking. At the time of interviewing she was unable to work because she had hurt her jaw and was on painkillers. She explained that she had to go to the nearest village with a shop to buy painkillers and that they were expensive. She was responsible for this cost herself (with the 15 cents patients make per day distributed between soap, sugar, sanitary napkins, and tea, it is not hard to see why it is difficult to afford painkillers).

Ernest, a former patient, put it well:

A patient living here can get medication for mental illness it's not a problem but for other illness like malaria or any types of fever it's a big problem because the patient is supposed to wait for free transportation to town which is available at Tuesdays or Thursdays. Other days if patient get fever must depend on themselves. So you can see what a big problem it is.

When I asked about doing work, Ernest told me, "I was feeling good because there is work that I have done, like grazing cows, feeding chickens. I was happy. Getting exercise." Feeling productive and getting exercise were benefits that were mentioned by several patients when I asked them how they felt about working. Ernest elaborated on this when he told me that,

If they have patient suffering mental illness it's better to send them here because in the clinic they are only getting medication that can lead to tiredness. So it's better in the village they can do different kind of work. They will be physically and mentally fit.

Ernest was a patient who left the village a few months before I met him, but he returned periodically to continue with the batik and tie-dye work that Tuyu, the occupational therapist, taught him. The day I talked to him he showed me the large piece of material he had just dyed and which was lying in the sun, drying. He taught me with some pride how he had tied the string

to produce certain effects, and explained that there were other effects that could be produced if the string were tied differently. When I asked him if he was working at the time, he replied,

Yes I am continuing with batik because it was my plan before leaving here. My brother gave me capital, an amount of money then I sold contents for batik as you have seen today kinds of batik. It's my projects.

He has taken a skill he developed in the village, and which he seemed to enjoy, and is attempting to use it to start his own batik business at home, with the help of some money from his brother. In this sense the skills he learnt in the village seem to be benefiting him upon leaving.

Another patient, Kumi, told me that, "It was difficult for me because I wasn't participating before [in agriculture] even at home." Because he was not familiar with what was involved in agriculture, it took him a little while to adjust to working in the village. There was a great deal of variation regarding the backgrounds of patients in the village and their background affected their response to and adjustment life in the village in general, and more specifically, to the types of work required of them. The labourers and nurses fill out evaluation forms for the patients, so that patients can see their progress and areas of work that need improvement. According to Grace, the head of the village, this evaluation, although I did not get a chance to see one, reflects the patient's progress both in work and in their state of wellbeing.

Grace also told me that the staff and patients have a meeting at least once a month or more often if required, for example if a problem arises that needs addressing. The nurses have the most contact with patients, as they are the ones who administer medication and monitor progress and who talk to the patients about problems. The other staff members, such as the occupational therapist and the administrators, are also familiar with the personalities of the various patients.

Doris, a patient who had been in the village for 10 years, explained to me that,

We participate in agriculture at Monday up to Friday. Saturday and Sunday are break days. If you are allocated to livestock there is no break, only in agricultural activities. But in livestock, gardening there is no break days, no Sunday or Saturday, no celebration day. It's every day. I like agriculture, I am a good farmer. I don't want to be hated by doctors.

Her last comment suggests that being accepted by the “doctors” (Dr. Kilonzo, the psychiatrist in charge of the village, checks in on the village only periodically – perhaps once a month, so the “doctors” she refers to seem to be the staff at the village, including the nurses, occupational therapist and the administrators) is part of her motivation for working. At the same time, however, she has found enjoyment in the process of doing labour, evident in her next comment: “I love all works, like to cook, gardening, batik, making bags as you have seen outside there, the simple works, I love them.”

Other patients, such as Simon, echoed this positive response to life in the village:

S - During the night I feel happy. When I am away I am working tough jobs and here it is easier.

I - Because you can rest, get food?

S - Long time for resting.

I - Do you like to work in the shambas here?

S - I like.

I - Why?

S - It is exercise.

Patients articulated the ability to rest as being a positive aspect of life at Uhuru. This is something that distinguished it from their life before they arrived at Uhuru and the rest seemed to be an aspect of life at the village that allowed them to heal and get some perspective on their lives. In the second set of interviews I conducted, which were concerned more with the patients’

lives before arriving at Uhuru, the struggle to make money to survive was common to most of the patients' experiences, although there was a lot of variety in the ways they had earned money.

Like most patients, Fayaz arrived at Uhuru after staying in the psychiatric ward at Muhumbili hospital. His comments reflect the difference he felt between the hospital and the village and help to point out some of the reasons patients enjoy living in Uhuru. The fact that they were active and had relative freedom (this will be discussed further in the next chapter) were benefits of being there.

Fayaz:

F - I am improving well. At Muhumbili I couldn't sleep, but here I am getting it.

I - Do you like the village?

F - Yes because when you wake up in the morning can walk around more than Muhumbili where you are always inside. If you don't work you will not heal and improve. You work, you improve, you get strong.

Not all patients, however, agreed. Mapunda, the one patient I talked to when I visited Amani village, gave me a sense of his daily life in the village and was able to articulate his dissatisfaction with life in the village while capturing some of his ambiguity at living there. His wife was a nurse at Amani, and they had moved there together. I was informed by Andrew, the nurse in charge of Amani village, that Mapunda was schizophrenic. Mapunda himself, however, informed me that he had stomach problems, not head problems, and that these problems were a result of being in the village.

Mapunda:

M - What I'm trying to explain to you is there is no restfulness here.

I - Because you are working?

M - No I am not working.

I - Did you work before in the shamba or with the animals?

M - Just the shamba a bit. Because the stomach... the pain of the stomach makes me weak.

I - So what do you usually do here every day?

M - me I wake up, take a bath, I do some reading, I read the bible. I like the bible.

I - Are you helping your wife in the farm?

M - Yes I work in the farm.

Although at first Mapunda says he is not working, it is clear he is indeed working to some degree, and also staying active with reading when he is not doing physical labour. The day I talked to him he was planning on going for a walk outside the village and he wanted money for a coke, which I gave him. He said he enjoyed going out for a coke. Of all the patients I talked to, he seemed to have developed the most sense of routine. This could have been for a number of reasons. Perhaps it was a result of the length of time he had been there, three years, or the fact that his wife and their four children lived with him. Perhaps it is because his English was very clear and he was therefore able to articulate himself more fully with me, without the assistance of a translator. Whatever the reason, he seemed to have settled into life in Amani, although he displayed obvious distrust of the staff when he accused them of spraying something in his room that was causing his stomach problems. The fact that he was adamant about being there for stomach problems, and not for schizophrenia, as I was informed, struck me as somehow touching and reflective of some of the larger issues surrounding mental health, such as stigma and its impact on a person's identity.

Stories in Repair

Chaos is never transcended but must be accepted before new lives can be built and new stories told. (Frank 1995:110)

In this chapter I have outlined how the villages work, what daily life looks like for patients, and some of the patients' responses to work and life in the village. I have tried to capture some of the reality of the life of the patients – the financial hardships they face, the work they do and their feelings about that work. As there is little information available about rehabilitation villages in Tanzania, this chapter serves to describe daily life in the village.

It is hard to know how candid the patients were with me or whether they were giving me the responses they thought I wanted to hear. As patients still living in a psychiatric rehabilitation village, they likely were somewhat reserved in their critiques of the village knowing that they need the support of the staff in order to live there. The patients seemed a little uncertain at times about my motivation for being there, and who I was giving my information to, despite the fact that in each interview my research assistant went through the informed consent form, explaining the research and that each interview was confidential.

For the most part patients mentioned the benefits of living in the village; they talked of the ability to rest and the ability to work. They brought up the fact that as opposed to being in the hospital, they were not only on medication but were also able to move around and be “free”. They touched on the skills they were learning by being in the village. Most of the patients seemed to me to be in the midst of putting their lives together. They talked about the role the village was playing in their lives.

As they talked about their lives in the village, their narratives became less chaotic than when they talked about their pasts. The village provided them with structure, and their time there was finite,

so there was some frame for their discussion of living in the village. In many ways, it allowed them to begin to talk about themselves and their lives again as they formulated narratives around the new life they were living. This life was extremely removed from the lives they had all lived before moving to the village. It is as if it offered some respite and a break from their daily life at home. They were able to begin to make some sense of their experiences with mental illness or addiction, while at the same time being involved in work and part of a community. They had to re-conceptualize themselves, their daily lives, and their relationships, in their new environment. Their stories reflected this.

In the following chapter I focus on relationships; both within the village and family relationships. I talk about patients' hopes and goals for the future.

CHAPTER SIX: RELATIONSHIPS AND FUTURE PLANS

A recent survey on world mental health observed that in all different age, gender and cultural categories everywhere, the most important risk factor for mental health is social disruption. Social isolation also seems to exact a high cost. (Luhman 2000:20)

According to Dr. Mbatia, family is social security in Tanzania. Social networks are a vital survival mechanism and resource in Tanzania, where poverty is widespread and material resources are scarce for the majority of the population. This is reflected in agricultural psychiatric rehabilitation villages. One of the goals of the villages is to socialize patients and to create a sense of community where patients have some semblance of belonging. In my interviews I asked questions about relationships to see if staff and patients felt that a sense of community actually existed and if so, how it operated and what it meant to them.

The focus of this chapter is social relationships. The first part of this chapter deals with the concept of community within the villages – the interactions that occur between individuals, the relationships that exist, some of the roles people take on, and networking that occurs. The second part of this chapter deals with the importance and relevance of family for patients living in an agricultural psychiatric rehabilitation village. I then go on to discuss healing and the patients' plans and hopes for the future, as this seems like a fitting way to end my thesis.

Sense of Community

Staff

The way we talk and we live with them, they feel good. Also others don't want to leave this place because they get everything here... Life at home is too tough.
-James, nurse

There was consensus among the staff I talked to that they enjoyed working (and in many cases, also living) in the village. Several of them mentioned feeling satisfaction and pleasure in knowing they were helping people. Most of them had worked in the village for at least five years, some for ten years, and one woman for twenty-five years. They all felt a personal connection to the patients and knew details about many of the patients' lives. This seems inevitable considering that patients generally live in the village for at least three months and have daily contact with the staff. The staff members see the patients as villagers, not as patients, and can often be found talking to and joking with the patients. The staff and patients meet monthly to talk about issues that arise in the village and this time allows patients a chance to voice their concerns. Generally patients have daily contact with the nurses and occupational therapists. The nurses oversee their use of medication and talk to them about their progress, while the occupational therapist helps them with skills such as personal hygiene and craft making.

In both of the villages I visited, some of the staff live in the village. Although they have their own areas/houses on the same grounds and they prepare their own meals and eat separately, their lives seem very much grounded in the village. One of the nurses, for instance, has a daughter with multiple sclerosis who is in a wheelchair, and living in the village makes it easier for her to go home and check on her daughter and take care of her throughout the day.

The staff members have an understanding of mental illness and an empathetic attitude towards the patients, likely developed through years of working with patients facing similar issues and

struggles. This attitude in itself undoubtedly makes the village a more comfortable place for patients to live as they are automatically accepted by the staff, and also by other patients. One of the occupational therapists talked about the need to listen to the patient to find out what kind of work the patient wants to do so that they aren't being forced to do work they aren't interested in.

One of the male nurses, Joseph, said that he sees the patients as friends and that the patients often call him and other staff members "grandfather", "uncle" or other family names. He said that he talks a lot with the patients and that he uses talking to them as a chance to teach the patients about things they might need to understand. He said that he is happy when patients leave because, "My target is that someone returns to normal, gains understanding, is going to do things clearly, and his or her relatives will be happy." Although he lives at the village, his wife and children live with his wife's family. When I asked about this, he replied, "I don't allow children to have contact with the patients, it's not good somehow. Maybe they meet when walking it's okay, but we don't allow contact. Other patients, if they meet our children, they can beat them." This seemed to contradict what he told me about feeling as if the patients are his friends, but reflects the perception that many people have of mental health patients being unpredictable.

I noticed very few altercations in the village, although I did see one of the patients yell at people twice. Julianna always noticed our arrival in the village and sauntered over to us and spent quite a bit of time making small talk or complaining to us about something or asking us questions. Some days she sang several songs for me and on one particular day she brought me a gift of lettuce from the garden for which she was later told off by the occupational therapist as the lettuce belonged to all the patients and was not hers' to give away. This resulted in her yelling at the occupational therapist about how she felt like she was in prison and was tired of working. She stormed off and the occupational therapist laughed.

On another day one of the patients, Frank, came in for an interview and, noticing that Julianna was sitting with us, commented that she should be working like everyone else. Julianna got extremely upset. She began to yell and called Frank a “motherfucker” (in English) and threw something at him. Her response to the occupational therapist who told her off for giving me lettuce was similar – she yelled loudly and swore and then stormed off. Talib, the assistant administrative head of the village, commented about Julianna that, “right now if you talk to Julianna you have to calm her down at least to soothe her. She even thinks about wanting to die so I tell her why should you die what does it help you?”

This attitude of attempting to understand and communicate with the patients seemed common among staff. Although tensions did arise, they generally were smoothed over on their own or were ignored. Talib felt that the patients, “feel safer when they are here. Even safer than at home.” When I asked him to elaborate, he replied, “Because we are treating them here. We trust them, we respect them, we give them rehabilitation. We take them just as normal people.” When I asked Grace, the head of the village, if she felt that she knew the patients, she replied, “Yes, I know them. You talk to them, you know them. Once you know them you can help them.”

Patients

Most of the patients I talked to made reference to a sense of community in the village. They spend time together while they are eating, when they are doing their work, and when they are resting in the afternoon. The patients all mentioned talking with other patients during this time. Frank said that when they are finished work, patients talk together, and that he likes to talk about his problems and tell the other patients his life story. He said that knowing about the other patients makes it easier for the patients to help one another. Doris said, “I love my fellow patients because we are friends, discussing ourselves, our mental illness.” Kumi echoed these sentiments

by telling me: “I have been here for a month talking with them. I love them. We share a room, living as friends; if we are similar we can become best friends.” Nicholas commented that having other patients around keeps him from being lonely: “I don’t feel alone. I feel happy because I am living with people. Sometimes resting together with other patients, we are talking as usual. I feel like this is home.”

When I asked Ernest, who had left the village several months earlier but returned periodically to work on batiks with the occupational therapist as he hoped to start his own batik business, how he felt about the other patients, he replied, “I am missing it here, but anytime you leave a place you must miss your friends.” When I asked Mary what she talked to the other patients about she said, “the usual things.” Julianna mentioned singing with the other patients, teaching them Christian songs and also playing games with them. She said she tells them about her problems, but not everything; she keeps some secrets from them.

The fact that patients felt close to other patients is natural. They have been physically separated from their homes, communities, families, and friends, and they are receiving treatment for mental illness or addiction. Their identity is stigmatized by these labels. In the village they are around others who are dealing with similarly stigmatized identities in a country where public awareness about mental health is slowly growing. With the other patients they do not need to worry about stigma or feeling alienated; they are all in the same position. This creates an instant connection and common ground between patients and allows for some degree of comfort and familiarity in their relationships with one another. They live together, work together, eat together and spend their free time together. It is inevitable that they grow close to each other.

This is not to say that relationships in the village are always harmonious, however. Julianna had a few conflicts with staff members when I was at the village and seemed to resent being told to

work. She said that she doesn't like to be controlled and that she likes to play and not "work like a slave." She was the only patient who openly complained about working in the village. She also told me that some boys from the community surrounding the village throw stones at the doors and windows of patients and claim that they have slept with her although she said that they haven't. None of the other patients talked about the community surrounding the village, except to say that they left to buy basic goods (soap, toothpaste, sugar, tea) in dukas (small stores fashioned out of old shipping containers or even just a few pieces of wood forming a table stall) in the nearby villages. Julianna's description of her run-in with the local boys was the only time a patient mentioned a negative interaction with the surrounding community. It drew my interest as I was suddenly curious who these boys were and how they, and the rest of the surrounding villages, perceived the patients in Uhuru village.

A few of the patients mentioned not being able to leave the village when I asked how they felt about living there. Frank said that although he could talk openly with the nurses, he needed permission to leave. This suggests a power imbalance in the relationship between nurses and patients, whereby, the nurses are in control. This dynamic played out in the first few interviews I conducted where Jamila, one of the nurses, sat in and watched the interviews. The patients in these interviews seemed more subdued and complacent than when I talked to them alone. They kept looking at Jamila as if to verify they had given the "correct" response to my questions. Several of the patients used the word "abscond" when talking about leaving the village, as an option they had. One day Julianna, one of the patients, asked me for money so that she could take a bus home; she said that there were too many problems in the village such as no water, no food, and too much work, and being too busy.

On another occasion, one of the patients, Mary, left the village for a day and Julianna told me she had "absconded" and that she was never coming back. When I returned to the village the next

day Mary was there and explained that she had left the village and taken a bus to see her sister who took her to the doctor to see if she was pregnant (it turns out she was not). When I mentioned her leaving to Talib, the administrative assistant, he was not aware she had left at all and did not seem concerned.

A few of the staff also used the word “abscond” when referring to patients leaving the village. The choice of the word and the fact that most of them knew this word in English without much fluency in English, is interesting. It suggests that although there is rhetoric in the village of patients being there willingly, there is a degree to which patients feel they are unable to leave until given permission by the medical professionals (the nurses, mostly, as the psychiatrist rarely visits the village). This speaks to Nick Crossley’s point brought up earlier about the power of psychiatry to ‘disqualify’ patients, and create a sense of learned helplessness among them (2004:169).

Margaret, only in the village for four days when we met, talked about wanting to leave the village as she repeatedly told me, “I feel like a normal person.” She said the staff thought that she needed to be there, but she knew she was fine and was just waiting to leave and go find her son. She also mentioned being scared of the other patients, who she said beat her: “When they start beating me, I am just praying to my God to ask for help because I have no power, no strength to fight them.” I never saw any physical altercations between patients, and none of the staff ever mentioned anything to me about it, so I am still unsure whether or not patients were physically attacking Margaret in the village. However, the fact that she had a negative perception of other patients matters more to me than whether or not they beat her. It suggests that she did not feel safe or comfortable around the other patients. She was only in the village for a few days when I interviewed her. I would have liked to have talked to her again after she had spent more time in

the village, to see if her perceptions had changed at all. Unfortunately, I left Tanzania a few days after meeting her.

Family

Staff

As was established in the chapter on the patients' lives before they arrived in the village, family and friendships are important for most people in Tanzania. For mental health patients, they are a vital part of their support system. Families were mentioned repeatedly by staff and patients alike in terms of their involvement in the healing process and how essential they are in the path to wellness and rehabilitation.

Staff members talked about the involvement of families in the village and the fact that ultimately if a patient doesn't have any family or support system they are unlikely to be admitted to the village. The role of family in reintegrating patients into society and in helping them financially is invaluable. There is a hostel in the village outside of Dar Es Salaam where, theoretically, families can stay overnight for visits at the village. However, this hostel was out of commission when I was there. The staff all said that families are encouraged to visit so that they can maintain a relationship with the patients, see the patients' improvement and progress, and to learn about mental illness and how to deal with it.

There is one patient, Doris, who has been in the village for ten years because her family is very far away. She is the exception in the village as most of the patients spend three months to one year there, with six months being the average duration of residence.

Dr. Mbatia, the psychiatrist working at the Ministry of Health, said that poverty and marginality in Tanzania leads to dependency upon family. He stressed the need for family to be involved in treatment for mental health patients. Dr. Mbatia explained that because some of the patients' illnesses are chronic and long term, their families may give up, but that they are urged to visit the village regularly and to talk about the home environment, life in the community, patterns of the patient, and their roles in the family. He said that although most of the patients' families are living in poverty, they make an effort to help the patients. I was struck by the level of disclosure that seemed to occur with families, by health care professionals, and mentioned this to Dr. Mbatia. I explained to him that in Vancouver I have heard repeated complaints by the families of mental health patients that although they want to help their mentally ill relatives, they are not included in any discussions of treatment due to confidentiality laws and practices. There are now family advocacy groups struggling for inclusion in the mental health care treatment of their relatives. Dr. Mbatia seemed surprised by this and said that as a clinician the families and patients invest trust in him and everything he discloses or says is always in the interest of the patient. He said that in Tanzania there are not the same ideas of confidentiality between patient and family, mostly because the family is instrumental in helping the patient reintegrate and rehabilitate. He said that, "whatever is good for the patient is important for the family." He also said, however, that sometimes contact with family can lead to patients experiencing relapses, and that family arrangements are often not as supportive as they could be.

Grace, the administrative head of the village, put it simply: "Once you don't have family you can't do anything because once you are discharged you have nowhere to go. So you have to cooperate with the family." She, like some of the other staff, commented that, "Anybody who comes here must have a relative" because otherwise the patients will stay too long. Some of the staff acknowledged that it is very difficult for patients whose families live far away and said that those families do not visit very often or at all and that this is hard on the patients. Joseph, one of

the nurses, said that, “When they don’t come to visit, the patient becomes more confused because they feel their family left them alone.” Even when families are far away, Joseph informed me that a social worker will try to track them down and keep in touch with them so that they are prepared for when the patient returns home, because families are “a vital role of healing.” Andrew, the physiotherapist at the village outside Moshi, said that if families don’t visit, the patients, “get frustrated, and after this frustration they become unmotivated. It is increasing the illness.” A psychiatric nurse, Tizo, said that if the families aren’t involved then the staff members “are going to release them to no care.”

The staff articulated a sense of continuity of care from the village to home. The role of family in this transition was deemed pivotal. Johnson, the nurse in charge of Amani village outside of Moshi, said, “You have to communicate with the community also so they can accept the patient before discharge.” The occupational therapist in Amani village mentioned that he has gone into communities before and talked to non-family members about the patient to help ease their transition home. Talib, the assistant administrative head of the village, mentioned that, “for even some of the relatives of patients after being at Uhuru for some time after discharge after going back home they still don’t trust the patient. So some of them relapse, they come back again.” This is an interesting point as it suggests that the patients’ degree of wellness can be affected drastically by the perception their relatives have of them.

Despite how important the staff said that family is for the patients, I did not once see a family member in the village in my 6 weeks there. Granted, I was not in the village on the weekends which is when families are more likely to have the time to visit. Patients provided another picture of how often their families visited.

Patients

Most of the patients talked about their families in a relatively positive light; they missed them, they wanted to see them, they hoped to live with them when they left the village. However, generally patients did not see their families very often while living in the village.

Nicholas, for instance, when I asked him how often he saw his family, replied, “Here it is only one time, they came two weeks ago, have come to see me only one time. I didn’t visit them according to the procedures here. I am not allowed so I am just waiting for permission.” A few of the patients mentioned not being able to go to visit their families, and implied that this was something they would like to be able to do. However, Ernest told me, “My family visited me and I have visited them two times,” so perhaps for some patients exceptions are made and they are allowed to travel home.

Kumi said, “I see my family. Sometimes they come every end of the month or after three weeks. But several times they come more than the days which do not come. I don’t visit them because I am not allowed.” When I asked how his family felt about his living in the village, he replied, “I don’t understand because we can’t talk deeply so I don’t understand honestly whether they feel good about my being here or they want me to go home. I don’t understand.”

Doris, who has lived in the village for ten years, said, “I don’t see my family for a long time because I came here from faraway Kigoma. It is too far. I couldn’t see them since I have been here also couldn’t visit them because it’s so far.” Julianna, also from a village in the North of Tanzania, said that she has not seen her family since being in the village. She said it is painful, but she is used to it now. She said she feels “strong like a man” now and she thinks a lot about her own daughter and how she is living in the world. Her daughter’s father takes care of her

daughter. She said, “It is rehabilitations which have helped me because my family didn’t want me.”

When I first interviewed Mary she said that her family comes frequently. She is happy when her father and two small siblings visit and they talk and greet each other. In my second interview with her, however, she said, “My young brother comes, then my sister, it’s only two times [in three months].”

Frank said that his family comes every week and stays for “some time” and that his family thinks the village is a good place for him and wants him to “follow the procedure” at the village. He then went on to say of his family that they are “making me uncomfortable” but did not elaborate on this.

Simon said that he is “depending on people” because his “father is gone now.” He said his uncle can’t visit him, but his small sisters do visit, almost weekly. They bring him money “for food. For sugar. And bread.” When I asked him where he would live when he left the village, he replied, “When I talk to my uncle who sent me here then I will know where I am going to be.” In his next interview he said, “I will live with my relatives... they will help me, prepare a place to live. Together with them.”

Fayaz said, when I asked about his family, “It’s been seven months now that I haven’t seen them. Before I visited them, but after being ill I haven’t seen them.” I asked if he missed them and he said yes. He said “My family are far away I didn’t contact them. There is no way to contact.”

When I asked Mapunda, the patient I interviewed in English in the village outside of Moshi, whether he thought that most patients’ families understood the patients, he said,

They are not liked by their families. Their families bring them here and they leave them here. They don't bring them money; they don't pay for their toothpaste. For example, we get injection. The government pays about 5,000/= [\$5]. The patient is required to pay 1000/= and they can't afford because their families don't give them money they just abandon them.

When I asked why he thought families abandoned patients, he replied,

Because they are not people who are productive. Productive people. They don't have incomes. They don't have children. They don't have wives. And they don't have husbands to support them. They are people who have been afflicted. Afflicted persons. People who don't have a good life.

When I asked him if his family visited him in the village, he replied, “Yes they come. They argue me to stay. They say it is good for me here.”

There was some variation in the frequency with which family members visited the patients. Some of the patients had not seen their families since arriving in the village and others saw their relatives every week or two. Those whose families did visit said that they depended on their families to bring them basic supplies like soap and sugar and tea. I had the impression, after conducting interviews, that families were less involved in treatment than the healthcare professionals wanted me to believe they were. Although there is a lot of rhetoric about including family members, the reality differs. For various reasons, mostly financial and practical factors like living far away from the village and the cost of travel, family members are unable to visit as frequently as the patients might like. As Mapunda points out in the excerpts above, there is still a great deal of stigma around mental health. This could also be a factor in why family members do not visit the patients regularly.

Healing in the Village

Staff

*It helps them. You can see the difference before and after –Johnson
(nurse at Amani village)*

*The village like this it is essential for these patients because you occupy
their mind, you are using their body –Andrew (occupational therapist at
Amani village)*

Andrew, the occupational therapist who worked in the village outside of Moshi, was in his mid-twenties and extremely passionate about his job as an occupational therapist in the village. He spent quite some time explaining to me an intake assessment form he had designed for the patients. The form seemed extremely comprehensive and highlighted, to me, the degree to which the staff members become familiar with the patients. I am including Andrew's description of the intake form to capture the complexity of mental illness and all the factors that are affected by it and the areas the staff focus on in this particular village:

Social history, economic history, personal history of illness, present situation, appearance... we are looking for the social... for how this social affects their relapse. How this is affecting the illness. How it is contributing. How often relapsing and what is the reason which he was. Things like that... behavior issues, cognitive issues, occupational conference, perception, cognitive ability – concentration, attendance, problem solving, whatever. How he is doing things. Perception. How he perceives each and every thing in his environment. Motor function. And psychological well being. Mood changes. Self-care. Washing, toilet issues, dressing, combing. Leisure. Free time is spent for what? Productive activities. What he likes that day.

Living in the village is meant to be holistic for patients. As the above quote shows, the staff members pay attention to the details of each patient's unique situation: their history, their various abilities and strengths. There is recognition by the staff members that each patient has a complex

history and symptoms which need to be treated and there is an attempt to address each patient's needs individually.

Patients

Most of the patients seemed to feel that living in the village was beneficial for them and that it was a good place to be for healing. As mentioned in Chapter 4, most of the patients talked about medication and psychiatry as being helpful. Kumi ended our interview by stating,

I would like to say one thing. It's a good place here. If you have tolerance, obeying orders from doctors, respecting nurses, living peacefully and obediently then you will see changes to your condition. There will come a time when you stop taking medication to be a normal person in the community.

Ernest identified work as an important aspect of healing in the village. When I asked him what he would recommend to people experiencing mental illness, he replied,

That if they have a patient suffering mental illness it's better to send here because of clinic only getting medication that can lead to tiredness. So it's better in the village. They can perform different kinds of work so they will be physically and mentally fit.

Generally patients were positive when talking about life in the village and its effect on their well being. Doris, for instance, said,

I feel happy on how they treated me... I feel happy, comfortable to be here because I know that I am going to be against this illness. I feel happy here, I feel like I am already improved, I feel like this is home. When I feel abnormal changes to my body, just tell a nurse or my fellow patients that "today I feel abnormal to my body", they take the process of healing me. Like today I have a shaky hand so I want to tell a nurse to treat me.

This quote touches on the importance of having people close by, such as nurses, who are trained to deal with illness - physical and mental - and who can respond to problems as they arise. It is

interesting to compare Doris' response of telling a nurse about her hand to Mary's reluctance to talk about her pregnancy with staff at the village. The pregnancy is a much more personal and emotionally complex health issue and perhaps there is not a level of intimacy or comfort with the nurses that allows such conversations to occur. In retrospect, I wish that I had talked more to Mary about her thoughts about being pregnant, but at the time, she seemed reluctant to discuss the issue and I respected that. Mary commented, when I asked her about whether she has seen any improvements in herself since living in the village, that she used to hear voices and talk to herself, but does not anymore. She said she was "happy to be here. It is beautiful. They treat me well." The doctor told her she has another two and a half months to live there and she was happy with that decision.

Frank compared the village to being in the hospital and said that at the village he felt free, whereas being in the hospital was like being in prison. He also said that he has improved since coming to the village because being there keeps his mind busy so he is not thinking about the past. Fayaz, who said, "I am improving well here," also compared the village to the hospital. When I asked him if he liked the village, he replied, "Yes, because when you wake up here you can walk around more than Muhumbili. There you are always inside."

Simon said that being in the village "is a cure because the mind is resting. It is very nice. Helpful. During the night I am feeling very happy. When I am away I am working tough jobs and here it is easier. Long time for resting." John similarly said he has improved and that he likes the village because outside of the village, life is hard. He also mentioned twice that he is ready to go home.

A few of the patients mentioned being ready to leave, but said that the staff did not think they were ready. This is interesting, and begs the question of just how optional it is to be there. The

patients could “abscond”, but the implicit trust that many of them have in the doctors, leaves them doubting their own ability to judge when they should leave. Instead, they defer their decision to the staff. This is often a feature of mental illness: questioning one’s own ability to make decisions.

Mapunda, the patient outside of Moshi who several times denied having mental health problems and insisted he was living at the village because of his stomach problems, summed up simply how he felt about the village. It is the only segment of the interview I conducted with him in which he acknowledges his mental illness:

I – Has your condition improved since coming here?

M – Yes. It improved much.

I – Because before you had problems in your head?

M – Yes and now I have less.

It is clear that relationships are vital for mental health patients in Tanzania. They are integral to identifying mental illness, they are integral to seeking help or treatment, they are integral to living in the rehabilitation villages, and they are integral part to leaving the villages, and starting life over again. Family is the crux of survival in Tanzania and can be broadly defined, as with several patients who referred to other patients as “brothers” or “sisters.” The social aspect of the village is a large part of the reason patients say they enjoy living there. Rather than dealing with the ostracism and alienation they experienced when their symptoms first began, they are around people with similar problems and who face similar issues. This offers some support and comfort at a time when the patients are putting their lives back together again in most cases. They are trying to rediscover a sense of normalcy and balance and are planning their futures, trying to gain the skills they need to survive outside of the village after a few months. The support of staff and

fellow patients in a place where there is a semblance of community and where they are not judged for their problems without a doubt benefits their healing.

Future Goals of the Patients

When we empathize with someone through the psychodynamic model, we empathize with the unique life course of that person: his hopes, his losses, his mistakes, his frailties, his courage and his strength. (Luhrman 2000:276)

Hope can arrive only when you recognize that there are real options and that you have genuine choices. Hope can flourish only when you believe that what you do can make a difference, that your actions can bring a future different from the present. To have hope, then, is to acquire a belief in your ability to have some control over your circumstances. You are no longer entirely at the mercy of forces outside yourself. (Groopman 2005:26)

In order to get a holistic sense of their lives, I asked patients about their goals and plans for when they left the village. Living in the village was, for most of them, only a few months to a year out of their entire life. I wanted to know how they saw their lives continuing once they left. Mental illness or addictions in any context rupture a person's life in serious and often traumatic ways. In a country where the majority of the population lives in poverty and for individuals who are not, generally, educated beyond secondary school (most of whom, in fact, did not finish secondary school), dealing with mental illness disrupts their already limited options for survival. I was curious if the patients could envision a life for themselves outside of the village and what they wanted to do.

Nicholas was somewhat optimistic about his future. He said, "Since I am in this village, so grateful. Improving well... because I am going in a good direction." He went on to tell me, "after leaving here I plan to go home to my family, maybe I will get a sponsor to bring me any activities among those in which have learnt here maybe I will be able to develop."

Ernest, the patient who had already left the village and had returned to work on a batik project, explained, “Yes, I am continuing with batik because it was my plan before leaving here. My brother gave me capital amount of money. As you have seen today the kinds of batiks, it’s my projects.”

Doris has lived in the village for ten years and the staff commented that she would likely be there for quite some time, as it seemed she had nowhere else to go. However, she told me that her plan was, “to go home to take care of myself like that time when I was living with my relatives... so I will start the process of developing myself as we do here, like making batik, bags, sewing things. I know these things.” This quote draws attention to some of the skills she feels she has gained in the village and sense of confidence that she feels of “know[ing] these things” and her hope that she will return “home” one day, despite seeming unclear about where “home” is.

Most of the patients talked about returning “home” to live with their families after they left the village. Mary told me she, “will return home near Temeke” and “will do business, cook, sell food.” Frank said he will return home and his family will help him with money and school.

Some of the patients talked about wanting to earn money to help others. Julianna’s plan was to clean houses and to, “start selling fresh milk, cake, eggs, making chapattis so I will be okay I hope.” She said she wanted to make enough money to pay her twelve year old daughter’s school fees. Margaret said she, “will go to look after my children to care for them... to treat them well as mother to cook for them, washing their clothes; it’s my work.” Fayaz said that he wanted to make carpets. He told me: “My hope is to get improved and make money to help my mother.” When I asked him why he wanted to help his mother, he replied,

B – Because she is the only one who led me to become a man like I am.

I – Now you don't see your mother?

B – No

I – What do you feel about that?

B – I feel pain because it's a long time I have been living without seeing my mother. I am missing her so much.

I – When you leave you want to see your mother?

B – Yes. It is tomorrow I will be going to my mother. I love her. I want to see her and to stay together.

Although he didn't leave the next day, and likely did not leave the village for a while after making this comment, it captures the desire he had to be home with his mother and some sense of the frustration patients felt in being far away from their families.

Simon and John both said that they wanted to start their own businesses but needed money first. In my second interview with Simon, however, he said, "I want to rest. I am 50 years old... I want to get married so that she can cook and wash for me." Mapunda similarly told me he would not work when he left. He said, "I am an old man. I am 56 years old." The notion of 50 being old took me by surprise until I thought about the fact that life expectancy in rural Tanzania is significantly shorter than life expectancy in Canada.

All of the patients articulated some sense of their goals for when they left. They had envisioned their lives after leaving the village to some degree. They were generally realistic about what was possible for them considering the resources available to them. From an outside perspective, their goals come across as humble, simple goals. For the patients, however, their goals represent positive steps towards taking control of their own economic reality. Their goals were to work, essentially; to be able to support themselves, and in some cases support their families. They wanted to return to live with their families and reintegrate back into a daily routine with a sense of purpose and a sense that they are contributing financially to their own, and their families',

lives. For patients with mental health issues that range from addiction to schizophrenia to bipolar disorder, being able to work and earn money and maintain positive relationships with a social network is no small feat. It is the goal of most rehabilitation in mental health: to allow the patient to live a satisfying life in which they are engaged and active members of a community. Living in a rehabilitation village gives the patients I talked to in Tanzania an opportunity to develop some of the skills necessary to do this.

Healing Through Stories

Stories have to *repair* the damage that illness has done to the ill person's sense of where she is in life, and where she may be going. Stories are a way of redrawing maps and finding new destinations. (Frank 1995:53)

By daring to imagine lives for themselves beyond the village and beyond their illness or addiction, the patients I talked to were healing themselves through their stories. They were “redrawing maps and finding new destinations.” Mental illness, like any illness, interrupts a person's life. In many ways, it puts a life on hold. According to Frank, “Telling an interrupted life requires a new kind of narrative” (1995:58), and this is what the patients have created when they talk about their futures. Their new narratives involve possibility and hope and life beyond illness. They may be simple, but by imagining futures that are *possible*, patients are creating order from the chaos and interruption caused by their illness. By doing so they are defying the illness itself.

Relationships play a key role in this redefining. Through their interactions with other patients, the staff, and the labourers, as well as through the contact with their families that some patients spoke of, the interviewees were able to redefine themselves and begin to see themselves as more than mentally ill or addicted. They were able to see their strengths and in turn to look outward to life beyond the village and to imagine themselves returning to their communities and families and

reintegrating. It makes sense that patients would talk about their lives in terms of the people they are connected to. When a life is disrupted, as it is by mental illness and addiction, a person's frame of reference is lost. Their sense of self has shifted. As their life begins to unravel (as they lose their job or quit working; as it becomes increasingly difficult to take part in simple parts of daily life; as they alienate people they know), they need to find a new frame of reference. The danger that those experiencing mental illness or addiction face is the tendency to isolate when they begin to feel confusion or despair. This isolation compounds and magnifies the symptoms they are experiencing. The fact that relationships are emphasized in agricultural psychiatric rehabilitation villages, in addition to the structure and routine provided by daily schedules involving work, makes it impossible for patients to isolate themselves. They are encouraged to rely on their social support system, to create a new frame of reference based on that support system, and to piece together a new story for themselves.

The chaos that linked the patients' stories about their pasts was not existent when they talked clearly and assuredly about their futures. Their time in the village gave them the space to adjust to their illness or addiction, to recognize their worth despite their illness or addiction, and to imagine lives for themselves beyond their illness or addiction.

CONCLUSION

The way we as a society conceive of mental illness matters. It affects the way mental illness is experienced by those who deal with it. (Luhrman 2000:266)

There is still a large degree of stigma surrounding mental health in Tanzania. This was evident in the interviews with health care professionals who talked about the need for education, particularly in rural communities, so that patients are able to return to their communities and be accepted rather than ostracized. In a country where the majority of the population still lives in rural areas, it is difficult to disseminate information. When HIV and AIDS is a national health priority and the majority of resources and energy in public awareness campaigns go to life threatening illnesses such as these, mental health is low on the list of priorities. In Tanzania there is, therefore, still a great deal of mystery surrounding mental illness; whether its causes are supernatural or biological; whether it is best treated with local healers or at the nearest hospital. This ambiguity was evident in the interviews I conducted with twelve patients, several of whom had tried multiple forms of healing, including local healing and faith healing through prayer, as well as biomedicine.

Resistance

...psychiatric knowledge seeps into popular culture like the dye from a red shirt in hot water... (Luhrman 2000:20)

I found in my research, both in the literature and talking to individuals in Tanzania, that individuals' perception and experience of mental health is directly related to the way it is framed within a culture; by biomedical professionals, the media, and the way it is talked about in the

general public. This perception is reflected in the way we experience mental illness. In many ways the patients' experience has been decided for them by the way mental illness is conceived of within their culture and the way that others relate to them based on this pre-conceived notion. Despite this, there is a degree of resistance in terms of how patients deal with, experience and talk about their 'illness'. One of the most interesting parts of conducting this research was witnessing the agency that the patients exhibited and vocalized.

This sense of resistance was evident throughout the interviews. Much like the "everyday forms of resistance" that James Scott elaborates on in his article 'Everyday Forms of Peasant Resistance' (1986), the patients I talked to used subtle forms of resistance to assert themselves. An example of such resistance is the patients using illness as a reason not to do any work. There were times when the patients would have minor injuries or illnesses, such as a sore throat or ear ache or pains in their hands or feet, and would not work for a day or two. Rather, they stayed in their rooms or near their rooms, spending their time as they chose. When I first visited the village with Dr. Kilonzo, he joked with one of the patients who wasn't feeling well and told him he should get better quickly so he could get back to work. The patient smiled and laughed.

Another example of resistance expressed by patients is when Mary left the village for a day without telling any staff members to meet with her sister and to see a doctor. Although patients are supposed to get permission to leave the village and are generally not supposed to leave the village unescorted, Mary made the decision to leave for personal reasons and then return again once she dealt with her situation. It seemed that staff members were not aware that she was gone or if they were it was not a big deal. Rather than waiting (or asking) for permission, Mary made an autonomous decision related to her own health to leave for a day.

On several occasions when I was present in the village, Julianna refused to do work, or complained about work while she was doing it. This is a resistance strategy as well. She worked when she wanted to work and did not work when she did not want to. As such she controlled how she spent her days and asserted herself against the authority figures she perceived as trying to “control” her, as she put it. As a result, however, a staff member usually talked to her when she refused to do work. I am not aware of any repercussions she faced as a result of not working aside from being talked to.

When some of the patients talked about ‘absconding’, or leaving, the village, they were resisting. I do not know what would have happened if one of them had left and not returned, as I did not see any patients do this. Interestingly, of the several patients who mentioned wanting to leave the village, none did. These same patients talked at other times about reasons they enjoyed life in the village. It is not surprising that patients would be both grateful for having a place to live and receive medication, and simultaneously feel frustrated and trapped and eager to return to their homes.

Patients also expressed resistance through telling their stories and talking about their futures. Storytelling is resistance in itself; it is saying that one’s life is worth talking about. In a country where the majority of the population has limited prospects, the patients in the village dared to imagine a life for themselves. They talked about their plans; how they would earn money, where they would live, who they would help, the relationships they would work on and create. Being vocal about their hopes for the future was the patients’ way of saying that they believed in their ability to start their lives again against all odds, which is perhaps the strongest statement of resistance.

The final way that patients displayed resistance was through their relationships: with one another, with their family and friends, and with the staff in the village. Relationships can be seen as resistance in that they exhibit a reaching out and connecting with others despite the constraints patients feel on psychological and societal levels. Regardless of the stigma, mystery and confusion that surround mental illness and addictions in Tanzania, the patients have maintained relationships. They have salvaged enough sense of self-worth and holism to understand the importance of relationships in their lives. These relationships have been instrumental in sustaining them to the point of being able to talk about the future and imagine a life for themselves beyond the village and beyond their illness or addiction.

Relationships

When medications take the place of relationships, not only do patients suffer the side effects of aggressive medication, but they lose the healing power of the relationship. (Luhrman 2000:259)

Luhrman, in her 2000 book *Of Two Minds; The Growing Disorder in American Psychiatry*, writes about the two competing ways of looking at and treating psychiatric illness in the United States. These are the biomedical (or pharmaceutical) model, and the psychodynamic model. She writes that, “The way we understand these illnesses affects not only the way they are treated but the way they are experienced, their outcomes and our sense of responsibility to those who suffer.” (Luhrman 2000:20) If we see mental illness as purely biological and reduce it to a chemical imbalance then when medication fails to help, patients potentially lose hope and a sense of humanity. If, however, we are able to see mental illness as a deeply human condition and to treat it as such, using social relationships and connection as an intrinsic part of the healing process, then perhaps patients will be less likely to lose faith or to give up on themselves. Alienation is inevitable with mental illness. The state of being mentally ill, and the confusion and changes in

moods and thoughts it brings, alienate a person from themselves, as well as from those they know and love. By focusing on the humanizing aspects of treatment and healing and the social forces available to support patients, it is possible to reduce the alienation that mental health patients experience.

The patients in the village complained at various times about being in the village and as time passed, some of their issues with the other patients or staff became apparent. Ultimately, though, all but one of them expressed gratitude for the relationships they had developed in their time there. The connections they developed were not difficult to see as they sat around the one water tap talking and waiting their turn to fill their buckets with water, or as they talked or sang as they swung their hoes into the dirt. Even when they weren't talking, there was a sense of cooperation necessary in order to complete tasks, such as collecting chickens' eggs or cooking dinner, together. The socialization element of living in the villages is the key upon which the patients' wellbeing hinges.

Andrew, the occupational therapist at Amani village outside of Moshi, articulated this when he said, "Socialization is the most important part." He went on to say that,

...small groups, small friends where they meet talk, are so important. To share their problems. They get the method of how to go about your own problem and hear from someone, it's very important... That's why I think these villages are good. Because patients live together with other patients. They are not alone, they can talk about problems.

Some of the staff members also live in the village, and are on-site most of the time. This fosters familiarity and a sense of community. This is the "healing power of the relationship" that Luhrman refers to. In a country where social networks are vital for the majority of the population to survive, it is extremely prudent that the treatment for mental health patients includes a

component of socializing and working with others. It is not an individual-based model of treatment. Patients do not receive daily counselling sessions with psychiatrists and are often not aware of the medication they are taking or the illness they have been diagnosed with. They do not seem to find this information relevant. Rather, they are engaged with others in completing tasks and working. This helps to ease their transition back to the community.

Clearly agricultural work is not as prevalent in Tanzania now as it was in the 1960s when rehabilitation villages were first created. Only a few of the patients talked about wanting to be involved in agricultural work once they left the village. Most of them wanted to start small businesses or go back to school or engage in work such as cleaning homes. Yet most of them found life in the village useful as a stepping stone towards their goals. Perhaps this just reflects the lack of options mental health patients have for treatment in Tanzania. Many of them compared the village to the psychiatric ward at the hospital and the village came out favourably in that comparison. Patients noted the ability to walk around, to be “free”, to talk to other patients, and to work, as reasons they preferred living in the village.

The villages give patients the chance to exist without judgment – to be engaged in work, to live among peers, to plan for their future. They offer some respite when life becomes overwhelming, confusing, alienating and disorienting. Most patients stay in the villages for three to six months before returning home, and very few patients ever return to live in the village. They reintegrate into their communities. Living in the village allows patients to see themselves as whole individuals again, to regroup and re-gather in many ways. Although they are suffering from illness, they are given a chance to find new strengths and develop their communication skills. This connects to Luhrman’s idea of “intentional, effective personhood”:

Circumstances are obviously important. It matters enormously that you suffer from schizophrenia or bipolar disorder, that you were born with a

vulnerability and that the vulnerability has become an illness, that you were traumatized by events outside your control. This is the context of suffering. Yet within those circumstances you must learn to see yourself as an intentional, effective, whole person and be so perceived by others. Those mutual commitments create the conditions for intentional, effective personhood. (2000:290)

By not focusing on the diagnosis or illness, the patients are given the space to focus on moving forward in their lives by adapting to their conditions. They are allowed a chance to imagine a life that feels both possible and manageable.

It is clear that there is a lack of resources available for agricultural psychiatric rehabilitation villages in Tanzania, and this impacts their functioning. The living conditions are extremely basic, which limits the potential of the villages to fully engage the patients. There is no funding for sports equipment or technological equipment which might offer an alternative to agricultural training. The relevance of agriculture in a country that is becoming increasingly urbanized is questionable. Patients expressed that their options are limited and several expressed that they were ready to leave despite the staff saying otherwise. The patients do not have access to medicine, except for psychiatric pharmaceuticals, and also do not have access to basic supplies such as soap, tea, toothpaste and sanitary napkins.

Despite all of this, most patients expressed a sense of relief at having a place to be for a few months where they are able to receive medication to help their mental health. They are able to interact with other patients, they have access to food, and they learn some basic skills through agriculture. These skills potentially benefit them in the future, as in the case of Ernest who was starting his own batik business. In a country with extremely limited resources, agricultural psychiatric rehabilitation villages offer some respite from the economic realities facing patients. They have a chance to regroup and plan for their future before going home to the daily economic struggles facing their families and communities.

Contributions

This thesis contributes to understanding a community-based model of mental health treatment. Mental health treatment is changing around the world. The World Health Organization is currently placing considerable emphasis on “community-based models” of treatment. There is ongoing dialogue and discussion in communities across the world on institutional versus community-based modes of treatment. As deinstitutionalization occurs, and has been gradually occurring for the past several decades, there is a search for comprehensive, holistic and effective ways, in the community, of managing mental health problems. This coincides with an increasing prevalence of mental illness globally. By understanding the model that one country, Tanzania, uses, and its emphasis on relationships, it is possible to reflect on ways in which other countries can learn from agricultural psychiatric rehabilitation villages.

In many ways the villages compare to assisted living situations in North America; where groups of patients live together in a home where there are staff persons who help to make sure they are taking medication and who monitor their progress. The difference is that in the villages, patients are also engaged in learning new skills related to agriculture. They are also only in the village for a limited amount of time as the ultimate goal is to get them reintegrated into their communities and with their families so they can work and live fulfilling lives.

This thesis contributes to understanding the important role of relationships in the process of healing from mental illness. As Dr. Kilonzo told me, “society [in Tanzania] is centred around each other.” Agricultural psychiatric rehabilitation villages attempt to maintain a key aspect of Tanzanian society through a focus on relationships and communal living. Patients cook together, eat together and work together. They engage in occupational therapy with other patients and they develop relationships with the staff members who work, and sometimes live, in the villages.

They are given a reprieve from struggling to survive and a chance to re-imagine a life for themselves beyond the constraints of their illness or addiction.

By including family members in their treatment as much as possible, staff members at the village acknowledge the essential role of social relationships for survival in Tanzania. When the patients leave the village, the goal is that they return to support networks that are ideally more supportive and understanding of their condition. The goal is that, between support from their families, time spent in the village adjusting to medications, and time spent developing a daily routine, patients will have a greater chance of living without mental illness or addictions. This relatively simple model could be applied in other contexts to enhance healing.

This thesis contributes to Anthropology by looking at the impact of mental illness and addictions on narrative. It also adds to anthropological literature on the cultural context of illness experience by focusing on the patients' perspectives. The final contribution it makes to Anthropology is through its analysis of the political and historical context of a form of treatment.

It would be interesting to return to Tanzania to find out if the patients are indeed living the lives they imagined for themselves; to find out whether they are still taking medication, and/or experiencing symptoms related to mental illness or addictions, and how they have reintegrated into their communities. I would like to know where their stories, and the distinct voices they told their stories with, have taken them.

APPENDICES

Appendix A: List of Patients Interviewed

Uhuru - Village outside of Dar Es Salaam

Nicholas

Male. Born in Kigoma region, 1979. Five brothers and sisters. Left school in 1999 because of “problem”. Lived with mother, father worked far away. After school, did odd jobs like making bricks. Been in the village for three weeks. Saw a local healer before going to the hospital. Spent time in the hospital before, returned again for four days, then escaped, then sent back to hospital. After one month in hospital, went to the village.

Kumi

Male. Mid-twenties. Been in the village for one month. Been to the hospital three times and once to a local healer. Feels improved since being in the village – doesn’t see “terrifying things” anymore. Mom sent him to the village for mental illness. He likes the village.

Ernest

Male. Mid-thirties to forties. Former patient. Spent one year in the village before leaving. Was a mechanic, but psychiatric medication affected his vision and he couldn’t work without full vision so his psychiatrist suggested going to the village. In 1997 he went to a clinic to get medication for the first time for psychiatric problems. Then in 2001 his family sent him to the psychiatric ward at a hospital for medication again when they noticed changes in his behaviour. He went back and forth to clinic frequently for medication. He has not been to local healers. He liked living in village a lot – talking to other patients, working, getting exercise. He is continuing with the batik work he learnt with the occupational therapist in the village; he returns to the village to work on batiks.

Doris

Female. Early thirties. Been in the village for ten years, went for mental illness. Spent one year in the hospital before going to the village. Has seen a local healer, prefers psychiatrist. She feels she is slowly improving. She is from Kigoma and hasn’t seen her family since arriving in the village. She likes living in the village. She may be discharged within the month. The person taking care of her died and she could not find anyone else to take care of her. She got on a train to Dar Es Salaam, wanted to kill herself, went to hospital. Wants to make batiks and bags, to sew, when she leaves the village.

Mary

Female. Born in Arusha in 1980. Been in village for one month. Sister sent her. Has not been to local healers. Used to hear voices, doesn't anymore. Likes the village. Three brothers, four sisters. Did not attend secondary school. Wants to continue with school. Worked cleaning peoples' homes when she lived with her family. Thought she was pregnant so left village to go meet sister. Has a husband but since she has been in the village he has not come to visit her. She wants to sew when she leaves the village.

Julianna

Female. Born in Dodoma, 1975. Several half brothers and half sisters. Left school in Form Two because she was pregnant. Lived with aunt because father and mother died. Started earning money at age eighteen. Sold clothes without permit. Mental "confusion" started after her father's death. Thought she was possessed by a demon. Saw local healer. Escaped from "witchdoctor" and went to hospital. She now believes in Jesus, after seeing local healers, she started believing in Jesus. Talked a lot about not having any money. Has been in village for two weeks. Wants to clean houses and take care of her daughter.

Frank

Male. Born in Dar Es Salaam, 1969. Two brothers, two sisters. Spoke English. Attended primary and secondary school. Worked in Capetown for three years doing casual jobs. Family lives in Dar Es Salaam. Problems with drugs started 1996. Used heroin. Went to hospital in 2002 but left after ten days. Been in village for one and a half months. Spent two weeks at hospital first. Used to work at the front desk of a hotel in 1994, then worked for a water company as a driver. Doesn't trust witchdoctors; said that, "You can't prove them." He trusts doctors. Wants to return home and go back to school.

John

Male. Been in village for three months. Used to work in a mine in Arusha. Been to local healers two times, three years ago. They cut chicken and goat necks and put blood on him. Doesn't trust local healers, trusts psychiatrists more. Likes village because life is hard. He works hard and needs money. Wants to go home to start his own business and live alone. Needs money. Nurses say he isn't ready. He was married but does not talk to his wife now. Takes medication to help him sleep.

Simon

Male. Born at Lake Nassa, South Tanzania, in 1956. Lived for twenty years with parents and brothers and sisters. Father was Muslim and had four wives. Finished secondary school and was an assistant manager at national insurance corporation, worked in Dar Es Salaam for eleven years. Lived with younger brothers. Father went to Dar Es Salaam to help him find a wife, she left him in 1982 when he went into the hospital for the first time for "problems in the head". A friend took him to the hospital. Took medication and went

back to hospital in 1985. In 1987 went to live with father. Father took him to local healers. Half his face was paralyzed so it was difficult to speak. He said that a witchdoctor/wizard caused this problem in 1999. Has seen local healers repeatedly. Been in village for two weeks. Before the village he was studying insurance in Dar Es Salaam. Finds the village helpful and restful. Will live with uncle when leaves village. Is Christian – has used prayer and friends have prayed for him.

Fayaz

Male. Born Ukerewe, 1982. Three brothers, no sisters. He left school before secondary school because he had to work to pay for his brothers' educations. Lived with family. He cultivated rice, cassava and worked on craft projects to earn money. One of his jobs was to carry things. Had addiction problems. Felt like an animal. Didn't contact his family. Medication helps. Wants to help mother when leaves village. Been in village four days. Was living on the street, grazing cows. Policemen sent him to hospital. Prefers village to hospital. Couldn't sleep in hospital. Sister noticed he was confused in hospital.

Margaret

Female. Mid thirties. Been in village four days. Brother took her to hospital, they gave her medication and sent her to village. Has mental illness. Noticed problems in 1996. Her son was taken by his father and she became confused and her brother told her she was crazy, but she knows she is not. Has two children. Has used prayer to try to heal. Goes to church. Wants to go home to be with her children and to be a mother. Brother sent her to local healer. She feels she is okay and should go home. Says other patients are beating her.

Amani - Village outside of Moshi

Mapunda

Male. 56 years old. Lived in the village for three years. Wife works in the village as a nurse. According to staff, he has schizophrenia. According to him, he has stomach problems caused by a chemical the staff sprays in his room. Feels there is no restfulness in the village. Talks to other patients about Jesus Christ. Pastor comes to village on Sundays. Works with wife in the farm at the village. Spent three weeks in hospital in Dodoma for stomach problems apparently because someone bewitched him, but he could not tell me who. Was bewitched while training to be a laboratory technician in 1968. Left school and worked for meteorological department. Then from 1972 to 1977 worked in telecommunications. Then was a telephone sales assistant, promoted to senior assistant until 1987 when his stomach pain became worse. He went on a pension then, which is what he still lives on.

Appendix B: List of Healthcare Professionals Interviewed

Dar Es Salaam

Dr. Kilonzo

Psychiatrist based out of Muhumbili Hospital. Professor at Muhumbili College of Health Sciences, Dar Es Salaam. Has been in charge of rehabilitation village outside of Dar Es Salaam since 1997.

Dr. Mbatia

Psychiatrist. Professor at Muhumbili College of Health Sciences. Head of mental health division of Tanzania's Ministry of Health. Was in charge of rehabilitation village outside of Dar Es Salaam from 1989 to 1997, when Dr. Kilonzo took over.

Grace

Administrative head of the rehabilitation village outside of Dar Es Salaam. Has worked there for sixteen years as head of the village. She conducted a Masters in Agriculture in Australia for two years, and when she returned she was hired by Muhumbili hospital to work in the village based on her agricultural training and background. She does not live in the village, but travels to work each day. Spends two days each week at the hospital.

Jamila

Nurse in the rehabilitation village outside of Dar Es Salaam. Has worked in the village for one year and two months. Her role in the village is to make sure all the villagers are present, to allocate work, to make sure they have food and treatment. She lives in a house in the village with her daughter who has cerebral palsy. She works five days a week.

Tuyu

Occupational therapist in the rehabilitation village outside of Dar Es Salaam. She has worked in the village for one year, before that she spent twenty three years working at Muhumbili hospital with psychiatric patients. Her role is to work with patients on their tasks like gardening, and to teach them skills such as sewing, batiking, basket-making. She is in the village five days a week for most of the day.

James

Nurse in the rehabilitation village outside of Dar Es Salaam. Has worked in the village for five years. Before that was in another rehabilitation village thirty kilometres away. Supervises patients to ensure that their problems go away. Trains them how to take care of chickens, take care of cows, etc. Talks to patients, is close to them, makes sure are taking medication. Gives them medication. Spends two days a week at the hospital.

Talib

Assistant administrative head of the village outside of Dar Es Salaam. In charge of animals: chickens, cows, pigs. Has been working in the village for seventeen years. Used to live in village, does not anymore (although he enjoyed it, the lack of electricity and water was difficult to deal with). Teaches patients to work with animals – poultry keeping, cattle grazing, etc. Went to agriculture school and earned a certificate in dairy animal husbandry. Attended a ten month program in Japan on “vegetable growth.”

Joseph

Nurse in rehabilitation village outside of Dar Es Salaam. Has worked there for twelve years. Supervises patients. Gives patients medication. Allocates activities for patients to do, such as cooking, cultivating, getting water, gardening. Lives outside of village – travels by dala dala. Takes three hours to get to work.

Moshi

Andrew

Occupational therapist in village outside of Moshi. Trained for three years at university. Enjoys working with psychiatric patients because it is “different” and “challenging”. His role in the village is to assess patients’ abilities, the interests of the patients, etc. Then he comes up with a plan for which activities the patients should be involved in, what to focus on, prioritize, etc. He encourages patients to do activities. Designed an intake form for patients that assesses their social history, their economic history, personal history of illness, present situation, appearance, psychological well being, mood changes, self-care, leisure, productive activities. Focuses on the each patient holistically. Teaches patients to take care of themselves, basic things like washing, making bed, dressing, cooking, eating, etc. Used to do home visits to patients’ homes/communities, but the funds no longer exist for that. Also teaches the patients to make stools, sells stools to make money for patients. Does tie and dye with patients.

Tizo

Psychiatric nurse. Works for Mawenzi Hospital as the regional mental health coordinator. Also works for Mental Health Association of Tanzania [MEHATA] part time, an NGO working towards bettering mental health treatment in Tanzania. Coordinates activities in region. Trained as general nurse and midwife, took a special psychiatry course. MEHATA started in 1984. The government and private donors fund MEHATA.

Johnson

Nurse in charge of village outside of Moshi. Worked in village for twelve years. Trained for four years as a nurse. His role is to take care of village, take care of patients, take care of labourers, show them what to do. His wife is a nurse assistant working in the village; they live in the village with their children who attend school most days.

Appendix C: Demographic Profile of Patients

Name	Gender	Age	Village	Home	Level of Education	Previous Occupation	Length of time in Village
Doris	Female	30	Uhuru	Kigoma	No secondary		10 years
Ernest	Male	35	Uhuru			Mechanic	Former patient
Fayaz	Male	23	Uhuru	Ukerewe	No secondary	Carrying things	4 days
Frank	Male	35	Uhuru	Dar Es Salaam	Completed secondary	Front desk Driver	1.5 months
John	Male		Uhuru	Arusha		Miner	3 months
Julianna	Female	30	Uhuru	Dodoma	Some secondary	Sold clothes	2 weeks
Kumi	Male	25	Uhuru				1 month
Mapunda	Male	56	Amani	Arusha	Post-secondary	Sales Assistant	3 years
Margaret	Female	35	Uhuru			Mother	4 days
Mary	Female	24	Uhuru	Arusha	No secondary	Housekeeper	1 month
Nicholas	Male	25	Uhuru	Kigoma	Some secondary	Brick-making	3 weeks
Simon	Male	50	Uhuru	Lake Nassa	Completed secondary	Assistant Manager	2 weeks

REFERENCE LIST

- Abu-Lughod, Lila. 2000. Locating Ethnography. In *Ethnography*. 1(2):261-267.
- Appleton, Ann. 2000. 'Do you have anything to add?': Narrative as Reflection and Commentary on the Social Experience of Mental Illness. In *Anthropology and Humanism*. 25(1):24-49.
- Barker, Jonathan. 1979. The Debate on Rural Socialism in Tanzania. In *Towards Socialism in Tanzania* (edited by Mwanasasu). University of Toronto Press. Toronto.
- Becker and Kleinman (Ed). 1991. *Psychosocial Aspects of Depression*. Lawrence Erlbaum Associates, Publishers. New Jersey.
- Boesen, Jannik. 1979. Tanzania from Ujamaa to Villagization. In *Towards Socialism in Tanzania* (edited by Mwanasasu). University of Toronto Press. Toronto.
- Bryceson, Deborah. 1998. Household, Hoe and Nation: Development Policies of the Nyerere Era. In *Tanzania After Nyerere* (edited by Hodd). Printer Publishers. London.
- Crossley, Nick. 2004. Not Being Mentally Ill. In *Anthropology and Medicine*. 11(2):161-180.
- Cruikshank, Julie. 1990. *Life Lived Like a Story*. University of British Columbia Press. Vancouver.
- Duggan, W. and J. Civile. 1976. *Tanzania and Nyerere; A Study of Ujamaa and Nationhood*. Orbis Books. New York.
- Frank, Arthur. 1995. *The Wounded Storyteller; Body, Illness, and Ethics*. The University of Chicago Press. Chicago.
- Gish, Oscar. 1975. *Planning the Health Sector; The Tanzanian Experience*. Croom Helm. London.
- Goffman, Erving. 1963. *Stigma; Notes on the Management of Spoiled Identity*. Simon and Schuster Inc. New York.
- Gottlieb, Manuel. 1975. *Health Care Financing In Mainland Tanzania*. Maxwell School of Citizenship and Public Affairs. Syracuse University. Syracuse, New York.
- Groleau, Danielle. 2004. Sociosomatic Theory in Vietnamese Immigrants' Narratives of Distress. In *Anthropology and Medicine*. 11(2):117-133.

- Groopman, Jerome. 2005. *The Anatomy of Hope; How People Prevail in the Face of Illness*. Random House Trade Paperbacks. New York.
- Hahn, Robert. 1995. *Sickness and Healing; An Anthropological Perspective*. New York University Press. New Haven and London.
- Hammersley, M. and P. Atkinson. 1995. *Ethnography: Principles in Practice*. Routledge. New York.
- Hammersley, Martyn. 1992. *What's Wrong with Ethnography?* Routledge. London and New York.
- Jackson, Michael. 2002. *The Politics of Storytelling; Violence, Transgression, and Intersubjectivity*. Museum Tusulanum Press. University of Copenhagen.
- Jadhar, Sushrut. 2001. Cultural Experience of Depression Among White Britons in London. In *Anthropology and Medicine*. 8(1):47-69.
- Kahn, Marc S. 2001. Cultural Tensions in Psychiatric Nursing: Managing the Interface between Western Mental Health Care and Xhosa Traditional Healing in South Africa. In *Hispanic Psychiatry: From Margin to Mainstream*. 38(1):35-50.
- Khort, Brandon. 2005. "Somatization" and "Comorbidity": A Study of jhum-jhum and depression in rural Nepal. In *Building Biocultural Anthropology*. 33(1):125-147.
- Kilonzo and Simmons. 1998. Development of Mental Health Services in Tanzania: A Reappraisal for the Future. In *Social Science and Medicine*.
- Kirmayer, Laurence. 2003. Failures of imagination: the refugee's narrative in psychiatry. In *Anthropology and Medicine*. 10(2):167-185.
- Kleinman, Arthur. 1988. *The Illness Narratives; Suffering, Healing, and the Human Condition*. Basic Books, Inc., Publishers. New York.
- Kopoka, Peter. 2000. Provision Of Health Services in Tanzania in the Twenty First Century: Lessons From the Past. Institute of Development Studies. Dar Es Salaam.
- Legum and Mmari. 1995. *Mwalimu; The Influence of Nyerere*. James Currey. London.
- Luhrman, T.M. 2000. *Of Two Minds; The Growing Disorder of American Psychiatry*. Alfred A. Knopf. New York.
- Mabunda, Michael. 2001. Perception of Disease, Illness and Healing among Selected Black Communities in the Northern Province, South Africa. In *Etnologie*. 24(1):11-16.
- Mascarenhas, Adolpho. 1979. After Villagization – What? In *Towards Socialism in Tanzania* (edited by Mwanasasu). University of Toronto Press. Toronto.
- McCulloch, J. 1995. *Colonial Psychiatry and the African Mind*. Cambridge University Press. Cambridge.

- Morrison, Christian. 2002. *Education and Health Expenditure and Poverty Reduction in East Africa: Madagascar and Tanzania*. Development Center of the Organization for Economic Cooperation and Development.
- Mullings, Leith. 1984. *Therapy, Ideology and Social Change; Mental Healing in Urban Ghana*. University of California Press. Berkeley.
- Ndosi, N.K. 1995. Mental Disorders in Tanzania: A Cultural Perspective. In *Handbook of Culture and Mental Illness: An International Perspective*. International Universities Press, Inc. Madison.
- Offiong, Daniel A. 1999. Traditional Healers in the Nigerian Health Care Delivery System and the Debate over Integrating Traditional and Scientific Medicine. In *Anthropological Quarterly*. 72(3):118-130.
- Othman, Haroub. 1988. Nyerere's Political Legacy. In *Tanzania After Nyerere* (edited by Hodd). Printer Publishers. London.
- Raqruram, R. 2001. Cultural Dimensions of Clinical Depression in Bangalore, India. In *Anthropology and Medicine*. 8(1):31-46.
- Rasmussen, Susan J. 2000. Parallel and Divergent Landscapes: Cultural Encounters in the Ethnographic Space of Tuareg Medicine. In *Medical Anthropology Quarterly*. 14(2):242-270.
- Rekdal, Olebjirn. 1999. Cross-Cultural Healing in East African Ethnography. In *Medical Anthropology Quarterly*. 13(4):458-482.
- Scott, James. 1986. Everyday Forms of Peasant Resistance. In *Journal of Peasant Studies*. 13:5-35.
- Wallace, Marion. 2003. 'Making Tradition': Healing, history and ethnic identity among Otjiherero-speakers in Namibia. In *Journal of Southern African Studies*. 29(2):355-372.
- Young, T. Kue. 1986. Socialist Development and Primary Health Care: The Case of Tanzania. In *Human Organization*. 45(2):128-134