

A SITUATION
ANALYSIS OF
MENTAL HEALTH
IN SOMALIA





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■ Abbreviations ▶

AIMS	▶	Assessment Instruments for Mental Health Systems
DAC	▶	Development Assistance Committee
EC	▶	European Commission
EPI	▶	Expanded Programme on Immunization
GAVO	▶	General Assistance of Voluntary Organisation
GBV	▶	Gender Based Violence
GRT	▶	Gruppo per le Relazioni Transculturali
HMIS	▶	Health Management Information System
IASC	▶	Inter-agency standing committee
MDG	▶	Millennium Development Goals
MH	▶	Mental Health
NEZ	▶	North East Zone - Puntland
NMH	▶	National Mental Health
NWZ	▶	North West Zone- Somaliland
ODI	▶	Overseas Development Institute
PTSD	▶	Post Traumatic Stress Disorders
SCZ	▶	South Central Zone
THET	▶	Tropical Health and Education Trust
WHO	▶	World Health Organization

Executive Summary ▶

This situation analysis stems from an increasing commitment that community actors and a variety of stakeholders have put on Mental Health, including the development and wellbeing of the Somali population. As part of a twofold study, this situation analysis and the Strategy for Mental Health aim at catalyzing attention on the issue. At the same time, both documents are also an advocacy tool for practitioners, INGOs, mental health personnel and public authorities.

The document is the result of a participatory process, which has engaged stakeholders through desk review work, group discussions, data collection, and consultative meetings both done in Somalia and at Nairobi level.

- Mental health has been an underfunded and neglected sector in Somalia with lack of funds due to poor allocation of resources by the donor community as well as by the public health local authorities. The entire burden of the mentally ill is left to the family and thus to the local communities, causing a cost to the whole society in terms of development and resources.
- It is estimated that the prevalence of mental health disorders in Somalia is higher than in other low-income and war-torn countries (one person out of three is or has been affected by some kind of mental illness). There are many determinants that explain the high rate: overall insecurity (such as displacement and violence), war traumas, poverty, unemployment and substance abuse.
- Mental health discourse in Somali is strictly embedded in a peculiar context and is influenced by specific socio-cultural patterns. Mentally challenged people are stigmatized, discriminated and socially isolated. Degrading and dangerous cultural practices such as being restrained with chains are not only widespread but also socially and medically accepted. Traditional healers play an important role; however, they are not medically involved in any real rehabilitation of the patients. New forms of distress and disorders have started to appear in the country that needs to be further investigated and addressed. Women and ex-combatants are exposed to a higher extent of development of severe forms of distress.
- No legislation, policies or governance mechanisms are in place in any region of the country, leading to the existence of a plurality of micro and uncoordinated interventions and to a context where human rights abuses are very common, and above all, accepted.
- The financing scenario of mental health over the past years but especially for the near future is very worrying. No donor has taken the lead in strengthening the sub-sector or do local authorities have the technical, managerial, and financial capacities to implement a sustainable and equitable mental health programme. Too much is left to the communities and a few Diaspora associations, who do not have the means to cover the burden of costs related to it.
- Mental health services in Somalia are insufficient in number, lack proper equipment and geographical coverage is limited for addressing all the needs of the country. Eight facilities were reported to exist and were assessed. They all have a different nature and offer various services according to their locations, qualifications of staff and extent of support from external actors.
- Outpatient services are available in seven of the eight facilities; however, it was not feasible to draw statistical conclusions due to the poor capacity of record keeping and the way the information systems are organized. Additionally, inpatient services are available in a different way in all the facilities where people were reported to have stayed from a period of three weeks up to 18 years!
- Psychotropic drugs, essential for medical treatment and for managing the most acute and initially aggressive cases, are not always available at the facility level. Serious doubts arise regarding the capacity of medical staff to properly prescribe and make use of them. Moreover, the fact that those drugs are available on the unregulated private market, can lead to a worsening of the patient conditions and to a distortion of the professional values of qualified mental health workers.
- The availability of Human Resources, education, preparation, motivation, performances, supervision and monitoring are other areas of concern to strengthen the mental health system and the delivery of quality and equitable mental health services. Only three psychiatrists are reported to be working in the facilities, however, their professional background is not up to the international standards. Very few organizations have recently focused on the development of educational programmes for mental health and they need to be supported for an extension of their objectives.
- There is a very poor and partial understanding of mental health by the general public. This has a negative impact on the existing difficulties in carrying out an advocacy programme. This also results in the isolation and stigmatization of the mentally ill and on the spreading of dangerous practices and humiliating treatment of patients.
- Mental health is still seen as an isolated sector and should be integrated into primary health care as well as other development sectors such as education, gender policies, demobilization, livelihoods and human rights programmes.
- Many areas of mental health still need to be better explored and investigated especially in the field of post-conflict, substance abuse, GBV and children.

This situation analysis acts as a stepping stone towards an increased international commitment to strengthen the delivery of quality mental health services to the Somali population. It is further intended to support the health authorities in establishing a fully functional mental health system and promote community based mental health programmes for the relief of the thousands of people suffering from mental health disorders.



1. Introduction and Background



➤ 1.1 Country Overview

Since 1991, conflicts and statelessness profoundly affected the health care system in Somalia. After the collapse of the central government and the descent into civil war, many efforts to restore a central government were unsuccessful. Powerful internal forces and regional dynamics resulted in a state of chaos. The impact of lack of governance has resulted in a generation without adequate access to social services and the collapse of public institutions for health and welfare. Despite the success of some business sectors, Somalia is marred with widespread social and economic problems and a dire lack of public institutions. In 1991, the North West Region declared an independent Republic of Somaliland. Later, in 1998, the North East declared itself as the autonomous State of Puntland. The South and Central zones of Somalia remain locked in intermittent conflict and violence. There had been an international recognized entity 'The Transitional Federal Government' (TFG) that continued functioning from 2004-2009. Recently, it has been replaced by the Transient Federal Government (TFG). The new entity is trying its best to establish jurisdiction in Mogadishu while facing tremendous resistance from opposing factions.

➤ 1.2 Regional Division

Somalia, comprising of the three zones of North West (NWZ - Somaliland), North East (NEZ - Puntland) and the South Central Zone (SCZ), has an estimated population of 7.7 million people, 1.46 million of them being IDPs¹. According to the Food Security and Nutrition Analysis Unit (FSNAU) the current situation is the worst humanitarian crisis in eighteen years, with an estimated 2 million people who are in need of emergency livelihood and life saving assistance².

Table 1
Somali Population, UNDP (2006)

ZONE	MALE	FEMALE	TOTAL
Somaliland	966.100	920.400	1.886.500
Puntland	455.400	433.800	889.200
South Central	2.536.300	2.415.700	4.952.000
TOTAL	3.957.800	3.769.900	7.727.700

The **North West Zone** (Somaliland) enjoys relative stability and peace. Despite lack of international recognition as a sovereign and independent state, the overall security and stability of the region have attracted developmental activities and donor projects. Thanks to the Berbera harbor and the Diaspora investment in the region, private initiatives have led to a lively and thriving private sector. The recent lift of the ban on the Somali livestock, the core Somali economic source of income, to the Gulf States which lasted over 10 years, shed a new light on future economic development possibilities. Nevertheless, after the Hargeisa bombing in October 2008 and the stalemate of the electoral process, the general political situation of Somaliland remains volatile.

In 1998, the **North East** declared itself as the autonomous State of Puntland but within the realms of the federal state of Somalia. The state is governed by its own administration in the capital Garowe. Puntland and Somaliland have seen sporadic fighting over the disputed region of Sool and Sanaag. Deterioration in security and political issues with the local authorities has recently hampered donor interest and investment in the region. Puntland has a majority of nomads amongst the population as well as a large IDP population and mixed migrants, originating from the South Central Zone and Ethiopia. Due to the high potential for conflict outbreaks, not many international NGOs are present and few coordination mechanisms are in place. Unlike the northwestern, southern and central regions, northeast Somalia did not suffer from major factional conflicts during the civil war. It did, however, indirectly suffer from the consequences of the long period of civil strife, since a huge number of people were fleeing the war-torn areas and settling in the major towns of the region. This resulted in a chaotic urbanisation process, especially in Bosaso town, due to the presence of the port which rendered the town very attractive in terms of employment opportunities. This rapid and uncontrolled urbanisation brought massive migration, and created a situation whereby existing infrastructures and services designed for a much smaller population, became grossly inadequate.

The **South Central** Somalia remains locked in intermittent conflict and violence, which has escalated over the past months. South Central Somalia has endured most of the fighting during recent years, causing a high number of IDPs and a general population dependant on aid or Diaspora remittances. The recent sharp deterioration in security has put a good number of planned interventions and projects on hold. Remote control strategies seem not to deliver the expected results. This bitter scenario does not lead to any better expectation for humanitarian assistance to be carried out in a comprehensive way. The humanitarian condition of the local population is worrying, especially due to the lack of access to the area by the major international assistance delivery mechanisms.

¹ Somali Population (2010), UNDP Sources.

² Food Security and Nutrition Analysis Unit - Somalia Technical Series Report No VI.33, 2010 Post Gu Analysis.

Taking into account the geographical and political division in Somalia, it is of paramount importance that the following is considered:

- Engagement of different political actors in the respective areas
- Differing strategies should be implemented simultaneously in the respective areas
- Multilayered interventions with different modules should be implemented at different stages of each and every intervention
- Costs and logistics will have a variable impact on the budget plan in the different regions.

➤ 1.3 Health Sector Overview

Even before the outbreak of the internal conflict, the health system in Somalia was rather weak and underfunded. The centralized government did not manage to allocate any budget to some services like mental health and some facilities were completely neglected. In 1989, the Ministry of Health was allocated 2.95% of the government's regular budget. While in 1984, 67% of the total health budget came from external aid, 95% of the utilized budget came from this source during 1990. In 1990, over 79% of the Ministry of Health's financial resources were allocated to the capital Mogadishu, alone.

After 19 years of conflict, the health care system in Somalia remains underdeveloped, poorly resourced, inequitable and unbalanced. It struggles to provide services to a limited number of Somalis against crushing constraints. Insecurity, geographical challenges and nomadic populations, an unstructured and unskilled workforce, lack of motivation and vision, uncertainty about the political future and administrative settings, financial and operational fragmentation and poor information and surveillance are some of the key issues that the Somali Health System is facing. The country has an internationally recognized Federal Ministry of Health (MOH), while the self-declared autonomous zones of Puntland and Somaliland have separate Ministries. There is currently no functional link between the federal and zonal ministries, regional authorities and programme management levels. The MOH's ability to coordinate and monitor health services provided by NGOs, public and private sector is almost absent.

A fragmented health sector provides limited services to the Somali population. The public health care network is small. It mostly relies on national and international NGOs that tend to be concentrated in towns and in secure areas. The health workforce is small, under-skilled and ageing, often engaged in dual (public and private) practices, and forced to work in an insecure and de-motivating environment. Direct provision by ministries of health is marginal. Private health care outlets have proliferated throughout the country and are now estimated to be with thousands with large variations in size, type of services offered, staff qualifications and performance. In aggregated terms at USD 8 per capita, external financing looks modest (World Bank-2008), while private spending is not quantified but considered to be substantial. Health information is fragmented, unreliable and underused. In Somalia, the Millennium Development Goals (MDG) health-related indicators are among the worst in the world. The collapse of the pre-war public health system has encouraged the emergence of a variety of relief and vertical programmes, run by donors, NGOs and UN agencies.

The 2000 UNDP's Human Development Report (HDR) ranked Somalia lowest in all health indicators, except life expectancy. In the latest HDR, the country is not even ranked, due to the lack of reliable data. As a result, it was noted that "most Somalis spend most of their time trying to stay alive and keep their families alive" (UN, 2005). Extreme poverty in Somalia is estimated to be 43% with large disparities between the urban population (23%) and the rural and nomadic populations (53%) (UNICEF, 2001)

Currently, financial as well as human resources are utterly inadequate. All Somali zones depend almost entirely on external sources (international aid or international remittances) for health financing. This reflection becomes more worrying when it is applied on mental health, a neglected and almost forgotten sector. It is widely perceived that no governmental or institutional infrastructure exists in the country which is capable of supporting the development or expansion of mental health care. Therefore, despite some pilot and effective interventions in some areas of the country, mental health for almost all activities must start again from zero.

Mental health key challenges and opportunities for its development are interlinked with the strengthening of the health system in Somalia as a whole. It has some peculiar features that should be taken into account. This document will highlight few of them that can be summarized as follows:

- Need of policies, strategic plans and guidelines on mental health tailored to the three zones;
- Need of allocating national budget and international assistance for the development of the mental health sector;
- Need of qualified and properly trained health workers;
- Need to improve access to quality mental health services.



2. Methodology



This study has been carried out by using different methodologies and sources in order to collect information as accurate and complete as possible. The following methods were used to collect information:

- Desk review of documents and data collected by partners and stakeholders involved in the Health Sector in Somalia. GAVO and GRT documents, reports and inputs have been of paramount importance in understanding the magnitude of the problems for the mapping exercise;
- Questionnaire (Annex I), directly filled and/or sent to the field in order to have quantitative data on facilities/hospitals providing mental health services. Six were distributed and properly filled;
- 3W Matrix (who does what and where) in order to map out actors and mental health interventions implemented in the past and/or currently carried out in the country;
- Interviews and group discussions directly carried out with partners, local authorities, medical personnel and local population representatives to gather qualitative data on the mental health needs and perceptions of the problem at local level.

In order to promote harmonization and sharing the same tools with other international agencies working in the health sector, the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) methodology has been extensively used during this assessment. The WHO-AIMS has clearly defined the path to be taken. WHO AIMS Report on Mogadishu and WHO AIMS Report on Somaliland were both consulted.

3. Findings



➤ 3.1 Prevalence of Mental Health Disorders

During the study, no clear national picture on the prevalence of mental disorders could be collected. Therefore, little data could be discussed in order to draw the general picture of the worrying situation of mental health in Somalia. It is generally accepted that the current prevalence of mental health disorders is quite high if we consider that the country has not only suffered from the cruelty of the civil war and ineffective foreign interventions but also from a tremendous state of insecurity and violence at all levels of the community. In addition, there is a continuous impoverishment of the already poor resources, harsh droughts and more than eighteen years lack of authority and government institutions. This scenario is also confirmed by the recent declaration by local authorities, who prioritized mental health as one of the key sectors that needs to be addressed within the health framework.

According to the GAVO Report (December 2004), the prevalence of mental illness in Somaliland is thought to be the highest in the world. It is estimated that at least one person in every two households has some form of mental illness. There is no accurate data collected in the entire country, except in Hargeisa. Moreover, a survey conducted by VIVO in Hargeisa in 2002, indicated that 21% of surveyed households care for at least one family member with a severe mental health problem. The figures obtained from a group of 50 persons, indicated that 26.5% of them have at least one person in their household with a mental or behavioral disorder. GRT data in Puntland confirms these worrying statistics, stating that one person out of three households suffer or has suffered in the past from certain forms of mental distress. As mentioned earlier, the exact number of people with a mental or psychological disorder is unknown. The estimated prevalence of at least one person in every four or five households seems very high when compared to the estimates in the 2001 Mental Health World Report.

Finally, Somalis are more likely to report physical pain when they are experiencing depression or sadness. Psychological problems are often expressed physically as headaches, chest pain, forgetfulness sleep problems, nightmares and sweating. Mental health (*caafimadka maskaxda*) and treatment (*daawayn*) are still relatively new concepts among many Somalis. Depression for example, has no direct translation in Af-Somali. Instead, it is described as: *'qulub, qalbi-jab iyo murugo joogto ah.'* 'Qulub' refers to the feelings a camel has when its friend dies. When discussing mental health topics, Somali mental health providers often have to describe the illness through its recognized symptoms rather than by referring to by category or labels, such as depression³.

According to the data analysis carried out through the questionnaires submitted in mental health facilities, it was very difficult to have an analytical view of the prevalence of mental disorders due to scarce diagnostic capabilities and poor data collection and interpretation. Nevertheless, the below table tries to give an overall reference picture:

Table 2
Prevalence of mental disorders

MAIN DIAGNOSIS	% MEN	% WOMEN
Psychosis	33,84%	11,66%
Drug Abuse (khat or hashish)	10,76%	6,66%
Schizophrenia	20%	20%
Epilepsy	7,69%	8,33%
Mental Retardation	1,53%	5%
Depressions	7,69%	20%
Paranoia	3%	0%
Dementia	1,53%	0%
Maniac/Bipolar Disorders	9,23%	16,66%
Post-Traumatic Stress Disorders	4,61%	5%
Post Partum Depression	0%	6,66%

The percentage and data reported in the table above should be carefully interpreted:

- Serious doubts arise from the diagnostic capacity of the medical staff;
- Some overlap of diseases;
- No data could be collected on mental disorders prevalence in children;
- Khat abuses was often related to different kind of disorders while it was not possible to identify the causal relationship;

The length of stay/admission in the mental health facilities was also very difficult to analyse due to poor data collection and record keeping system. It is important to mention that the minimum length of stay was reported to be 3 months while the longest period was 18 years! This raises serious issues on the efficacy of some of the treatments, but especially on the linkages between homeless and

mental disorders. Many patients are abandoned in the facilities because there is nobody to take care of them. In the Mental Health Department of Bosaso one of the male patients has been employed as watchmen in order to provide him a shelter.

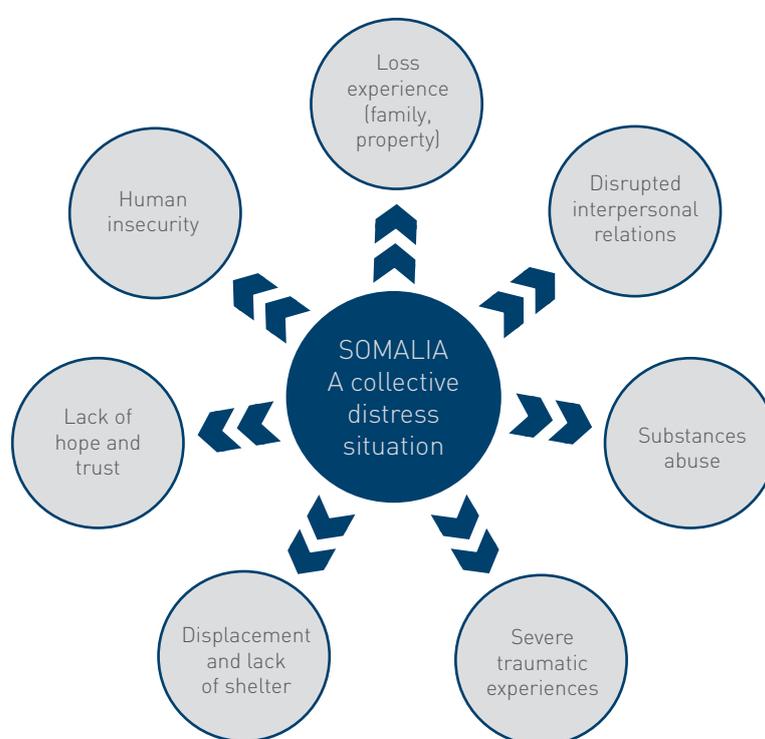
➤ 3.2 Determinants of Mental Health Disorders in Somalia

According to WHO, 10% of the world population is affected by some kind of mental distress and mental disorder. This percentage increases up to 20% in war-torn and conflict-prone countries, such as Somalia, where the extent of violence has permeated the different layers of the society. The following have been highlighted as the main factors for the development of such a high prevalence of mental disorders:

3.2.1 Overall Insecurity: Violence and Displacement

According to GRT analysis in Somalia, there is what can be labeled as 'collective distress': The general violent context, extreme insecurity, lack of shelter and access to basic needs increase the risk of developing mental disorders.

Graph 1
Collective Distress in Somalia (GRT Source)



According to the IASC (Inter-agency standing committee) Guidelines on Mental Health and Psychosocial Support, armed conflicts cause significant psychological and social suffering to affected populations. The psychological and social impacts of violence and conflicts may be acute in the short term, but they can also undermine the long-term mental health and psychosocial well-being of the affected population. These impacts may threaten peace, human rights and development. This statement depicts a rather scary picture in view of the enduring raging conflict in Somalia, which has resulted in one of the most complex and long lasting crises in the world. This study does not hold the view that conflicts necessarily lead to mental disorders. Many people showed a high degree of resilience and communities can rely on very effective coping mechanisms. However, war and violence may cause mental disorders if no action is taken. Even if all sub-groups of a population can be potentially at risk in a complex crisis, the following groups of people are the most vulnerable:

- Women (e.g. pregnant women, mothers, single mothers, widows, unmarried adult women and teenage girls);
- Men (e.g. ex-combatants, idle men who have lost the means to take care of their families, young men at risk of detention, abduction or being targets of violence);
- Children (from newborn infants to young people of 18 years of age), such as separated or unaccompanied children (including orphans), children recruited or used by armed forces or groups, trafficked children, children engaged in dangerous labour, children who live or work on the streets and malnourished children;

- Elderly people (especially when they have lost family members who were care-givers);
- Extremely poor people;
- Refugees, internally displaced persons (IDPs) and migrants in irregular situations.

All the above mentioned categories are widely present in Somalia and have increased in recent times due to the raging war in South Central and the increased trend of mixed migration across the Gulf of Aden.

3.2.2 War Trauma

All around the world, the psychiatric literature shows that conflict situations increase the prevalence of mental health disorders. In addition to conflict-related head injuries, this difference can be explained by the high levels of stress which can serve as a catalyst for the emergence of psychiatric disorders that otherwise might have remained dormant. Furthermore, violent acts such as targeted killings, amputations, gender-based violence and physical maiming often have long-term psychological effects on those who have experienced or witnessed. Other forms of conflict-related violence can include forced displacement, restricted movement, forced recruitment, harassment and intimidation, and the dangers posed by landmines and unexploded ordnance. Widespread insecurity and increased poverty, coupled with a lack of basic services such as healthcare, education, housing, water and sanitation, exacerbate mental problems in war-torn countries.

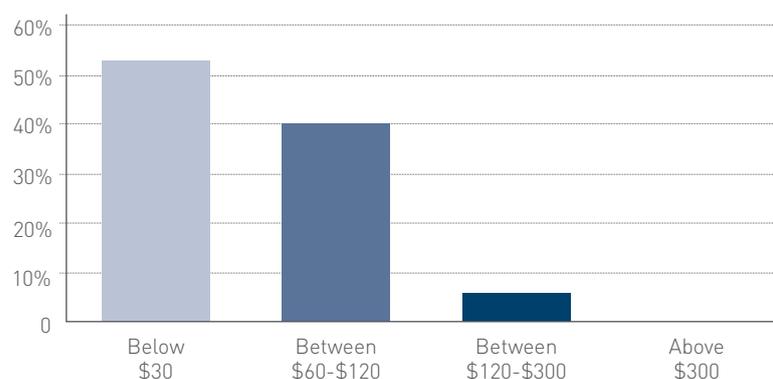
According to GAVO, the prevalence of mental disorders in Somaliland is high due to the fact that the local population has experienced persistent civil conflicts during the last two decades, leading to a breakdown of the public and private infrastructures. The Somaliland population is in a transitional period with many people experiencing post-war traumatic disorders, while some of them suffer from a severe mental disorder. The assessment conducted in Somaliland by VIVO indicates that 23.1% of the people with mental disorders are ex-combatants and at least one sixth of persons who have been actively involved in a war developed later in their lives a very severe form of mental disorder. Research clearly showed that a large number of ex-combatants suffer from drug abuse and complex psychiatric disorders. The disorder reduces their ability to reintegrate into the civil society, eventually constituting a burden for the society as a whole. No clear-cut research has been done in South Central Somalia on the issue. However, in the presence of continuing violence, it is reasonable to conclude that there is a high prevalence of mental disorders that can have a long-term impact on the development of the people and their communities.

3.2.3 Poverty and Unemployment

Another factor that highly contributes to mental or psychological disorders in Somalia is the effect of poverty and unemployment on the population. Unofficial statistics of the unemployment rate in Somaliland's working age population is estimated to be more than 80%. Although no data is available for Puntland and South Central, the unemployment rate is expected to be even higher. This factor has a huge impact, especially on mental and psychosocial disorders developed by the male population. Traditionally considered as the bread-winner of the family, men are now lacking any means to fulfill this role. This state of despair often leads to substance abuse, depression and violent behavior which perpetuate the cycle of violence between sexes and generations (domestic violence and children abuses are very high in Somalia).

Although we cannot conclude that mental disorders are entirely caused by poverty or unemployment, their consequences have a profound effect on the Somali people. In Somalia Unemployed men and youth, poor women and girls, and idle youngsters feel more and more hopeless. Some of these symptoms are likely to turn out into depressive moods which eventually lead to mental or psychological disorders in the long-term. GAVO survey (2004) clearly pointed out that out of 50 patients, 52% were unemployed when first diagnosed with mental or psychological disorder. Further analysis indicated that most of them also had very poor standards of living, surviving on an income of less than one dollar a day.

Graph 2
Monthly income of patient's household (GAVO Source)



3.2.4 Substance Abuse

Abuse of drugs is known to be a factor that leads to severe mental disorders in many people. Khat is the most commonly abused substance in Somalia and has an implication on the society, economy and health of the country.

In Somalia and in neighboring countries chewing khat leaves is a traditional practice that is believed to go back to ancient times. During the recent decades, khat, which had traditionally only been consumed by certain regional, ethnic and religious groups, has had a remarkable boom. Its production is now the backbone of several local economies. In the Somali tradition, the social act of khat chewing has an important function for coping with the experience of violence, especially as the khat session becomes a source of social support. Studies among Somali refugees living in western countries report khat use as the way to cope with the psychological problems associated with staying in a foreign and hostile environment or with past traumatic experiences⁴. They describe how in this extended period of transition, excessive khat use is a frequent response to cope with insecurity and hopelessness and how it contributes to the development of mental illness.

The main psychoactive component within these leaves is cathinone, which resembles amphetamine in chemical structure and similarly affects the central and peripheral nervous system as well as behavior.

A cross-sectional study carried out by VIVO in 2003 in Hargeisa, states that 16% of former combatants were severely impaired in their everyday functioning due to psychiatric problems, consisting mostly of psychotic disorders and associated excessive khat abuse. The greatest amount of khat use was among respondents with Post Traumatic Stress Disorders (PTSD) who indicated that drugs helped them to forget war experiences. This supports the hypothesis that PTSD and khat use have contributory effects on paranoia and that PTSD causes the use of higher quantities of khat. Moreover, another survey conducted by VIVO in 2002 revealed that 80% of patients that suffer from psychosis were excessively using khat before they became ill. The survey statistics indicated that at least 76% of the patients consumed khat before becoming mentally ill, whereas 70% of them were still consuming it.

Table 3

Khat abusers with psychiatric problems against the total number of patients (GRT, 2005)

TOTAL NUMBER OF PATIENTS	KHAT ABUSER	PERCENTAGE/TOTAL
785	185	23.6 %

Khat is not the only substance used in Somalia. Hashish (marijuana) is also largely used by youth (note that khat is used by youth, adults and elderly) especially among those living in the countryside where the illegal plantations are widespread. In the common belief the use of hashish leads to the development of mental problems. Hashish consumers, when found, are often kept in jail with the approval (or request) of the family. No data is available on this phenomenon which is believed to be widespread in the country and not accepted by the society, causing stigma and segregation of the young hashish consumers.

Although Somalia is a Muslim country, the practice of consuming alcohol (often home-made and very dangerous) to forget war experiences and the harshness of the everyday life has become quite widespread, especially among the refugees and displaced communities. Even though alcohol is not legal in the country, it is very easy to smuggle it across the border with Ethiopia. No clear data is available on the extent of alcohol consumption/abuse, however, it has been increasingly reported that alcoholism has become a serious problem especially amongst male adults in urban settings and IDP/refugee settlements.

➤ 3.3 Mental Health in the Somali Context

3.3.1 Cultural Stigma Related to Mental Illnesses

Many Somalis with mental illness are socially isolated. The pain of this isolation is felt intensely because Somali culture is traditionally communal and family oriented. While a person with mental illness may be ostracized from the community, their fear of stigma may be even more powerful. Whether the ostracism is created by the community or self-imposed due to anticipated negative responses, the social isolation creates a profound worsening of the mental illness. This social isolation can be very disorienting and can make the process of healing very difficult. In fact, even without prior mental health problems, isolation from the community alone can contribute to the development of depression. The situation of the mentally ill people is worsened by the fact that Somalis believe that once a person becomes mentally ill, he/she will never recover. A Somali proverb says that a mentally challenged person can only improve but never recover (*nin waashay wuu ladnaaday mooyee wuu bogsaday maleh*).

Significant stigma shrouding mental health issues prevents many Somalis from seeking treatment or assistance. In the Somali culture, concepts of mental health only include perspectives on mental illness (one is crazy (waali) or one is not crazy). There is no conceptual framework that includes a spectrum of health and disease, mental health and mental illness. Beliefs in the causes of mental illness

⁴ 'Use of khat and posttraumatic stress disorder as risk factors for psychotic symptoms: A study of Somali combatants', by Michael Odenwald, Harald Hinkel, Elisabeth Schauer, Maggie Schauer, Thomas Elbert, Frank Neuner, Brigitte Rockstroh in *Social Science and Medicine Journal* (2009).

are predominately spiritual or metaphysical (mental illness comes from God or evil spirits (jin) or can also be brought on by another person, through curses or bad behavior). Somalis traditionally explain behavioral problems as an expected result of spiritual causes or possession by an evil spirit. Healing for these problems is provided by religious leaders or by traditional healers⁵.

Mental illnesses are widely addressed solely in a repressed and outmoded manner. The mentally ill are generally chained and/or confined. Next to extreme isolation, discrimination and stigmatisation, expressed through violent actions, such as throwing of stones, represent the most common behavioural attitudes towards the mentally ill. Those actions constitute barriers to societal reintegration and acceptance of the practice of medical treatment itself.

Graph 3
Opinion of the public on mental illness (GAVO Source)



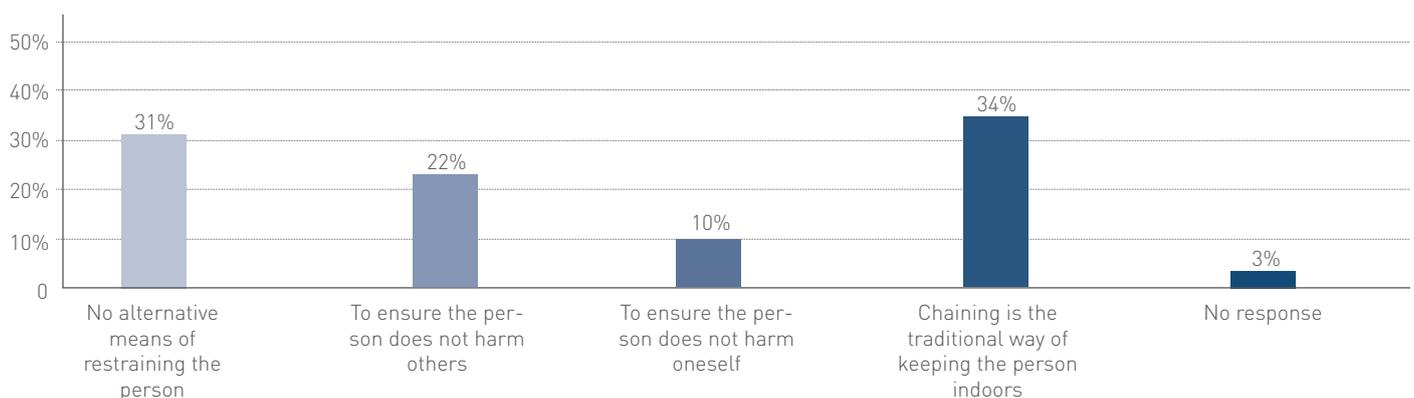
According to the assessment of GRT in the North East zone as well as in South Central Somalia, the stigmatisation of mental disorders improperly labeled as ‘madness’ is evident and severe. Once the person gets mental problems the stigma of ‘mad’ will accompany him/her even after a possible recovery. Understanding when a person is considered mentally disturbed is very important for mental health education and awareness purposes. The signs of arising madness are similar in northern and southern regions of Somalia: “disoriented speech, too much thinking (brooding over problems)”, or actions such as “running, escaping, crying, undressing oneself in public without shame, throwing stones”, and “refusing of food, lack of hygiene”. The mentally challenged people are widely recognized only as a danger and described as “always aggressive, [...] troublemaking and those who create problems to the community”. This stigma associated with the mentally challenged people results in them being imprisoned in the police station or restrained at home with chains (see following section)⁶.

3.3.2 Chain Containment

The containment with chains of mentally challenged people is prevalent in both urban and rural areas and is widespread regardless of gender. This is also used as a locally accepted medical treatment in many mental health facilities.

GRT intervention in the last decade reveals that 90% of the treated patients were subjected at least once in their lifetime to chaining. Chaining patients is seen as an alternative medication, with not only leaving the patients stigmatised but also causing physical injuries on their hands and legs. Some of the chained patients end up committing suicide. It should be noticed that the person is usually chained not only during the ‘acute crisis’ but throughout his/her life. The GRT encountered patients who have been chained for up to 8 consecutive years or even a total of 13 years in different times of their lives.

Graph 4
Why chaining of mentally ill people is rampant among the local community (GAVO Source)



⁵ David McGraw Schuchman “Somali Mental Health”, An International Journal of Somali Studies, 2004.

⁶ Assessment Report and feasibility Study on Mental Health in Merka, GRT (2004).

The graph above shows the reasons behind containment of patients with chains. It is more an act of despair of the family who does not know how to handle the problem, especially in a community where very few facilities and services are available and in a country where a mental health policy and plan are not in place. Obviously, this undignified practice leads to an increased societal stigma. The chaining experience remains in the patient's mind as a permanent trauma and he/she is identified by the community as 'aggressive' and 'mad'.

This statement has been partly addressed by some initiatives, such as the Chain Free Initiative, developed and implemented by WHO, and in general by the awareness and education campaigns carried out by GRT and GAVO in the northern region of Somalia.

Table 4

Users of mental health department in Bosaso hospital chained at the time of their first visit (GRT Source)

PERIOD	NO. OF PATIENTS	NO. OF PATIENTS CHAINED	PERCENTAGE
From 8 June 2003 to 26 June 2004	373	106	28.4
From 1 July 2004 to 26 March 2005	411	50	12.2

The table clearly shows that at the beginning of GRT intervention the percentage of persons chained at the time of their first contact was almost 30% (one out of three patients was chained). During the second year the percentage decreased to 12%, showing that the chain containment practice is more related to a lack of understanding of mental health than to real shame and stigma towards the member of the family.

Another form of Human Rights violation experienced by the mentally challenged is the practice of imprisonment, both at the request of the family and by the local authorities for homeless people. The officer responsible for the regional jail of Merka once explained to GRT staff why mentally disturbed people are kept in prison: "[...] there are two ways a person considered mad is captured:

- the family asks the police to keep them because they are not able to manage the situation at home;
- the police directly puts them in jail because they are "troublemaking", so that they create problems to the community (disturbing, security)".

Usually the detention "doesn't last for less than 6 months, but it can last even for two years, as it has happened to the last madmen we captured because of security and drug problems (hashish)".

According to the survey carried out, the following table shows the number of patients who are still in chains in the mental health facilities:

Table 5

People in chains in mental health facilities

NAME OF THE FACILITY	PEOPLE IN CHAINS		CAPACITY OF THE FACILITY	% PATIENTS CHAINED/FACILITY
	MEN	WOMEN		
Berbera Mental Health Hospital	14	0	100	14%
Hargeisa Mental Health Hospital	30	1	100	31%
Mental Health Department Bosaso	0	0	4	0%
Nasrulah Garowe	16	0	33	48,48%
Habeb Mental Health Hospitals	0	0	232	0%

This clearly indicates the need of carrying out a comprehensive mental health intervention in order to improve the conditions in mental health facilities and increasing the knowledge, attitude and capacity of the medical staff through in-service training.

3.3.3 Traditional Healers

Due to the lack of proper medical treatment and facilities and the huge need for them, the communities are faced with several kinds of traditional healers where some of them allegedly treat mental disorders. Each treatment has its own rituals, rationale, procedures and complexity that is not easy to explain. Amongst the rites used in dealing with mental related problems are:

- Koranic treatment;
- Mingis (originally from the north, pagan origin but blended with some Islamic believes similar to Ethiopian rite of Saar);
- Dawo Somali (traditional medicine with herbal and natural infusions);
- Sharax (officiated on the coastal region, Arabic origin);
- Borane (similar to Mingis in the area of Juba, Lower Shabelle...);
- Xayaad.

The Koranic System refers to the well known traditional Muslim healing system used in some Muslim countries. The Dawo-Somali refers to a traditional system which mainly uses burning, herbs and plants as remedies while the Minghis refers to an autochthon cult of possession similar to the Ethiopian Zaar (or Saar).

Table 6

Percentage of contact with different healing systems (GRT Source)

HEALING SYSTEM	NUMBER	SAMPLE	PERCENTAGE
Dawo-Somali	136	793	17%
Koranic	577	793	73%
Saar-Minghis	81	793	10%
Psychiatrist	40	793	5%
Neurologist	301	793	38%
Other	156	793	20%

Traditional healing systems are more often sought as a first point of help. Of great relevance, is the relatively high percentage of people who sought help from a neurologist. The neurologist is the only professional figure “near” to the psychiatrist who is recognized as a professional healer for mental health problems.

Other interesting data refers to the number of times that the family brought the patient to the same healers (not intended as a “follow-up,” but rather as a second or third isolated recovery attempt). In fact, for the majority of different healers, the number of attempts is one, while for the Koranic system, 391 patients out of a total of 793 patients registered by GRT in Bosaso sought the help of such healers three to ten different times. In terms of percentage, this means that even after obtaining unsatisfactory results, in more than 45% of the cases, the families insisted upon Koranic treatment on at least three different occasions. This data is significant as it underlines the importance of the traditional system as a meaningful cultural and not merely healing system.

More and more local communities are opting for alternative mental health providers in order to treat mentally ill persons. Religious and traditional healers are seen as a substitute to normal medication. Many mentally ill persons are seeking treatment from centres that are run by Sheikhs or a traditional herbalist. These centres mostly deal with people with spirit possession, diseases and even drug abuse. Although it was reported that some patients recovered through this kind of medication, many mentally ill patients suffered due to the treatments they received from some of the untrained healers. The GRT findings highlight three main considerations:

- Families try every kind of means available for the wellbeing of their relative with mental illness;
- It has been reported by few patients that traditional treatments can produce temporary good results as solutions for acute and/or hysteric crises;
- Medical treatment and traditional healing practices are both sought when available.

Traditional healing practices should be taken into consideration for the development of any intervention related to mental health. There are many practices that can result in human rights violations, abuses and often injuries or death of the patients. In the Mental Health Department of Bosaso a woman was referred after having undergone a Mingis practice. Her clothes caught fire causing severe injuries to her and burning her shelter (August 2009). Even more dangerous and shocking is a practice reported to happen in South Central Zone by Abdurahman Ali Awale (Dr. Habeb), the national mental health focal point of the Ministry of Health of Somalia. Mentally challenged people, including children at early age, are locked in a hut for a whole night with hyenas. Those animals are believed to be able to eat (by biting the poor victim) the evil spirit possessing the mentally ill. This practice causes long lasting trauma, physical injuries and can even lead to death.

3.3.4 Somali-Related New Mental Disease, Buufis

The Somali context with its peculiarities has developed a unique way of considering mental disorders, giving different names to them and developing traditional way of treatments. Some mental disorders have been encountered in the country to an extent that they are not found in other regions of the world. Some scholars, following Cindy Horst's initial contribution, have started to talk about a new phenomenon referred to as 'buufis'. The Somali word *buufis* was initially found in common use in the Kenyan refugee camps of Dadaab, referring to a person's dream of resettlement. It is an ambiguous phenomenon, bringing hope and remittances into the community but also removing investments from the region and, when the dream cannot be reached, sometimes having adverse psychological effects. *Buufis* is triggered by the fact that, due to transnational flows of remittances and information, refugees in remote camps, like Dadaab, can compare their camp life to those of others elsewhere. This illustrates how the opportunities, constraints, hopes and dreams that refugees experience locally are often determined by transnational factors. Whereas the resettlement dreams analysed are likely to occur in other contexts as well, it should be noted that they are more intense and elaborated amongst communities with a strong culture of migration, like the Somalis. This desire/obsession/compulsion to flee abroad can have important pathological consequences. There is still little data available, therefore the following case study is informative:

CASE STUDY

Ahmed lived in Hagadera and he was satisfied with his life. His brother decided to sponsor his resettlement and Ahmed had to stay in Nairobi for over 1 year, while *buufis* was growing in his mind. He learned English and developed his skills. He was sure that he would soon be in America or that he was in America already. He thought about that during the day and dreamed about it at night. Whenever he and his friends were together, all they used to talk about was America. One day he was called for his interview and he passed. After a while, the Immigration and Naturalization Service (INS) called Ahmed for screening, which he actually failed. After that, he left for Garissa. Then, he took another bus which brought him to Hagadera. As he came out of the bus, he reached a small tree between the butcher and the bus station. First, he took off his shirt and hung it on one of the branches of the tree, and after that, he took off his trousers and hung it on another branch. Then, he took off his t-shirt and pants and hung them on another branch, after which he started walking. He then went to Kismaayo where traditional healers tried to cure him.

3.3.5 Women, Children and Ex-Combatants

Women and young girls living in harsh conditions are often victims of abuses and different forms of GBV, including rape, sexual assault, forced prostitution, domestic violence and other forms of gender-related violence and abuses.⁸ Moreover, the Somali society still practices FGM, although not directly related to mental disorders; it can lead to long term distresses, such as sleeping and appetite disorders, lack of self esteem, depression and suicide. Forced marriage at a very early age is also very common in the country and is often used as a traditional way to settle disputes between families in case of rape. Indeed, forcing the young girl to marry the perpetrator often causes a double trauma for the victim and long-lasting psychosocial disorders, often leading to depression and suicide. Unfortunately, no data is available on this issue. Women and young girls are exposed to a higher risk to develop certain traumas which, if not treated, can lead to chronic psychosocial disorders.

Surprisingly, according to the data collected, women using mental health services are less in number compared to men. In Somaliland, GAVO estimated that 25% of users are women while in Puntland GRT registered 34% of the admitted inpatients as female. No data from South Central is available. This leads to some reflections: even if women are more likely to be in need of mental health services and support, they have less access to those services, when available. Further research to explore these gender-related barriers is required.

In the three regions no services and facilities exist exclusively for children and adolescents. Children with epilepsy, mental retardation and other mental disorders are kept away from any kind of basic services and often die at an early age.

Finally, further investigation should be conducted on ex-combatants and their relation to mental disorders. This will constitute a major problem for the future of Somalia. According to VIVO, 15% of the interviewed ex-combatants suffer from a severe mental disorder (mostly psychosis). Ex-combatants are four times more likely to suffer from severe and incapacitating mental disorders than the already high prevalence in the general population.⁹

⁸ WHO Manual, Mental Health for Refugees, (1996).

⁹ "War-trauma, Khat Abuse and Psychosis: Mental Health in the Demobilization and Reintegration Program Somaliland", Final Report of the VIVO Mission 2 within the EC/GTZ Demobilization and Reintegration Program in Somaliland, September-November 2002.



4. Policy and Legislations



One important way to improve the lives of people with mental disorders is through policies, plans and programmes that lead to better services. To implement such policies and plans, a country needs good legislation. That is law that places the policies and plans in the context of internationally accepted human rights standards and good practices. On the other hand, legislation can be used as a framework for policy development. It can establish a system of enforceable rights to protect persons with mental disorders from discrimination and other human rights violations by government and private entities as well as guaranteeing fair and equal treatment in all areas of life. Legislation sets minimum qualifications and skills for accreditation of mental health professionals and minimum staffing standards for accreditation of mental health facilities. Additionally, it creates affirmative obligations to improve access to mental health care, treatment and support. Legal protections may be extended through laws of general applicability or through specialized legislation specifically targeted at persons with mental disorders. Policy-makers within government (at national, regional and district levels), the private sector and civil society, who may have been reluctant to pursue changes to the status quo, may be obliged to do so based on a legislative mandate. Others who may have been restricted from developing progressive policies may be enabled through legislative changes.

The important role of mental health legislation should be taken into high consideration for any future mental health interventions and strategies for Somalia. Limited data is available on mental disorders prevalence and mental health facilities. The scenario becomes more and more worrying when it comes to assessing and drawing conclusions on the regional, national, and local mental health framework. According to WHO's Mental Health Human Rights Booklet, a comprehensive and well conceived mental health policy should address critical issues such as:

- Establishment of high quality mental health facilities and services;
- Access to quality mental health care;
- Protection of human rights;
- Patients' right to treatment;
- Development of robust procedural protections;
- Integration of persons with mental disorders into the community; and
- Promotion of mental health throughout society.

None of the abovementioned systems are in place in Somalia. Indeed, no mental health policy is available and drafted by any of the Somalia zones. As the 'Mogadishu and South Central Somalia' WHO-AIMS Report (2009) confirmed, Mogadishu and South Central Somalia have no mental health policy. A mental health strategic plan and an emergency/disaster preparedness plan for mental health are also missing. The civil war caused the collapse of all public/private institutions. The Mental Health Care Act is being designed with the help of proposals from the mental health focal point and responsible bodies. This was endorsed in 2007 and includes the following areas:

- Access to mental health care for every individual who is in need is assured, particularly for patients living in the provinces where there is no mental health facility;
- Rights of mental health service consumers, family members, and other care givers;
- Competency, capacity of service and guardianship of wellbeing issues for people with mental illness in the general population;
- Voluntarily and involuntary admission procedures;
- Accreditation of professionals and facilities.

However, lobbying initiatives from a local NGO have led to the establishment of a mental health unit in the Ministry of Health and Labour (MOHL). Some progress has been made by GAVO at advocacy level who has called recent meetings with the local authorities to develop a draft for a Somaliland Mental Health Policy. This shows a general lack of understanding from the local authorities. Even if they appointed mental health Focal Points in the three areas, they do not have a clear job description, no supervision and no proactive guidance to take the lead in the development of this very much needed national tools. Therefore, the small pilot initiatives on mental health are often not coordinated, scarcely harmonized and moreover not framed and institutionalised into a broader strategy. Stakeholders, particularly practitioners and mental health workers at different levels still act in a vacuum of directions, guidelines and plans. No monitoring, training or supervisions are provided by the central level.

This blurred scenario can be very dangerous, especially in Somaliland where many private clinics have started to be operative in 2008 and 2009. They are often run by psychiatrists coming from the Diaspora for a few weeks per year and then handing over for the remaining months to general health workers without any proper qualification. Group discussions with patients and health workers shows that these services are for well-off patients and the majority resort to seeking care by unqualified personnel and to traditional and dangerous treatment practices including chain containment.

In Puntland, the lack of legal and political framework left the floor to the proliferation of Diaspora-run community facility centres. Despite the good intentions behind these initiatives, patients are often kept behind bars and no proper medical treatment is provided. Nevertheless, these community-run initiatives are a sign that there is at the grassroots level an increased awareness of the magnitude of the mental health problems.

Recently, during the biennial planning exercise with WHO, local authorities from the three zones have clearly pointed out the need to invest in mental health. At this point, it is highly recommended that the two synergies coming either from the top or bottom should be merged into a comprehensive national policy and into an operative regional plan, with international/donor assistance.

➤ 4.1 Human Rights Legislation

Finally, the fundamental aim of mental health legislation is to protect, promote and improve the lives and mental wellbeing of citizens. Legislation that protects vulnerable citizens (including people with mental disorders) reflects a society that respects and cares for its people. Progressive legislation is an effective tool to promote access to mental health care as well as to promote and protect the rights of persons with mental disorders. The need for human rights based mental health legislation in Somalia stems from an increasing understanding of the personal, social and economic burdens of mental disorders in the country. Mental disorders account for a high proportion of all disability adjusted life years lost and this is predicted to grow significantly in the future. Somalia will be no exception. People with mental disorders in Somalia are particularly vulnerable to abuse and violation of rights. In addition to the obvious suffering due to mental disorders, there is a hidden burden of stigma and discrimination faced by those Somalis with mental disorders. Violations of basic human rights and freedom, and denial of civil, political, economic, social and cultural rights to those suffering from mental disorders are a common occurrence in the different Somali regions, both within mental health facilities and in the community. Much of this goes unreported and therefore remains unquantifiable.

In accordance with the objectives of the United Nations (UN) Charter, the UN General Assembly Resolutions, such as Principles for the Protection of Persons with Mental Illness, and the Improvement of Mental Health Care (MI Principles, 1991), constitutes a fundamental basis for mental health legislation as a human right. Key rights and principles include equality and non-discrimination, the right to privacy and individual autonomy, freedom from inhuman and degrading treatment, the principle of the least restrictive environment and the rights to information and participation.

The questionnaires submitted in the few existent mental health facilities in Somalia clearly showed that there is no internal or external independent body in charge of monitoring of violations and abuses experienced by patients.

Mentally ill people often live in poor and humiliating conditions in their own communities, where they are prevented from having access to health and education services, sanitation facilities and often do not have freedom of movement (enchainment). Very few schools for special needs are in place. Hargeisa has an institution of this kind. However, it lacks funding and human resources and does not comply with Human Rights international standards.

Moreover, due to the complexity of the issue and limited time and resources, this assessment could not explore the linkage between justice and mental health. Researchers did not enter and monitor the local Somali prisons, where many of the mentally challenged are detained. Without psychosocial support, many of them are likely to develop some sort of mental distress. Despite the fact that specific data on Human Rights violations perpetrated on the mentally ill are not available in Somalia, stories and case studies have been collected in the past by stakeholders working in the sector. The following case study (recorded by GRT in Bosaso March 2009) sheds some light on the magnitude of the problem:

CASE STUDY

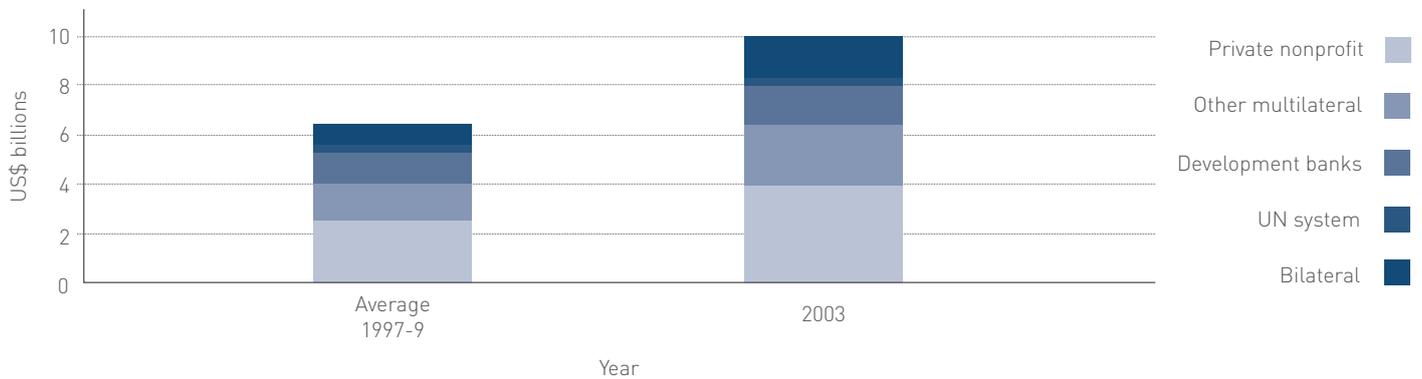
Hodan 18- years old, lives in Shebelle settlement around Bosaso and was visited by a GRT social worker for the first time in March 2009. The patient fled Mogadishu with her mother and a younger sister. They settled in Laas Anood where together with her mother they started a small business. Here she married a man. While pregnant of her second child, the man left the country for Yemen and died on the way. Already suffering from grief and distress, her husband's death became unbearable for her. She became mentally disturbed dreaming of sexual assaults happening to her every night. She got confined to the house and was chained. The mother could not continue with the business since the daughter needed her constant care at home and therefore the family's lifeline collapsed. With nothing else to do, the mother finally escorted her daughter to Bosaso in search of medication. Since then she has given birth to a baby girl and is currently pregnant from a man whose identity nobody knows, not even her.

➤ 4.2 Financing of Mental Health Services

According to the World Bank Report 'Total Health Sector Aid financing' (2000-2006), conventional donor funding for the health sector grew almost three-fold in seven years, passing from US\$ 23 million in 2000 to US\$ 62 million in 2006. The contributions of bilateral donors decreased from 63 percent in 2000 to 35 percent in 2006. Multilateral donors, and particularly the UN, considerably increased their share. Health sector financing progressively shifted from horizontal to vertical programs, thus, leaving aside some sectors including mental health.

Graph 5

Development assistance for health by source (1997-2003)



Source: Michaud 2005.
 Note: The category of other multilateral includes the European Union and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

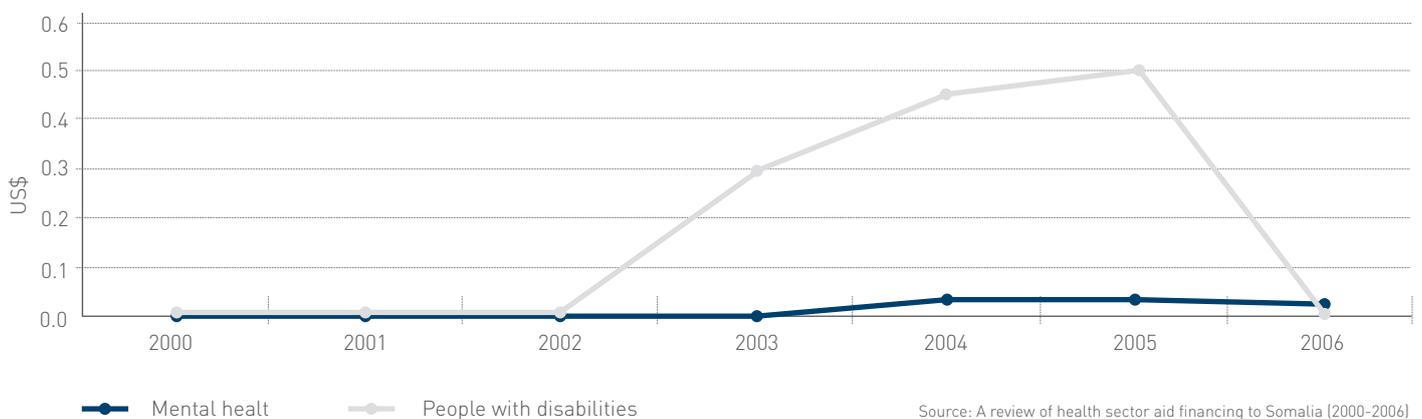
Other non-traditional donor countries have reportedly provided international aid to Somalia. Precise estimates are not available, though it is likely to be substantial given the large presence of Islamic charities mostly financed by the Gulf States. A recent study by ODI found that on a global scale, non-DAC contributions constituted between 1 and 12 percent of the total global humanitarian assistance reported by the OCHA's Financial Tracking System for the period 1999-2004. Remittances are vital to the Somali economy. It is estimated that remittances to Somalia are roughly four times higher than official development assistance¹⁰ figures indicate. It is also estimated that between 25 and 40 percent of all families in Somalia receive remittances¹¹. At least half of the remittances are used for direct consumption by the household, including education and health. Contributions are often channeled through informal solidarity networks. However, finances from the Diaspora also support structured organizations such as local NGOs and training institutions. In the health sector, Diaspora remittances appear to be used to meet the needs for common and emergency medical treatment and to support health facilities, principally hospitals¹². Same considerations can be applied for the few mental health initiatives in Somalia.

In 2006, malaria, TB, HIV and the polio programmes alone accounted for 50 percent of total aid compared to 25 percent in 2000. Within vertical programmes, EPI, reproductive health, non-communicable diseases (including mental health) and nutrition received inadequate funding. Contributions to the health sector should be made more strategically. Funding gaps in key areas (EPI, reproductive health, nutrition and non-communicable diseases, including mental health disorders) were recommended to be addressed as a matter of priority. This suggests that priorities to aid the health sector tend to be set on the basis of donors' political needs rather than on the objective needs of people in distress. This becomes more apparent when applied to the mental health sector.

Despite the expected heavy burden of non-communicable diseases in Somalia, practically no funding was allocated for that purpose in the period 2000-2006¹³. Non-communicable diseases and injuries represent 27 percent of the total burden of disease in Africa and this percentage may be higher in Somalia, given the high incidence of neuro-psychiatric disorders linked to almost 20 years of war. Yet, the annual average expenditure for non-communicable diseases from 2000-2006 was less than US\$200,000. This trend can also be confirmed for the period 2006-2009, albeit no proper study has been carried out to date. Although the difficulties of targeting chronic diseases in a fragile state are recognized, the absence of funding for diseases with such a high burden on the population is a matter of concern.

Graph 6

Health expenditure: Non-communicable diseases (2000-2006)



Source: A review of health sector aid financing to Somalia (2000-2006)

10 Kulaksiz, S. and Purdekova, A. Somali remittance sector: A macro-economic perspective in Remittances and economic development in Somalia. An overview. The World Bank 2006.
 11 KPMG/UNDP/EC. Feasibility study on financial services in Somalia -Final Report. KPMG/UNDP/EC 2003.
 12 Development and the Diaspora: support for sustainable health services in Somalia Kent, by R. and Von Hippel, K. Social facilitation (2004).
 13 KPMG/UNDP/EC. Feasibility study on financial services in Somalia -Final Report. KPMG/UNDP/EC; 2003

Non-communicable diseases have been generally neglected by the donor community. The small number of implementing partners and the high cost for service provision may have been limiting factors for resource mobilization. Although there is no official data on the burden of mental illness and disabilities in Somalia, overall stakeholders interviewed were unanimous in recognizing the extent and severity of these diseases within Somali communities and the general underfunding of the sector.

Regarding mental health, it is difficult to get proper information on financing, thus the overall amount of funds poured into the sector are negligible. In the period 2006-2009 the EC showed some commitment in providing funds to the running of mental health activities, however they can be quantified at around 150,000 USD channeled to INGOs through the Health Programme. Except for WHO, no other UN agency has allocated funds for mental health programmes, activities and staff. Besides the delivery of psychotropic drugs to some mental health facilities, WHO implemented a chain free initiative in Mogadishu. This initiative is planned to be extended to Somaliland and Puntland during the current biennium. In addition, WHO is involved in capacity building of health staff in mental health. Recently, a three month training course was organized by WHO for participants from all three zones. However, the funds allocated for mental health programmes by WHO are not sufficient to meet the needs of the whole country.

The other few stakeholders involved in mental health rely on private donations and private donors. The main funds for the maintenance of mental health facilities come from the Diaspora, charity and local communities which through in-kind contribution (provision of food, clothes and water) and cash, contribute to their running. According to interviews and discussions in Puntland, the newly established Puntland Agency for Social Welfare managed to catalyze the interest of local businessmen and international Diaspora to fund mental health related projects, contributing about 80,000 USD for 2009-2010. The local NGO SAHAN runs three community-based mental health centres in Hargeisa with the contribution of local businessmen and Diaspora. It was not possible to quantify the overall budget available to them.

Finally, no governmental aid is put into the mental health sector either in Somaliland, Puntland or South Central Somalia. Mental health facilities are struggling to survive due to the following main reasons:

- Mental health wards and hospitals are not always located within the general public hospital, putting them aside from the general budget of the premises;
- Difficulty in applying recovery mechanisms for the expenses incurred, mentally challenged people are often the poorest of the poor and services are generally free of charge;
- High costs of procuring and maintaining psychotropic drugs in many locations.

In conclusion, the following assumptions regarding the health system are true when applied to mental health:

- Negligible/non-existent contribution by the health authorities;
- Lack of cost-sharing and cost-recovery mechanisms;
- Fragmented and uncoordinated donations from private businessmen and Diaspora;
- Fragmented and insignificant funding from external donors;
- Irregular and uncoordinated donations and funding from Islamic institutions and organizations.

In future, no relevant (almost non-existent) budget allocations are foreseen for the mental health sector, besides the above-mentioned and unquantifiable private donations, charity and local community contributions.

Moreover in terms of future financing, other financing mechanisms used by other health sub-sectors such as 'Out-of-Pocket Payments', 'Cost-sharing' and 'User fees' are not considered as conceivable and feasible solutions for mental health services in Somalia. Indeed, introducing cost-sharing policies generally tend to limit access to health services, if not accompanied by other measures like exemption mechanisms. The mentally ill usually come from the poorest communities and in most cases lack the means to bear the cost of the medical treatments required. Besides community/family contributions on a discretionary basis, no recovery mechanisms and/or income generated by fees collected from patients have been reported in any of the facilities assessed.



5. Mental health services available in Somalia



Specific data was collected through the submission of a questionnaire to all the known mental health facilities in Somalia. The questionnaires were filled in the following facilities, under the supervision of the consultant:

Table 7
Mental health facilities in Somalia

TYPE OF FACILITY	NW SOMALIA	NE SOMALIA	SC ZONE	NO FACILITY	%
Mental Hospital	Berbera Mental Health Hospital		Habeb Public Mental Hospitals (3)	4	50%
Ward Within a General Hospital	Hargeisa Group Hospital	Mental Health of Bosaso General Hospital		2	25%
Community Owned Psychiatric Inpatients Units	Sahan Clinic			1	12,5%
Mental Health Outpatients Facility	-	-	-	-	-
Community Residential Facility		Nasrulah Community Centre Garowe		1	12,5%
Mental Health Day Treatment Facility	-	-	-	-	-
Number per Region	3	2	3	8	

Concerning the general background information of the facilities, the main data were related to the ownership of the infrastructure/facilities that highlights the discrepancy in terms of support between the different Somali regions. In the South, much is still left on the initiative of individuals able to catalyze attention and mobilize resources, while in the northern areas some public facilities are available to the populations.

Table 8
Type of mental health facilities in Somalia

	N	%	NW	NE	SCZ
Public	3	37,5%	2	2	-
Private	N/A	N/A	N/A	N/A	N/A
Private/NGO/Non-Profit	5	62,5%	1		3

The catchments area of the facilities was difficult to calculate since data were not provided in a scientific manner by the respondents. Besides the small number of facilities, they seem to offer a relatively good range of services. In terms of opening hours, 50% of the facilities remain open for 24 hours, while 50% are open on an average of 5 hours a day.

The overall availability of specific services in Somalia can be summarized in the following way:

Table 9
Type of mental health facilities in Somalia

SERVICES	NO	%
Outpatient Care	7	87,5%
Inpatient Care	8	100%
Outreach Activities (by Hospital Staff)	4	50%
Preventive / Promotive Services	3	37,5%

ORGANIZATION AND MANAGEMENT SUPPORT		
In- Service Training	3	37,5%
Supervision	5	62,5%
Health Information System	4	50%
Drug Supply System	8	100%

The above table clearly shows that all facilities have an inpatients unit that should be taken into account in order to mainstream human rights into mental health interventions in the future.

Outreach activities outside the hospitals such as patient-monitoring, follow-up, preventive campaigns through mass media, and awareness initiatives in schools are generally carried out in those facilities supported by INGOs. Alternately they are carried out by organizations that have a strong leadership regardless of the general management of the facility.

Concerning the maintenance of the facilities, the answers were rather diverse. According to the data collected the majority of the infrastructure, such as the main walls, doors and sanitation, need rehabilitation works. A better separation between the inpatients and outpatients department and between women and men is also highly recommended. None of the facility has a dedicated space for children.

Table 10
Hospital Management and Support System Questionnaire

HOSPITAL MANAGEMENT AND SUPPORT SYSTEMS	YES	NO
Do you have job descriptions for your technical staff (If yes, ask to see)?	7	1
Do you have a job description yourself?	7	1
Are areas of responsibility clearly defined within the health team (if yes, ask for definition/description)?	5	3
Are all staff receiving their salaries regularly?	3	5
Is there a formal means by which the community can influence hospital policy and practice?	4	4
Have you attended any training courses during the past year?	5	3
Has any of your staff attended any training courses during the past year?	7	1
Do you have any health manuals/books at the facility or for your personal use?	5	3

There seems to be an informal management of the structure, whereby tasks and responsibilities are shared. When asked to provide a clear definition of terms of references and duties, no documents were provided and roles overlap.

A major problem related to human resources in Somalia is the lack of regular and decent salaries. This is also the case for the mental health sector. In the majority of surveyed facilities staff is not getting their salaries on a regular basis.

In most facilities (seven out of eight), at least one person has received training on mental health during the past year. This is due to the fact that WHO has recently conducted three month training course on mental health for participants from all three zones.

There is an informal system of supervision in the majority of the facilities in terms of observing the delivery of services and making suggestions for improvements. Only two facilities had any system of rewarding/offering praise for good work. Therefore motivation of staff is generally very low.

Table 11
Information on records

RECORDS KEPT IN THE FACILITY	YES	NO
Number of outpatient visits	7	1
Outpatient diagnoses	7	1
Records of first and follow-up visits	5	2
Number of admissions (inpatients)	8	-
Outreach activities (i.e. home visits, etc.)	5	3

Most of the surveyed facilities keep record of the number of outpatient visits, outpatient diagnosis and outreach activities. All the facilities keep records of inpatient admissions. However, they have different ways of collecting data. Only three facilities (Hargeisa, Berbera and Bosaso) use the HMIS system but none of them have received any training on HMIS or the use of information. Unfortunately lack of proper data collection and the inefficient information system available to the facilities make the referral mechanisms almost non-existent. Patients show up spontaneously in the facilities and are rarely referred by the staff of non-governmental organizations. This is mainly due to:

- Lack of knowledge of available mental health services (generally free of charge);
- Poor referral systems among health and social service providers;
- Complete lack of mental health services in remote areas of the country, especially outside the main urban dwellings;
- Low awareness of mental health issues and the fact that mental disorders can and should be considered treatable.

➤ 5.1 Performances and Outputs of Mental Health Facilities

5.1.1 Outpatient Care

The monthly outpatient visits vary depending on the facility. The Habeb Hospitals in SCZ offers services for up to 701 patients in a month, while the mental health in Hargeisa do not register the outpatients visits and the MHD in Bosaso registers a maximum of 65 visits per month. However, some remarks should be made regarding the outpatients services provided by the mental health facilities:

- It was not possible to collect proper data per age or gender breakdown;
- Data does not reflect the movements of the people in some areas of Somalia during the hot seasons, like Bosaso and Berbera when people migrate to cooler areas;
- The higher percentage of the patients registered in SCZ reflects the impact of the outreach and awareness campaigns carried out by the facilities rather than the quality of the services provided.

5.1.2 Inpatient Care

	NW		NE			SCZ	
	F	M	F	M	C	F	M
Number of beds	70	125	9	22	7	100	132
Total	465 (179 females, 279 males and 7 children.)						

The facility with the highest number of beds (170) is the Habeb Rehabilitation Treatment Center in Mogadishu, while the MHD of Bosaso has only 4 beds for a severe and acute crisis.

A total of 49.9% of the inpatients care services in terms of beds is located in the South, while only 8.17% are in NE Somalia. This underlies the unequal access to mental health services in the country. It is reported that Nasrulah mental health Hospital can also accommodate seven children, however after an assessment carried out by the consultant, the hospital cannot be seen as child-friendly. Data from one facility in Hargeisa could not be collected on this issue.

It should be noted that the majority of the patients sleep on the floor or mattresses and it often happens that the structures are overstretched, accommodating twice the number of patients shown in the previous table.

5.1.3 Availability of Essential Psychotropic Medicines

The availability of drugs on a daily basis has been an issue raised by all respondents. The hospitals do not purchase the drugs. They are usually provided on an irregular basis by WHO and/or by private donations/INGO supplies. Only five facilities receive drugs, whereby two in NW Somalia receive them on a regular basis. Hargeisa and Berbera rely mainly on different channels of provisions, while two facilities out of seven rely on private donations and another two on INGO contributions. WHO do not provide drugs to community-run facilities, which very occasionally receive contributions from charity and private donations. All of the facilities complained about very poor storage conditions such as poor safety of the store, ventilation and space arrangements.

During the survey, following psychotropic drugs were available:

DRUGS AND SUPPLIES	BERBERA MENTAL HEALTH HOSPITAL	HARGEISA MENTAL HEALTH HOSPITAL	SAHAN VOLUNTARY ORG.	NASRULAH MENTAL HEALTH HOSPITAL	MENTAL HEALTH DEPARTMENT BOSASO	HABEB PUBLIC MENTAL HEALTH HOSPITALS
Amipriptyline Tablets 100mg	X	X	X		X	X
Chlorpromazine Injection 50mg/2ml			X		X	X
Chlorpromazine HCl Tablets 100mg	X	X	X			X
Diazepam Injection 10mg	X	X	X		X	X
Haloperidol Injection 5mg/amp	X	X	X		X	X
Haloperidol Tablets 5mg	X	X	X		X	X
Phenobarbitone Tablets 30mg	X	X	X		X	X
Phenytoin Sodium Tablets 100mg	X	X			X	X
Promethazine HCl Injection 50mg/2ml	X	X			X	X
Benzhexol Tablets 5mg					X	X
Syringes 5ml + Needles G21					X	X
Amipriptyline Tablets 100mg						X

The average period of drugs out of stock in the facilities was significant with very irregular provision of drugs.

Private pharmacies throughout Somalia are selling psychotropic drugs. There is no existing regulation on pharmacies, qualifications of their staff and ways of prescribing drugs. This increases the risk of wrong prescription, misuse of medicines and selling expired drugs. Data collected during the assessment in the table below provide an overall picture of available drugs and their price in the major urban towns in the northern regions of Somalia. These drugs are available to the general population without any prescription.

Table 12
Prices of psychotropic drugs in private pharmacies

PSYCHOTROPIC DRUGS	PRICE IN USD			
	BOSASO	GAALKACYO	HARGEISA	BOROMA
Amipriptyline Tablets 100mg 100pc	1,6	2,6	2	13
Chlorpromazine Injection 50mg/2ml 100pc	20	17,6	16,6	25
Chlorpromazine HCl Tablets 100mg 100pc	3	3,3	3	3
Diazepam Injection 10mg 25pc	6	5,6	2,3	5
Haloperidol Injection 5mg/amp, 100pc		35		
Haloperidol Tablets 5mg 100pc	6	5	5,6	5
Phenobarbitone Tablets 30mg	2	2,3	1	2
Phenytoin Sodium Tablets 100mg 100pc	10	7	10	18
Promethazine HCl Injection 50mg/2ml 1pc	16	2,5	13,6	17
Benzhexol Tablets 5mg, 100pc		5,3	2,5	3
Syringes 5ml + Needles G21, 100pc	3	3,3	3,3	

6. Human Resources



6.1 Number of Human Resources

Table 13

Human resources per location

CATEGORY	NW	NE	SC ZONE	TOT
Psychiatrists	2	-	1	3
Other Medical Doctors, Not Specialized in Psychiatry	-	1	-	1
Nurses	3	7	12	22
Psychologists	-	-	-	-
Mental Health Social Workers	8	1	10	19
Others (Including Auxiliary Staff, Non-Doctor Primary Health Care Workers, Health Assistants, Medical Assistants)	9		24	33
Support Staff	21	10	10	41
N/AREA	43	19	57	119
%/AREA	36,1%	15,95%	47,95%	100%

The overview of the human resources available in Somalia depicts a very worrying scenario. Only three psychiatrists with a fair experience and qualifications in mental health are working in public facilities in the country. In NE and SC, due to the brain drain only general practitioners acting as psychiatrists are available. Generally, nurses and social workers have been trained by INGOs and/or WHO in two courses of training on mental health carried out in 2005 initially in Bosaso MHD and later in 2009 in Hargeisa. Nevertheless, lack of qualifications and an accreditation system raises some serious doubts on the experience of medical staff engaged in mental health facilities in Somalia.

6.2 Training Professionals in Mental Health

Medical education and training of health professionals is a key issue for the health sector as a whole. Medical institutes, universities and schools do not have an internationally recognized and standardized curriculum. The only exception is the Nursing School in Hargeisa, recognized by WHO. In Somaliland, the training for medical and paramedical staff is provided through the above-mentioned nursing school and two universities, funded by the Diaspora, businessmen and Islamic organizations (i.e. Hargeisa and Boroma - Amuud School). According to the Somaliland WHO-AIMS Report, medical students at Hargeisa and Borama universities received a total of 100 hours training on mental health (1% of total training hours) and student nurses at Hargeisa Nursing Institute received 348 hours of training on mental health (8% of total training hours).

Puntland has one medical faculty in Bosaso, whose curriculum does not meet international standards, being mainly funded by Islamic charities and institutions. There is one private medical school in Gaalkacyo, the Gaalkacyo University, which started in 2006 a first basic training for Assistant Physicians (three years course). In the South, the Benadir School covers the whole SCZ. Besides NW Somalia no intervention has been focused on introducing a mental health curriculum into the basic teaching package.

Table 14

Health education facilities by zone and availability of mental health training/curriculum (Source WHO 2008)

ZONE	LOCATION	FACILITY	LAST/PLANNED GRADUATION	MENTAL HEALTH TRAINING/CURRICULUM
NWZ	Borama	Amoud University	10 Graduates in 2008	Yes, THET Project
	Hargeisa	University of Hargeisa	25 Graduates Planned for 2010	Yes, THET Project
NEZ	Bosaso	Bosasso Faculty of Medicine	40 students The First Trimester 2009	None
	Gaalkacyo	Gaalkacyo Faculty of Health Sciences	Graduation Planned for 2012	None
SCZ	Mogadishu	Banadir Medical University	21 Graduates Planned for 2009	None

On the other hand, over 20 years of humanitarian interventions have been invested in human resources through a plethora of different capacity building programmes, aiming at providing both technical and on-the-job training to the health workers at different levels. In general, on-the-job training is reported to be uncoordinated and not necessarily up to the standards. It often focuses on project indicators and is often agency-mandate-driven. No proper follow-up is carried out as part of supportive supervision by the authorities or by an independent body. The benefits and impact of such courses are therefore limited.

The mental health sector in Somalia is clearly framed in this education/training system. Therefore, Mental Health Training needs in Somalia remain very high.

In terms of education and training in the recent past and present there are four main stakeholders who deserve to be mentioned in terms of capabilities and technical inputs.

6.2.1 The World Health Organization (WHO)

WHO organized in 2005 and in 2009, specific three-month trainings on mental health for mental health practitioners coming from all the regions of Somalia. The first one was held in the GRT-run Mental Health Department in Bosaso and the last one took place in Hargeisa. Concerning the last one, officers in charge of the various regions of Somalia were requested by the ministries to nominate suitable candidates to undergo the 10 weeks training that started in October 2009 at the University of Health Science in Hargeisa. The group consisted of one trained medical doctor, two mental health coordinators, three nursing tutors, five Auxiliary Nursing and Midwifery staff, four lay social workers and the rest were qualified nurses.

Participants' knowledge, skills, and attitude towards mental disorders were generally poor even if the majority of them have been exposed to mental health issues for a long time. The majority had no skills to diagnose, manage and initiate psychosocial interventions for persons with mental health problems and did not know about psychotropic or anti-depressants drugs. Furthermore, they had no knowledge of psychopathology. Some of the trainees even believed that mental disorders are not treatable and that mentally ill people are very dangerous. It was surprising that despite exposure to mental health they seemed still rather ignorant on the subject. Therefore the EMRO-WHO sponsored training largely focused on practical work and experiences as well as theoretical discussions on clinical issues. The trainees gained skills for diagnosis identification, development of a care plan during the stay in the ward, starting up psycho-social interventions in the facility. These activities not only increased their technical and management skills, but also raised their sensitivity towards the mentally ill and their skills to work with families. To widen the scope of mental health care beyond the inpatients facilities, outpatient services were also implemented in the Hargeisa group so that the trainees could grasp the meaning of activities to be carried out at community level. This aspect sensitized the training participants on the necessary process of setting up community based mental health care at the same time as secondary mental health care.

At the end of the training, most of the trainees were convinced that mental disorders are treatable; that acutely excited patients can be managed with medication. They realized that families cared for the ill relatives as best as they could, given the harsh conditions in Somalia, and that providing treatment for the mentally ill can be a great relief to families in terms of reducing the burden. They realized that physical restraint, such as using chains, was an act of desperation by the families rather than cruelty shown towards the patients. The trainees also acknowledged that collecting information from the families of the patients was important since the history and examination formed two important complementary pillars to arrive at a coherent diagnosis.

6.2.2 Tropical Health and Education Trust (THET)

The UK-based non-profit organization, active in Somaliland, has been providing since mid-2008 mental health education for interns attending the Hargeisa and Boroma nursing school. The programmes involved incorporating a mental health -related curriculum into the health curriculum of the training institutes of Boroma and Hargeisa and a technical follow up of the interns in their psychiatric practice in order to support professional development career for medical students into the mental health sector.

6.2.3 Grupo per le Relazioni Transculturali (GRT)

Since the establishment of the ward of MHD Bosaso general Hospital in 2003, the Italian NGO has focused on capacity building/training of the medical staff following a bio-psychosocial model. On the job training and ad-hoc consultancies were organized for three years for three nurses and one doctor in Bosaso, later acting as psychiatrist. The training focused on diagnosis of main common mental disorders in Somalia, how to treat mental health disorders, drugs prescription, setting up rehabilitation plans for patients and their families and how to engage communities in dealing with mental disorders through awareness campaigns and advocacy.

In July-August 2009, a three-week mental health training was facilitated in the Bosaso MHD in the framework of the EC-funded project "Strengthening Health Sector in Somalia", aiming at providing technical knowledge and expertise to the selected medical staff of Merka with the intention of giving them a general knowledge on mental health for the local hospital professionals.

Training on mental health for social workers and nurses from the Hargeisa Group Hospital, Puntland and Somaliland has been conducted in 2008 and 2009 in order to stress mental health advocacy, community engagement on mental health, and the importance of outreach visits.

6.2.4 VIVO

VIVO, in collaboration with the German University of Konstanz, has been particularly active in Somaliland in terms of provision of technical training to social workers of the local NGO GAVO. They have provided training for the past 3 years on diagnostic and psycho-social care for schizophrenic outpatients and their care-givers (community-based care model), anti-psychotic-medication, care-givers' education, education on Khat and scientific evaluation.

➤ 6.3 User/Consumer and Family Associations

No proper and well defined user/consumers' associations are available in Somalia, neither family associations representing mental health patients interests and needs. Self-help groups and community initiatives proved to play an important role in the local political agenda in NW Somalia where they are advocating for a draft of mental health Policy and mobilize economic resources for the care of the mentally ill. Somali local NGOs, such as GAVO, represent the permanent resources and catalyst to keep the attention high on mental health in Somaliland; while the Puntland Agency for Social Welfare has started to play an increasingly important political role (starting from August 2009) in terms of resources mobilization in Puntland. No data on SCZ are available and/or were reported, besides the community mobilization carried out by Habeb hospital.

➤ 6.4 Key Issues and Concerns for Human Resources in Mental Health

Any intervention addressing mental health human resources should take into account the following factors:

6.4.1. Lack of Human Resources

Only four psychiatrists were reported to work in the Forlanini mental health Hospital in Mogadishu. Even before the outbreak of the civil war, no clinical psychologists or psychiatrist social workers were present in the country. The situation has worsened in the last 20 years. The mental health facilities survey clearly pointed out that no proper qualified psychiatrist is working in the registered mental health facilities. Few psychiatrists that are available are only temporarily in the country and are benefitting only the private sector (not controlled by any central authority)¹⁴.

Qualified mental health nurses are also lacking in numbers and on country coverage. Other very much needed professionals, such as psychologists and occupational therapists, are not available at all. The backbone of the mental health sector in Somalia is constituted by social workers which in the past have received mental health training and which through psychosocial support are indirectly offering relief and assistance to the larger number of mentally ill.

6.4.2. Poorly Qualified mental health Human Resources

Human resources currently in charge of all the facilities assessed during the survey are lacking proper qualifications and knowledge. Indeed, in the past little on-the-job trainings do not qualify general doctors as psychiatrists. Paradoxically, second level operators are better placed in terms of education. Nurses and social workers have shown to have a good level of knowledge in line with their terms of references. None of those professionals are supervised by a central body and/or receive refresher trainings on a regular basis. The poor qualifications of the personnel in charge of the mental health facilities represent a big challenge for a proper future mental health intervention which should be based on ethical medical treatments and on the protection of Human Rights of the patients.

6.4.3. Frequent Turn-over and Brain-Drain

Brain-drain of human resources has affected the availability of mental health professionals, especially at higher level (doctors being the first to leave the country). A high turnover of personnel has also been reported, due to the lack of funding for mental health facilities. In less than six years, four different doctors have been in charge of the department in the MHD of Bosaso.

Different projects have attempted to strengthen a network with the Somali Diaspora to bring human resource back to the country, but the outcome of this approach is still far from being quantifiable. The available doctors working in health facilities have often another source of income coming from private clinics, where they spend the majority of their time.

Any Mental Health Policy should therefore aim at establishing an autonomous certification body, possibly recognized by the three health administrations, with the task of reviewing the qualifications of health workers, issuing standard diplomas, proposing training programmes aimed at attaining a recognized qualification for workers holding non-standard ones, and testing and certifying health workers without proper documentation. This body should also be tasked with reviewing job descriptions, training programmes and materials in use across Somalia, and to formulate recommendations aimed at improving and harmonizing the mental health sector.

¹⁴ It has been reported that some psychiatrists from the Diaspora are in the country, such as Dr.Abdishakur Sh.Ali Jowhar (at the moment of writngn in Canada), Dr.Who in charge of Raywan psycho-social center in SL and such Dr. Mohamed Hassam Abdulle (Arabey) in Garowe-PL.

7. Public education, awareness
and links with other sectors



Public education and raising awareness are an integral part of any mental health intervention. The mentally ill are often hidden and kept away from the community because of social stigma, alleged aggressiveness, and the powerlessness of the family. It has been reported by all the mental health stakeholders that through an appropriate awareness campaign, behavior change and communication campaign/strategy, the mentally ill are likely to voluntarily go to the mental health facilities. The families are also likely to collaborate and join social rehabilitation plans for the patients, and chains could be removed.

GRT reported that following the establishment of the Mental Health Department in Bosaso (2003), a few months after outreach campaigns were carried out at household level, a large number of people showed up to the newly opened building. Patients had to wait up to three months to be visited. This success was mainly due to the important preparation carried out before the opening of the ward. The population was well informed and understood the exact potential of the Mental Health Department and the services it could offer.

Unfortunately no proper mental health education is currently carried out in Somalia. GAVO is the only organization properly advocating at community and political level for the set up of education and awareness programmes aimed at sensitizing the local population on the protection of mentally ill, and on the need for treating mental disorders as curable diseases. In Puntland, the last campaign on raising awareness on mentally ill rights was carried out by GRT in 2008, while in SCZ Dr. Habeb mobilized significant resources in terms of awareness raising and community engagement. Habeb public mental health institution has started a public awareness campaign in collaboration with the local broadcasting media. Through this, people are informed that mental disorders are treatable; mental health is part of general health and that physical restriction/restraint of people with mental illness is prohibited. The institution is running mental health awareness programs in the public schools as well.

WHO showed commitment in public education on mental health and awareness of the rights of the mentally ill through the chain-free initiative. Its overall purpose is 'to develop, implement, and evaluate a model for quality of mental health services. The initiative focused on improvement of the quality of life of patients with mental disorders through combating the stigma, providing them with equal opportunity to access basic humanitarian treatment in hospitals, homes and the environment in which they live. WHO's chain-free initiative involves the following three phases:

Phase 1. Chain-free hospitals: removing the chains, reforming the hospital into a patient friendly and humane place with minimum restraints.

Phase 2. Chain-free homes: removing the chains, providing family psycho-education, training family members on a realistic, recovery-oriented approach, provision of home visits.

Phase 3. Chain-free environment: removing the "invisible chains" of stigma and restrictions to human rights of persons with mental illness, the right to universal access to all opportunities with and for persons with mental illness.

Currently, Phase 1 and Phase 2 have been completed in SCZ by Dr. Habeb, while Phase 3 is scheduled for 2009 and 2010. Consultations are ongoing for Bosaso Mental Health Department and Berbera mental health Hospital to start phase 1.

Interesting dynamics have been noted in the private sector: Local communities, Diaspora representatives, and supposedly medical personnel with mental health background have started to advocate for a better recognition of the mentally ill needs. Few initiatives and centres have been established in the regions of Northern Somalia. Even if the interventions are based on good intentions, the awareness and education programmes should target and include these private service providers in terms of Human Rights and internationally accepted medical treatments.

Local authorities and ministers have not played any significant role yet in terms of awareness and public education.

➤ 7.1 Links with Other Sectors

Mental health still suffers from being accepted as a peer by the other health departments/sector. Everyone recognizes its importance, although hospitals themselves struggle to consider mental health departments/wards/facilities as an integral part of hospital premises. By the same token, mental health has been completely put aside by other sectors whose linkages could have potentially promoted good synergies.

The education sector in Somalia does not foresee the integration and support to mentally ill children. Psychosocial support is provided within schools; however, special classes for children in need are almost non-existent.

Human Rights and Good Governance intervention rarely include in their advocacy programmes the rights of the mentally disabled and no policies aiming at integrating them into the social fabric of the society.

Finally, the nutrition sector should also explore better the linkages between malnourished children and the development of mental retardation/disorders. These linkages have still not been established.

8. Monitoring and Research



One of the main challenges faced during this assessment was the general lack of data on mental health, lack of information tools to collect them, complete fragmentation between small pilot initiatives (often led by INGOs) and a lack of central control/supervision/management of the data.

Overall, the facility based reporting is of low quality and limited coverage. There is weak capacity for information management at all levels. Catchment populations of health facilities are almost never defined making it difficult to estimate and monitor coverage indicators.

Since 2003, the GRT in Bosaso has been regularly collecting data, even though the data of the past two years was not completely reliable due to the irregular funds, lack of staff and turnover of the medical staff in the Mental Health Department. The GAVO has also been collecting data on the Berbera Mental Hospital and conducted in 2004 a rather comprehensive survey in Somaliland. Nevertheless, these remained isolated efforts, not coordinated and/or consolidated into a bigger vision.

In the past two years some efforts have been made to develop and implement a standardized HMIS. Recording and reporting forms have been developed, although the system lacks the coverage of all three zones. The quality and completeness of information is questionable and staff has not been trained in the use of HMIS tools and information. The HMIS software was developed jointly by WHO and UNICEF but it is not widely used. It covers at the moment data on mental health from three locations: Berbera, Hargeisa and Bosaso. However, data is not always complete and there is not an appropriate breakdown in terms of typology of mental disorders. Thus, HMIS can be considered to be developed as a monitoring tool. In the next collaboration phase with the programmes it should be sought to incorporate mental health in the HMIS for data collection, analysis and reporting. There is still no agreement or discussion regarding the inclusion of core mental health indicators in the final version of HMIS forms.

No data is collected from the private sector which is a significant problem related to the information collection.

➤ 8.1 Mental Health Research

There is no evidence of scientific research being carried out on mental health in Somalia, although a few recent initiatives deserve special attention, such as VIVO (a German NGO) who published studies on khat use (and abuse). These initiatives are still considered as sporadic interventions and are not able to capture the whole complexity and the inter-linkages of mental health in Somalia. Moreover, special attention and research should be focused on the following areas:

- **Mental health and Gender:** Women are increasingly reported to suffer from different forms of mental disorders. The prevalence must have been increased in the recent years due to exposure to GBV and SGBV.
- **Mental health and Children:** None of the assessed facilities has ever taken into consideration a physical division and/or a division of tasks/competences among workers to target children's special needs. Child protection issues should be properly investigated and mainstreamed into mental health.
- **Mental health and Vulnerable Groups:** IDPs, refugees, and mixed migrants are considered to be at risk to develop mental disorders and distress. Future studies on strengthening individual resilience and community coping with mechanisms should be promoted.
- **Mental health and Substance Abuse:** There have been researches carried out on khat abuse, but there is a further need for investigation and study expanding on other kinds of substance abuse, such as alcohol and drugs.
- **Mental health and Conflict:** The burden of mental health disorders on a society that experiences different ways of direct and indirect violence for the last 20 years remains unquantifiable. Therefore, there should be strategies developed in order to cope with such a burden.

9. Conclusions



It is very difficult to calculate the prevalence of the main mental health disorders in Somalia and the number of people affected. However, surveys, desk review of existing documents and group discussions of stakeholders clearly point out the high number of mentally challenged people living in the country and their needs. The insecure Somali context and local cultural patterns underline the fact that the burden for the society will be soon overwhelming if no action is taken, especially considering the consequences of PTSD. Whilst it is difficult to quantify the magnitude of the issue, the social impact of the problem in the country is self-evident. Mentally challenged people are stigmatized, isolated and prevented from having access to basic human rights and services.

This is mainly due to the lack of awareness on mental health and on the fact that mental disorders can be treated and patients can be reintegrated into the society.

Moreover, no legislation and strategic plan exist at regional, national and local level, leading to a fragmentation and plurality of initiatives which are not able to face the reality on the ground.

Very few mental health facilities are functioning in Somalia. They are not able to cover the whole country, to diagnose properly, treat and follow-up patients, to provide quality services to the affected population and to meet their families' needs.

Lack of qualified and evenly distributed human resources are another key factor for the underdevelopment of the mental health sector and the poor quality of the services provided. There is no proper psychiatrist available in public institutions of the country and a greater responsibility has been given to nurses and health workers only equipped with training provided by international agencies and organizations.

10. Recommendations



Mental and neurological disorders such as depression, schizophrenia, epilepsy and substance abuse, amongst others, cause immense suffering for those affected and amplify people's vulnerability.

By treating many of the debilitating mental disorders and by promoting mental health, Somali mentally challenged people, their families and the society as a whole will experience major improvements. They will be able to work and rise out of poverty, provide their children with the right social and emotional environment to participate productively in community life and contribute to the economy of their country.

In particular:

- Somali local authorities need to put in place human rights oriented mental health policies, strategic plans and laws to ensure that effective treatment, prevention and promotion programmes are made available to all people who need them;
- Development of community-based mental health services for mentally challenged people (e.g. support to households who care for mentally impaired persons, ambulatory treatment services, etc) in order to face the shortage of mental health facilities and the unequal access to them;
- Enabling existing inpatient treatment centers to provide qualified services, capacity building, training of staff, and allocation of resources;
- Development of culturally adequate treatment procedures, including drug rehabilitation;
- Raising awareness by the general population on mental disorders and the risk factors in relation to out-of-control khat intake;
- Assessment of prevalence of psychiatric disorders in the whole country and the comparison between urban and rural areas, between ex-combatants and civilian war survivors, women and men;
- Independent assessment on GBV and mental health in Somalia in order to streamline equal access to mental health services for women;
- Setting up of Psycho-social Intervention Modules, including:
 - a. Outpatient psychiatric care for beneficiaries with severe mental disorders (outpatient psychopharmacological treatment, referrals to inpatient treatment centers, psycho-social interventions with family and beneficiary, reintegration activities);
 - b. Monitoring of critical cases (regular visits at home and sessions with whole family over a longer period of time);
 - c. Crisis intervention for the most severe and aggressive cases;
 - d. Development of reintegration potentials for physically or mentally impaired beneficiaries.

Annexes



➤ Annex I

Questionnaire Mental Health Facility/Hospital

Questionnaire no. _____ Date: _____

General Information:

- Name of the facility: _____
 - Name of the respondent: _____
 - Position of the respondent: _____
 - Ownership of facility: Public Private (for profit) Private/NGO (non-profit)
 - Type of Health facility (please tick (✓) where appropriate)
- Mental Hospital (a specialized hospital-based facility that provides inpatient care and long-stay residential services for people with mental disorders).
- Ward within a General Hospital (a specialized ward within a hospital providing other health services);
- Community-based psychiatric inpatient units (psychiatric unit that provides inpatient care for the management of mental disorders within a *community-based facility*). These units are usually located within general hospitals, they provide care to users with acute problems and the period of stay is usually short (weeks to months);
- Mental health outpatient facilities (a non-hospital, community-based mental health facility that provides overnight residence for people with mental disorders);
- Community residential facility (a non-hospital, community-based mental health facility that provides overnight residence for people with mental disorders);
- Mental health day treatment facilities (a facility that typically provides care for users during the day);
- Other (Please specify)
- District: _____ Region _____ Zone _____

Section 1: catchment population and availability of services

Catchment Area & Population:

What is the total area in sq km that is covered by the facility? _____ or Don't know

What is the total catchment population of this facility? _____ or Don't know

Availability of Services:

How many days in a month the facility is open for ambulatory care?

Timing: 24 hour? Or from _____ to _____

Section 2: input assessment

Availability of Specific Services:

Does this facility offer the following services?

Please tick (✓) where appropriate. Ask the respondent for each of the categories.

1. Outpatient care
2. Inpatient care
3. Outreach (by hospital staff)
4. Preventive/Promotive services (such as awareness, advocacy)
5. Organization and management support
 - In-service training (provided by the facility management): Yes No
 - Supervision: Yes No
 - Health information system (system of data collection and data sharing): Yes No
 - Drug supply system: Yes No
 - Other specify: _____

Availability of Mental Health Staff

(To be asked of the hospital management team: Medical superintendent, senior nurse, or administrator.)

TYPE OF STAFF	POSITION	QUALIFICATION	EXPERIENCE IN MENTAL HEALTH (YEARS)
A. Technical Staff			
B. Support Staff			

Finance

What is the total budget for your hospital/facility per year? _____ or Don't know

Do you have a budget breakdown by line items? Yes/No

If not, can you enumerate the recurrent financial inputs at your hospital? Yes/No

If yes, list according to the line items below:

Amount spent annually on drugs: _____

Approximate total annual budget: _____

Do you charge any fee for services or drugs: Yes/No

If yes, what services do you charge for and what is the fee:

SERVICE	FEE/RATE	SERVICE	FEE/RATE
1.		2.	
3.		4.	
5.		6.	

What is your average income per month? NA/DNK/or _____

Do you retain your income here? NA/Yes/No

If yes, what is it used for?

If no, to whom / where does it go to?

Drugs and Supplies

Check for the presence and integrity of each of the following drugs/supplies in both the outpatient department and the hospital pharmacy/store and tick (✓) the appropriate response.

DRUGS AND SUPPLIES	OUTPATIENT DEPARTMENT		CENTRAL PHARMACY/STORE	
	PRESENT	ABSENT	PRESENT	ABSENT
Amipriptyline Tablets 100mg				
Chlorpromazine Injection 50mg/2ml				
Chlorpromazine HCl Tablets 100mg				

Diazepam Injection 10mg				
Haloperidol Injection 5mg/amp				
Haloperidol Tablets 5mg				
Phenobarbitone Tablets 30mg				
Phenytoin Sodium Tablets 100mg				
Promethazine HCl Injection 50mg/2ml				
Benzhexol Tablets 5mg				
Syringes 5ml + Needles G21				

Hospital/Facility Physical Inventory

Please tick (✓) the appropriate response

Building

MAIN BUILDING	YES	NO
Is the main building generally in good repair?		
Are any of the walls, floor(s), roof(s) in the main building(s) in need of maintenance and repair?		
Are all the rooms clean?		
Can all of the doors and windows be securely locked?		
Is there a latrine for patients?		
Is it clean and usable?		
Is there a reliable source of power to enable all the essential equipment of the facility to function/be used?		
Has there been a constant supply of running water in the facility over the last 3 months?		
Is there a refuse pit slash incinerator on the ground for disposal of solid wastes/rubbish?		
Is the ground around the main building free from rubbish, waste, puddles and feces?		

Please tick (✓) the appropriate response

OUTPATIENT DEPARTMENT	YES	NO
Is the outpatient department block generally in good repair?		
Are any of the walls, floor(s), roof(s) in need of maintenance and repair in the outpatient department block?		
Are all the rooms clean?		
Is there a waiting room for female patients?		
Is there a waiting room for male patients?		
Is there a latrine for female patients?		
Is it clean and usable?		
Is there a latrine for male patients?		
Is it clean and usable?		

Please tick (✓) the appropriate response

INPATIENT WARDS	YES	NO
Is the Inpatient ward block generally in good repair?		
Are any of the walls, floor(s), roof(s) in need of maintenance and repair in the inpatient ward block?		
Are all the rooms clean?		
Can all of the doors and windows be securely locked?		
Is there a latrine for patients?		
Is it clean and usable?		

Section 3: hospital management and support systems

Facility Planning and Management

Please tick (✓) the appropriate response

	YES	NO
Do you have job descriptions for your technical staff (if yes, ask to see)?		
Do you have a job description yourself?		
Are areas of responsibility clearly defined within the health team (if yes, ask for definition/description)?		
Is all staff receiving their salaries regularly?		
Is there a formal means by which the community can influence hospital policy and practice?		

In-service Training and Supervision

Please tick (✓) the appropriate response

	YES	NO
Have you attended any training/courses during the past year?		
Has any of your staff attended any training/courses during the past year?		
Do you have any health manuals/books at the facility or for your personal use?		
Do you have any person who regularly supports and supervises your work?		
Did she/he visit your facility during the last three months?		
Did she/he use any supervisory checklist?		
What did he/she do during supervisory visit?		
<ul style="list-style-type: none"> • Observe delivery of services 		
<ul style="list-style-type: none"> • Inquire about service delivery problems 		
<ul style="list-style-type: none"> • Examine the records 		
<ul style="list-style-type: none"> • Make suggestions for improvement 		
<ul style="list-style-type: none"> • Offer praise for good work 		
<ul style="list-style-type: none"> • Other 		

Information on Records and HMIS

Are records available that provide information on *(Please tick (✓) the appropriate response)*

RECORDS	YES	NO
Number of outpatient visits		
Outpatient diagnoses		
Whether it is first or follow-up visit		
Number of admissions (inpatient)		
Out-reach activities (i.e. home visits, etc.)		

Has somebody from this facility been trained in HMIS reporting? Yes No

If yes, who?

How many HMIS reports have been submitted during the last three months? _____

Are copies of the monthly reports available in the facility? Yes No

Is there any evidence that HMIS information is being used at the hospital level, such as ordering drugs or for any other planning or management purpose?

Yes No Partially

Did you receive any feedback on HMIS reports submitted during last three months?

Yes No

Did you submit, in addition to HMIS report, any other reports to supervisors?

Yes No

Do you have adequate HMIS instruments with you? (Yes, if sufficient for three months)

Yes No

Is there sufficient general stationary available? (Yes, if sufficient for three months)

Yes No

Drug Management

Are psychotropic drug available?

Yes No Periodically

If available, how often are they supplied?

Monthly _____ Every 3 months _____ Every 6 months _____

Storage conditions:

- (i) Is there enough space for the drugs? Yes No
- (ii) Is the store well secured? Yes No
- (iii) Is there a functioning air conditioner? Yes No
- (iv) If there is no air conditioner, is the store well ventilated? Yes No
- (v) Is the store well illuminated? Yes No
- (vi) Is a ceiling available under the roof to prevent heat radiation? Yes No
- (vii) Are the drugs arranged on shelves? Yes No
- (viii) Is there a thermometer to monitor the temperature? Yes No
- (ix) Is there a functioning refrigerator for storing the injectables? Yes No
- (x) Is a functioning fire extinguisher available? Yes No

From where do you get supplies and medicine? (Please circle all those that apply)

- (i) The hospital, free of charge;
- (ii) WHO, free of charge;
- (iii) Patients have to buy them;
- (iv) Charity/Private donors;
- (v) INGO.

Days out of stock of psychotropic drugs/supplies during last one month

DRUGS/SUPPLIES	NO OF DAYS OUT OF STOCK	DRUGS/SUPPLIES	NO. OF DAYS OUT OF STOCK
Amipriptyline Tablets 100mg		Phenobarbitone Tablets 30mg	
Chlorpromazine Injection 50mg/2ml		Phenytoin Sodium Tablets 100mg	
Chlorpromazine HCl Tablets 100mg		Promethazine HCl Injection 50mg/2ml	
Diazepam Injection 10mg		Benzhexol Tablets 5mg	
Haloperidol Injection 5mg/amp		Syringes 5ml + Needles G21	
Haloperidol Tablets 5mg			

Patient Referral

Are records kept on referral? Yes No

(If yes, use this record to answer the questions).

How many persons were referred to the hospital within the last one month? _____

What were the reasons for their referral?

1.	2.	3.
4.	5.	6.
7.	8.	9.
10.	11.	12.

How many persons were referred to a higher center within last one month?

What were the most common reasons for referral?

1.	2.	3.
4.	5.	6.
7.	8.	9.

Where were most of the patients referred?

Section 4: output/outcome assessment

Hospital Activities

Please tick (✓) the appropriate response

Records are available

Records are not available

Outpatient Care

Determine the total number of outpatient visits to the facility within one complete month for randomly selected four months in the year preceding your appraisal:

Information not available: () or;

a) _____ b) _____ c) _____ d) _____

Out of the total patients, number of: Children (under 15 years) _____ Women _____ Men _____

Inpatient Care

How many beds does the facility have? _____

What is the capacity of the building? _____

Out of these, how many are for: Children (under 15 years) _____ Women _____ Men _____

Do you keep records on (please tick (✓) where appropriate):

- Dates of admission ()
- Dates of discharge ()
- Diagnosis ()

(If yes, on all three accounts, use this record for the next two questions).

Starting with two months before today's date, record the reasons for the 12 admissions for adult males (15 years of age or older) immediately preceding that date and duration of stay for each patient:

	REASON FOR ADMISSION	DURATION OF STAY
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

Starting with two months before today's date, record the reasons for the 12 admissions in women immediately preceding that date and duration of stay for each patient:

	REASON FOR ADMISSION	DURATION OF STAY
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

Starting with two months before today's date, record the reasons for the 12 children (less than 15) admissions immediately preceding that date:

1.	2.	3.
4.	5.	6.
7.	8.	9.
10.	11.	12.

If records are not available, what are the most common symptoms reported by the patients?

If records are not available, what are the main diseases diagnosed in the facility?

Number of patients in chains: Males _____ Females _____

Outreach Activities

Are staff members from the facility regularly carrying out home visits? Yes No Do not know

If yes, number of home visits related to mental health by hospital staff within last six months;

Not available () or _____

Section 5: hospital morbidity statistics

From hospital records, tabulate the reasons for 20 consecutive outpatient visits of:

5.1. Children (under 15 years)

5.2. Women

5.3. Men

Any Comments:

NAME OF THE INTERVIEWER: _____

SIGNATURE OF THE INTERVIEWER: _____

➤ Annex II

SWOT ANALYSYS

STRENGTHS

- Eight centres available in the main urban areas
- Good network of qualified mental health social workers
- Relatively small costs of mental health interventions (no specific equipment, space requirements).

WEAKNESSES

- Incomplete coverage of Somali regions
- Scarcity of qualified human resources
- Shortage of psychotropic drugs
- Inadequate access to services (for women and in the rural areas)
- Harmful traditional practices
- Uncoordinated and poorly qualified private initiatives
- Lack of mental health policy based on Human Resources
- Little national budget allocation
- Weak capacity at the zonal level to plan, implement and monitor mental health programmes

OPPORTUNITIES

- Increased interest and commitment by the local authorities
- Engagement of the private sector
- Contribution from Diaspora and local communities
- Synergies at regional level amongst practitioners
- Potential to involve recently trained health professionals

THREATS

- Ongoing conflict in the South Central Zone
- Insecurity in Puntland and Somaliland
- Lack of collaboration by the local authorities
- Difficulties in engaging proper psychiatrist

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