

WHO-AIMS

**WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN MOGADISHU AND
SOUTH/CENTRAL SOMALIA**



MINISTRY OF HEALTH
REPUBLIC OF SOMALIA

WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN MOGADISHU AND SOUTH/CENTRAL SOMALIA

*A report of the assessment of the mental health system in Somalia
Using the World Health Organization - Assessment Instrument for
Mental Health Systems (WHO-AIMS).*

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http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

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The WHO-AIMS project is coordinated by Shekhar Saxena.

Foreword

This study was carried out by the Ministry of Health of Somalia. Abdirahman Ali Awale and Hussein Ali Mohamed are the mental health coordinators for south and central Somalia and Dr. Abdi Awad Ibrahim is the resident advisor for the ministry of health TFG SOMALIA. Technical support was provided by WHO's Mental Health Policy and Service Development team (MHP) in Geneva; Dr. Shekhar Saxena, program manager department of mental health and substance Abuse, coordinator Evidence Research and action on mental and brain disorders (MER) , Dr. Khalid Saeed technical advisor, mental health and substance abuse. Data collection was done with the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) document, version 2.2. Data was collected in 2008 and is based on the calendar year 2007.

Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Mogadishu and S/C Somalia for the year of 2007. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the changes. This will enable Somalia to develop information-based mental health plans with clear base-line information and targets. This information will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Policy and Legislative Framework

Mogadishu and S/C Somalia has 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. There is a lack of data on current budget allocations to mental health in the country.

Few UN/International NGO s are working in the development sector in country.

Mental Health Services

There are national mental health focal points nominated by the MOH who are authorized to implement mental health services in South/Central Somalia. There are no centralized health services and budgets. There are three mental hospitals. One is a public/private mental health inpatient hospital to help psychiatric emergency cases, the second one is a rehabilitation treatment center located in Mogadishu, and the third hospital is a mental hospital established in the year 2008 in the central Somalia.

Mental Health in Primary Health Care

There is no primary health care program that includes mental health in the country. There is no availability of assessment and treatment protocols for key mental health conditions in south/central Somalia within primary care facilities. There are five qualified senior nurse who attended 3 months training course in mental health held at Bosaso in Puntland, sponsored by WHO EMRO in the year 2004 –2005. These nurses are the only qualified manpower in S/C Somalia and can prescribe all medications on the essential psychotropic drug list.

Human Resources

The total number of human resources working in Department of Health mental health facilities in the country is 86 (0.95 per 100,000)*. There is no International NGO in the country.

There are no psychiatrists or primary health care doctors working in the field of mental health. There are six nurses (ie .066 nurses per 100,000)* providing Mental health services to the entire country. There is no psychologist or occupational therapist. There are seventy social workers (ie 0.77 social workers per 100,000) * and ten health workers (0.11 MH workers per 100,000)* working in the area of mental health. These Health workers include the psychiatric diploma holders who were trained by WHO. The country has a weak monitoring system and hence it is difficult to identify the exact service location of the mental health staff. There is no data available on professional training and continuing professional development of the MH staff.

Public education and links with other sectors

Habebe 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 etc. Habebe The public mental health institution is running mental health awareness programs in the public schools.

There is no user or family association in the country.

Monitoring and Research

No researches in the area of mental health have been undertaken. Monitoring is usually done by the implementing agency and sometimes WHO. They give feedback and suggestions to the organizations on how to strengthen the service delivery and performance.

*** All the rates per 100,000 stated in this report are based on the population estimate of entire Somalia. Please note that these rates may be an underestimation of the actual situation in S/C Somalia**

INTRODUCTION

Somalia is located in east Africa, bordering the Gulf of Aden on the north and Indian Ocean, east of Ethiopia. Its ethnic groups include the African Bantu and Arab. The estimated population is 9118773 (Est. population figure were copied from UNITED STATE CIA world fact book on 2008). It has land boundaries with Kenya (682 km), Djibouti (58 km), and Ethiopia (1.600). Somalia has the longest coastal areas in Africa, ie 3,025 km and the territorial sea claims 200 nm.

Climate conditions vary across the year and the region.

The country's economy relies mainly on agriculture. Livestock constitutes about 65% of export earnings, however the recent ban on Somali's livestock has negatively impacted the livestock's earning and few industries.

Culturally the Somali peoples are nomads and semi nomads. They rigidly follow the clan based traditional behaviors.

Age structure:

0-14 years: 44.4% (male 2,031,682/female 2,019,629)

15-64 years: 53% (male 2,423,602/female 2,410,126)

65 years and over: 2.6% (male 97,932/female 135,802) (2007 est)

Median age:

total: 17.6 years

male: 17.5 years

female: 17.7 years (2007 est)

Population growth rate:

2.832% (2007 est.)

Birth rate:

44.6 births/1,000 population (2007 est)

Death rate:

16.28 deaths/1,000 population (2007 est)

Sex ratio:

at birth: 1.03 male(s)/female

under 15 years: 1.006 male(s)/female

15-64 years: 1.006 male(s)/female

65 years and over: 0.721 male(s)/female

total population: 0.997 male(s)/female (2007 est)

Infant mortality rate:

total: 113.08 deaths/1,000 live births
male: 122.29 deaths/1,000 live births
female: 103.59 deaths/1,000 live births (2007 est)

Life expectancy at birth

Total population: 48.84 years

Total fertility rate:

6.68 children born/woman (2007 est)

HIV/AIDS - adult prevalence rate:

1% (2001 est)

HIV/AIDS - people living with HIV/AIDS:

43,000 (2001 est)

HIV/AIDS - deaths:

NA

Major infectious diseases:

degree of risk: very high
food or waterborne diseases: bacterial and protozoal diarrhea, hepatitis A and E, and typhoid fever
vector borne diseases: malaria and dengue fever are high risks in some locations
water contact disease: schistosomiasis
animal contact disease: rabies (2007)

Nationality:

noun: Somali(s)
adjective: Somali

Ethnic groups:

Somali 85%, Bantu and other non-Somali 15% (including Arabs 30,000)

Languages:

Somali (official), Arabic, Italian, English

Literacy:

definition: age 15 and over can read and write
total population: 37.8%
male: 49.7%
female: 25.8% (2001 est)

The proportion of the government's health budget to GDP is 0%. Most health related activities are run by private/public institutions or through the unofficial out-of-pocket system. The healthcare scheme of the country is more or less a legacy of the colonial government that has weakened over the time due to political and economic changes.

On October 1969 military led bloodless insurgency coup that took over the power, and the military ruled the country for 21 years. On 1991 an ousted popular uprising armed civilian militant war broke out. Soon after the fall of the government the country become totally disintegrated and got divided into clan zones controlled by militia leaders supported by their individual clans.

In 1993, US/UNISOM interventions tried to make the atmosphere more stable, even though the inter-clan armed conflicts and political disputes persisted. Now there is TFG government established in Nairobi/Kenya after 3 years of debates and political negotiations. The Somali politicians, armed factions leaders, members of civil society groups and community elders elected a president and established a clan based parliamentary members and ministers.

MENTAL HEALTH HISTORICAL BACKGROUND

Many African countries practice the old and traditional ways to treat mental illness, especially the countries in east, west and central Africa. Somalia is one of the African countries where people use superstitious ways to treat mental illness. These are based on the following beliefs:

* Religious beliefs: Most Somali people believe that mental disorder can be treated only with the help of Koran and scientific medicine is not suitable to treat the illness.

*Cultural beliefs: Some people in Somalia believe that people with mental illness (usually depression or schizophrenia) have the special powers given by God and hence they should be respected. Still other believe that the people with mental illness possess the black magic or are evil.

Domain 1: Policy and Legislative Framework

1.1 Mental Health Policy

Somalia has no mental health policy. However, psychotropic medicines are included on the essential medicines list.

1.2 Mental health plans

There is no national mental health plan at present. There is a national mental health focal point responsible for Mental Health and Substance Abuse planning and service delivery. There is no emergency/disaster preparedness plan for mental health either at the national or provincial levels.

1.3 mental health legislation

There is no mental health legislation in Somalia

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:

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

1.4 Monitoring and training on human rights

There are no monitoring oversight bodies except for the mental health institutions that regularly monitor patients at health facilities

WHO conducted a training session on the human rights protection of people with mental illness in the year 2007.

1.5 Financing of mental health services

There are no budget allocations for mental health by the MoH. There is no fund allocated from the government for mental Health services in Somalia. World health organization allocated \$8000 for the chain free initiative implemented by Habeb public/private mental hospital in 2007. About \$ 3000 of this budget was used to purchase essential psychotropic medications. The length of this project was 81 days.

Essential psychotropic medicines are provided by WHO at no cost in all public health facilities. For those who pay out of pocket, the estimated cost of antipsychotic medicines is 5% and cost of antidepressants is 2% of the minimum daily wages. . People with schizophrenia, epilepsy and the people with first and second group of disability due to mental illnesses who are registered in mental health outpatient facilities have free access to essential psychotropic medicines. At least one free psychotropic medicine from each category is available for registered patient. However, during the period of assessment, we discovered that less than 20% of the patient population of the country was registered and entitled to these free medicines. The majority of patients in country seek the traditional methods or other superstitious ways of treatment before they finally arrive at the mental health facility. Mental health services are not covered in social insurance schemes.

Domain 2: Mental Health Services

Organizations of mental health services

There is a mental health unit within the MOH and a nominated focal point for mental health. Mental health is not incorporated into the essential package of health services at the level of basic health center, referral health center and district hospital which is not yet implemented at national level. In terms of community involvement, there is intermittent community support from the Somali Diaspora and youth support.

Mental health outpatient facilities

There are 2 OPD mental health facilities. One is connected with the Habeb public mental hospital and the other the Jalaqsi hospital.

The OPD facility connected with the Habeb public mental hospital treated 1094 users during 2007 (12 users per 100,000 population)* and gender wise these composed 51% male and 49% female. Children and adolescents are 22.6% of the users and the rest are adults. Data on the diagnosis of users treated in outpatient is routinely collected and kept in OPD clinic, but this data is not used for service planning. In terms of diagnosis, users were primarily diagnosed with epilepsy (36%), functional and organic psychosis (32%), neurosis (28.3%), and depression (1.6%).

*** The rates per 100,000 stated in this report are based on the population estimate of entire Somalia. Please note that these rates may be an underestimation of the actual situation in S/C Somalia**

Day treatment facilities

There is no day treatment facility in Mogadishu and S/C Somalia.

Community-based psychiatric inpatient units (psychiatric inpatient units in general hospitals)

There is no community-based inpatient unit in Somalia.

Community residential facilities

There are NO community residential facilities available in the country.

Mental hospitals

There are three mental hospitals in the country with a total of 232 beds. Habeb Public Mental Hospital is located in Waberi District. The bed capacity is 53. It mostly treats the acute cases and the estimated length of stay here is 2-3 weeks. In the Habeb Rehabilitation Treatment Centre that is located in the Madina District, mostly chronic cases are treated. There are 170 beds in this hospital and the estimated Length of stay for 3 months -one year. Jalalaqsi Mental Hospital is situated in the central Somalia and its capacity is 9 beds. It treats both the acute and chronic cases of psychiatric illness and the length of stay is usually between 3 to 8 months. Both the Habeb public mental hospital and the habeb rehabilitation center have at least one psychotropic medicine available.

Forensic and other residential facilities

There are no forensic and other residential facilities in the country.

Human rights and equity

There are no data available on human rights and equity indicators

Domain 3: Mental Health in Primary Health Care

Mental health is not integrated into primary health care in the country. There are no physician based primary health care (PHC) and non-physician based PHC clinics providing the mental health services in the country

None of the primary health care clinics or non-physician-based primary health care have assessment and treatment protocols for key mental health conditions available. Almost all (81-100%) of the primary health care doctors make at least one monthly referral to a mental

health professional. The percentage of the referral of the non-physician based primary health care clinics to a higher level of care (e.g., mental health professional or physician-based primary health clinic) is 1-20%.

As for professional interaction between primary health care staff and other care providers, none of primary care doctors have interacted with a mental health professional at least once in the last year. None of the physician-based-primary health care clinics, non-physician-based-primary health care clinics or mental health facilities have had interaction with a complementary /alternative/ traditional practitioner.

Training in mental health care for primary care staff

Two percent of the total hours in undergraduate training for medical doctors are devoted to mental health in comparison to 30% for nurses.

In terms of refresher training, no data were available, though we trained twice about 40 individual nurses selected from 10 provinces in S/C health facilities. The length of training was 4 days. The refresher course talked about mental health issues.

Prescription in primary health care

Few (ie 1-20%) physician-based PHC and non physician PHC have at least one psychotropic medicine available in the facility or in a nearby pharmacy. Physician based PHC mostly have antiepileptic drugs (Phenobarbital 30mg) available.

Nurses are allowed to prescribe but with restrictions, others are not allowed to initiate prescription

Domain 4: Human Resources

Number of human resources in mental health care

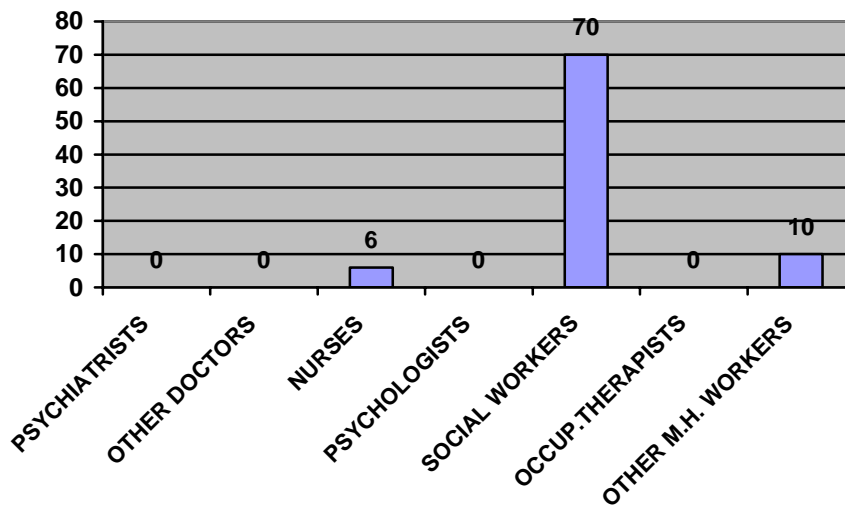
There are no psychiatrists, medical doctors working in the field of mental health nor psychologist in the country. There are 6 nurses (0.066 per 100,000)*, 70 social workers (0.77 per 100,000)* and 10 other health workers (0.11 per 100,000)* working in the Mental health field. These ten mental health workers include the psychiatric diploma holders who were trained by the WHO.

Information systems for monitoring the staff are weak, with very few provinces able to identify the service locations of mental health staff. There is a lack of data regarding either professional training or continuing professional development after qualification in all provincial Departments of Health.

* All the rates per 100,000 stated in this report are based on the population estimate of entire Somalia. Please note that these rates may be an underestimation of the actual situation in S/C Somalia

**GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH IN S/C SOMALIA
(Numbers)**

**GRAPH 4.1 - HUMAN RESOURCES IN MENTAL
HEALTH
(Total number)**



Consumer and family associations

There are neither consumers associations nor family associations in the country. There is a small local base of associations established/select for induction of mental health activities per province. These groups are very effective and had a great role mainly during performance of the mental health for each province.

Domain 5: Public Education and Links to other Sectors

Public education and awareness campaigns on mental health

The Habeb public mental health hospital has collaborated with the several well-known local broadcasting groups to raise community awareness about mental disorders. Prepared mental health lessons are released to inform the audience on various issues such as 'mental disorders are treatable', 'mental health is part of general health' and 'chaining of mental ill people is prohibited'. An attempt is made to try to persuade family members to bring mental disorder patients to the hospital. In addition, visits are made to public schools to educate staff on mental health issues.

Legislative and financial provisions for persons with mental disorders

There is no legislative support and financial support given to people with mental disorders in the country.

Links with other sectors

The Habeb Mental Hospital has effective relations with local broadcasting groups, nursing institutions, hospitals, youth groups, the medical association, and the Banadir regional commissioner.

Some primary and secondary schools (21-50%) have school-based activities to promote mental health and to prevent mental disorders. Neither police officers nor judges and lawyers have participated in educational activities on mental health in the last five years.

Non -Governmental Organizations

NGOs are not involved with mental health in the country.

Domain 6: Monitoring and Research

There is neither an external/internal monitoring system nor research exercises being undertaken. All the data concerning the service implementation of mental health facilities were transmitted to WHO. This information is kept and it's available as a reference for further use.

Information gathering system

There is no mental health reporting system in the country. The data collection system is poor and undependable. The country has no data collection system or epidemiological study on mental health. There are no funds or personnel to carry out epidemiological studies.

Programmes for special population

The country has no specific programmers for mental health for refugees and children. UNICEF/WHO are the two major UN agencies supporting the following sectors - EPI, Nutrition, FGM, TB, Education, Bilharzias, etc. There is no special attention given to migrants, elderly, refugees, displaced and homeless and children. No mental health school programme is present in any of the provinces.

Therapeutic drugs

The following psychotropic drugs are available in the country and are provided by WHO for the support of mental ill people or are brought by private business groups with estimated cost in USD

Carbamazepine 200mg available each table cost \$ 0.15 forensic

Phenobarbital 30mg available each tablet cost \$ 0.01

Phenytoin 100mg available each tablet cost \$ 0.05

Sodium Valporate 200mg each tablet cost \$ 0.08

Amitriptyline 25mg available each tablet cost \$ 0.018

Imipramine 25mg (Tofranil) tablet available each cost 0.018

Chlorpromazine 100mg available each tablet cost \$ 0.02

Chlorpromazine 50mg Vial available each vial cost \$ 0.2

Promathzine 50mg injection available each vial cost \$ 0.15

Promathzine 25 mg tablet available each tablet cost \$ 0.005

Diazepam 5mg available each tablet cost \$ 0.005

Fluphenazine vials available each vial cost \$ 5

Haloperidol 5mg tablet available each tablet cost \$ 0.05

Haloperidol 5mg vial available each vial cost \$ 0.2

Respradone (depex 2mg) Tablet available each tablet cost \$ 0.18

Lithium not available

Levodopa not available

Benzaxysole 5mg available each tablet cost \$ 0.0026

Since mental health is not integrated in primary care level most of the drugs are not available at primary care level.

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in South/Central Somalia. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change.

Given the political and economic turmoil in S/C Somalia, the mental health systems in the state are not well organized and it was difficult to collect reliable information on the scarce mental health services that exist. There is no official mental health policy, mental health plan or legislation in the country. There is no budget allocation or expenditure on the mental health by the government. WHO is the main donor of the psychotropic medication. WHO sponsored the 'chain free initiative and it is being implemented by Habeb public mental hospital.

Mental health care is available in both the physician based and non physician based primary health care centers. There are no assessment or treatment protocols for the staff at either of the PHC. Few of the Physician based and non physician based PHC have psychotropic medicines available. Doctors and nurses at PHC are allowed to prescribe the drugs.

S/C Somalia has two outpatient departments and three mental hospitals. Both the outpatient facilities are integrated with the mental hospitals.

The total number of human resources providing mental health services in Somalia is 86. There are no psychiatrists or medical doctors trained in mental health. The mental health sector is mainly run by the 6 nurses and the 10 health professionals, most of them trained by the WHO.

There is no formal system to monitor the mental health services in the country.

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