GAVO

GENERAL ASSISTANCE AND VOLUNTEERS ORGANIZATION

COMMUNITY MENTAL HEALTH INITIATIVE

BASELINE SURVEY REPORT

ON

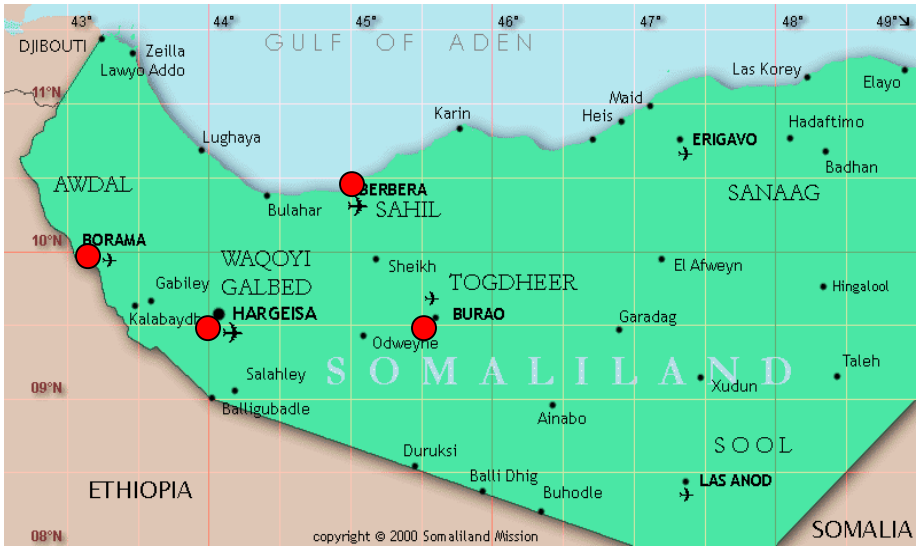
MENTAL HEALTH SITUATION

IN SOMALILAND

November – December 2004

Conducted in four Regions in Somaliland

Hargeisa, Togdher, Sahil and Awdal



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Lastly, we would like to extend our appreciation to Somali Refugee Action Group which played a big role in soliciting funds for the Somaliland Mental Health Initiative not forgetting the Comic Relief support for their extended hand in providing the funds to implement the mental health initiative in Somaliland. With their funding, this survey and other activities that will go towards supporting the mentally ill people in Somaliland has become a reality.

LIST OF ABBREVIATIONS AND ACRONYMS

BMA	Berbera Mental Hospital
CARE	Care Relief Everywhere
CBO	Community-Based Organization
DAN	Disability Action Network
GAVO	General Assistance and Volunteer Organisation
GDP	Gross Domestic Product
GRT	Grouppo per Relatiozzione trans-culturalle (Italian)
HAVAYOCO	Horn of African Volunteers Youth Committee
HMW	Hargeisa Mental Ward
IAS	International Aid Sweden
ICD	International Cooperation for Development
MOHL	Ministry of Health and Labour
N	Number (of Participants/ subjects)
NGO	Non-Governmental Organization
OCD	Obsessive Compulsive Disorders
PHC	Primary Health Care
PTSD	Post Traumatic Stress Disorder
SORAG	Somali Refugee Action Group
UN	United Nations
UNDP	United Nations Development Programme
WFP	World Food Programme
WHO	World Health Organisation

1. PREFACE

In November and December 2004, GAVO conducted a baseline survey in Somaliland towns notably Hargeisa, Berbera, Borama and Burao to find out facts on the mental illness of the four regions in Somaliland. The core objective of the study was to establish benchmark for mental health initiative so that the collected information could be used for future assessment after the implementation of Mental Health Initiative in Somaliland. Another paramount objective of the baseline study was to get a tool that may well serve as a guide for future mental health interventions in Somaliland. The Mental Health Initiative; a three year programme which is currently being implemented by GAVO in partnership with SORAG in Somaliland aims at building the capacity of the mental health professionals in the country so that they can better serve the mentally ill persons. The activities of this program are geared towards improving services of the two already existing mental hospitals; Berbera and Hargeisa Hargeisa Mental Hospitals.

Although the current target sites are Berbera and Hargeisa towns, the project has a wider objective of assessing the status of the mentally ill people throughout the country. In respect to this, the survey covered the four main towns of Somaliland; Hargeisa, Berbera, Borama and Burao. Information gathered from Hargeisa and Berbera Mental Hospitals were through visits and in depth interviews with the mental hospitals personnel as well as the patients. The survey was tailored towards obtaining coherent and adequate information that could give impetus to actual status of mentally ill people in the country. Group consultations and in depth interviews were held with the patients and their carers through out the country.

The survey also collected information from the stakeholders working in mental health in Somaliland; institutions working in the sector were visited and information collected from them.

2.0 BACKGROUND

2.1 Historical and Geographical Background of Somaliland.

2.1.1 Location

The Republic of Somaliland is situated in the horn of Africa. Its boundaries are defined by the Gulf of Aden to the north, Somalia to the east, federal state of Ethiopia to the south and west, and republic of Djibouti in the northwest. The total area of Somaliland is 137,600 km2 with a coastline of 850kms.

The country is divided into 6 regions, namely Northwest, Awdal, Sahil, Togdher, Sool, and Sanaag, which are subdivided into 32 districts. The capital of Somaliland is Hargeisa. The estimated population of the city is about 0.5 million. Other principal towns are Borama, Berbera, Burao, Erigavo and Las-anod. The main port of Somaliland is Berbera

2.1.2 Population

Although no census has been conducted in Somaliland in the recent past, the population is estimated to be around three million persons. Approximately 55% of the population consists of nomadic people and while the rest (45%). are urban dwellers. The population density is estimated at 22 persons per km.

2.1.3 Climate

Somaliland is semi arid region. The daily average temperature range from 25c to 35c. The average annual rainfall is 14.5 inches in most part of the country.

2.1.4 Economy

Although, no data is available on GDP of the country, most people in Somaliland live with less than one dollar a day. The economy of the country depended a lot on livestock export destined to Saudi Arabia and other Arabian countries. A ban was imposed in 2000 due to outbreak of unfounded rift valley fever. The ban has had severe economic effects in the country leading to sudden depreciation of local currency, unemployment and steady process of population growth in the cities. The monthly remittance sent by relatives from western countries has made life

better for many in Somaliland, though a big chunk of this money is spent by most Somali men to buy khat[1] and as a result drain the already depleted economy.

2.2 Political Background of Somaliland

Somaliland is derived from British Somaliland protectorate, which it used to be called when it was under Great Britain in 1886 to 1960.Somaliland got its independence from the British government in June 1960. In July 1960, the state of Somaliland united with Italian Somaliland which was under Italian government. The union created the Somalia Republic which later collapsed in 1991 after the broke up of a civil war.

After the total collapse of Somalia, Somaliland restored its independence on 18th May 1991; a decision that was made by the congress of council of clan elders in Burao city in May 1991. Relative peace was established in Somaliland after the formation of a government with its capital in Hargeisa. However, sporadic fighting continued between the government and resistance factions in various parts of the country. In early 1997, following a successful inter-clan peace conference of elders, President Mohamed Egal was re-elected for an additional five- year term. The positive signal greatly improved security and had accelerated efforts such as rehabilitation and re-integration although a civil war erupted again in Somaliland, resulting in the mass destruction of property and a complete breakdown of infrastructure. Tens of thousands of civilians were internally displaced while hundreds of thousands were forced to flee and seek refuge in the neighbouring countries as refugees, where some of them still remained in countries such as Ethiopia, Djibouti and Kenya to date. After Somaliland held the Presidential and Municipal elections in 2003, utmost peace was established throughout the country.

The government in place is struggling to provide basic services to hospitals and schools that have been destroyed during the civil war. Somaliland government, which is unrecognised to date, is one of the poorest countries in the world, a situation aggravated by civil conflict and the absence of a support to the governmental institution from international donors for over a decade. The impact of state failure on human development has been profound, resulting in the destruction of social and economic infrastructure and massive internal and external migrations. Despite this difficult environment, the government, international and local organizations as well as UN agencies strive to provide limited health services to major towns.

[1] Information on khat is detailed in section 4.2.2 of this document.

2.3 Health Situation

Since Somaliland government is unrecognised, health situation is generally in the same situation as other ruined social infrastructures like water, education and electricity. In spite of this strenuous environment, the Ministry of Health and Labour make every effort to re-establish the ruined infrastructures which were already limited even before the war. In the last couple of years, various projects have been implemented in a bid to support community health service recovery placing the community service at the centre in restoring and sustaining basic health services. Despite these efforts, health indicators suggest that health standards in Somaliland are among the worst in Africa. Life expectancy is 47 years and nearly one-quarter of all children die before the age of five.

Somaliland is not only experiencing lack of health facilities, but also lacks enough medical professionals to run the available ones. The whole country is served by approximately 100 doctors, which gives astonishing figure of 1 doctor per 30,000 persons and about 300 nurses and thus 1 nurse per 10,000 persons. The lack of resources further limits possibility of training more medical professionals. Currently there is only functional nursing school while the two universities have started offering medicine faculties recently. The available health facilities and professionals also tend to be concentrated in urban areas hence rural population have limited access to health services. A report released by MOHL in August 2003 indicated that 61% of doctors, 39% of nurses and 72% of midwives are in Hargeisa region as opposed to Sool and Sanag regions where there are only 6% of doctors, 19% qualified nurses and 0% midwives.

In this situation, where there is lack of enough human and material resources, the MOHL is struggling to provide essential public health services in which the needs clearly outmatch the available resources. Consequently, private health services have mushroomed throughout the country which lack of quality control; generic drugs that come from Asian countries have flooded the markets and mostly sold in private pharmacies. These private pharmacies are largely unregulated, often run by unqualified personnel dispensing inadequate or incorrect treatment. On the other hand, UN agencies, International and local Non Governmental Organisations have established a strong partnership with the MOHL in providing health services to the larger public. WHO, UNICEF, ICD, CARE International, WFP, SRCS, DAN, NPA, HAVAYOCO, Swiss Group, WFP and UNHCR are amongst organisation providing support to the health sector in

Somaliland. These organisations provide services ranging from training of the staff, provision of drugs, provision of vaccines, construction and rehabilitation of health centers, to dietary provision to patients. Even so, with growing number of agencies taking part in provision of health services, the challenge of the MOHL has come in form of coordinating their activities and ensuring there are no overlaps in their activities.

2.4 Mental Health

The prevalence of mental illness in Somaliland is thought to be the highest in the world. It is estimated that at least one person has some form of mental illness in every two households though there is no accurate data collected in the entire country except in Hargeisa. This is very high compared to the estimates by the Mental Health World Report in 2001, which estimates one in four families as being likely to have at least one member with a behavioural or mental disorder in the whole world. A survey conducted by VIVO in Hargeisa in 2002, indicated that 21% of surveyed households, care for at least one family member with severe mental health problem. The situation is further aggravated by rapid increase in the number of people who either face mental illness or psychological disorder. Many factors are behind these rise; drug abuse, post war trauma, diseases and employment are the most common in Somaliland.

Although there are only 95 patients admitted in the two mental hospitals, it is estimated that there are other tens of thousands mentally ill patients at home or loitering in the streets. In spite of the fact that the number of mentally persons in the country being very high, it is amazing to know there is only one trained psychiatrist in the whole country, no trained psychiatric nurse and only a handful of trained social workers. There are only two mental hospitals in the whole country which are understaffed and with poor structures. The personnel in these hospitals are untrained on psychiatry and poorly remunerated. Considering the inadequate capacity of the mental hospitals; many mentally ill patients are kept at home, mostly in very pathetic conditions and under mistreatment. They are mostly chained in both legs and kept in rooms with steel doors. Chaining is seen as a remedy to keep the aggressive patients indoors and consequently this has become a culturally acceptable act which is not abhorred or seen as a form of abuse by the larger population. The survey revealed that 90% of the interviewed patients were subjected to chaining at least once in their lifetime. The chaining of patients which is seen as an alternative medication not only leaves the patients stigmatised but also cause physical injuries on their hands and legs. Some of these chained patients end up committing suicide.

In Somaliland, it can be estimated that they are as many as half of the total number mentally ill patients in the country loitering in the streets. Their physical presence can be observed in the streets of the main towns. Surprisingly these people have relatives but they receive little or no care from them. They sleep on cold and dirty streets and scavenge for leftover food on the waste dumps. The aggressive ones who commit any form of harm are mostly taken to the prisons without any judgement or court hearing.

The situation of the mentally ill people is further worsened by the fact that Somali believe that once a person becomes mentally ill, he will never recover. A Somali proverb says mentally ill person can only get better but can never recover (*nin waashay wuu ladnaaday mooyee wuu bogsaday maleh*) supports the notion that if one become mentally ill once in a life time then the chances of him or her recovering is slim. This concept furthers the isolation and lack of consideration for the mentally ill in the country. Even though there is high prevalence of mental illness and pitiable conditions of mentally ill people in Somaliland, there is neither a strategy nor a policy set out by the authority to deal with the problem. Neither has the MOHL included a national policy nor the respective local authorities given a priority to deal with the grim situation.

Spontaneously the local community are opting for alternative mental health providers in order to treat their 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 traditional herbalist. These centres mostly attend to 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 ill advised treatments that they received from some of the untrained healers.

2.5 GAVO's Mental Health Intervention

In 1993, just after its inception, GAVO started its first activities in the mental hospital of Berbera by helping the in-patients in hygiene improvement. It assisted in laundry or rather in washing, trimming of finger nails and shaving of hair and provided second-hand clothes. These are among the activities carried out by GAVO members as part of voluntary work for the mentally ill patients. It further targeted the local community and solicited funds, both in kind and in

monetary form to extend support to the mental hospital. In response, the business community provided material, livestock, food and other resources to the hospital on regular basis

The organization also appealed to the UN and International agencies operating in Berbera to support the hospital in providing medicine. WFP was among those organisations that accepted to support hospital with food for patients and for staff as well. COOPI (an Italian NGO) provided insufficient drugs.

After resources were got from the local community and the other donors, GAVO assigned 6 of its volunteers and administrator to work regularly in the hospital. The volunteers who were medical professionals, used to work in the hospital as psychiatric nurses to administer the medicine and distribute food for the patients. GAVO also requested from the local doctors working in the other hospitals to give a bit of their time to visit mental patients and prescribe treatment.

GAVO contacted external agencies who are willing to work in partnership with GAVO in the mental hospital of Berbera. The purpose was to improve the activities of the mental health by exploring new ways. An Italian NGO called GRT that had a long experience in working with mental health programs came to work in the mental hospital with GAVO. It was a genuine opportunity for GAVO and for the hospital.

- GRT started to build the human resource capacity of GAVO volunteers by providing a long-term different trainings on mental health
- It provided the incentive of the volunteers and other supporting staff
- It brought enough drugs for the inpatients and outpatients as well

Therefore, Berbera mental hospital became a well-functioning mental hospital catering for diverse mental needs in the entire Somaliland.

GAVO in collaboration with GRT established a psychosocial centre in the heart of the town.

This was a part of GAVO's efforts to expand its mental health activities into the community. In October 2003, GRT the Italian partner with GAVO ended its project in Berbera Mental Hospital and it withdrew from Berbera Mental hospital. But with the local fundraising the activities of the hospitals got sustained GAVO also engaged the management of the activities of Berbera Mental Hospital.

GAVO conducted public awareness campaigns in Somaliland, through Dramas, publications, workshops, and other means. It started in Berbera , Burao, and Borama.

GAVO has become the only local NGO working in the improvement of mentally ill people.

In 2004, GAVO strategically extended its services to other regions of the country. The proposal was to start new initiatives in Hargeisa and continue that of Berbera.

3. SURVEY OBJECTIVES, METHODOLOGY AND SAMPLING

3.1 Objectives

The following were the main objectives of this study survey:

a. To know the issues revolving around mental health in Somaliland, the prevalence of mental illness, their causes and impact to the affected people and how it affects the wider public
b. To ascertain the conditions and needs of the mentally ill people in the country
c. To find out the knowledge, attitude and perception of the wider public on mentally ill people
d. To know how the mental health facilities operate, their capacity and needs
e. To know roles of different stakeholders on mental health

3.2 Methodology

Several methods were employed during the baseline survey to get maximum and accurate information. Hereunder were the methodologies used during the process of gathering information.

- Group discussions- the surveyors visited various mental hospitals, brought the patients together and had consultative meetings with them. To better understand their condition, the patients and their carers were asked set out questions to know how their world is and their needs. Group discussions were also used to gather information from other public institutes like University of Hargeisa.
- Questionnaires- pre-prepared questionnaires were used to gather information from individual patients and their carers. The questions were used to interview patients and their carers, members of the public, elders, students, medical professionals and representatives of institution working in mental health sector.

- Observations: The survey team collected information by visiting various mental hospitals and observed the status of the patients as well as the hospital set up and available facilities.

3.3 Sampling

As mentioned earlier, the survey covered the four main towns of Somaliland.

The table below summarises samples of the collected information.

Table 1: information sampling

Category	Explanation	Hargeisa	Burao	Borama	Berbera	Total
Patients	Patients were visited at the two main hospitals in Hargeisa and Berbera. Also visits were made to patients at home and interviews held with them on one to one case.	26	8	5	11	50
Group consultations	Group discussions were held with mentally ill patients and the carers as one lot.	1	1	1	1	4
Professionals	Doctors were visited in their working , mostly in their private clinics	5	1	5	1	12
Religious/ traditional healers	The main religious centers of each town was visited and discussion held with the personnel	1	1	1	1	4
Members of the public	Information was randomly collected from members of the public. These included: community elders, stakeholders, students, businessmen and even people on the streets	20	10	10	10	50

3.4 Table 2: Demographic data of the interviewed patients

Patients	Number interviewed	Level of Education			
		None	Primary Education	Secondary education	College
Male	40	16	12	11	1

Female	10	9	0	1	0
Total	50	25	12	12	1

From the above table, it can be deduced that many of the patients were either illiterate or semi-illiterate, female patients being the most illiterate in particular.

4.0 FINDINGS

4.1 Prevalence of Mental Illness

As mentioned earlier, the exact number of people with mental disorder or psychological disorder is not known. The estimated prevalence of at least one person in every 2 households seems very high when compared to the estimates in the World Mental Health Report in 2001, which estimates one in four families as being likely to have at least one member with a behavioural or mental disorder in the whole world. The figures obtained from a group of 50 persons, indicated that 26.5% of them have at least one person in their household with mental or behavioural disorder. A survey conducted by VIVO in 2002 indicated that 21% of the surveyed households in Hargeisa care for at least one family member with severe mental health problems.

The situation is further aggravated by comparing the percentage of people with mental illness to the same report produced by WHO. The report brings to light the mental and behavioural disorders that are common and affecting the world population.

The table below compares the estimates of the World Mental Health Report to estimated number of people in the Somaliland that could face similar mental and behavioural disorders.

Table 3.Estimated Somaliland statistics for mentally ill persons in relations to 2001 World Health Report.

Situation of Mental Illness as indicated in the Mental Health World Report of 2001	**Estimated persons that could be affected if the WHO Report was true picture in Somaliland**
The behavioural disorders that could be present at any point in time in about 10% of the adult population.	300,000
The mental and behavioural disorders that are common and affecting more than 25% of all people at some time during their lives	750,000
Around 20% of all patients seen by primary health care professionals have one or more mental	600,000

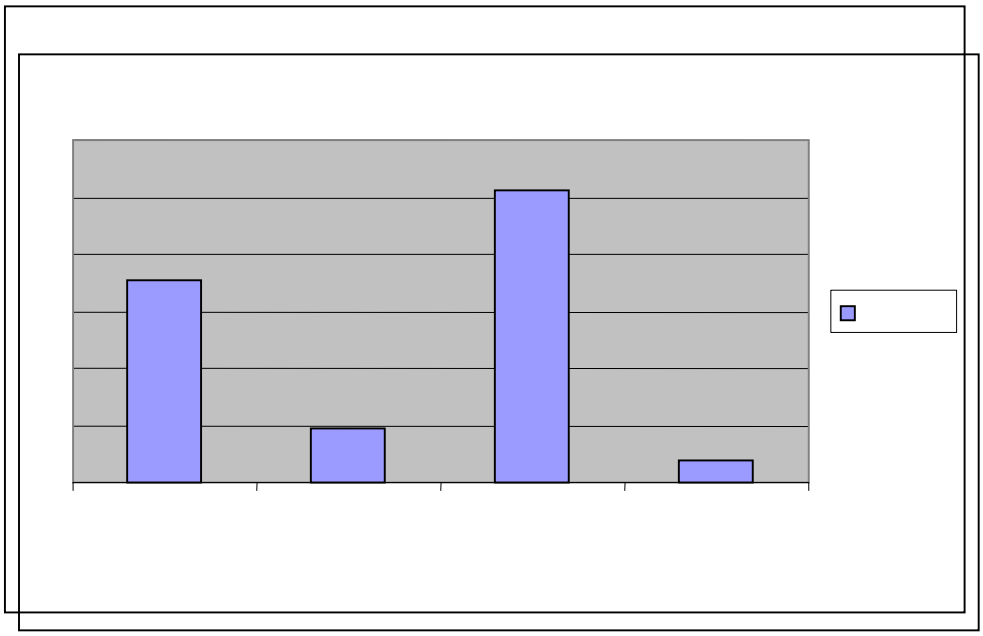
disorders

By 2020, it is projected that the burden of these disorders will have increased to 15%.

450,000 (if the population growth remains constant)

Going by the WHO estimates on number of people with mental disorder at any time, then there will be 300,000 having the mental disorder in Somaliland. Results from survey also indicated that at least 26% of persons have one person who is mentally ill. Further figures indicated that 35.5% of these people have at least one person at home who is mentally ill.

Chart 1: The prevalence of mental illness in regards to households. The data is analysis of responds from 50 people.



Given the fact that there only 95 patients in the two mental hospitals, the rest which could potentially be in terms of hundreds of thousands are on the streets or chained at homes.

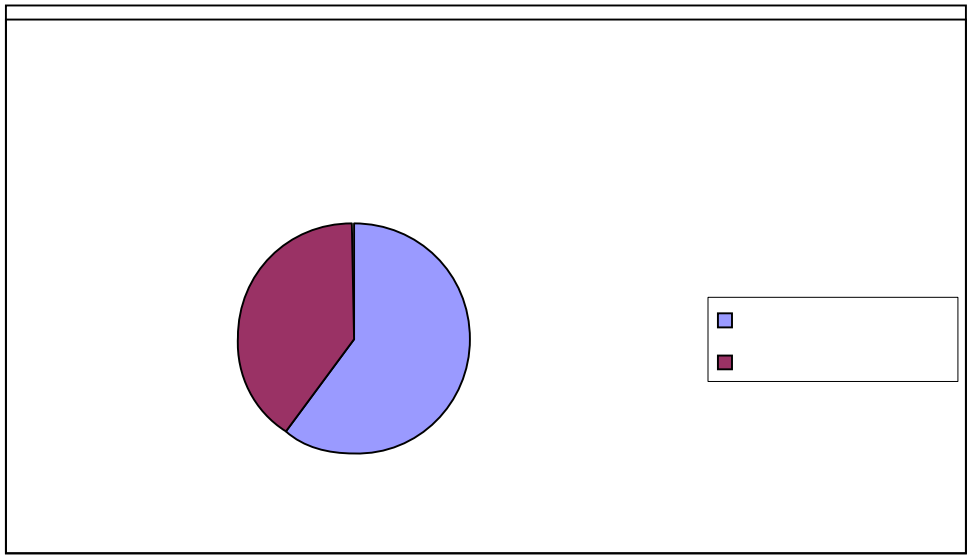
4.2 Factors affecting Mental Health in Somaliland

4.2.1 War Trauma

As mentioned before, Somaliland population has experienced persistent civil conflicts in the last 2 decades, which has led to break down of all public and private infrastructures. Under normal circumstances, 1-3 percent of the population has some form of psychiatric disorder, but situation in Somaliland is much different due to long civil wars that it has faced for a considerable period. The psychiatric literature shows that conflict situations increase disorder prevalence (Hoge et al. 2004, Scholte et al. 2004). 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 them. 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.

The Somaliland population are in transitional period which entails coming to grips with what has occurred and adjusting to life in new. It also means impoverishment due to loss of assets and livelihoods, uncertainty regarding the status of loved ones, unemployment and a lack of professional skills suitable for the current location and circumstances. As such many people are experiencing post war traumatic disorder, leading some of them to get severe mental disorder. The assessment conducted by VIVO is Somaliland indicated that 23.1% of the people with mental disorders are ex combatants and at least one sixth of persons who have actively been in a war developed a very severe form of mental disorder later in their lives. The graph 2 which is shown below indicates that at least 60% of the interviewed patients were involved directly or indirectly involved in war before experiencing mental disorder. War involvement of the interviewed male patients was higher than the female ones; it showed that at least 48% of interviewed male patients were involved in war compared to and 12% of the interviewed female patients who were involved in the civil war before falling mental ill.

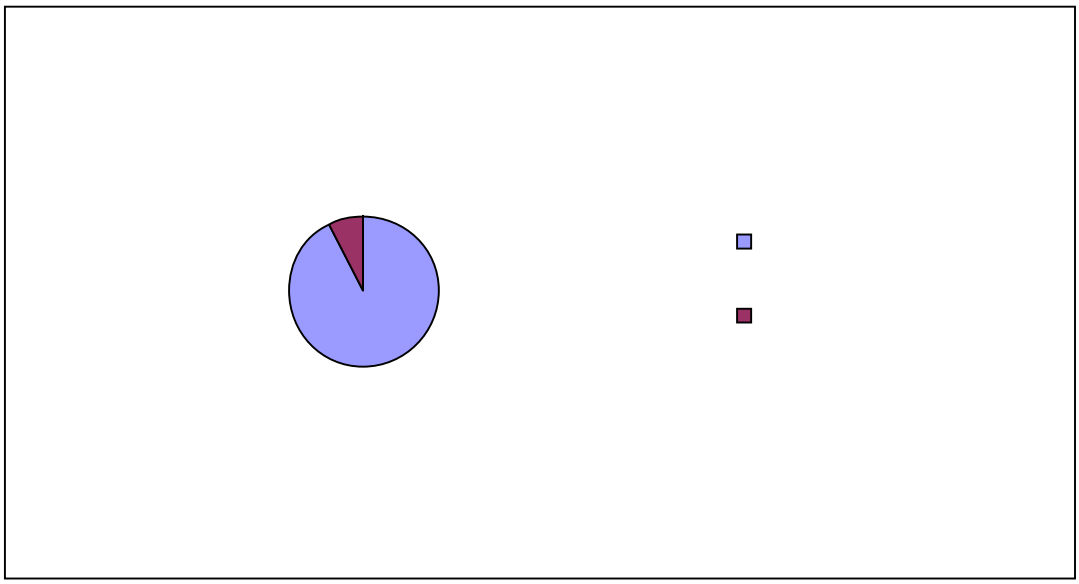
Chart 2: Percentage of patients that were either active or inactive in war engagement before their mental illness



4.2.2 Substance Abuse

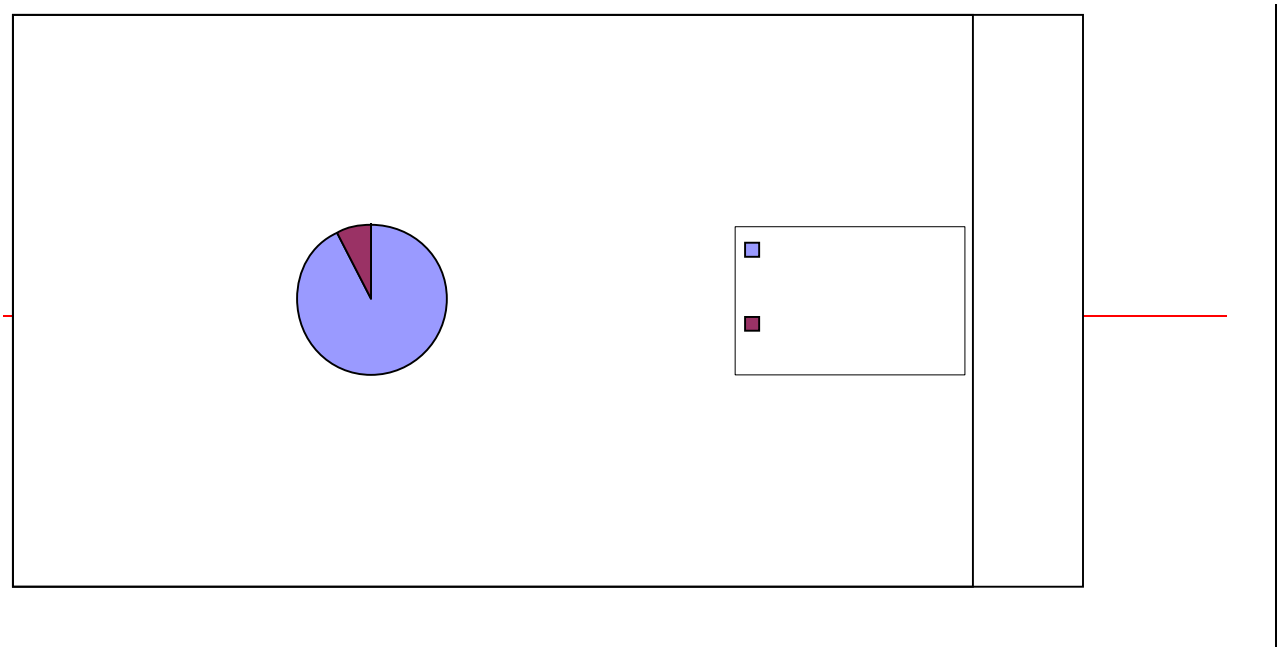
Abuse of drugs is known to be a factor that leads to sometimes severe mental disorder to many people. In Somaliland, a substance known as khat is widely consumed by many. Khat is a drug with stimulating effects and categorised in the family of amphetamines. Most Somali men chew them in form of fresh leaves. Though sparsely grown by Somaliland farmers, they are imported from Ethiopia. The amount of money consumed on Khat imported from Ethiopia is estimated to be US$200,000 a day. Apart from the economic effect, khat has negative effect on health. Most khat consumers develop paranoia and prolonged lack of sleep sometimes leading to severe mental illness. The survey conducted by VIVO in 2002 revealed that 80% of patients that suffer psychosis were excessively using khat before they became ill. The statistics collected from the survey indicated that at least 76% of the patients consumed khat before becoming mentally ill, whereas 70% of the patients are still consuming it. Moreover, most male patient consumed and only few female patients consumed it. The chart below shows the usage of Khat on both male and female interviewed during the survey.

Chart 3: Khat consumption rate between female and masculine mentally ill patients



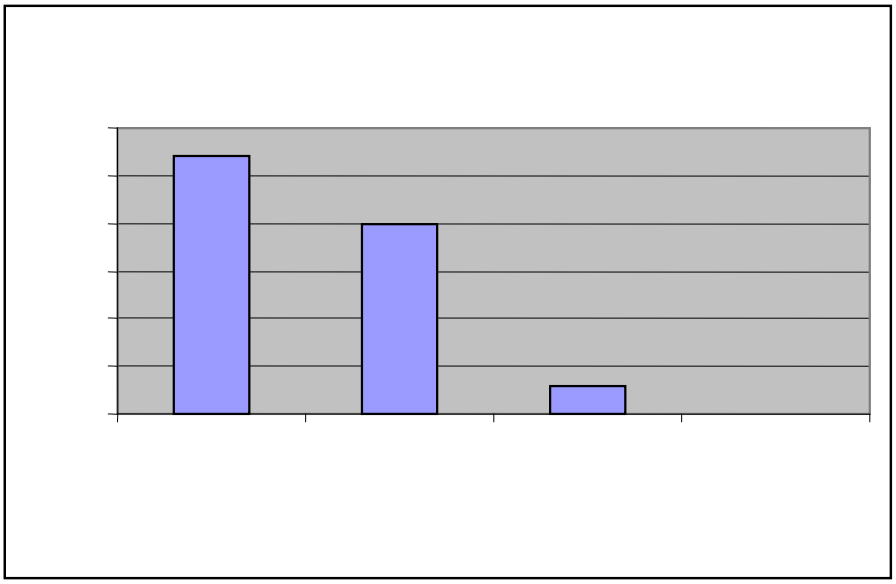
The fact that male patient register higher consumption of the drug, the summation that can be deprived is that what forms the core basis or rather it's the epicentre for a big chunk of mentally ill persons. The sole reason for having low percentage of female consuming the drug could be due to the nature of their being that they are deeply engrossed in domestic chores and for those who find a lee way in chewing the stuff can be attributed to a number of reasons that revolves around family disintegration emanating from stress which looms large.

4.2.3 Poverty and Unemployment



Another factor that highly contributes to mental or psychological disorder in Somaliland is the effect of poverty and unemployment on larger population. Unofficial statistics on the rate of unemployment in Somaliland's working age population is estimated at more than 80%. The situation was worsened by the ban of export of livestock to Arabian countries in 2000. Livestock export to Arabian countries accounted to loss of approximately 500 million US$ per annum earned from the sale. Consequently many people who depended on livestock business are now unemployed and living in the overcrowded cities with limited job opportunities. Moreover all other employment opportunities are limited due to limited government resources. The private sector too can accommodate only handful of people. Consequently many of these unemployed persons do not live in stable conditions. The situation is further exacerbated since big numbers of these people are breadwinners of the families and therefore feel the burden to fulfil their role. Although one cannot conclude that the main cause of mental disorder is entirely caused by joblessness, its consequence has a profound effect on many people. It is obvious that most unemployed people feel hopelessness and sometimes loose meaning of living. Some of these symptoms increasingly end up with depressive moods which eventually lead to mental or psychological disorders amongst the affected persons. The survey from 50 patients indicated that at least 52% of interviewed patients were jobless when first diagnosed with mental or psychological disorder. Further analysis indicated that most of these jobless patients are in very poor standards of living, surviving on an income that is less than a dollar a day. The graph shown below compares the level of income versus the interviewed patients.

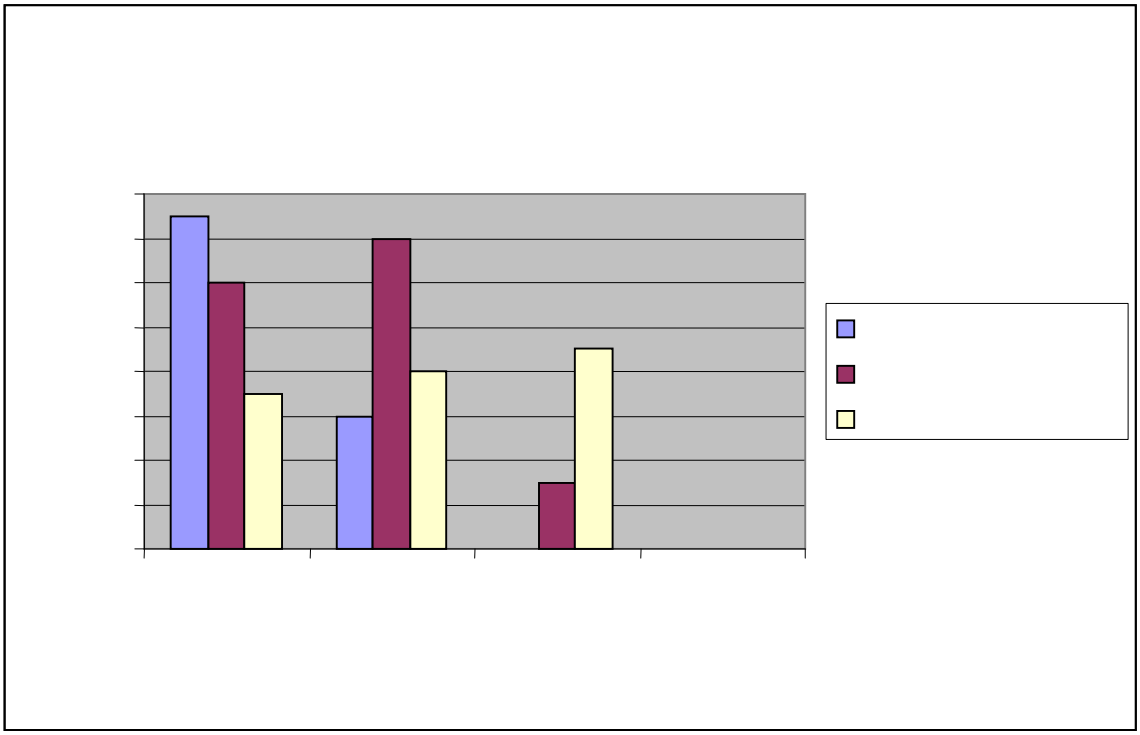
Graph 3: Monthly income of patient's household



The survey collected information on the socioeconomic aspects of the patients to find out contrast between economic status and mental illness. To this end, the survey sought to ascertain level of household income and the standard of living and this was basically achieved through interrogation

The graph below summarises the findings.

Graph4: Economic status versus household type



4.2.3 Other factors

Apart from the above mentioned factors, diseases, spirits possessions and witchcraft are thought to be other reported causes of mental and psychological disorders in Somaliland. It is a fact that age and sex are associated with mental and behavioral disorders, and these associations were depicted during the baseline survey. Most of the youth who missed the opportunity to go to school, were proned to jobless. As a result of jobless and hopelessness some of these youth got frustrated and consequently became mentally and psychologically sick. Other practices like female genital mutilation performed to young girls, a practice that is rampant among the local community led to stigma on the accused which eventually develops to psychological and mental disturbance.

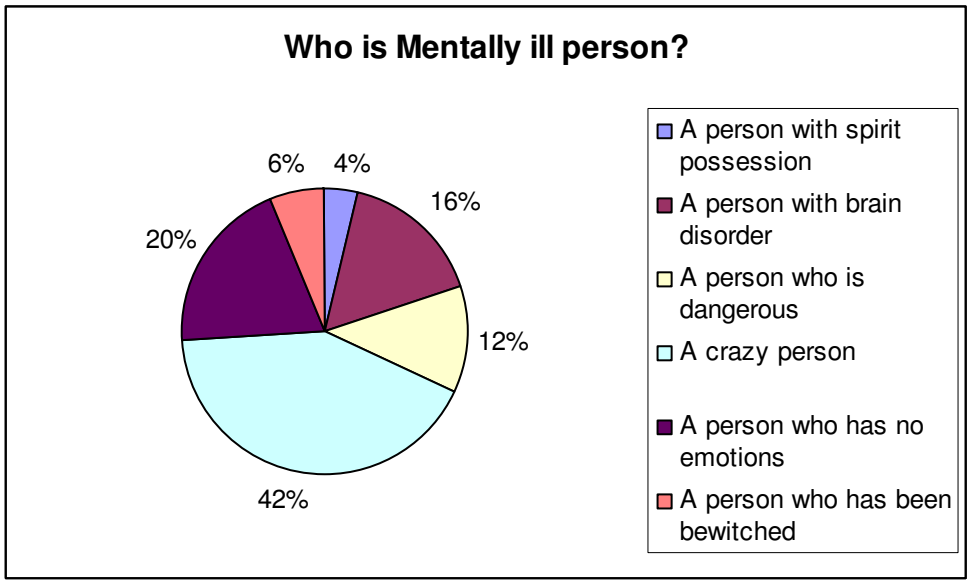
4.3 Public Opinion on Mental illness versus the reality in Somaliland

This section highlights the opinion of different members of the community as far as mental illness is concerned. It also compares their opinions to the facts and realities on mental health in Somaliland. It illustrates issues surrounding mental health in Somaliland with a particular emphasize on the conditions of the mentally ill people.

4.3.1 Definition of Mental Illness

It was important to find out how the public defines mental illness. Different people gave different opinion on description of mentally ill person. The following chart shows differing opinion of the interviewed people.

Chart 4: Opinion of the public on mental illness



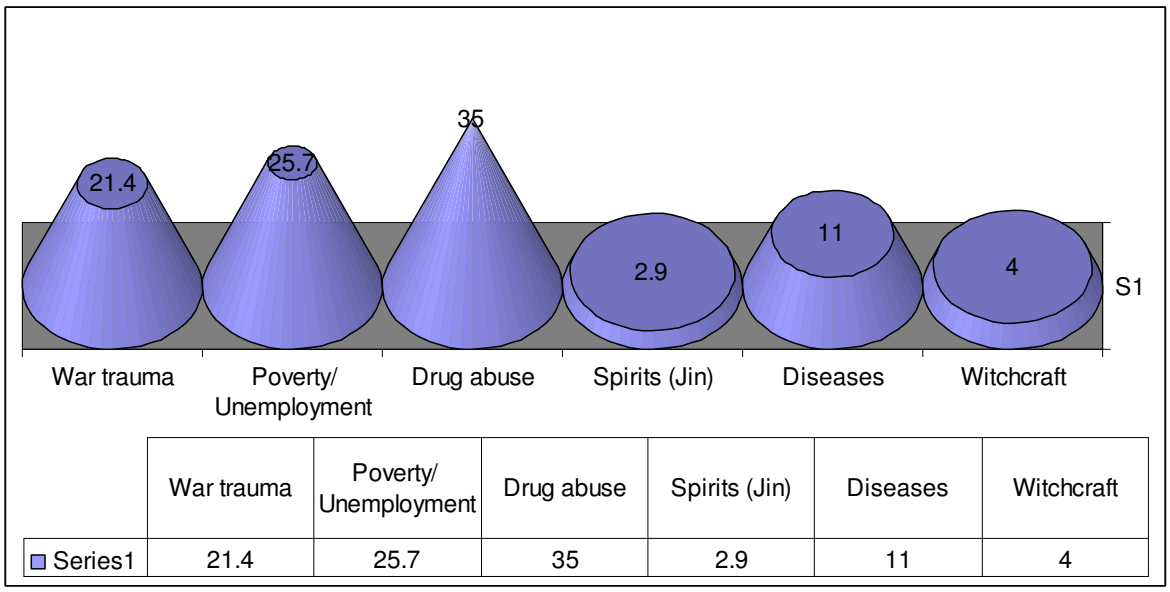
As illustrated above, few could describe who a mentally ill person is. The fact that majority of the respondents (42%) described mentally ill persons as crazy persons gives the impression that they are ignorant on mental illness. It also depicts the negative attitude that the larger community population has for a person who is mentally unstable. The above data also indicates that the community mostly associates mental illness with spirits possession and witchcraft. From the information collected it is apparent the public cannot differentiate between mental illness and psychiatry disorder. Perhaps partly because of this confusion, people with mental health

problems are often stigmatised by our society, labelled as being particularly violent, unpredictable and dangerous to other people.

4.3.2 Main Issues surrounding Mental Illness

Opinions on factors that cause mental illness were collected from the public as well as from doctors who come across mentally ill people in their places of work. The collected information does not give scientific conclusions but can indicate some degree of reality.

Graph 5: Perception of the public on causes of mental illness



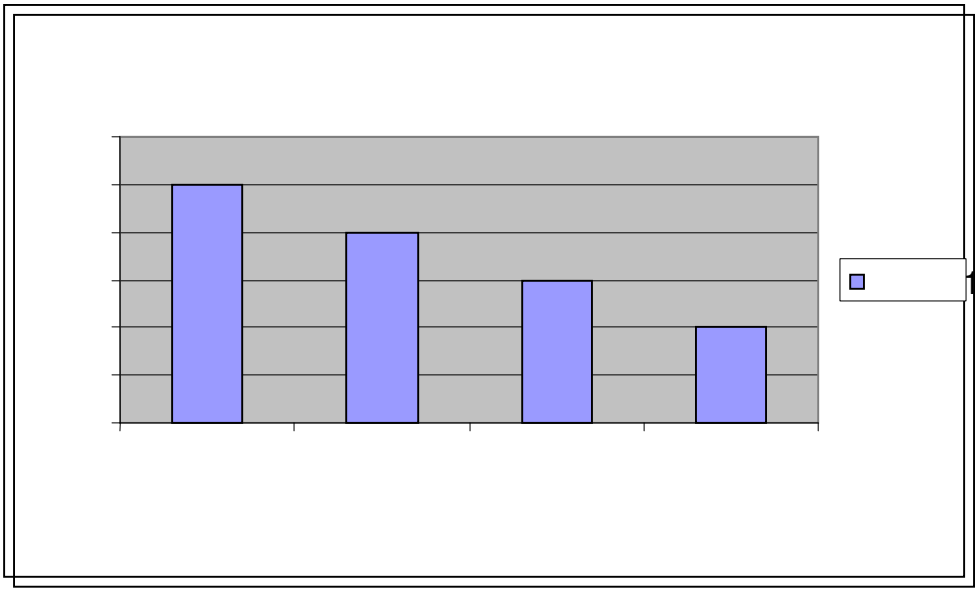
	War trauma	Poverty/ Unemployment	Drug abuse	Spirits (Jin)	Diseases	Witchcraft
Series1	21.4	25.7	35	2.9	11	4

From the above analysis of people's response on what they perceive as the main cause of mental illness, it is clear that drug abuse ranks the highest. Khat which is widely consumed by better part of the population is seen as the main cause of mental disorder in the community.

Social factors are also perceived as the other main cause of mental illness in the society. War trauma, poverty and unemployment are realities that face the larger population and are therefore increasing the prevalence of mental disorder mostly on adults.

The above data can be put side by side on information collected from a group of medical professionals. The doctors were asked to rank the main causes of the mental illness on the patients that visit them. The graph below ranks the response given by the doctors as far as causes of mental illness are concerned.

Graph 6: Response of medical professionals on their perception of causes of mental illness



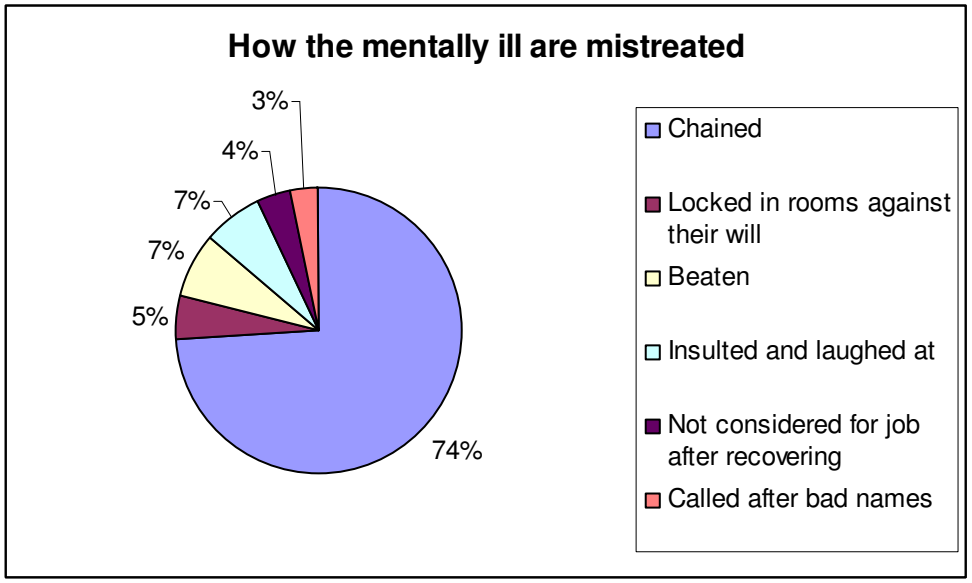
The above chart which is an analysis of information collected from doctors that were involved in treating mentally ill patients, clearly shows that poverty, drug abuse and war trauma as being the three main causes of mental illness in Somaliland.

4.3.3 Distress faced by the mentally ill people

The public opinion indicated that there is a widespread abuse of rights of the mentally ill people. Some of the abuses are deeply rooted within the society and are therefore not seen as mistreatment. Some respondents argued that the people who are suffering from drug abuse should not be treated well and they think that they should not be sympathised with because their problems are seen to be self-inflicted.

The chart below indicates opinions of the interviewed public members on mistreatments that are commonly inflicted on the mentally ill people.

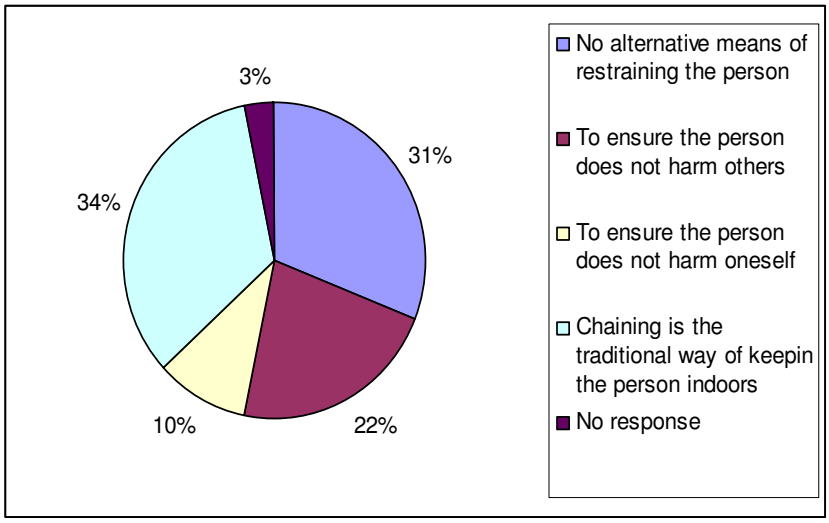
Chart 5: How mentally ill people are treated by the members of the community



As seen on the above chart, chaining is thought to be the most common form of mistreatment faced by mentally ill people. This maltreatment is very common because the offenders do not see it as an abuse since they seem not to understand the rights of the mentally ill people. Insults and even beating are also subjected to the mentally ill people. These acts are committed in order to instil fear on them not and absurdly to ensure they don't harm others. In contrary the mentally ill people become stigmatised and at times end up harming other people or committing suicide. A patient who committed suicide after he was chained and locked in a room by the relative in Hargeisa Mental ward is just an evidence of patients reacting to maltreatment.

Chart 6: Why chaining of mentally ill people is rampant among the local community

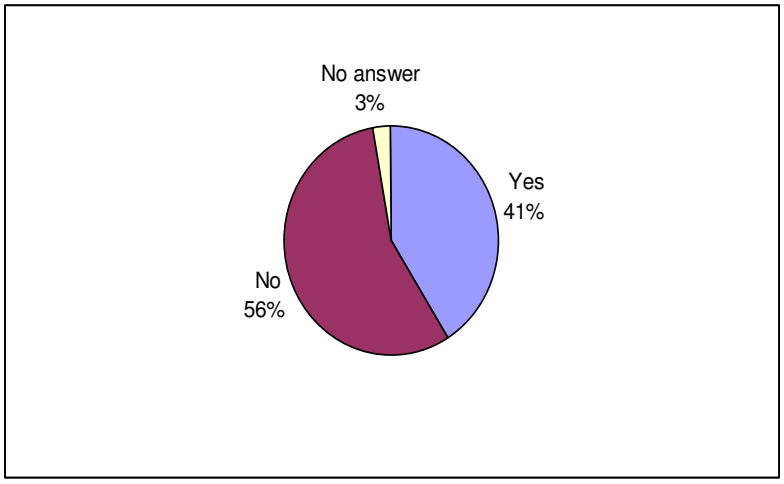
Further information from the members of the public revealed that ignorance is not the only reason why chaining of mentally ill is unbridled, but it is equally shocking to know that it is seen as only means of restraining the aggressive patients. As seen in the below graph, chaining is also traditional way of keeping the mentally ill persons indoors. Therefore most people do not



see it as an offence against the mentally ill patients. Interestingly 22% of respondents thought chaining is a means of ensuring the patient does not harm other people. Thinking of how to protecting themselves, seems that some members are inhumane enough to prioritise their safety to that of the mentally ill patients.

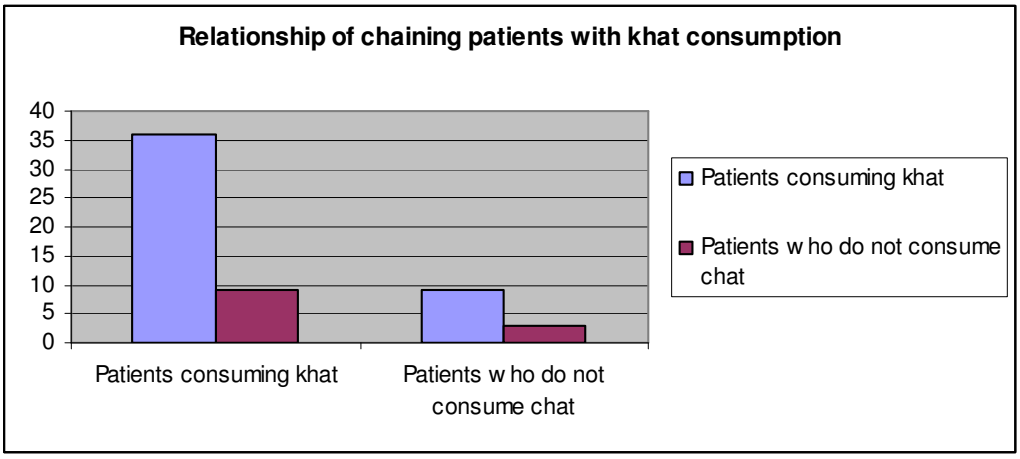
As mentioned earlier, it is also a fact that many people in the society do not perceive chaining as mistreatment. During the survey the cross-section of people that were asked whether it was right to chain the mentally ill or not gave a clear evidence of this argument. It was shocking to know that 41% of the respondents thought that chaining of mentally ill people was right thing to do. The chart below illustrates the responses on the question of chaining.

Chart 7: Consciousness of the public on righteousness of chaining the mentally ill people



Although 56% of the respondents indicated that it is wrong to chain the mentally ill people, statistics collected from the interviewed patients clearly indicated its practise is significantly high. Captivatingly, patients who consumed were more likely to be chained than those who do not. The graph below compares the percentage of patients and their relationship with people who consume chat.

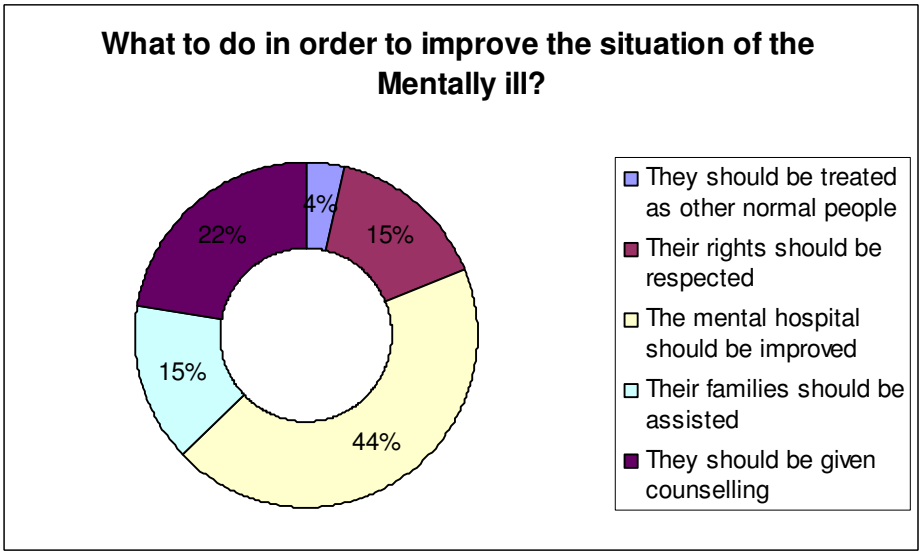
Graph 6: The link between chaining of mentally ill patients and the consumption of Khat



4.3.4 Needs of the mentally ill people

Further information was collected from both the members of the public and medical professionals on what things that should be done to improve the lives of the mentally ill people in Somaliland.

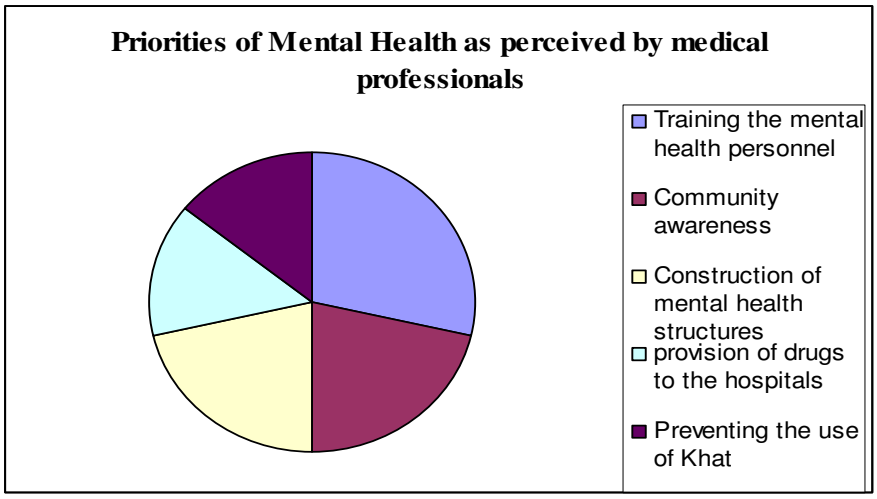
Chart 8: the needs of the mentally ill as perceived by the members of the public



As shown in the above chart, although improvement of mental hospitals was seen as a priority to the needs of the mentally ill people, the respondents were more concerned on improvement of social aspects of the mentally ill people than material being. Equal treatment, respect for their rights and giving them counselling is seen equally important aspects of improving the well being of mentally ill people.

Further information collected from the medical professionals showed that they see training of mental health workers, construction of mental health hospital and community awareness as the main priorities in mental health.

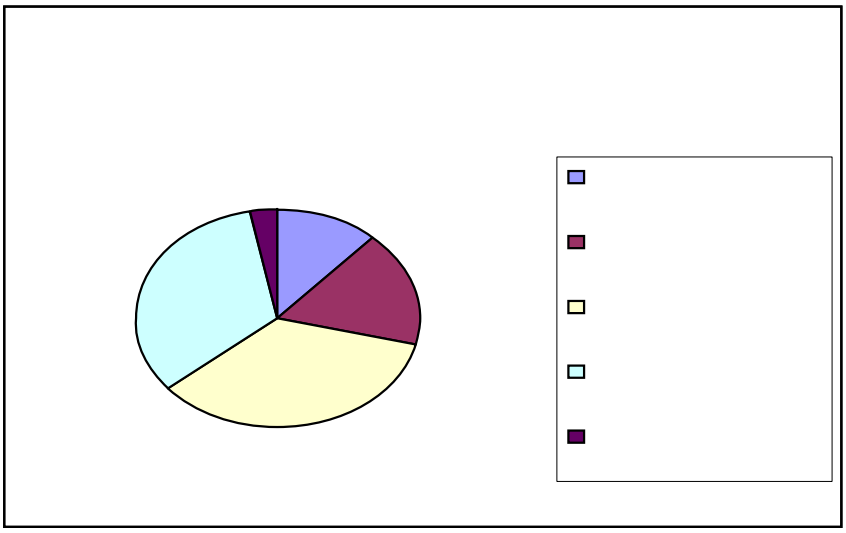
Chart 9: The priorities of the mental health sector as perceived by the medical professionals



4.3.5 Preference of the public on services rendered to the mentally ill people

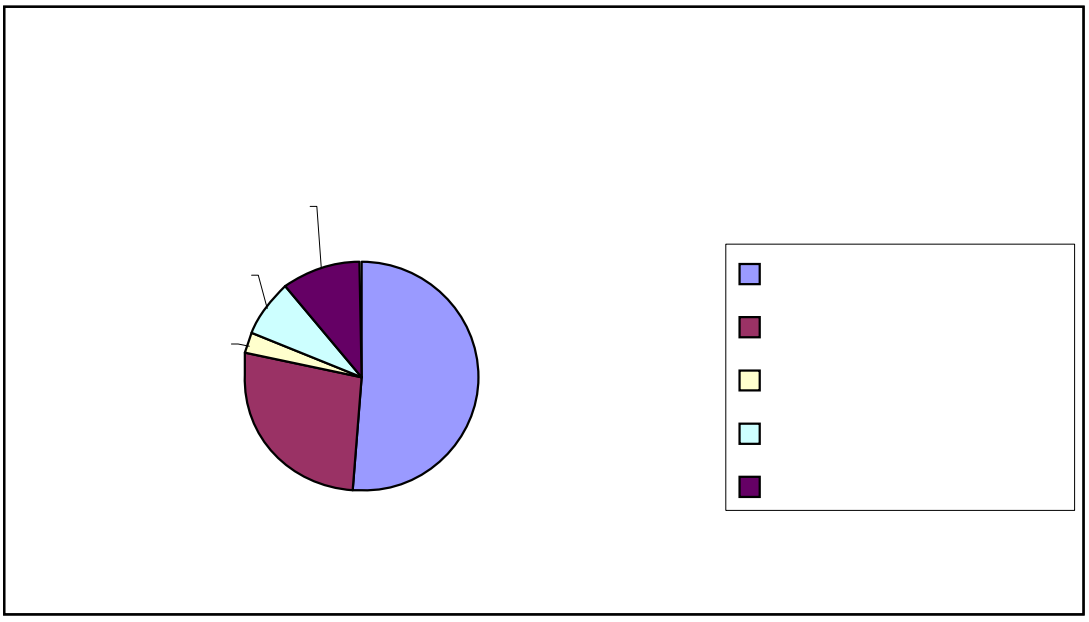
The preference of the public on where to take the mentally ill patients was collected from the public and there were clear indicators that people preferred religious and traditional healers and home care to mental hospital and psychiatric clinics. The reason given for non preference mental hospital due to lack of trained professionals and services.

Chart 10: Preference of the public on public on where mentally ill should be treated.



The need to closely work with religious and traditional healers as well as carers of patients at home will be of utmost importance to the mental health imitative.

Chart 11: Obligation to assist the mentally ill patients as perceived by the community



The information collected from different members of the public clearly indicated that they see authorities as having the obligation to assist the mentally ill patients. A particular emphasize was also put on the shoulder of the mental hospitals. But in reality, there are no well laid structures to support or assist the mentally ill patients in mental hospitals as well as the authorities.

5.0 RESPONSE OF THE STAKEHOLDERS TO MENTAL HEALTH ISSUES

The following issues some of which are discussed in length in the following chapter, gives indications on what the stakeholders of mental health sector have undertaken in order to address the dilemma facing the mental health sector in Somaliland.

5.1 Mental Health Facilities

In Somaliland Mental health clinics are very limited and few. There are currently only two hospitals that accommodate and provide inadequate services to the thousands of mentally ill people. The two hospitals which are situated in Hargeisa and Berbera serve only a portion of the people who require mental health services. Considering that these two hospitals are far from those who live in remote areas, many of them opt to chain their patients at their dwellings because they cannot meet of taking their sick these facilities. Besides the scarcity of the mental facilities; the existing ones are not good enough to serve the few who get access to their services. The conditions of the two mental hospitals are detailed in the next chapter.

5.2 Psychotropic Drugs

Psychotropic Drugs play a greater role in the improvement of the conditions of the mentally ill people, since these drugs can ameliorate symptoms, reduce disability, shorten the course of many disorders, and prevent relapse. They are often used as the first-line treatment, especially in situations where psychosocial interventions and highly skilled professionals are unavailable.

In Somaliland, availability of the psychotropic drugs is lacking. Although these drugs are sometimes available in the private pharmacies and in the two public mental hospitals, they are mainly the generic. In the public aspect, WHO supplies only two existing hospitals of Berbera and Hargeisa but these drugs are often supplied in inconsistently and in insufficient quantities. Berbera hospital reported lack of some of the essential drugs for more than three months. Recovery of the patients was mostly hindered due lack of continuous supply of medication. Relapse of recovered patients increased in Berbera owing to unavailability of prescribed psychotropic drugs. Even though the hospital staff in both Berbera and Hargeisa sought alternative means of drugs supply, which were from relatives and well-wishers may not sustain the needs of the many poor patients.

5.3 Human Resource

As mentioned earlier, the lack of trained mental health professional is one of the main problems affecting the mental health sector in Somaliland. The two hospitals in the country are run by medical personnel that have been trained haphazardly on psychiatry. Although organizations such as GRT trained some mental health professionals in the country, most of them left for better pay. During the survey, the Ministry of Health and Labour availed plans to train social workers with the support of WHO, but the challenge is to encourage the trained personnel to remain in the public hospitals where remuneration is very low.

5.4 Policies and Legislation

Good policies, legislations and programmes are the required catalyst to achieving lasting solutions to the needs of the mentally ill people. Where the three are lacking, pitiful services are luckily to be available to the mentally ill people. When these three issues were explored during the survey, the following became apparent.

- The constitution of Somaliland does not mention the special needs for the mentally ill people. No article in constitution explains the rights of the mentally ill and how they should be treated before the law. Lack of this stipulation in the government system has led uncountable abuses committed against the mentally ill people. These further explain why the mentally ill people are taken to prison without considering the mental health status. In Hargeisa prison alone there are mentally ill patients who were mostly taken to prisons without trial or medical check up. It was also discovered that the ill and even those who recovered are almost excluded from getting access to rights such as; Security, education, employment, housing and right to information and participation, and freedom of assembly and movement.

-Information received from the Ministry of Health and Labour indicated that prior to 2004, there has not been clear mental health policy .However, it was revealed that the Ministry is in the process of putting policy and strategic direction for the mental health. The policy is likely to be included in national health policy and strategy in the coming year. However, till mental health is considered as a priority in primary health care, the services to the mental health facilities will continue to deteriorate.

6.0 MENTAL HEALTH FACILITIES IN SOMALILAND

6.1 Hargeisa Mental Ward

Hargeiea Mental Hospital was established in 1971 by the Ministry of Health and Labour under former government of Somalia. It was recently reopened under the management of Hargeisa Group Hospital, though it is somewhat run independently with the meagre assistance of humanitarian organisations and volunteers.

The hospital has a well furnished office room with a computer, printer, tables and executive chairs. The office serves as a consultation and a reception room for the in and outpatients. This is also where patients' records are kept. The available medical forms which were recently introduced are scantly filled. Even though there are no enough medical forms for all patients, the only available register is blank. As such, it is very hard to deduce medical history and diagnosis for the patients.

6.1.1 Structures

The hospital has two fenced sections, male and female patients sections. The male patients are admitted in three different sections according to their degree of illness.

- Zone A: This is a high zone. Aggressive patients are kept here. Each patient in one closed room with iron doors. Very aggressive patients in this section are mostly chained. Though this section was recently renovated by UNDP, it has poor sanitary conditions. Sewage-like terraces with the patients' wastes are seen around the corridors.
- Zone B: These are large closed rooms where 2 to 4 chained patients are kept. The rooms are overcrowded since it was probably meant for one patient in each room.
- Zone C: It is an open large hall/ward with single beds. The hall can accommodate as many as 20 patients. Most of the patients in this hall are calm and are on the process of recovering. Few patients in this section are chained to ensure they don't run away. where you can see about 20 both chained and unchained patients
- There is an open veranda where the patients are allowed to sit and move about. Most of the patients in this area are very calm though some of them are still chained.

6.1.2 The personnel

Table 4: The staffing of HMW

Type of staff	Number of the personnel			Remarks I.e Qualifications
	Male	Female	Total	
Doctors	1	0	1	General physician
Assistant doctors	1	0	1	Medical student
Nurses	0	3	3	Auxiliary nurses
Cleaners	1	4	5	Their work is to maintain the cleanliness of the patients' rooms as well as that of whole compound.
Volunteers	1	1	2	There work mostly entails keeping the aggressive patients from escaping from the hospitals and assisting the weak ones
Watchmen				
Hospital standard custodians	2	0	2	Their work is to ensure they look after the set of standards at the hospital and ensure they are adhered to.

As seen in the above statistics, the hospital is very understaffed which unintentially leads to poor services to the mentally ill patients. It is obvious that mentally ill people need special attention but with the limited number of staff at the hospital, they receive no individual attentions from them. Although, the doctor conducts irregular routine monitoring of patients conditions, records of their improvement or change of drugs is not available.

Contacts with patients are mostly limited to first prescription, dispensing of drugs, cleaning and during the discharge. With patients seen behind the closed iron bars, one can easily compare it to a prison.

While the staff at hospital could spell out some of their presumed task, clear written job descriptions is lacking. This leads to misunderstanding of ones responsibility. With written job description, division of labour could easily been established as well as the overall efficiency of the hospital activities.

6.1.3 The Patients

According to the doctor in Charge and assistant doctor, Dr. Abdirizaq and Mustafe, most of the patients that visit the hospital are brought by either their relatives or by well-wishers and authorities. On their first visits, most of the patients are in shackles which are mostly used in place of tranquillizers. The condition of the patient is diagnosed by the doctor and then either given prescription as an outpatient or admitted in according to their status. The admitted patients are sent to the big hall, rooms or small cells as explained above. A fee of 50,000 Somaliland Shillings ($8) is paid during admission, but other services such as food and medicine are not charged. The hospital discourages the use of chains to keep the patients, but due to lack of continuous supply of sedatives or unwillingness of the family members to unchain the patients, most the patients are still left with chained legs. Surprisingly, some of the relatives take with them the keys of patients' room with iron-bar-door with them. This was particularly found risky because should the patients face any danger, there would be no way the hospital personnel could assist them. At the time of the survey there were 64 in-patients admitted to the hospitals. 9 patients, 7 of them being males and 2 females were found to be in chains and 18 male patients were kept in the high security rooms.

Further information on the diagnosis of patients could not be established due to lack of proper records. Nonetheless, Post Traumatic Syndrome (PSD), Neotiric Depression, Schriizoremia, Paranoia, Catatonic, and Bipular Disorder are the most common mental disorders that were reported at the hospital.

6.1.4 The role of relatives/ carers

Relatives/Carers play a major role in admission and discharging of patients. They give extra support to the hospitals workers and ensure the welfare of the patients is taken care of. Provision of meals and cleaning of clothes and sometimes the patients themselves are amongst the tasks undertaken by the relatives.

However, the discussions held with the patients and their relatives indicated that not only do the carers mistreat the patients but also they perceive their actions as being beneficial to the patients. Chaining and locking the patients in the iron barred door rooms are some of the mistreatments. During the consultation, it became apparent that the relatives were engaged in some of the

activities due to lack of knowledge on how to care for patients with mental or psychological disorder.

Due to the lack of agreement between the patients and the hospital, the relatives sometimes disregard the hospital staff advice on timing of discharging. Cases of unreported discharging or refusal to discharge recovered patients were reported by the hospital. .

6.1.5 Available psychotropic drugs

It was noted that there were some but not enough of needed psychotropic drugs that were available in the ward. These drugs are mostly contributed by a local NGO (Candlelight) and sometimes by WHO. They are stored in a central location where all the drugs under General Hospital are kept. A request is made for 1000 tablets each time and kept in the cupboard before being administered to the patients by the doctor. Again, without the patients' records, the effectiveness of the drugs management could not be assessed. In fact it was noted that almost 90% of patients were taking the same medication, chlrop, pro.

The following are the available drugs at the hospital.

Table 5: Available psychotropic drugs in Hargeisa Mental Ward

Name of the drug	Form
Haloperidole	Injection, Tablets
Chloropromazine	Injection, Tablets
Amitriptilline	Tablets
Carbomezapine	Tablets
Promethazine	Injection, Tablets
Diazepam	Tablets, Injection

6.1.6 Specific Hospital Problems and Needs

The following issues are summary of the identified problems and the needs of the hospital. They were mostly noted from the interviews held with Dr. Abdirisak and Mustafe (junior doctor) and general observations during the visit to the hospital.

- Inadequate number of staff
- Lack of proficient training
- Lack of motivation for the currently working staff

- The supply of drugs is poor. They are not enough, there quality is not satisfactory and some of the most necessary ones are not available.
- Poor management of the patients records as well as other administrative aspects
- Poor sanitation and hygiene
- Need for motivated volunteers
- The need for sensitisation of the relatives role to enhance future collaboration
- The need to have a separate administration office, store for drugs and other materials under the hospital Director.

6.2 Berbera Mental Hospital

It was built in 1928 by British protectorate as prison, but it was later utilised as mental hospital and hence it became the first mental hospital of its kind. Until recently rehabilitated by GAVO with the funding of GRT, the hospital was ruined. Currently GAVO runs the hospital with the support of the regional health coordinator. Among other things, the role of GAVO is to: lobby for local fundraising as well as advocate for external support; assist the hospital staff in management of the hospital activities, advocate for the rights of the mentally ill patient and discourage the abuse of their rights.

6.2.1 Structures

The BMH is partitioned into two; male and female apartments. Although its first architectural design was formulated to contain prison inmates, little has been done to make it look as hospital. Some of the rooms have metal bars and chains that are concreted to the floor. In total male section has got 39 rooms of which 10 were recently rehabilitated and firm steel doors fixed on them so that the prisoners could not escape.

Despite the fact that some have got steel doors installed, equivalent numbers do not have doors. There are 10 rooms with proper roofing but without doors. Amazingly the remaining room are not roofed. To be coherent, hereunder is the breakdown for men section:

Table 6: The available rooms in BMH and their conditions

Total number of rooms for men	39
Rehabilitated rooms fitted with steel doors	10
Rooms with proper roofs but without doors	10
Rooms without roofs	10

It was observed that due to the age of the building the some of walls of the rooms have cracks. It was reported that aggressive patients could easily dig out these walls and escape if not watched all the time.

Female section has got 14 rooms less than the male section that is, in other words 25 rooms. Of these 25 rooms 8 of them are roofed and the rest of the rooms have got neither doors nor roofs. A veranda for early crisis and first stage of admission is in place.

The hospital has spacious compound where patients can roam about with a lot of ease.

The mental hospital ward is equipped with 20 beds meant for male, and 4 bed spaces for female. Lavatories are 6 in number, 4 of them being male latrines and one for female patients, employees have also separate latrine.

Kitchen where meals are prepared for the patients is in place with its store which is meant for storage of food commodities. A long these, catering services has been a primary concern; therefore a cafeteria is also in place. Because hygiene is paramount and for that matter an essential factor that can not be overlooked it is rather unfortunate that the sewage system is blocked therefore waste matter is trapped in. The municipality council collects the garbage given that it is the caretaker of such responsibility.

6.2.2 The Personnel

Table 7: The staffing for BMH

Type of staff	**Male**	**Female**	**Total**	**Remarks i.e qualification**
Administrator	1	0	1	
Doctor	1		1	Received 3 months psychiatry training
Nurses	1	1	2	
Trained social workers	3	1	4	
Untrained social Workers	3	1	4	
Cleaners	1	3	4	
Watchmen	2	0	2	
Cooks	0	2	2	

Given the fact that the hospital serves the whole of Somaliland, the numbers of staff members are inadequate. To make it worse some of the trained social workers have left the hospital in such of better pay. Therefore it has been made difficult to continue with the kind of individual attention that the hospital wanted to establish for all patients.

6.2.3 The Patients

In Berbera Mental Hospital, patients first come through the hospital consultation room where they are received by a doctor, a nurse or by a social worker. A medical form is filled whereby the patients' history, diagnosis and medication are recorded. From there, the doctor decides whether the patient needs to be admitted or to be an outpatient. If admitted, an agreement is signed between the hospital and the family member or the carer. This is to ensure the support and follow up of patients' condition is not lost with the family member or the carer. The duration medication and stay at the hospital, depends on the health status of the patients. Each patient is assigned to a social worker to monitor his status and who in turn reports to the doctor. Unless there is urgent case, a weekly medical check up is done by the doctor to monitor the status of the patients.

It is worth mentioning that the hospital does not only offer only drugs but also other social activities to ensure the psychologically ill patients are better served. Counselling of patients is conducted routinely at the community psychosocial center which is situated near GAVO's office. Some of the less aggressive patients also have outing days whereby they are either taken to the beach or allowed to watch TV.

Before the patient is discharged, a session is held between the hospital authorities (mostly the doctor and a social worker) and either the family members or the carers. The family members are briefed on the status of the patient and advised on how to take care of and rehabilitate the patient back to the community. A follow up program is also given to the patients to check whether they have fully recovered or having any complications while at home. The follow up is mostly done by social workers through visits. Even though the hospital has maintained good relationship with both patients and their carers, some of the patients have run away without being released from the hospital.

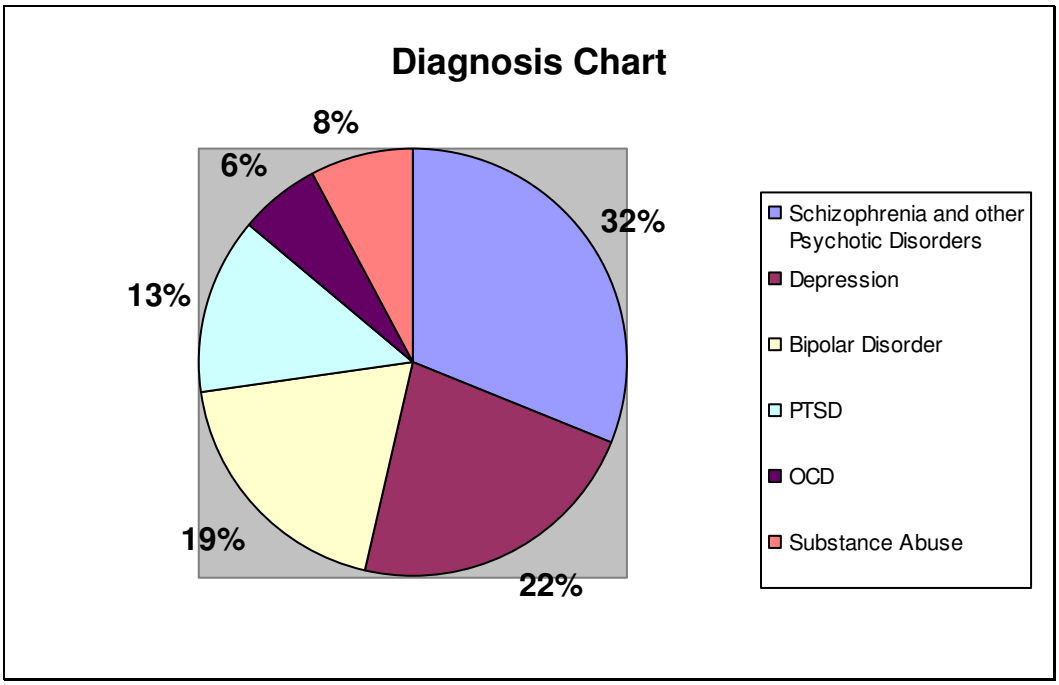
The table below shows, the records of patients that were discharged, escaped, died or transferred in 2004.

Table 8: Statistics of in-patients that visited BMH 2004

	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Discharged	20	20	15	16	10	14	8	10	9	13	7	13	155
Escaped	4	0	3	4	10	1	2	2	8	4	2	3	43
Died		0	0	0	0	0	0	0	1	0	0	0	1
Transferred	2	0	0	0	0	0	0	0	0	0	0	0	2
Total	**26**	**20**	**18**	**20**	**20**	**15**	**10**	**12**	**18**	**17**	**9**	**16**	**201**

The chart below summarises diagnosis of mental or psychological disorders that were reported in Berbera mental hospital in 2004. The highest mental disorder reported is schizophrenia and psychotic disorders and depression. The prevalence of this disorder and depression could be attributed to rampant khat abuse and the effects of war trauma in the society.

Chart 12: Diagnosis of patients that visited BMH in 2004



Though the hospital currently serves as many as 50 outpatients from all regions of Somaliland, the wards and equipment can only accommodate 30 male patients and 15 female patients. At the time of the survey there were 25 male and 6 female patients admitted to the hospital. Though the hospital staff discourage the chaining of patients, its use is still evident at the hospital. Encouragingly, only 3 patients were in chains although 18 of the patients were in high security

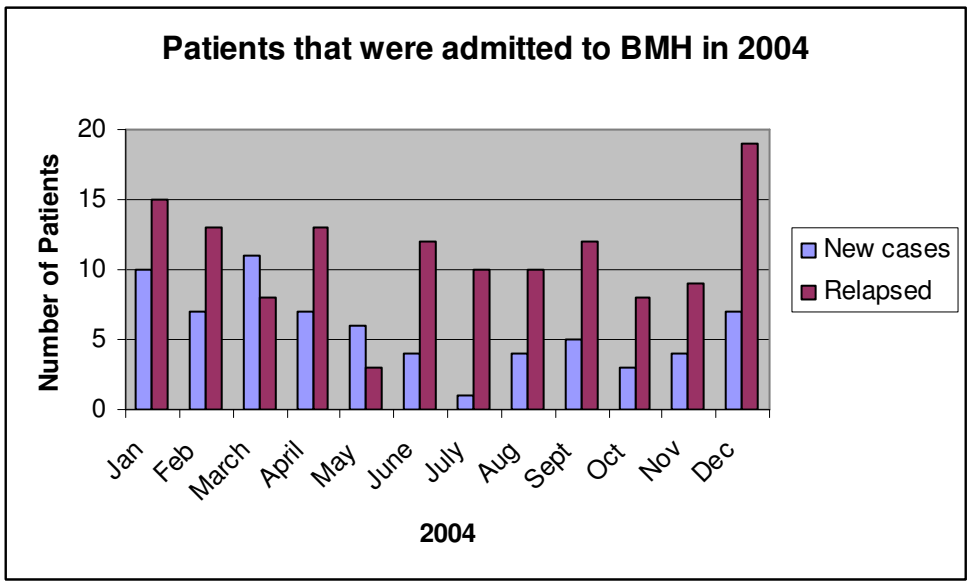
cells which were not in good hygienic conditions. The hospital also housed chronic patients in which some of them have stayed in the hospital for more than 10 years.

Since the hospital keeps a record of each patient, the data below summarises the number of mentally ill patients that visited BMH in the year 2004 as outpatients.

Table 9: Outpatients for BMH in 2004

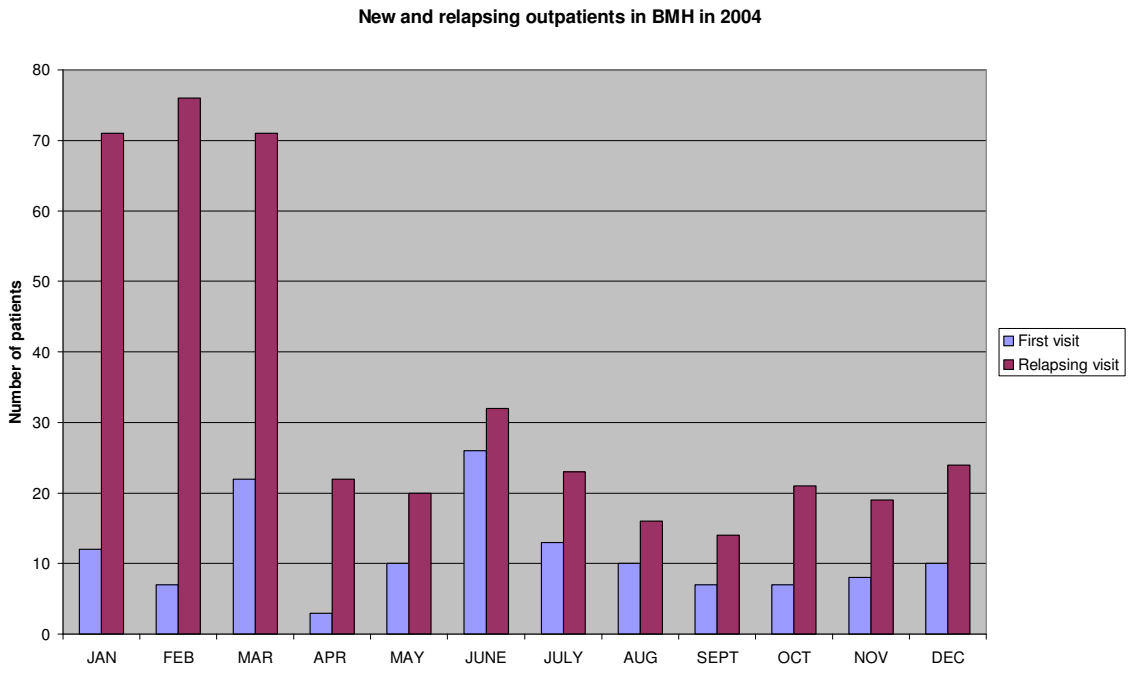
	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
MALE	65	66	79	22	20	40	28	20	16	20	20	26	422
FEMALE	18	17	14	3	10	18	8	6	5	8	7	8	122
TOTAL	83	83	93	25	30	58	36	26	21	28	27	34	544

Graph 7: Number of new admissions versus the relapsing patients in BMH in 2004.



In the year 2004, the hospital admitted 201 patients. 34.3% of them were new patients while 65.7% were patients that relapsed to the hospital after becoming ill again. The main cause of relapse was due to abuse of drugs. Most of the patients relapsing to the hospital reportedly consumed khat before becoming ill again. The percentage of relapse for outpatients was even high due to the fact they have more access to chat than others. The graph below compares the newly registered outpatients to the relapsing ones to Berbera Mental Hospital in the year 2004.

Graph 8: Number of new versus relapsing outpatients in BMH in 2004



6.2.4 The role of relatives/ carers/ Community members

As mentioned earlier, there is a strong relationship between the hospital authority and the relatives. The agreement entered between the hospital and the relatives clearly defines the role of each other and therefore encourages mutual support from the side of relatives. The hospital allows the relatives to visit their patients as much as possible. Washing of clothes, assisting the patients to take birth and provision of food are roles that are taken by the relatives. There are also regular consultation meetings between the patients and their carers which also enhances the knowledge of the relatives on how to deal with mentally or psychologically ill patients in future.

The hospital has received enormous support from the local community members over the years. Most of the support is in kind. Provision of food and cleaning materials, clothes are among the donations given by the Berbera community members to the mental hospital.

6.2.5 Available psychotropic drugs

WHO donates drugs to the hospital through GAVO. The drugs are kept in central store in Berbera General Hospital. A record of the usage of the drugs is kept at the hospital. Moreover, each patient has a record of what drugs he or she has received during the medication period at the hospital. There is however, lack of continuous supply of drugs to the hospital.

Table10: Psychotropic drugs available in BMH

Name of the drug	Form
Haloperidole	Injection, Tablets
Chloropromazine	Injection, Tablets
Amitriptilline	Tablets
Carbomezapine	Tablets
Promethazine	Injection, Tablets
Diazepam	Tablets, Injection
Phenbarbitone	Tablets
Phenytoin	Tablets
Trihexyphenidyl	Tablets

6.2.6 Specific Hospital Problems and Needs

- Poor structure- the patients dig out and escape through the damaged old walls. They need repair so that the place is secure and prevent patients from running away.
- Insufficient drugs- there have been shortage of the essential drugs. Although the WHO has been the main provider, in the recent past there has been no constant supply from either WHO or any other source. As such many patients did not recover as required and some even relapsed to the hospital.
- In adequate motivated personnel- it was reported that many trained social workers left the hospital is such of better pay. They few present staff are inadequate, most of them being untrained and poorly paid. This affects their morale to serve the patients better.

7. OTHER SERVICE PROVIDERS

Due to the lack of capacity of the Mental Hospital to deal with the growing number of mentally ill patients, other stakeholders have taken a bigger role to help them. Private clinics, traditional and religious healers are some of them. They provide services ranging from medication, admission, education to counselling.

7.1 Private clinics

The survey indicated that there are many doctors providing services to the mentally ill people in their private clinics. As mentioned earlier, the survey team randomly visited various private clinics to assess the capacity and how they deal with the mentally ill people. Out of the 12 visited doctors, 7 of them are currently offering medical treatment. They offer different form of services to the mentally ill people. Out of the 12 visited doctors, 5 had at least received minor course on psychiatry and utmost 2 months of training.

Only 1 doctor mentioned that he had received 2 months seminar on psychiatry. Others mentioned that they last received some minor training on psychiatry in college. One of them mentioned he last received it in 22 years ago. Some of these doctors (5) mentioned that they visit hospitals and offer assistance to the mentally ill people in utmost once a week.

The following are the recommendations of the visited doctors on how to improve mental health.

- Training the mental health personnel (N=4),
- Conduct Community awareness on mental health(3),
- Construction of mental health structures (N=3).
- Advocating for prevention of the use of Khat (N=2),
- Provision of drugs to the hospitals (N=2),

Note: Some respondents gave more than one answer.

7.2 Religious and Traditional Healers

In the absence of psychiatric clinic, many centers have sprung up in towns to treat people with mental illness. The use of religious and the traditional medicine in Somaliland has been on the increase. Although less documented, the use of complementary medicines and consultations with religious traditional healers is widely acknowledged by the local community. Here too the

limited availability of health services motivates the use of a wide range of alternative systems of care for various ailments, including mental illness. In addition to herbal and other traditional medicines, sheikhs are seen as providing curative and spiritual healing for those possessed by Jin (spirits). Although the survey did not interview or ascertain the psychiatric status of the people coming for help at these religious centres or the clinical impact of healing. Information was got from 4 centres that were visited, one in each of the four towns and the following were the findings from the centres.

- Significant numbers of mentally ill patients visit these centers before going for any form of treatment or to mental hospitals. The reason given behind this was the fact that most of the patients relatives' believe that they are possessed by spirits and cannot be treated by conventional medicine. It was observed that some of these centers receive as many as 20 patients a day, though not all of them are diagnosed as being mentally or psychologically ill.
- All the centers are run by people with religious and herbal background. They keep 2- 4 assistants in their centers. Few apparatus are available in such centers. A cassette recorder attached to loud speakers which are used for reciting Quran, electric apparatus with low voltage, and the Quran are mostly found in the consultation rooms of these centers.
- These religious healers mostly use recitation of Quran and herbs to treat the mentally ill persons. They store the herbs in small stores inside their buildings. It was observed that conventional medicines were also administered by some healers. An example is Sheikh Mohamed Ismail who coincidently also has a background on medicine.
- Proximity to the community was seen important by these service providers as most this centres are located in middle of community residential places. They are easily accessible to the sick ones and can be reachable at anytime.
- It was also revealed that each of such facilities offer services to 20-30 patients in day. Some of the centers like Sh. Mohamed Ismail Center has inpatient department. It helps outs the patients who cannot go to the hospitals and it is situated in the immediacy of the community.
- From the discussion held with these service providers, it was apparent that there is a good working relationship between them and the centers. These centers refer patients who do need medical doctors' treatment to the hospitals. Of the visited centers, only in Borama who also apparently refused to give interview, does cooperate with other medical doctors.

7.3 Humanitarian Organisations

In Somaliland various UN agencies, International and Local Non Governmental Organisations are providing some form of mental health services in different ways. The organisations included: World Health Organisation, United Nations Development Programme, General Assistance and Volunteer Organisation, Candlelight for Health and Education and Medical Foundation. From the information collected from the different organisations, the following are the roles that they play in the mental health sector.

- Candlelight donates drugs worth of USD$ 500 to the hospital it also helps in improving the sanitation of the mental hospital by paying the salary of 2 cleaners. It also provides cleaning equipment and detergents to the hospital. and pays incentives to cleaners.
- UNDP rehabilitated Hargeisa Mental Hospital and provided beds to the hospital. It is rehabilitating the Hargeisa mental. It also providing support and rehabilitation and reintegration to 30 mentally ill people who had face PTSD.
- Over the years, WHO has been providing drugs to mental health hospitals in Berbera and Hargeisa. It will continue to do so and take part in training to social workers.

8. BASELINE SURVEY TOOLS

8.3 Questionnaire for Service Providers

Name of Institution: _____ Location_____
Name of Interviewee_____ Title_____
Date of Interview_____
No of Staff_____ No of beneficiaries_____

Date of establishment_____

Source of income/support
_____
_____

1. Personnel Titles/Roles:

For mental health institutions:

	Male	Female	Remarks /qualifications
Doctors			
Social workers (trained)			
Social workers (untrained)			
Psychiatric nurses (trained)			
Psychiatric nurses (untrained)			
Cleaners			
Cooks			
Watchmen			
Others specify…..			

Activities and services they perform:
_____
_____
_____
_____

_____
_____
_____
_____
_____

Major types of illnesses
1._____
2_____
3_____
4_____

5_____

Administration office
Who is responsible for the office?_____
Patients Record keeping _____
Other activities that take place in the office
_____
_____

Visits and Patient Management
Who conducts it and how?
_____
_____
Diagnosing system:
_____
_____
Admission system: decision, authorization & role of relatives
_____
_____
_____
_____
_____
_____
Case management process (from First Visit to last):
_____
_____
_____
Discharging process: decision, authorization & role of relatives
_____
_____
_____
_____

Drugs:
Types of drugs available_____
_____
Availability & source of Drugs_____

Administration of drugs storage to distribution
_____
_____
_____
_____

What is the current role of relatives towards the care of patients in the hospital?
_____
_____

_____
_____
_____
_____

Current Patients		
	Male	Female
Number of patient in total		
Chained		
Unchained		
Security cells		
Chronic		
Others specify_____		

Last Six months

No of patients	*male*	*Female*	*Remarks*
Admitted			
Escaped (discharge)			
Improved (discharged)			
Re-admitted/Relapse			
Died (suicide)			
Transferred to other centers			

6. How many institutions who are caring for mentally ill people do exist in the Region/Country
_____

7. Do you think that they are enough

_____

8. How do our communities care the mentally unstable people in the community/clinics?
_____
_____
_____

10. Do you provide any assistance/services to the mental health projects/ill people
Yes_____ No_____

If yes what kind of assistance do you extend and how do you provide
_____
_____
_____
_____

11. What do you think that are the factors of mental illnesses in our community

_____
_____
_____

- Psychological (
- Biological (Physical Diseases, etc)
- Social (poverty, unemployment, etc)
- Drugs (chat, Hashish…….)

12. How do our communities try to treat their mentally unstable people?

- Do they take to health clinical
- Do they bring traditional or religious healers
- Do they keep at homes chained
- Do they keep at homes unchained
- Do they let them go around the town……?

13. What could be done to prevent these factors?
_____

_____

14. How can we improve the mental health situation in our community
_____
_____
_____

15. What role can you play/contribution or assistance can you provide to mental unstable people?
_____
_____
_____
_____

16. What role do the communities can play in assisting these people?
_____
_____
_____
_____

17. What role can the local authority play
_____
_____
_____
_____

19. Their Constraints

20. Lessons learned

_____
_____
_____

21. Have you any recorded data or published

8.2 Questionnaire for Medical Professionals

COMMUNITY MENTAL HEALTH PROJECT
BASELINE ASSESSMENT TOOL

Date: _____ Name of interviewer: _____

Name of interviewee:_____ Designation: _____
Location_____

1. What do you know about the status mental health in your area?

_____
_____
_____
_____
_____

2. Do you offer any services to support the mentally unstable people? Yes ( ) No ( ).
3. If yes, what are the main services that you are offering?

_____
_____
_____
_____

4. If no, do you have any plans to support the mentally unstable people? Yes ( ) No ( ).
5. If yes, what are the activities?

_____
_____
_____
_____

6. Have you been ever had training on Psychiatry, lessons based on mental health issues? If yes plse Identify which Area?

_____
_____
_____

7. How can your personally contribute/support the mentally health project?

_____
_____
_____

8. How many psychiatric Doctors (professional) do you know in the country?

_____
_____
_____

9. How and whom in the community should play important role in the mental health project

_____
_____
_____
_____

10. Do you visit a mentally unstable person? Yes ( ) No ( ).

11. If yes, how did you manage/deal with the situation of the mentally unstable person?
_____
_____
_____

12. What do you think are the main causes of the mental illness?

_____
_____
_____

13. What needs to be done to improve the status of the mentally unstable people?

_____
_____
_____

14. how many institutions/organizations are so far providing service to mentally unstable people? If there is a relationship with you?…
_____
_____
_____
_____

15. Are their services enough? If not what is missing?
_____
_____
_____
_____

8.3 Questionnaire for other service providers

COMMUNITY MENTAL HEALTH PROJECT
BASELINE ASSESSMENT TOOL

Date: _____ Name of interviewer:_____

Name of interviewee:_____ Designation: _____
Location_____

1. What are the current activities you undertake?
_____
_____
_____
_____

2. How many staff do you have in your project and what are there background?

Title	Male	Female	Background

3. Target beneficiaries
_____
Current number of clients of the project

Type of clients problem	Male	Female

4. Specific objectives and expected outputs
_____
_____
_____
_____
_____

5. Do you admit mentally unstable people into your center?

_____

_____

_____

___

6. How do you identify your target groups?

_____
_____
_____
_____

7. What is the common cause of mentally illness for your target group particularly and in general?

_____
_____
_____

8. What kind of apparatus do you suggest to treat mentally unstable people?

_____
_____
_____
_____
_____
_____
_____

9. what is your idea of restraining mentally unstable people? *Chain*

_____
_____
_____
_____

10. What is your point of view of using Drugs (psychotropic) for treatment?

_____
_____
_____

11. Do you have a relationship with psychiatrist doctors or provide assistance a clinic center? What kind of assistance…….

_____
_____
_____

12. What do you think are main issues surrounding issues surrounding mental illness?

_____
_____
_____
_____

13. How/What would you contribute to mental health project

_____
_____
_____

14. What would you recommend in order to improve the status of the mentally unstable people in this country?

_____
_____
_____
_____

15. Have you any recorded data or published? If yes could you plse give us a copy of it?

16. Lessons learned

_____
_____
_____

17 About discrimination on females patients

_____

8.4 Questionnaire for the members of the public

1. Name: _____
2. Organization:_____
3. Designation:_____

Information on Mental Illness:

4. In your opinion who is a mentally ill person?
    a. A person with brain disorder
    b. A person with spirit possession
    c. A person who is dangerous to other people.
    d. A crazy person
    e. Others. Please mention._____
5. What do you think are the causes of mental illness in the society?
    a. Diseases
    b. War trauma
    c. Unemployment
    d. Khat consumption
    e. Witchcraft
    f. Spirits (Jin)
    g. Others. Please mention._____
6. How are mentally ill people treated in our community?
    a. Chained
    b. Beaten
    c. Laughed at
    d. Insulted
    e. Others. Please mention._____
7. Do you think it is right to chain mentally ill people:
    a. Yes
    b. No
8. If yes, why?
    a. To ensure the person doesn't harm oneself

b. To ensure the person doesn't harm others.
c. No other means of keeping the person indoors
d. It is a form of medications
e. Others: Please mention

9. How best should the mentally ill people be treated?
   a. They should be taken for treatment
   b. They should be taken for counselling
   c. They should be
   d. They should be cared for
   e. Others. Please mention._____

10. Is there mentally ill person in your household?
   a. Yes
   b. No

11. If yes, how many?
   a. One
   b. Two
   c. Three
   d. Four
   e. More than four

12. If you had mentally ill person in your family where would take him or her for treatment?
   a. Sheikh center
   b. Mental Hospital
   c. Traditional Healer
   d. Keep him at home
   e. Others: Please mention?_____

13. In your opinion, who do you think has the obligation to support the mentally ill people?
   a. The authorities
   b. The family members
   c. The NGOs
   d. Others: Please mention._____

14. What role is or can your organization play to support the mentally ill people?

9.0 PICTURE GALLERY

10. BIBLIOGRAPHY

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World Health Organization: The World health report: 2001: Mental health: new understanding, new hope. Rangaswamy Srinivasa Murthy (editor-in-chief), José Manoel Bertolote, JoAnne Epping-Jordan, Michelle Funk, Thomson Prentice, Benedetto Saraceno, and Shekhar Saxena. The report wasdirected by a steering committee formed by Susan Holck, Christopher Murray (chair), Rangaswamy Srinivasa Murthy, Thomson Prentice, Benedetto Saraceno, and Derek Yach.