

WHO-AIMS

**WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN
SOMALILAND REGION
OF SOMALIA**



**MINISTRY OF HEALTH
REPUBLIC OF SOMALIA**



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SOMALILAND**

WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN SOMALILAND REGION OF 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)*

Somaliland region of Somalia

2006



**MINISTRY OF HEALTH
REPUBLIC OF SOMALIA**



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SOMALILAND**

*WHO, Country office Somalia
WHO, Regional Office for the Eastern Mediterranean
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This study was carried out by Abdirisak Mohamed Warsame of the General Assistance and Volunteers Organization's (GAVO) Community Mental Health Program located in Hargeisa, Somaliland region of Somalia.

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The World Health Organization Assessment Instrument for Mental health Systems (WHO-AIMS) has been conceptualized and developed by the Mental Health Evidence and Research team (MER) of the Department of Mental Health and Substance Abuse (MSD), World Health Organization (WHO), Geneva, in collaboration with colleagues inside and outside of WHO.

Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website.

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.

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 Somaliland region of Somalia. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring change. This will enable Somaliland region of Somalia, to develop information-based mental health plans with clear baseline information and targets. It 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.

Domain One: Policy and Legislative Framework

A policy and legislative framework for mental health does not exist in Somaliland region of Somalia. However, lobbying initiatives from a local NGO have led to the establishment of a mental health unit in the Ministry of Health and Labour (MOHL), a very limited budget being allocated for mental health in the 2008 budget, and a proposal for a mental health policy.

Domain Two: Mental Health Services

Since the Somaliland region of Somalia government is not yet recognized by the international community, mental health facilities and service provision to those in need are very limited. There are only two mental hospitals (Berbera and Hargeisa hospital) and one community based inpatient unit (Borama). Outpatient services are only available at the two mental hospitals. In addition, there are two mental health units in Mother and Child Care Centres (MHC Centres). The currently available mental health facilities do not use a proper data recording system. Berbera and Hargeisa hospitals are the only two facilities that collect any data whatsoever. This lack of a data recording system has made it impossible to find proper information.

Domain Three: Mental Health in Primary Health Care

In Somaliland region of Somalia, the integration of mental health care into the primary health care system is a desirable goal and seems possible given the relative peace and stability of the region, the establishment of a mental health division in the Ministry of Health and Labour (MOHL), and the advocacy of the General Assistance and Volunteer Organization (GAVO), a local NGO. For example, GAVO with support from MOHL has successfully established two mental health care units in Mother and Child Care Centres (MCH Centres).

Domain Four: Human Resources

In Somaliland region of Somalia, resources remain very limited. There are two psychiatrists, 1 other medical doctor working in mental health, 14 social workers, one psychologist, and 20 other mental health workers in Somaliland region of Somalia.

Domain Five: Public Education and Links with Other Sectors

In Somaliland region of Somalia, there is no strong government mental health units at any level. The Somaliland region of Somalia MOHL has just recently established a mental

health division but it is still quite weak. Local organizations like GAVO and international organizations like WHO are the only groups working on public education.

Domain Six: Monitoring and Research

The fragility of the Somaliland region of Somalia government makes monitoring and research activities virtually non-existent. . The Somaliland region of Somalia, mental health unit is not yet capable of monitoring mental health activities. However, NGOs and multilateral agencies involved in providing mental health support like GAVO (Berbera and Hargeisa mental hospitals) and UNDP (Hargeisa) monitor the scope of their interventions.

Introduction

Introduction

Somalia has been in a state of anarchy for the last 18 years after the collapse of the Mohammed Siad Barre Regime in 1991. It now has an internationally recognized but weak government known as the Transitional Federal Government that is protected by Ethiopian and African Union troops. As a result, it is not surprising that little useful data on mental health is available.

Somalia is divided into three regions - Somalia in the South-Central Zone, Somaliland¹ in the Northwest, and Puntland in the Northeast.

The main language used in all regions is the Somali-language. The main ethnic group is Somali although there are tribal entities; population is 100% Muslim.

Geography

Somalia is located on the east coast of Africa between the Gulf of Aden on the north and Indian Ocean on the east. It forms the region known as the Horn of Africa together with Ethiopia, Eritrea, and Djibouti. It borders Djibouti on the northwest, Ethiopia on the west, and Kenya on the southwest. Somaliland is slightly larger than England with a total area of 637,657 sq km which includes 627,337 sq km of land and 10,320 sq km of water. Somaliland has 460 miles (740 km) of coast with the majority along the Red Sea.

General Statistics

Population

Somaliland has an approximate population of three million.

Literacy Rate

Definition: those aged 15 years old and over who can read and write

Total population: 38.9%

Male: 25.1%

Female: 13.8% (2001 est.)

Life Expectancy: 45 years

The Current Health and Mental Health Structure

In Somaliland overall there are no well functioning health and mental health structures. There is a Ministry of Health and Labour (MOHL) in Somaliland. It has a communicable disease control department within which there is a mental health unit.

There are only two mental hospitals in Somaliland (Berbera and Hargeisa). There is one community-based inpatient unit (Borama). There are privately owned health facilities which have inpatient and outpatient facilities with pharmacies in Somaliland but there are no private mental hospitals or inpatient mental health units.

¹ "Somaliland" represents "Somaliland region of Somalia" all through the document

Somaliland hasn't allocated a budget for mental health yet, but MOHL in Somaliland has pledged that they will budget some money for mental health in 2008.

The government of Somaliland is considering developing a Mental Health Policy.

Data was collected between November and June 2007 and is based on 2005-2006 data.

Domain 1: Policy and Legislative Framework

Policy, plans, and legislation

A mental health policy does not exist and no mental health policies are in development for Somaliland. There are no mental health laws at any level. In addition, no essential medicines list is present in the country. There are no developed plans or components of plans for mental health. No disaster/emergency preparedness plan for mental health is present. There is no current mental health legislation. The Somaliland government is currently considering the formulation of a mental health policy due to the extensive lobbying and advocacy efforts of GAVO.

Financing of mental health services

Most of the current resources for mental health are from either international and local organizations or the community. There is no budget for mental health from the government in Somaliland. The government of Somaliland's only financial contribution to mental health is to pay the salaries of 11 staff members in Berbera Mental Hospital and 12 staff members in Hargeisa Mental Hospital. Staff members include cleaners, watchmen, social workers, etc. No other funding is provided to the hospitals. They do not pay for the other possible expenses of the hospital like maintenance or running costs. Fortunately, the Somaliland government has pledged to add a mental health budget in its health care budget in 2008.

In terms of affordability, it still unclear the exact number of persons who have access to mental health services. All of the population has free access to mental hospitals run by the government and humanitarian associations, but some mental hospitals like Hargeisa charge patients for services. Some people are able to get psychotropic medicines for free, but this can be difficult. We estimate that at least 30% of the population has access to essential psychotropic medicines. For those who have to pay for their medicines out of pocket, the cost of antipsychotic medication is 1500 (Somaliland shilling) equal to 0.25 dollars per day, and the cost of antidepressant medication is 900 Somaliland shilling equal to 0.19 dollars per day. No social insurance schemes exist.

The local community contributes food items, and clothes and provides other support to the two mental hospitals in Somaliland.

Human Rights Policies

A human rights review body does not exist. As a result, hospitals control patients as they wish even though their methods may qualify as abuse. There are no mental hospitals, community-based inpatient psychiatric units or community residential facilities that have at least one review/inspection of human rights protection of patients per year. Currently, there is no legislation before the house of parliament in Somaliland, which would make such reviews mandatory for all mental health facilities. In terms of training, the staff of mental hospitals, community based inpatient psychiatric units, and community residential facilities have not had at least one day of training, meeting, or other type of working session on human rights protection of patients in the year of assessment. Since there is no policy or legislation on mental health that would protect the human rights of mentally ill people, most of the time the human rights of people with mental disorders are violated not only in the other public areas but also in the mental hospitals. These violations include restraining the mentally ill with chains, and isolating them in cells.

Domain 2: Mental Health Services

Organization of Mental Health Services

A Mental Health Department has recently been established in the Ministry of Health of Somaliland, but what it does is very limited and ineffective. It provides advice to the government on mental health policy and legislation. The mental health authority is not involved in service planning, monitoring or quality assessment of mental health services. Mental health services are not organized in terms of catchment/service areas. The two mental hospitals in Somaliland have mental health outpatient facilities organizationally integrated within their structure.

Mental health outpatient facilities

There are two outpatient mental health facilities in the country located in the country's two mental hospitals (Berbera, Hargeisa). Since these hospitals have both inpatient and outpatient sections, they are not dedicated exclusively to outpatient care. These hospitals' outpatient departments give outpatient service to the patients who need to be visited and treated in their homes. Overall, the outpatient facilities do not function properly due to a lack of well trained staff and psychotropic medications. No follow up care is provided and psychosocial care is only provided by GAVO. More specifically, Berbera and Hargeisa mental hospitals refer patients to the two GAVO Community mental health centres (located in Mother and Child Care Centres) for psychosocial support.

It is unknown how many users use the outpatient facilities and there is no data available on the amount of mental health outpatient contacts. It was impossible to obtain information on diagnoses, and the exact amount of women and children users since this data is not collected. We estimate that 25% of users are women. None of these services are exclusively for children and adolescents. Anecdotally, we know of a few children who have epilepsy who receive outpatient treatment.

Medicine in all categories is available, but can be difficult to obtain. Both outpatient facilities have at least some of the important psychotropic medicines of each therapeutic class available in the facility although usually not in adequate amounts. Medications are also available in local pharmacies. The two mental health outpatient facilities have mobile clinic teams that provide regular mental health care outside of the mental health facility.

Mental Health Day Treatment Facilities

Day treatment facilities are not available in Somaliland for adults or children. In Somaliland there is a school called School for Children with Special Needs where mentally handicapped children are cared for during the day. Educational and recreational activities are provided, but there is no medical treatment available. Although this facility is not included in the definition of a "Mental Health Day Treatment Facility" it is important to note.

Community-based Psychiatric Inpatient Units

There is one community-based psychiatric inpatient units available with a total of 10 beds (0.33 beds per 100,000 general population). In addition, 40 patients sleep on the floor on mattresses. It is located in the city of Borama in Somaliland. Very little data is available on these units. The Borama hospital is known to chain people in rooms and charge money.

There are no beds specifically for children and adolescents. Overall, there is no data on children and adolescents. There is also no data on the gender distribution of admissions or on admission of children and adolescents. We estimate that 20% of users are women.

The rate of admissions to these facilities is not available due to lack of proper data but appears to be very low. The diagnoses of admissions to community-based psychiatric inpatient units were also not available. There are no psychosocial interventions in these two units. It is unlikely that community based psychiatry inpatient units have enough psychotropic medication. They mostly buy it from private pharmacies in small quantities. They mainly purchase chlorpromazine and diazepam.

Community Residential Facilities

There are no community residential facilities in Somaliland.

Mental Hospitals

There are two mental hospitals overall providing a total of 90 beds - Berbera Mental Hospital has 40 beds, Hargeisa has 50 beds. In addition, 50 patients sleep on the floor in the Hargeisa mental hospital. Both mental hospitals are organizationally integrated with mental health outpatient facilities. There are no beds in mental hospitals reserved for children and adolescents. It is unknown whether any children and adolescents were treated.

On average, our best estimate is that the average length of admission is 90 days based on data from Hargeisa and Berbera. In Hargeisa and Berbera mental hospitals, 19% of patients spend less than one year, and 5% of patients spend 1-4 years in the hospital.

Regarding the data on admission, the patients admitted to these two mental hospitals belong primarily to the following diagnostic groups - mental and behavioural disorders due to substances (4%), schizophrenia (38%), mood disorders 30%, anxiety disorders (neurotic)11%, and all others 9%. According to data from the Berbera and Hargeisa mental hospitals, 25% of patients are female.

Few patients overall (1-20%) in mental hospitals received one or more psychosocial interventions in the past year. 20%-50% of patients in the Berbera and Hargeisa mental hospitals received psychosocial support from GAVO.

Although all of the hospitals have at least one psychotropic drug of each main category, they always suffer from inadequate amounts of medication which triggers them to use other forms of restraints such as chains. Both mental hospitals have inadequate supplies of anti-psychotic medications, and antidepressants. Some anxiolytics (Diazepam) are available. Very few antiepileptic medications (Pheynoin, Phenobarbitone) are available. No mood stabilizers are available. WHO supplies medications to Berbera and Hargeisa mental hospitals. Unfortunately, these medicines are not available consistently in adequate amounts. For example, suddenly sometimes hospitals are without medications. There are also not enough injectable medications. Presently, psychotropic medications available to the mental hospitals includes Chlorpromazine Injection (no tablets), Haloperidol Injection (no tablets), and Promethazine Injection. The occupancy rate of mental hospitals is 146%.

Forensic and other Residential Facilities

There are no beds for persons with mental disorders in forensic inpatient units or in other residential facilities such as homes for persons with mental retardation, detoxification inpatient facilities, homes for the destitute, etc. Offenders with mental health issues are kept in the central prisons or put in general mental health units.

Human rights and Equity

Most of the users admitted to both mental hospitals and community based psychiatric inpatients units are admitted on an involuntary basis. Carers/relatives usually bring them to the hospitals for treatment/admission against their will. From my observations, I have noted that in the community psychiatry inpatient units 80% of users are restrained and in the mental hospitals a little bit less than 50% of users are restrained.

There is no easy access in the rural areas to facilities. Controlling for population density, there are three times the number of psychiatric beds in the largest city than the rest of the country. Such a distribution limits access to rural users. People from the rural community sometimes come to the urban areas for treatment. Equity of access to mental health services for other minority users including linguistic, ethnic, and religious minorities is not a big

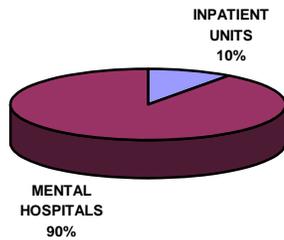
issue. However, the difficulty people with a low socioeconomic status have accessing care is a major issue.

Overall, there is not much data on the access to mental health care services for minority and rural users. Definitely, the rural community does not have easy access to services since all services are located in large cities. Almost everyone speaks the same language so there are few language barriers. Minority groups generally do not seem to have less access to care based on their ethnicity. However, there are other possible forms of discrimination like discrimination based on their economical status within the communities.

Summary Charts

Beds are available in mental hospitals and community based psychiatric inpatient units for the treatment of patients, but is important to remember that these beds are located in prison-like structures and the patients are essentially kept in jail cells and often restrained (Graph 2.1).

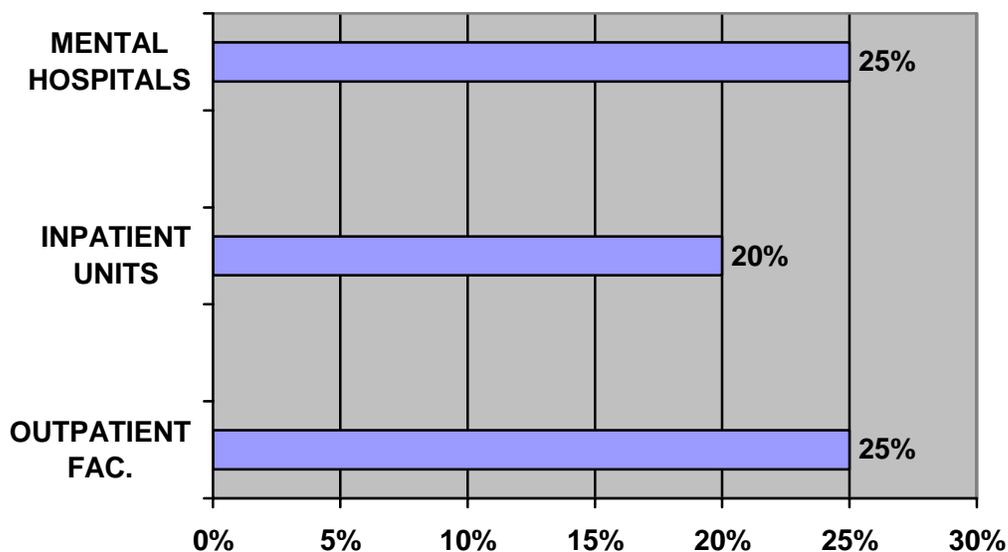
GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES



Summary for Graph 2.2

There are always less female users than male users in mental health facilities in Somaliland which is likely due to Somaliland norms and traditions regarding women. Interestingly, Berbera and Hargeisa mental hospital data shows that 25% of the admitted patients are female.

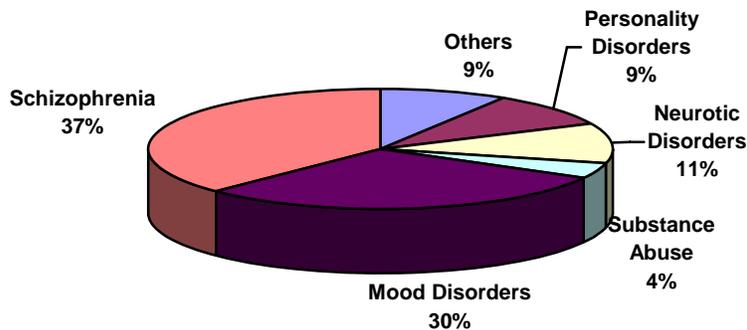
GRAPH 2.2 - PERCENTAGES OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES



Summary for Graph 2.3

Data on diagnoses is very difficult to find. There is no data on diagnoses treated in outpatient facilities or inpatient units. We were only able to obtain information from Berbera and Hargeisa mental hospitals. Their data shows that schizophrenia/psychotic disorders is the most common category of diagnoses treated, while mood disorders (mainly depression) is next and neurotic disease/anxiety disorders are next followed by substance-abuse.

GRAPH 2.3 - PATIENTS TREATED IN MENTAL HOSPITALS BY DIAGNOSIS

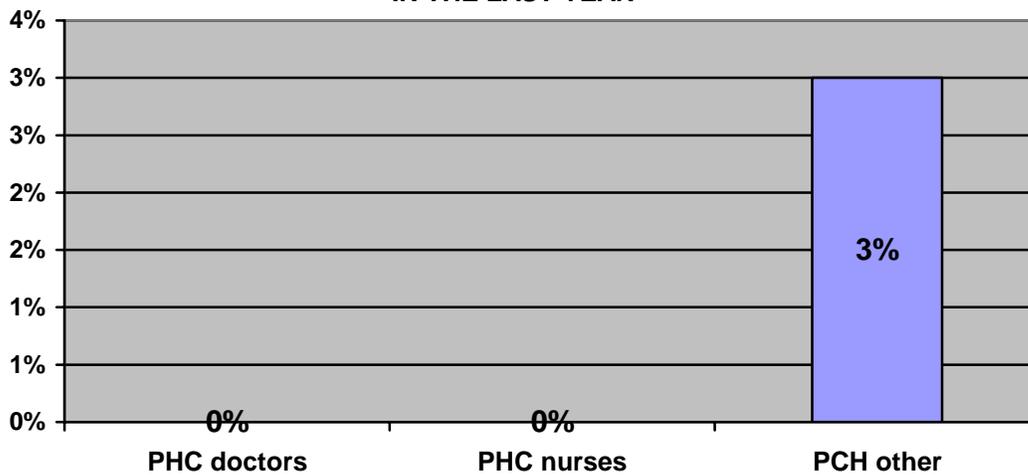


Domain 3: Mental health in primary health care

Training in mental health care for primary care staff

Medical students at Hargeisa and Borama universities received 100 hours total training on mental health (1% of total training hours) and student nurses at Hargeisa Nursing Institute received 348 hours of training total on mental health (8% of total training hours). There are no refresher trainings for the primary health care doctors and nurses in the primary health care clinics or assessment and treatment protocols. However, there are four social workers (non-doctor and non-nurse staff) who received refresher training from GAVO in Berbera and Hargeisa. Specifically, GAVO provided four trainings on mental health to the social workers who have been working in the existing mental health facilities. The proportion of training hours devoted to psychiatry and mental health-related subjects is 3%.

GRAPH 3.1 - % OF PRIMARY CARE PROFESSIONALS WITH AT LEAST 2 DAYS OF REFRESHER TRAINING IN MENTAL HEALTH IN THE LAST YEAR



Mental health in primary health care

Both physician based and non physician based primary health care clinics exist in Somaliland. Physician based clinics are mostly private while non physician based clinics are public. Assessment and treatment protocols are not available at any of these clinics. Very few (1-20%) of the physician based primary health care clinics make referrals to mental health professionals while none of the non-physician based clinics make referrals. In terms of professional interaction between primary health care staff and other care providers, 0% of primary care doctors have interacted with a mental health professional at least once in the past year.

Traditional mental health facilities exist in the local community. These traditional and spiritual mental health centers are run by some of the community members.

No physician based primary health care clinic has interacted with complimentary, alternative, or traditional practitioners at least once in the last year, in comparison to a few (less than 20%) non-physician based primary health care clinics and a few (less than 20%) mental health facilities (Graph 3.2).

Of note, in Somaliland GAVO has recently established two community mental health centers that are attached to the current Mother and Child Care Centres (MCHs).

Prescription in Primary Health Care

In Somaliland there are no regulations restricting who can and who can not prescribe medications. In most facilities, however, doctors and nurses are only allowed to prescribe medications. If another type of health professional prescribes medication and harm results the patient can take him to court. As for availability of psychotropic medicines, 21-50% of physician-based PHC clinics have at least one psychotropic medicine of each therapeutic

category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) in comparison to none of the non-physician-based clinics.

Domain 4: Human resources

Number of human resources in mental health care

Collecting data on human resources was one of the most challenging sections to complete. There is not enough data on community based inpatient units and outpatient facilities. The mental hospital staff includes staff working in both outpatient and inpatient facilities. They cannot be separated because they do both services and not in a separated or delegated way.

In Somaliland, the total number of known human resources is 48 people.

In Somaliland, there are only two psychiatrists. Neither psychiatrist works for government administered mental health facilities. They work in their own private mental health facilities.

There is only one psychologist who works in a privately owned clinic. There are no psychologists in the public mental health facilities.

There is one non-specialized medical doctor who works in the mental hospitals.

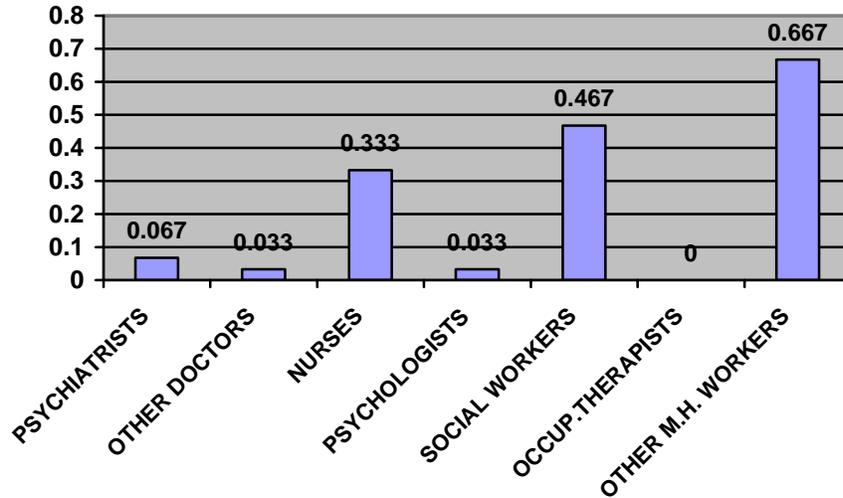
There are 14 social workers who work in the public mental hospitals only. There are no social workers in other mental health facilities.

As for nurses, there are 10 nurses working in the public mental hospitals. There are no occupational therapists in either private or public facilities.

There are 20 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, and other subordinates) who work in the public mental hospitals (including their outpatient facilities).

The distribution of human resources between urban and rural areas is disproportionate. There are no psychiatrists or clinics in the rural areas. The density of nurses is 2.4 greater in the largest city than the entire country.

GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100.000 population)

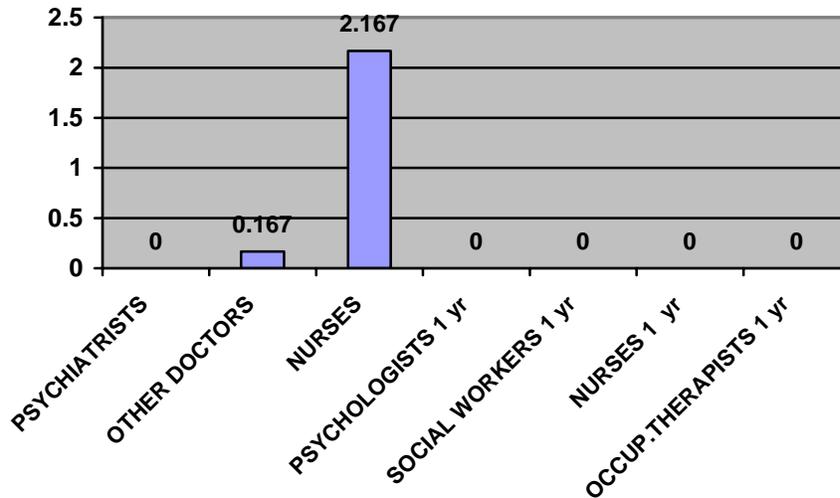


Training professionals in mental health

There were only 5 medical graduates from Amud University in Somaliland none of whom are psychiatrists. 65 nurses graduated from academic institutions in Hargeisa becoming qualified nurses for medical hospitals. No nurses, psychologists, social workers or occupational therapists who have one year training on mental health in last year completed studies. In Somaliland, 1-20% of psychiatrists emigrate to other countries but this was possibly to continue their medical studies. In the last five years, two psychiatrists have left Somaliland.

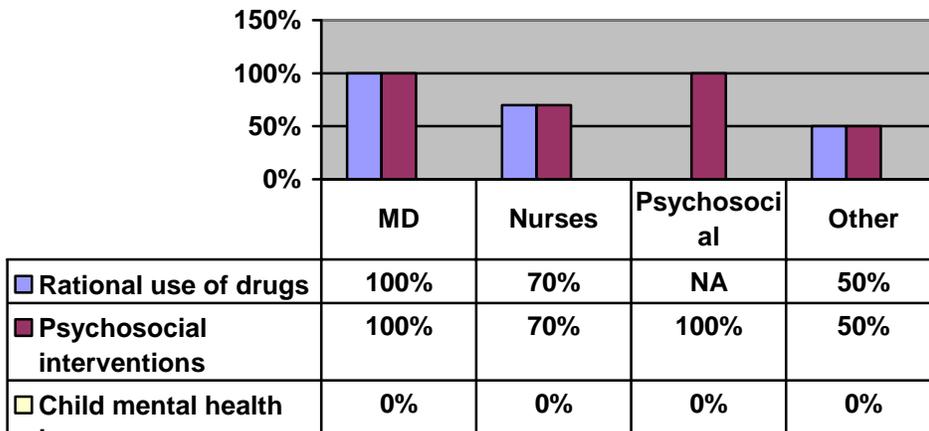
There is at least one medical doctor (who was already working in Berbera mental hospital) and at least 15 social workers who have had a few days of refresher training on the issues of psychosocial intervention and the drugs use.

GRAPH 4.2 - PROFESSIONALS GRADUATED IN MENTAL HEALTH LAST YEAR (rate per 100.000 population)



Graph 4.5 shows the percentage of mental health care staff with at least two days of refresher training in the rational use of drugs, psychosocial interventions, and child/adolescent mental health issues.

GRAPH 4.3 - PERCENTAGE OF MENTAL HEALTH STAFF WITH TWO DAYS OF REFRESHER TRAINING IN THE PAST YEAR



Consumer and family associations

In Somaliland, there are no existing consumer or family associations. The government does not provide economic support for either consumer or family associations. Mental health facilities interact with relatives individually or as a family. They do not interact with any collective groups. However, there are local and international organizations that support mentally ill people in facilities and in the community such as GAVO and WHO.

Domain 5: Public education and links with other sectors

Public education and awareness campaigns on mental health

There is a no coordinating body to oversee public education and awareness campaigns on mental health and mental disorders. In Somaliland, one local NGO (GAVO) and some international organizations including WHO have planned public education and awareness campaigns in the last five years. These campaigns have targeted the following groups: children and adolescents, women, community elders, religious groups, trauma survivors, other vulnerable minority groups, and authorities and other sectors in the community. In addition, there have been public education and awareness campaigns targeting professional groups including teachers, healthcare providers, and politicians. Activities include workshops, consultation meetings and other forms of transmitting information on mental health to the general public like media campaigns on the radio and in newspapers. GAVO, the only local NGO focused on mental health, has been planning activities for the last decade.

Legislative and financial provisions for persons with mental disorders

Legislative and financial provisions to protect and provide support for people with mental disorders do not exist. In Somaliland, it remains to be seen if the mental health department in MOHL will become capable of providing legislative and financial provisions to persons with mental disorders.

Links with other sectors

There are no formal collaborations between the government department responsible for mental health and the departments/agencies responsible for child and adolescent health, education, welfare, and criminal justice.

There are no mental health services for prisoners. The few mentally ill people in prison have no contact with mental health professionals. No data is available on the percentage of prisoners with psychosis or mental retardation. In Somaliland, mentally ill people accused of crimes do not have their mental illness taken into account. Mentally ill prisoners do not receive any special treatment.

In terms of support for child and adolescent health, 0% of primary and secondary schools have both a part-time or full-time mental health professional and 0% of primary and secondary schools have school-based activities to promote mental health and prevent mental disorders.

As for training, no police officers, judges or lawyers have participated in educational activities on mental health in the last five years. In terms of financial support for users, mental health facilities have no access to programs outside the mental health facility that provide outside employment for users with severe mental disorders. Finally, there is no social welfare system.

Domain 6: Monitoring and research

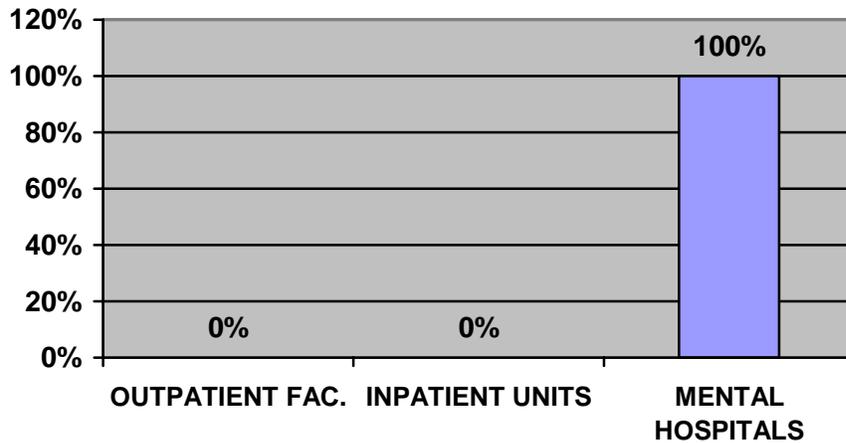
There is no formally defined minimum set of data items to be collected by mental health facilities. As shown in the table 6.1, the extent of data collection is minimal among mental health facilities. The government health department of Somaliland received data from only the two mental hospitals. The data submitted includes the number of beds, admissions, age-groups, and patient diagnoses. However, no reports have been produced with the data transmitted to the government health department. In Somaliland, the recently established mental health department in the Ministry of Health and Labour has little ability to effectively monitor mental health activities. GAVO is trying to support the department to allow for better information collecting.

In terms of research on mental health, only a small baseline study conducted by VIVO (a German organization) on Traumatized Ex-combatants in Somaliland in 2003 and a baseline survey on mental health in 2004 conducted by GAVO have been completed. The research focused on epidemiological areas. There are no health publications that exist in this country.

Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information in Somalia Overall

	MENTAL HOSPITALS	INPATIENT UNITS	OUTPATIENT FAC.
N° of beds	100%	0%	0%
N° inpatient admissions/users treated	100%	0%	0%
N° of days spent/user contacts in outpatient fac.	0%	0%	0%
N° of involuntary admissions	0%	0%	0%
N° of users restrained	0%	0%	0%
Diagnoses	100%	0%	0%

GRAPH 6.1 - PERCENTAGES OF MENTAL HEALTH FACILITIES TRANSMITTING DATA TO HEALTH DEPARTMENT



Strengths and Weaknesses of the Mental Health System in Somaliland region of Somalia

The mental health systems of Somaliland are understandably weak given the instability of this area. However, progress has been made in the last five years showing that positive substantial changes can occur which raises hope that more changes will soon come.

Weaknesses include the lack of mental health policy, little financial support from the government for mental health activities, lack of availability and accessibility to psychotropic drugs, lack of human rights legislation, lack of enough well run facilities overall including inpatient and outpatient units, absence of services specifically for adolescents and children, women's difficulty obtaining services due to social norms, lack of communication between traditional healers and modern health practitioner, absence of services for prisoners, limited education in mental health provided to health practitioners while in training, lack of widespread availability of mental health refresher training for professionals, absence of treatment protocols, lack of integration of mental health within the primary healthcare structure, inadequate human resources at every level including psychiatrists, psychologists, social workers, nurses, and support staff, lack of consumer and family associations, absence of effective data collection and research on mental health services and issues, lack of government promoted educational campaigns, lack of legislation to provide for and protect people with mental disorders, and lack of collaboration between mental health departments and other organizations.

Strengths include the recent creation of a mental health division within the MOHL of Somaliland, the development of a mental health budget within the overall health budget of Somaliland in 2008, GAVO and MOHL's development of mental health units within MHCs, GAVO and other's refresher trainings to mental health staff, GAVO and other's public education campaigns and advocacy work, and research attempts by NGOs.

It is important to remember that the mental health situation in Somaliland is currently better than it was five years ago. In Somaliland, more people are advocating for mental health. In Somaliland, there are new initiatives that should start soon. Overall, there is a demand from Somalis within Somaliland and abroad that mental health services are improved.

Next Steps in Planning Mental Health Action

Dissemination

The following organizations, ministries and institutions should receive a copy of the report when possible.

Somaliland

- Ministry of Health and Labour
- Judiciary institutions
- GAVO
- VIVO/Konstanz University
- NGOs/CBOs involved in mental health
- WHO office
- UNA/GRT

In addition any other international or local institution that is interested in the mental health condition of Somaliland should receive a copy of this report.

Planning workshop

As discussed above, all stakeholders involved in the day-to-day mental health activities of the country should be engaged in planning the next steps. A two days long consultation meeting in Hargeisa would be valuable so that we could discuss, share, and develop action plans together for mental health interventions within the Ministry of Health and Labour.

PARTICIPANTS to be invited

Somaliland

- Ministry of Health and Labour
- Judiciary institutions
- GAVO
- International and UN organizations involved in mental health
- Other service providers if any

The WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Somaliland including the mental health policy and legislative framework, mental health facilities, human resources, links with other sectors, and monitoring and research. The goal of collecting this information was to enable policy makers to develop information-based mental health plans with clear base-line information and targets.

A policy and legislative framework does not exist. However, lobbying initiatives from a local NGO have led to the establishment of a mental health unit in the Ministry of Health and Labour (MOHL), a very limited budget being allocated for mental health in the 2008 budget, and a proposal for a mental health policy.

The network of mental health facilities includes two mental hospitals (Berbera and Hargeisa hospital) and one community based inpatient unit (Borama). Outpatient services are only available at the two mental hospitals. In addition, there are two mental health units in Mother and Child Care Centres (MHC Centres). Provision of mental health care within the primary health care system is very limited.

Human resources are also very limited. There are two psychiatrists, 1 other medical doctor working in mental health, 14 social workers, and one psychologist, and 20 other mental health workers in Somaliland.

Next steps aimed at improving the mental health system in Somaliland include bridging the existing gaps such as, building a network of human resource for mental health, strengthening the capacity of the mental health Unit in the MOH, providing more psychotropic drugs to the existing facilities and establishing a coordination network among key stakeholders to raise public awareness.