Introducing the community psychiatry model in Somaliland

Project Assignment for Medical School

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# Table of contents

Acknowledgment................................................................................................................. 3  
Abstract................................................................................................................................. 4  
  Background and aims ............................................................................................................. 4  
  Methods................................................................................................................................. 4  
  Results................................................................................................................................. 4  
  Conclusion............................................................................................................................ 4  

1 Background ......................................................................................................................... 5  
  1.1 Mental health policy framework and infrastructure..................................................... 6  
  1.3 Human resources .......................................................................................................... 7  
  1.4 Aims and research question ......................................................................................... 8  

2 Methods ............................................................................................................................... 8  

3 Results .................................................................................................................................. 8  
  3.1 Introducing community mental health services............................................................ 8  
  3.2 Two community mental health programs ..................................................................... 9  
  3.3 History and context ....................................................................................................... 9  
  3.4 Orientation of services ................................................................................................. 11  
  3.5 Health workers ............................................................................................................. 12  
  3.6 Pattern of help–seeking ............................................................................................... 13  
  3.7 Funding of the program ............................................................................................... 13  
  3.8 Treatment coverage and outcome .............................................................................. 13  

4 Discussion ........................................................................................................................... 14  
  4.1 Goals achieved ............................................................................................................. 14  
  4.2 Challenges .................................................................................................................... 15  
  4.3 Strength and weakness ............................................................................................... 16  
  4.4 Conclusion .................................................................................................................... 17  

References ............................................................................................................................. 18
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Abstract

**Background and aims**

The purpose of this project is to look at the state of mental health care in Somaliland. I will present and discuss two novel programs that deliver mental health services in Borama and Burao. I have tried to answer two questions; Are these programs suitable models of organizing psychiatric care in Somaliland? What needs to be in place to successfully export these models to other parts of the country?

**Methods**

I utilized a combination of data from interviews with key persons from both programs and relevant literature. I spent 3 weeks in Borama in July 2014 where I visited two general hospitals and a mental health unit and talked with doctors, nurses and female health workers.

**Results**

Mental health care in Somaliland is in its infancy and underdeveloped even in comparison with other low-income countries. A general lack of resources and shortage of health workers trained in psychiatry makes it challenging to provide even basic mental health care for the majority of the population. The traditional hospital based model of delivering mental health services is costly and inefficient in terms of providing good mental health care. The two programs discussed in this paper show that a community based mental health care is a model that can work in a resource poor country like Somaliland if certain minimum conditions are met.

**Conclusion**

Training primary health care workers in psychiatry, integrating mental health care in already existing facilities such as mother and child care centers and utilizing technological innovations such as Skype to reach patients and health workers in remote parts of the country, are some of the conditions that need to be in place to deliver adequate mental health care.
1 Background

Somaliland is a Somali-inhabited territory in the northern part of Somalia with an estimated population of 3.5 million people. Prior to independence Somaliland was a British protectorate, and the country enjoyed a five-day spell as a sovereign country before uniting with the southern part of Somalia in 1960. When the Somali Civil War broke out, Somaliland declared unilateral independence from Somalia and formed the Republic of Somaliland on 18 May 1991 (1).

Somaliland was one of the regions that suffered most in the initial year of the civil war, and by the time of the independence much of the infrastructure, especially in the capital city Hargeisa, had been destroyed. Despite the relative security enjoyed by its inhabitants, having its own currency and a reasonable effective bureaucracy, Somaliland is yet to be recognized as a sovereign state. Somaliland’s health sector was, prior to the war, underfunded and understaffed and much of the health infrastructure that existed was destroyed by the civil war (2). Due to war, poverty, unemployment, and the endemic use of khat, Somaliland has some of the worst health-related indicators in the world. Despite lack of reliable statistics on the prevalence of mental illness in Somaliland, it is estimated that at least one person in every other household has some form of mental illness, a figure that is much higher than WHO estimates of one in every four families as likely to have one member with behavioral or mental disorder in the world (1).

Figure 1. Map of Somaliland
1.1 Mental health policy framework and infrastructure

Up to 2014 no mental health policy or mental health laws existed in Somaliland. In March 2014 the Ministry for Health in collaboration with the GRT (Gruppo per le Relazioni Transculturali), an Italian NGO, started working on a mental health policy document and a strategy for implementing the policy. The document contains positive features such as advocating the passing of a legislation that is in line with international standards. The government has yet to implement the policy and to date, no mental health legislation exists. GRT ended their work prematurely when further funding was cancelled.

A mental health unit within the Ministry of Health has been in place for some years to advise the government’s support for and oversight of the public and private mental health services but it is currently unstaffed (2).

There is no budget allocated specifically to mental health care in Somaliland and the government expenditure is limited to cover the salaries of staff in public institutions. Much of the funding comes from the community, NGOs, or family members. The diaspora contributes via remittances to families but they also raise money needed to build and maintain mental health facilities. A notable assistance is also provided by the medical staff from diaspora. Psychiatrists of Somali origin living in Scandinavia and other western countries travel to Somaliland for some weeks each year to treat patients and train health workers. They also regularly treat patients and advice health care workers via Skype with promising results (1).

1.2 Mental health services

Most Somalis with psychosocial disabilities are not likely to receive any formal treatment and the overwhelming majority is either supported by their families or left to fend for themselves. Mental health services available in Somaliland are mostly institution-based. There are four mental health wards throughout the country, with limited services to offer in terms of treatments and qualified personnel. The two largest wards, one in Hargeisa and the other in Berbera, have 40 beds and 60 beds, respectively. The occupancy rate of both hospitals is 146% (1). Essential psychotropic medications are available in Somaliland for those who can afford them. Medication is provided by international organizations; however, the supply of drugs to these facilities is sometimes erratic and not in adequate amount. These facilities have inadequate and substandard service in common (3).

The few existing community-based mental health services in place are provided by NGOs. Hargeisa Group Hospital, Berbera General Hospital, Borama mental hospital, and Mandhaye Mental Clinic in Burco have outpatient service; the latter has also an outreach program in place. Scarcity of public mental health services and the high prevalence rates of psychosocial conditions have seen a proliferation of private centers throughout Somaliland. There are few, if any, government oversights or regulations of their services. Numerous accounts have reported
serious human rights abuses within these private facilities, such as unlawful use of restraints, medical treatment, seclusion, and even physical abuse (2).

Traditional and religious healers still play a significant role in most Somali communities and in many instances they remain the only option available for those with psychosocial disabilities. There is a widespread belief among Somalis that mental illness are caused by Spirit (jinns). The treatments offered by these healers include readings from the Quran and using specific herbs that are purported to have a healing effect.

There are currently no forensic facilities in Somaliland and it is reasonable to suspect that many inmates in prisons across the country suffer from mental illness. When families are no longer able to carry much of the burden that follows having a sick member at home, some resort to desperate measures and confine their relatives in prisons even when they have not committed any crime. Collaboration between health workers and personnel in a prison in Borama has shown promising results. Medical doctors visit on a regular basis the prison and educate the guards on how to identify those inmates with psychosocial disabilities who then receive treatment on a regular basis (4).

1.3 Human resources

It is challenging to give an estimate of the total personnel working in mental health facilities. A number much used is that there are only two psychiatric doctors, no trained psychiatric nurses or psychologists working in Somaliland. In most facilities the majority of the staff function more as guards, and doctors are available only few hours each day. Understaffing and lack of qualified personnel is a serious problem that makes it difficult to give adequate care to the huge number of mentally sick patients. The few health care workers that chose to work in this field experience much stigma and skepticism from the community at large. Stigma, lack of financial incentives, and few opportunities to advance professionally deter new health workers from entering this field (2).

There has been some training for medical staff and social workers provided by WHO and NGO`s but this has been sporadic and dependent on donor funding. Despite the dire situation, there are a few encouraging developments made in recent years. In collaboration with King`s College London Global Health Center medical student from Amoud University and Hargeisa University have received training in psychiatry since 2007. Students that are particular interested in the field are given further training and they teach and provide mental health services in the community (5).
1.4 Aims and research question

The purpose of this project is to look at the state of mental health care in Somaliland. I will present and discuss two novel programs that deliver mental health services in Borama and Burao. I have tried to answer two questions; Are these programs suitable models of organizing psychiatric care in Somaliland? What needs to be in place to successfully export these models to other parts of the country?

2 Methods

Data was collected from various sources such as site visits in Borama, materials from Mandhaye’s’ website, documents, scientific article on community psychiatry in low-income countries and from interviewing key mental health personnel. I spent 3 weeks in Borama in July 2014 where I visited two general hospitals and a mental health unit and talked with doctors, nurses and female health workers. The greatest part of data was obtained through interviews and email – correspondence with three psychiatrists that are involved in the two community mental health programs that are the focus of this study. All interview subjects were presented with questionnaires with a set of narrative topics. I had a total of two telephone interviews and one personal interview with Dr. Jama Elmi and numerous email-correspondences with Dr. Yakoub Aden and Dr. Fatuma Ali. Following information gathering and cross-checking of references, the material was arranged into following topics: history and context, orientation of services, health workers, pattern of help-seeking, funding of the program and treatment coverage and outcome.

3 Results

3.1 Introducing community mental health services

For the greater part of the history of psychiatric care, patients have received treatment in a hospital – based setting and outside of their community. Psychiatric institutions have been, and still remain in many countries, places of widespread human rights abuses towards patients (6). Among some of these abuses are arbitrary and uncritical use of seclusion, restraints and involuntary treatment. Lack of resources, trained personnel, and implementation of legal standards makes it difficult to address these challenges (2).

Advances in available treatments, growth of human rights advocacy groups, and associated changing public perceptions on mental disorders brought much need reforms in service – delivery in high-income countries in the last half-century. These countries closed institutions in great numbers and services were shifted from traditional institution-based mental health care to community care. Similar reforms are now taking place in low-income countries and they are
backed by an increasing amount of evidence suggesting that mental health care services delivered in a community setting is clinically effective and less costly than institution-based care (6). There are many different ways of organizing community mental health services, and the models chosen must be based on local needs and existing health infrastructure. What most community mental health programs have in common is responsibility to a geographically defined population, treatment close to patients` homes, working in a multidisciplinary team, continuity of care and involvement of patients and their family (7).

Many poor countries such as Somaliland have few resources available to care for the huge numbers of people with severe mental health problems. Given the low level of resources, one option to reduce the treatment gap for mental health problems is to provide most or all of the mental health care in primary health care settings. In this model there are few specialists available to support primary health care workers with training, consultation for complex cases, and in patient assessment and treatments that cannot be managed in primary care setting (8).

The two programs discussed in this study represent the first attempts of introducing community mental health care in Somaliland. Both programs have the stated goal of shifting services from traditional institution-based psychiatric care to community care, but with some differences in organization. The program in Burao combine inpatient/outpatient services with community outreach program, while the program in Borama conduct outreach services and rely on female health workers to deliver mental health care at the doorstep of their patients.

3.2 Two community mental health programs

Two programs with the aim of delivering effective treatment within a community setting have been in place in Burao and Borama for a few years. Psychiatrists based in Scandinavia brought back to their native country a model of organizing mental health care that didn’t exist in Somaliland at the time. Their stated objective, besides training health workers, has been to replace hospital based psychiatric care with a model where patients are treated in their community. Fewer beds, shorter stay in inpatient wards, and cooperation with families and the community in the care of the mentally ill is the chosen model for the Mandhaye mental health center in Burao. The program in Borama engages a team of female health workers who also work in the field of mother and child care to deliver mental health service. They are backed up by a doctor and cooperation with the mental health unit in the general hospital in Borama.

3.3 History and context

Mandhaye Mental Health Center is located in Burao, a city with around 288 000 inhabitants. Prior to 2008 no psychiatric health care services were available in this part of Somaliland and people with mental health problems had few, if any, place to go to receive treatment. The sick would often be chained home by their family, or sent to traditional healers, or to the run-down state psychiatric hospital in Berbera. Many were abandoned by their community and lived
desperate lives as homeless. As a response to these challenges, an outpatient unit was established in 2008 by the joint effort of local health workers and Somali doctors based in Europe. In 2011 an inpatient unit was established with funding from Somali NGO (TAF, Togdher Abroad Foundation) based in UK. They also pledged to cover salary for the next two years. The community of Burao has also supported the project (9).

A Danish - Somali psychiatrist, Dr. Fatuma Ali established in Denmark the NGO Mental health in Somalia (MHIS) in 2009 with the aim of establishing psychiatric services in Burao. The program’s objective is training health workers in modern mental health care, establishing Burao as a center for community psychiatry and, in the long run, export the work done in Burao to other parts of the country. Dr. Fatuma and colleagues from Denmark have, since 2009, travelled to Burao each year to treat patients and train local health workers (9).

Dr. Fatuma has stayed in Burco for long periods of time in recent years where she, besides treating patients, also gave weekly theoretical courses in psychiatry and supervised the staff’s work with patients. Two other psychiatrists of Somali-origin, Dr. Jama Elmi from Norway and Dr. Yacoub from Sweden, joined the work in Burao and have, since the establishment of Mandhaye been engaged in weekly telepsychiatry sessions with patients receiving mental health services in Mandhaye. In 2013 the Ministry of Health recognized the work done by Mandhaye, by covering some of the salary for the staff. Mandhaye was also given the status as a ward in the general hospital of Burao (9).

Due to unfortunate circumstances of political nature, MHIS permanently ended all their activities in Mandhaye but the work still continues.

Borama is the capitol and largest city of the northwestern region Awdal in Somaliland with an estimated population of around 215 000 people. Prior to 2011 no public mental health service existed in Borama and in the region at large. The situation in Borama was not different from that in Burco, most patients with psychosocial disorders were treated by traditional healers, chained in their homes or left to fend for themselves in the streets as homeless. In 2011 a mental health clinic was added to the general hospital with support from the diaspora and Amoud University, and some outreach service was started in prison and schools.

One interesting program started in 2013 as a pilot project in one community in the city of Borama and has now been expanded to the rest of Borama and a few surrounding cities. The program is led by Dr. Yakoub A. Aden, a Somali psychiatrist, in collaboration with Amoud University in Borama, SIDA (the Swedish state development agency) and, diaspora. The program was established, according to Dr. Yakoub, to tackle the devastating impact mental illness is having on families and the community at large. Another stated vision expressed is to provide chain- free community- based mental health services, reduce stigma, and provide patients proper diagnosis and care. The program is integrated with the child and maternal health centers that are found across city.
3.4 Orientation of services

The city of Burao has one state-owned general hospital mainly founded by donors. The extent of services provided by the hospital largely depends on availability of funding and donor interest. Whenever donors withdraw their financial support the hospital functions poorly and the government will normally have no means to cover the outstanding amount needed to provide adequate services. Mandhaye collaborates with the hospital on a regular basis. In addition, there are numerous private clinics that provide health services for those who can afford it.

Mandhaye and its team of health workers are primarily based in a center that offers inpatient and outpatient services, and at least once a week, they visit nearby communities to identify new patients and follow up those who cannot make it to the center. The inpatient part of the clinic has 15 beds, 5 for women and 10 for men. All patients admitted get a single room during their stay in Mandhaye, and the center emphasize that the duration of the stay should be as short as possible, preferably 2–3 weeks. When a patient is admitted, his or her family is required to sign a contract where they commit themselves to follow up the treatment of their sick family members. Families agree to follow the policy of chain-free care, and each Friday patients at the center get a 12-hour-pass to visit their family. This is done to ensure that patients continue to be a part of the community. A major challenge for the state psychiatric hospitals has been the huge numbers of patients that have been abandoned by their families and ended up spending years in psychiatric wards (2). Family members are encouraged to stay in the center while the patient is receiving treatment. Family and patients report that this reduces the anxiety that follows from being admitted in an inpatient unit (10).

When a patient is admitted to the Mandhaye they meet the doctor and get diagnosed, and, for the majority of the patients this is their first encounter with modern psychiatric care. Besides the health workers based in Burao two doctors of Somali origin living in Scandinavia, Dr. Yacoub Aden Abdi and Yusuf Elmi have since March 2011 treated a large number of patients in Burao via Skype consultations. They have conducted weekly sessions where they see new patients and follow up with patients recently discharged from the inpatient ward. Their service has also been valuable for the community health workers since they now get regular specialist backup and supervision.

The program in Borama started by recruiting and training ten female community health workers (FCHW), a head nurse and a medical doctor practicing psychiatry. Health workers recruited conduct outreach activity where they, besides their work in child and maternal care, identify, treat, refer, and follow up individuals with psychosocial challenges. They educate patients, their family, and the community at large on mental disorders and encourage them to seek help. The service is community based, which means patients are supported at their homes. Patients too sick to be treated home are admitted to the mental health clinic in Borama, and as soon as the patient is stabilized all follow-up happens at their home. FCHWs work ambulatory in their designated communities but receive training and assistance from doctors working in the mental health unit (11).
The majority of those employed in the program today are female, and a guiding principle in their work has been to empower poor communities and particularly women. Women, being often hardest hit by poverty and marginalization in this region, have found in the program the tool needed to voice their claims on health related rights. The female workers have put in place a committee which advocates the interest and rights of women and children in the community. By actively recruiting local female workers the program has the major benefit of having firsthand knowledge about the needs and changing circumstances in the community.

The program’s arsenal of interventions includes counseling and pharmacological treatment, but also psychoeducation. There is access to a regular supply of basic psychotropic medications of older and newer generations such as TCA (Amitriptylin), SSRI (Zoloft), anticonvulsants (Orfirim, Tegretol), and antipsychotics (Haloperidol, Chlorpromazine, Zyprexa, Risperdal). All medications are free of charge while patients are hospitalized and after discharge. Services are also geared toward the family and a psychoeducation program is in place. The family learns more about the patient’s condition, its causes, and its treatment and they are discouraged from resuming chaining the patients once discharged. Follow up of patients’ takes place in the outpatient part of center or where the patients live and family members are expected to follow appointments and medication.

3.5 Health workers

Mandhaye center employs 12 nurses and auxiliary nurses and one doctor working full time. The personnel have been trained by psychiatrists from Scandinavia who travel a few times each year to Burao. Dr. Fatuma personally trained the majority of the workers during her extensive stays in Burao. They also receive training and guidance via Skype weekly and their training in psychiatry is unmatched by other health workers across the city. All staff alternate in working in the center and ambulatory in the community. For the time being there is no psychiatrist employed in the center but there are plans to recruit one from Syria.

Currently the program in Borama employs around 48 individuals work in the program; 1 project manager (Master in public health), 2 doctors, 5 nurses and 48 FCHWs (grade eighth level education). All FCHWs get, according to Dr. Yakoub, intensive courses of 3 months duration in psychiatry and in mother and child health. The focus of the training is put on how to identify serious mental disorders and provide basic mental health aid. Once every month, workers operating in distant communities travel to Borama to get refresher training. The recruitment of workers is managed by a committee appointed by the Amoud University and the process of recruitment is described as rigorous. Education, experience, and motivation are basic selection criteria for the higher staff and they need to pass -both oral and written examination.
3.6 Pattern of help-seeking

Traditionally, most families in Somaliland bring their sick family members to so-called Elaj, religious healers with special knowledge of treating people with mental illness. Elajs claim that mental illnesses are the result of “evil eye” or possession by Jinns or evil spirits. They offer different treatment regimen such as reading out loud Koranic verses to the patients, to more radical approaches such as subjecting the patient to electric current. The Elaj will normally charge the family a substantial amount of money for the treatment. Mandhaye outreach program and the female health workers in Borama have through interaction with the community managed to change the help-seeking pattern. Families that know about the services will normally make contact to receive medical treatment for their sick relative. Patients are now travelling great distance, some all the way from Mogadishu to find help. Some patients are also identified by the ambulatory team and offered treatment at home or, if necessary brought to the inpatient ward. Many of these patients have been sick for many years and kept in chain by their families. The practice of chaining is typically done out of desperation and to protect both the community and the mentally ill person from harm.

3.7 Funding of the program

The services provided by Mandhaye are funded for the most part by the Somali diaspora community from Norway. Money raised by the diaspora is used to cover the lion share of the salary and daily expenditure such as food, clothing and medications. Businesses across the city also donate to the center. The government of Somaliland covers some of the salary of the health workers in Mandhaye. The service provided by the doctors from Scandinavia is largely unpaid and all expenses are covered from their pocket. Securing stable funding is a great challenge for the center and as long as the government of Somaliland is struggling with poor finances the only source of funding is the diaspora community. For the time being, charging for services has not been in the agenda, and it would undermine the intention of delivering a much needed service to those who need it mostly.

The program in Borama currently receives funding from SIDA through another agency, an NGO called Forumsyd and grants are available until 2017 with a possibility of renewal. The doctors and other higher staff members receive some but not full salary from the program, but they have other sources of income from government and their private practices.

3.8 Treatment coverage and outcome

Mandhaye has statistics from 2008 to 2015 on numbers of people the center has treated. Data on 2015 are in place that also includes diagnoses. The Skype service in the center was started in September 2010 and, up to March 2011, a total of 132 patients received consultation (1). The services are still running and the two psychiatrists involved in this project estimate that they talk to more than a dozen patients each Sunday. No information on how many people with
psychosocial problems that potentially could benefit from the program is currently in place. The program has, for the time being, not evaluated the outcome of the treatment provided. Prior to the establishment of the program in Borama no systematic patient data was collected in the mental health unit. Dr. Yakoub is working to put in place a system of information gathering and he is currently working on the annual report for 2015. His preliminary estimate is that the program has given treatment to many hundreds of patients.

4 Discussion

The programs presented illustrate two ways of organizing community psychiatry based on local needs and existing health infrastructure. Both programs have the stated goal of shifting services from traditional institution-based psychiatric care to community care, and they adhere to the core principles of community psychiatry as defined earlier. In many ways these programs are closer to the community than the community psychiatry models that exist in western countries. The FCHWs in the program in Borama meet and have close interaction with the family at their home environment. The health workers live in the same neighborhood as their patients and can be easily approached by the families in case of need.

4.1 Goals achieved

The two novel programs discussed above clearly fill a void in the area of mental health care in Somaliland. Their presence has made a noticeable impact in their catchment area and beyond. By engaging directly with the public and community leaders, health workers have managed to gain trust and support for their work. It will take time to change deep-rooted belief and prejudices against people with mental illness, but these programs seems to be the best available tools to bring real improvements since no systematic campaigns from the government side to raise awareness of mental illness and against stigma exist. Health workers’ perception of mental illness and their willingness to consider a career in psychiatry is also changing. Doctors and nurses across the region are getting interested in psychiatry, a branch of medicine which has been disliked by most health professionals. The program in Borama is especially attractive for many young health workers and several are working voluntarily. In the last years, all doctors and nurses graduating from Amoud University have been through basic psychiatry training, and psychiatry is one of the core subjects in the final examination. The community mental health program in Borama has now strong links with the university and the public health system. Borama harbors one of the best institutions for higher education in Somalia, with many health workers graduating from the university each year. Graduates from Amoud University’s school of health are practicing across the region and many have in recent years been exposed to psychiatry through the community mental health program. The school of health has for some years cooperated with Kings College London in the area of mental health. Psychiatrists affiliated with the college have travelled to Borama on regular basis and have contributed by putting in place a curriculum in psychiatry for health students. They have introduced an examination in psychiatry
for medical and nurse students and also mentor students with special interest in field. Students receive clinical training and experience in psychiatry in both programs, and they are potentially future recruits in the field of mental health care (5).

Both programs have been in place only for few years but have already been making small but noticeable changes. Health workers are reaching the public through workshops and psychiatrists engaged in the programs are spreading knowledge on mental illness through media. A growing number of people are now aware of the services provided and seek professional help. A great part of the patients now in treatment are women as opposed to earlier when most patients in contact with mental health services were men. Local and national politicians are noticing and acknowledging the work done both in Borama and Burao. In December 2015 the project team in Borama held a workshop where higher officials from the Ministry of health, local health officials, and other major stakeholders in the region participated. One of the main parts of the agenda in that meeting was how to ensure the sustainability of the program and a committee was elected to work on integrating the project into the public health system before foreign funding dries up.

Psychiatrists’ who work on both projects agree that community-psychiatry is the model of choice for a resource poor country such as Somaliland. A traditional community-based mental health care model is workable with few modifications, such as recognizing the role family and religion play in Somali culture. Respecting the patient and his family need for spirituality and religious counselling is important and one has to accommodate these needs. One way of doing this is to engage in dialog with those offering faith-based treatment and put in place a division of labour where religious healers learn to identify and refer patients that present with symptoms that are beyond their area of expertise.

4.2 Challenges

There are many positive developments made in mental health care and both programs have contributed a great deal in delivering services where none existed before. The health workers have raised awareness of problems to the ministerial and community level, addressed the widespread practice of chaining patients, provided students with basic psychiatry training, include families in the treatment process by educating them on mental illness and potentially inspiring health professional in diaspora to get involved in the work started. But there are still many challenges that need to be addressed such as the chronic poverty, endemic use of khat, lack of basic patients’ rights, and stigma towards psychiatric patients that still dominate the health system. One major hindrance is the general lack of mental health specialists in the country. The psychiatrists involved in both programs are senior consultants working full time in their respective countries and they can only contribute part time. Developing the current services and expanding to other regions will require more specialists. A solution to this challenge could be to cooperate with neighboring countries and sending dedicated students to receive their specialist training abroad. Training health workers is challenging, but holding on to them is another
potential problem. In Mandhaye there is a problem with staff turnover and retaining health workers after training them since many chose to leave and start their own private practice. One commonly voiced concern in both projects is the widespread tendency among doctors to be engaged in many other sidetrack activities. This lack of commitment and focus on one job can be explained in many ways. Greed and the prospect of making huge salaries could be one reason. Another plausible explanation could be the fact that many doctors are often the sole breadwinners and many family members depend on them.

Mandhaye has been collecting patient data since the start of the program and there are available statistics on diagnoses and number of patients treated. No such data is publically available for the program in Borama, and for both programs there is no information on what treatment patients are getting, the length of their treatment, the outcome of the treatment or patients’ satisfaction with the services. Dr. Yacoub, the psychiatrist working on the program in Borama, highlights specific the shortage of staff with experience in developing and running projects. Finding personnel with basic knowledge in gathering and analyzing patient data is challenging, and bulk of the work is often done by him, and for the time being, lack of proper data makes it difficult to evaluate just how effective the services are.

The most challenging threat to both programs is sustainability and continuity. Keeping the work from collapsing due to lack of funding is a major concern and there are few if any other sources of funding if the current one dries up. The majority of patients suffering from mental health problems are from very poor families who lack money to buy medicine for their loved one. Securing enough supply of medicine is a daily struggle and few patients would afford to buy medicines should the supply fall short. Both projects are highly vulnerable to local and external changes. Despite of the relative security in this part of the country, circumstances can easily change. Dr. Fatuma, who has done a great job in Mandhaye, was forced to withdraw from the project after falling victim to unlawful treatment by the government of Somaliland. The government apologized for their conduct but the arbitrariness of the legal system forced her to leave the country. The few non-Somali health workers offering their services face tight security measures during their stay and the security situation, while being far better than in southern part of the Somalia, has a profound psychological impact. Foreign donors can withdraw their support, funding from diaspora community can be diverted to other equally important projects and the government can shut down the projects for any reason. Finally both programs can easily collapse if for some reason the psychiatrists leading the program step down from work.

4.3 Strength and weakness

The methodology that was the basis for this study has several strengths and limitations. A major strength is that I had access to key persons involved in both programs and they could provide detailed information. My trip to, (and some knowledge of Borama) made it easier to compare the state of mental health care before and after the introduction of the community mental health program. Major limitation is the lack of written data such as patients’ records or other
documents, which makes it challenging to evaluate the effectiveness of the programs. All available data on the program in Burao is based on interviews made with few informants and no site visits was conducted in Burao. The process of verifying information by cross-checking with various sources was less than ideal with access to only a few interview objects and minimal of data.

4.4 Conclusion

How are the possibilities of starting similar programs in other parts of the country? We can identify certain elements that have made it easier to establish these programs in Borama and Burao. The infrastructure in Burao and especially Borama is particularly favorable compared to other regions. In both cities there are functioning mental health centers with inpatient and outpatient services, some supply of medicine, and a supporting local community. Another important factor in place is the involvement of three senior psychiatrists from the diaspora community treating, training and supervising the staff. They travel on a regular basis to the region and do follow up work via Skype when they return back to their respective countries. Despite the favorable conditions in Borama and Burao, all those involved in both programs are convinced that the work done in these two cities can be exported to other parts of the country. This can be achieved by combining elements from both programs and by using resources that are already in place in many cities and villages across Somaliland, such as mother and child clinics. Much can be achieved by training primary health workers in these clinics in basic mental health care and equip them with connection Skype. This form of organization could be the most cost efficient way of providing mental health care since it requires few specialists. The specialists available could be based in the few mental health units with emergency function where patients that need acute care are referred to. Besides treating patients, the psychiatrists will supervise and assist health workers via Skype. By investing in laptops and Internet connection, most of the teaching, supervising, and even treatment of complicated cases can be conducted via Skype. This is already in place in Burao and there are plans to extend this to other cities and villages across Somaliland. Nevertheless, more research is needed to evaluate the effectiveness of the two programs introduced.


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