Project report – Assessment of the Mental Health Ward, Hargeisa Group Hospital in Somalia using the WHO QualityRights Tool Kit

INTERNATIONAL DIPLOMA IN MENTAL HEALTH LAW AND HUMAN RIGHTS

PROJECT

‘Best practice of Minimum Standards & Service Delivery Manual’ with reference to United Nations-Convention of Rights for People with Disability’ (UN-CRPD)

Academic Year 2011-2012

By Julie Currie
Introduction
Somalia has experienced war and environmental issues for the last four decades. Mental Health and/or Illness is disregarded as an unmentionable disease with the sufferers being treated as if they are no better than an animal, chained and locked away so that no-one may see them. There are Mental Health Facilities which have been used as a dumping ground for anyone that the community may see as undesirable.

Recently documented in the European Union, Essential Package of Health Services, Somaliland (2009) is that ‘Mental Health’ should be streamlined across all levels of the Health System. This is a desired aim, but currently there is not the financial and/or technical capacity to perform this goal. This requires input from all agencies to develop and champion the mainstreaming of mental health care.

My Project focuses on the Mental Health Ward, of Hargeisa Group Hospital where I am presently working as the Gruppo per le Relazioni Transculturali (GRT) Mental Health Project Manager, Mental Health Program, in Somalia. This ward was opened in 1971 by the then President of Somalia Mohamed Siyad Bare. It contains 62 beds, both male and female, large grounds that surround both sides with an administration building separating the wards. The care is present to some degree but the quality is non-existent, and along with chaining being used as the method used to restrain the patients.

Furthermore the inpatients are locked away in cell like rooms with no access to sunlight. No, regular hygiene practices transpire as well as no bed linen or mattresses are provided. Human rights violations of a person with a disability occur every day as evidenced by the staffs’ demonstration of complacency in his/her actions.

As detailed in the article written by Drew & Funk et al (2011) stigma and discrimination lead to pervasive human rights violation against people with mental and psychosocial disabilities in low-income countries and human rights violations span basic civil, cultural, economic, political and social rights. Of the key messages identified within this article, the two major concerns in the healthcare context that are pertinent to my project are that users of the service experience difficulty accessing the facility and if ones succeeds here then the user experiences ill treatment and abuse by the workers and/or other users.

Based on my findings upon completion of the assessment my International Law Society (ILS) Project for 2011-2012 will institute minimum standards within the Mental Health Ward of Hargeisa Group Hospital by developing a ‘Best practice of Minimum Standards & Service Delivery Manual’ with reference to United Nations-Convention on the Rights of Persons with Disabilities’ (UN-CRPD). The methodology used will be the ‘WHO Quality Rights Toolkit’ which will provide the foundation for the Manual. It is important to mention here that Somalia has not signed the UN-CRPD.
Moreover an important factor identified is to include all stakeholders working in mental health especially the Ministry of Health (MoH) to contribute to the development of this manual thus the implementation process will be achievable and sustainability will be foreseen in the future.

Aims and Objectives:

Mental illness is generally denied and discriminated against by Somalis. What’s more considering hospitalization because of mental illness is highly stigmatized in the Somali culture. Usually it is not until someone becomes ill and, for example, is struck by a psychosis and cannot take care of him/herself that psychiatric or biomedical health care is considered. Moreover there exists a certain mistrust of the biomedical health sector (Mc Crone et al. 2005).

Another common belief held by Somalis is that when people suffer from mental health problems, they are occasionally said to be possessed by a spirit known as jinn (“jinn” is plural and “jinni” is singular). A thirty-year old woman explained: “It mainly affects women and often those who are mentally weak, vulnerable and exposed to something. It may be that they are depressed and have problems.” People who lack relatives are said to be especially vulnerable. If someone wants to be alone, isolates him/herself, is quiet, irritable, or speaks incoherently, possession by jinn may be suspected (Whittaker et al. 2005).

Hence the aim of my Project is to identify bad practices and human rights violations then bring about change in the standard of service delivery and care provided within the Mental Health Ward, Hargeisa Group Hospital by using the CRPD as the benchmark. Followed by the collection of this data a clear understanding of the situation will be imminent. Subsequently this assists the GRT Project Manager in her task to achieve the goal of establishing a ‘Center of Excellency’ coupled with providing direction for the development of the ‘Best Practice of Minimum Standards & Service Delivery Manual’ with reference to the UN-CRPD.

This Manual is endorsed by the Ministry of Health (MoH), prepared in collaboration with World Health Organization (WHO) Nairobi Office and will be circulated throughout both Public and Private Mental Health Facilities.

Additionally this Project embraces a Holistic Approach ensuring that the findings are descriptive and comprehensive. What is more ‘Human Rights’ set the standards by being at the forefront thus any violations of these rights will be outstanding. Likewise, this project indicates how those persons with a mental health disability have been treated whilst being an inpatient of this facility as well as indicating the kind of care received.

After establishing the findings the way forward presents itself in the form of a sound basis for direction thus assisting GRT the implementing agency who is working on this ward for the next two years. What is more this assessment examines ideas and experiences of mental health problems among Somalis living with a Mental Health Disability.
Finally, it explores issues from a humanitarian perspective by emphasizing people’s own words and experiences about illness, healing and well-being. In doing so, the report added to the knowledge about Somalis in the Hargeisa Group Hospital Mental Health Ward whilst dealing and responding to a mental illness.

Objectives of this Project are four fold

- To assemble a team from the Mental Health Stakeholders in order to perform an assessment using WHO Quality Rights Assessment Tool Kit’ (Funk & Drew, 2011) on the Hargeisa Group Hospital
- To evaluate the Standard of Service Delivery and Care provided within the Mental Health Ward, Hargeisa Group Hospital
- To develop a manual which will be endorsed by the MoH, prepared and published in collaboration with World Health Organization (WHO) Nairobi Office then circulated throughout both Public and Private Mental Health Facilities in Somalia by the end of 2012. Its indicators which are derived from the ‘Quality Rights Toolkit’ will serve as the tool used for direction and improvement of quality rights.
- A foreseen objective to be forthcoming by the completion of the 2 year GRT Project (2013) a ‘Centre of Excellency’ in Mental Health for Somaliland will be observed as indicated in the “Best Practice & Minimum Standards Manual’ created for this Project.

Methodology

In the beginning, I obtained written permission from the Director General Mr. Abdi Ahmed Nour, Ministry of Health in order to perform an assessment while using the ‘WHO Quality Rights Toolkit’ on Hargeisa Group Hospital- Mental Health Ward subsequently followed by disseminating the findings to WHO Geneva Office in the form of a report. At this precise time I liaised and gathered with the most prevalent stakeholders in order to form our team who will perform the assessment.

An inception phase was carried out during the month January 2012, in order to introduce to all stakeholders to the ‘WHO Quality Rights Assessment Tool Kit’ (Funk & Drew, 2011). This toolkit presented the guidelines needed to assess together with providing the direction for the improvement in Human Rights and Standards in Mental Health Ward. In addition, the ‘WHO Toolkit’ formed the source by providing the tools needed for the data collection and the development of the Manual.

Besides, below are featured the areas of focus in the form of ‘Themes’ reflecting the articles within the CRPD along with providing the basis for change and the indicators used in the ‘Best Practice Service Delivery Manual’.

Theme 1: The right to an adequate standard of living (Article 28 of the CRPD)

Theme 2: The right to the enjoyment of the highest attainable standard of physical and mental health (Article 25 of the CRPD)
Theme 3: The right to exercise legal capacity and to personal liberty and the security of person (Articles 12 and 14 of the CRPD)

Theme 4: Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse (Article 15 and Article 16 of the CRPD)

Theme 5: The right to live independently and be included in the community (Article 19 of the CRPD)

As well, the CRPD provides a clear understanding of the rights to be addressed for those people suffering with a Mental Health Disability by providing the foundation and stepping stone for my work.

We started to collect the data in February and it was difficult encouraging all stakeholders to participate in the meetings at the same time. Once all were together the toolkit was distributed and discussed. Many questions and clarifications were addressed followed by a tour of the facility.

Staffs were receptive and helpful although at the beginning of GRT’s Project the staffs were hostile and aggressive. I believe being present on the ward for a few months prior to this assessment assisted this process by easing the aggression and creating a reception to change. Also the users that were on the ward at the time were cooperative and didn’t mind cooperating with all that was participating in this course of action.

Plus family members assisted in the activity and interviews transpired over this period of time. What’s more all the stakeholders indulged themselves in the observation process such as walking around the entire ward looking at what was down folding in the ward, engaging in conversation with the staff, families and users alike while at the same time making notes and completing the Interview Tool.

The ‘WHO-Quality Rights Interview Tool’ was the instrument used to obtain the required data. Prior to the beginning of the exercise a number of copies were produced and given to each team member so that s/he could complete his/her own version. After that, we met to discuss the findings and orientate each person to what was needed.

Approximately three meeting were arranged before finally getting all together to discuss thoroughly the exercise. A major constraint experienced with the team was attendance to the meetings, being on time while maintaining interest and enthusiasm during the meeting. Once we were all gathered a thorough examination of the tool transpired so that each person had a clear understanding of what was required of him/her.

Our team comprised of Mental Health Workers in Hargeisa, including representation from both the Private and Public Sector. My reason for the inclusion of the Private Sector is because the information gathered in this assessment provides the foundation for the ‘Best Practice Minimum Standards & Service Delivery Manual’ which is being developed and leads to the end result. So therefore having the Private Sector involved provides ownership of this manual hence leading to
the instillation of change into their practices thus discreetly addressing the ‘Human Rights Violations’ that are occurring daily throughout these centres of Hargeisa.

Our Team

Maryam Hassan Dyre - Head Nurse & Manager - Hargeisa Group Hospital - Mental Health Ward

Dr. Abdirazak Baraco - Doctor - Hargeisa Group Hospital - Mental Health Ward & Private Clinics

Abdi Gurey - Representative from WHO - Hargeisa Office

Farhan Adam - Chairman GAVO - Local Organization

Abdirashid Ismail - Local Project Manager - GRT

Julie Currie - Project Manager - GRT

Ahmed-Eid M. Ali - Maroodi-Jeex Private Hospital

Mohamed Mumin Habane - Daryeel Psychosocial Center

Abdurrahman Ahmed - Habwanaag Psychosocial Centre

Ahmed Al Jabril - Human Rights Lawyer

There was no special allocation of activities given to each member; everyone received a copy of the assessment tool, followed by a clear explanation combined with the time when the task was to be completed. Most of the members of the team were familiar with the users and the families for that reason it was easy for them to access and obtain the required information.

Over the last decade all the members of the team have received extensive training of Mental Health by WHO and GRT. Each member of the team gained previous knowledge in Human Rights; Clinical Management although as far as Mental Health Legislation is concerned it is a considered bit of a mystery for them all. Come to think of it and now knowing the people, I do not believe that they have ever thought about Legislation, although part of my activities within the Project is to develop the Somaliland ‘Mental Health Policy’ with all these people being part of that working group.

Pre-Visit Meeting of the Assessment Team

The location for the assessment was Hargeisa Group Hospital - Mental Health Ward and the meetings were conducted throughout the month of April, 2012. Albeit that a number of meetings were called before all the team members were together. The response received from the members of the Private Sector was one of positive unbelief as later this assessment would be directed to their practice and inevitable change was coming his/her way. Down the path and devoid of hesitation these people were feeling threatened now because instead of being openly able to
‘Chain’ someone and lock them away for a long time, the person now had the right to speak up for him/herself.

For such a long time the mighty dollar $ has played a major part in the lives of the Somali with no accountability mandatory so now to have ‘Human Rights’ mentioned created fear and resentment. By encouraging these people to be part of the change process took much time, effort and energy on the part of me, GRT Project Manager.

All of these stakeholders were part of the working group now being formed in order to develop the Mental Health Policy therefore all necessary documents were distributed to them. Included among these documents were the United Nations Convention on the Rights of Persons with Disabilities (UN-CRPD), Mental Health Policies from neighbouring countries together with WHO Standards & Policies, to name but a few. At this point in time it is that each of these members is being inundated with all the required documents that are needed to complete this task efficiently and effectively. On a timely note all these activities coincide with our assessment on best practice standards.

The Visit

Finally, the visits occurred over the month of April also during one’s own personal time. Each member had decided to perform the assessment at his/her’s own leisure since attempting to get all together was near impossible. Finally the team was given a date in which the assessment was due and it was left up to each member to perform his/her task. Appealingly, this seemed to work as each member worked at his/her own pace. In addition the permission that had been given by the Director General (MoH) was in place for this assessment to occur thus it was perceived that all were keen to take part.

Currently working within the Mental Health Ward are 22 staff, 2 Doctors, 1 Manager/Head Nurse, 4 Nurses, 7 Psychosocial Workers, 5 Cleaners and 3 Watchmen. Each staff member has been working in this facility for many years with the exception of one doctor who recently joined the team. In order to interview each staff member did not pose a problem because most are friends/acquaintances of one another and working in the field of Mental Health appears to guarantee a comradely between all of them.

There is no official form signed for consent although each interviewee did give verbal consent as evidenced by answering the questions. All the interviews were conducted by the Somali team members in the native language and written in English on the assessment tool. Therefore the assessment tool did not need to be translated into Somali because all members of the team were fluent in written and spoken English.

Being able to visit the facility at any time proved to be fruitful and everyone, users, family and staff alike are willing to talk! As far as maintaining confidentiality during the interview process it
presented as a problem because Somali’s do not know how to maintain confidentiality and are always listening to each other’s conversation. Therefore making sure a private space was available in order to perform these interviews was impossible and constant reinforcement was forever forthcoming.

<table>
<thead>
<tr>
<th>Name and Location of Facility</th>
<th>Number of Staff</th>
<th>Number of Service Users</th>
<th>Type and Date of Visit</th>
<th>Staff Interviews</th>
<th>User Interviews</th>
<th>Family Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Planned</td>
<td>Conducted</td>
<td>Planned</td>
</tr>
<tr>
<td>Hargeisa Group Hospital Mental Health Ward</td>
<td>22</td>
<td>30</td>
<td>03.04.12</td>
<td>10</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>08.04.12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>15.04.12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unplanned</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>22.04.21</td>
<td>Planned</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post visit action**

The post visit meeting transpired in the Mental Health Ward, where previously all the meetings transpired only because it was easier for accessibility and availability. As formerly mentioned ensuring that all stakeholders were present was a difficult task. Fortunately the last meeting we conducted all but one was present, and he sent his completed form.

The representative from WHO took on the role as supervising all, he believed that coming from WHO and this being a WHO Document it was his responsibility to direct. Myself as the initiator coming from GRT and being the Project Manager working on the Ward, I therefore became the coordinator and planner of this entire exercise.

As for the rest of the team, they mainly followed however the Private Sector wanted to work autonomously and surprisingly not together with their other colleagues coming from other Private Facilities. There appeared to be a rivalry with their counterparts and all of them did not want to be associated with the other.

In line with the intention of having the Private Sector involved was to ensure that each one of them had a clear understanding of what is anticipated for the future and that in Somaliland there will be a ‘Change of Practice’. Firstly the change will be in the Public Sector and then it will flow into the Private Sector. For that reason, our exercise is all about starting the process of planting the seeds while ensuring all are aware of what will come!
Mainly therefore, the key topics discussed at each meeting were about completing the tool effectively while ensuring that all clearly understood what is required. Consequently ‘Human Rights’ is the main focus encompassing all that it entailed. Over the years gone by Somalis’ did not embrace ‘Human Rights’ and come to think of it did not really care because of all the conflict that was occurring around them. Whether experiencing this two decades of conflict contributed to and encouraged the country to ignore human rights, is a question to ponder!

Finally the scoring for the tool is achieved through comparison of each one’s answer and by individual observation. Moreover for all to agree upon the same conclusion didn’t present itself as an obstacle.

RESULTS

What’s more the results of the findings are much to be expected after the initial glance at the Ward. Besides I am not surprised that the task ahead will be engulfing a great deal of time and effort in order to establish a ‘Centre of Excellence’ in Mental Health for Hargeisa Group Hospital by the end of the GRT Project in 2013.

During the assessment reinforcement was provided and presented itself as extremely important that all of those who were involved in conducting the assessment clearly understood and agreed upon the purpose of this assessment and how the results would be used. Therefore, assessing the quality of service and human rights in mental health facilities serves different purposes with the results being used in many different ways.

Some of the feedback unanimously received from the users was that ‘a user does not have any say in his/her treatment regime’ and ‘users are locked up and not allowed to see the light of day’ even ‘users are not allowed to access the toilet because we are locked in’. One user specifically stated that ‘I jump the perimeter fence every time I am locked up here and one time I broke my arm, but this did not stop me from escaping every time the family left me here’. Many users state that ‘common practice of the staff is physical & verbal abuse to them and even the watchman uses a stick to hit them if they try to leave the facility’.

Numerous family members stated that ‘it was a relief for the family member to be locked away, no more worrying about if the loved one is on the street’. As for the responses from the staff, many stated that ‘there are far too many users inside, most are aggressive and uncontrollable, and this is a scary place to work in’. Another comment was that ‘we are understaffed and to be there alone is a frightening experience’.
Once the assessment was completed, all members of the assessment committee met together as soon as possible after the assessment (because impressions and information fade quite quickly) in order to discuss, integrate and compile their respective results from the interviews, observation and review of documentation into a final report for the facility.

Then the assessment committee needed to score each of the criteria, standards and themes of the WHO Quality Rights Toolkit according to the following ratings:

<table>
<thead>
<tr>
<th>A/F</th>
<th>Achieved in full</th>
</tr>
</thead>
<tbody>
<tr>
<td>A/P</td>
<td>Achieved partially</td>
</tr>
<tr>
<td>A/I</td>
<td>Achievement initiated</td>
</tr>
<tr>
<td>N/I</td>
<td>Not initiated</td>
</tr>
<tr>
<td>N/A</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

It is important to note that these quantitative scores on their own are meaningless and that qualitative information is needed, in order to provide the substance and detail to the report and provide a comprehensive picture of the situation in the facility. The *WHO Quality Rights Reporting Form* provides a template for integrating both quantitative and qualitative findings into a single facility report (WHO 2011).

For the purpose of this assessment below are the findings of Hargeisa Group Hospital. Throughout this overview I will endeavour to provide a comprehensive report on the findings within each theme. Let’s start by going through each theme with bringing to light the main outcomes identified.

### OVERALL RESULTS

<table>
<thead>
<tr>
<th>Theme</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme 1: The right to an adequate standard of living (Article 28 of the CRPD)</td>
<td>Not initiated (N/I)</td>
</tr>
<tr>
<td>Theme 2: The right to the enjoyment of the highest attainable standard of physical and mental health (Article 25 of the CRPD)</td>
<td>Not initiated (N/I)</td>
</tr>
<tr>
<td>Theme 3: The right to exercise legal capacity and to personal liberty and the security of person (Articles 12 and 14 of the CRPD)</td>
<td>Not initiated (N/I)</td>
</tr>
<tr>
<td>Theme 4: Freedoms from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse (Articles 15 and 16 of the CRPD)</td>
<td>Not initiated (N/I)</td>
</tr>
</tbody>
</table>
Also the results of an assessment can be used to identify gaps in knowledge in relation human rights and quality issue. Consequently tailored training and education can be conducted with the staff, service users and families in order to ensure that each stakeholder has a comprehensive understanding of the rights of the people with Mental Health Disabilities and the quality standards that need to be respected and promoted in order to improve conditions within the service (WHO 2011).

The overall results of the mental health ward in relation to human rights are observed as apathetic to what is experienced in the rest of the hospital. Usually, users in the surgical and medical ward are treated with dignity and respect receiving the care that is needed to recover. Everyone including the staff avoids the mental health ward and its user like the plague so to have a user transferred is unmentionable.

**Theme 1: The right to an adequate standard of living (Article 28 of the CRPD)**

Theme one was focusing on the standard of living within the mental health ward. Regrettably the situation of this ward is dismal to say the least! It was built in 1971 and since then no attention has been given to it even though it is somehow included as part of the Hargeisa General Group Hospital. Sadly to say, while most workers within the hospital reject providing care to anyone that may be associated and/or diagnosed with a mental health illness. Unsurprisingly, it is a large ward keeping in line with the general consensus that these facilities should be designed as an institution/hospital in order to lock the sufferers away for a long-time Subsequently our facility consists of separate men’s and women’s section.

On the men’s side there are three different buildings that house the large number of users, approximately 45 beds in all, with each bed cemented to the floor and mental hoops for the chaining of the user are evident and concreted into the floor. At the back of the wards are three individual rooms, six showers and a block of three toilets. Also at the end of the ground to the left of the building is another toilet block of three-this means that there are 6 toilets in total.

Separately placed is an eating area away from the wards situated approximately at the entrance of the ward. Doors seclude the users from the outside world and if the watchman and/or staff wish to lock up the user it is easy and has frequently been the routine. In the centre separating the male and female wards are three offices, and a toilet facility for the staff.

On the women’s side which is smaller consists of one large building with approximately 5 individual rooms which contain 3 beds in each. This means that the women’s side can house
approximately 15 users. In the back of the building are 3 toilets, and 3 showers as well as 3 rooms that are used for storage.

The ground area around the wards is widespread with the space for many outdoor activities to occur. In the future I envisage this mental health ward as a perfect rehabilitation centre for many users to learn life skills. Upon observation the physical condition of the overall ward is much to be desired and the maintenance is nonexistent. There were doors, shutters and windows missing. Nothing was working and there were even holes in the walls.

The access to the ward is via stairs at the front of the entrance so if anyone was in a wheelchair it is difficult to enter; therefore this made it inaccessible for some. There is plenty of ventilation with the holes in the walls but on windy cold nights this makes the ward a miserable place to be.

The lightning of the ward is old with many missing sockets, bulbs and switches all of which is not functioning. Moreover the paintwork is falling off the wall and there is much graffiti present. As indicated in the tool which states ‘in case of fire are there fire alarms’ well no fire alarms are present, no fire extinguishers and another risk is that at night the women are locked in with the staff justifying this action by saying’ it is for security’.

Needless to say I could go on and on in regards to the state of the facility, specifying what it missing and what is not provided is however all apparent and transparent. As a result our overall assessment of the ward and our rating is –Not Initiated because this ward does not provide or meet the necessary requirements of ‘Quality Standards’.

Theme 2 addresses the right to the enjoyment of the highest attainable standard of physical and mental health (Article 25 of the CRPD)

<table>
<thead>
<tr>
<th>Theme 2: The right to the enjoyment of the highest attainable standard of physical and mental health (Article 25 of the CRPD)</th>
<th>Rated-Not initiated (N/I)</th>
</tr>
</thead>
</table>

In Theme 2 the ward provides some of the requirements needed for the standard of Physical and Mental Health for the user. Within this theme contains those requirements needed in order to provide the user with the appropriate service delivery. Thus no person is refused entry because of race, colour, sex and/or ethic values.

Seemingly the staffing however requires a great deal of attention in relation to training and their daily working habits. Even though this staffs has received extensive training in ‘Clinical Management’ over the last decade, it still has not made a difference to his/her service delivery and care for the user.

Formerly the treatments for the user is provided as if there was no tomorrow and there are no treatment plans, no monitoring and evaluation and no follow-up. Many of the users are not even know by name, so it is difficult to say that a person would receive the necessary treatment that is required.
As for the provision of medications, this has been in existence for a long time. WHO have provided the necessary psychotropic drugs although no monitoring or documentation has been in existence? Nonetheless I am unsure if the staff provide what is required in relation to drug administration, with the large amount of users present in the ward and/or if the staff are not sure who they are providing medications too henceforth it is a hit and miss affair.

Lastly the access and availability to medical and reproductive health is non-existent within the hospital. On some occasions there have been pregnant women admitted into the mental health ward and because of the ignorance and resistance of the other wards these women have to have their babies by themselves locked away in a mental health ward where no-one is present and/or experienced in midwifery.

Throughout the other wards in the hospital it is the same response for the mentally ill persons and the common myth is that the person with a mental health disability is one to be scared of and without doubt to be restricted from entering the other wards. Needless to say there is no referral system occurring and no health education and/or health promotion. Therefore the reason that the team has rated this theme as Not Initiated is because of the lack of competent and proficient service provision even though the staffs are willing to embrace change.

**Theme 3 addresses the right to exercise legal capacity and to personal liberty and the security of person (Articles 12 and 14 of the CRPD)**

<table>
<thead>
<tr>
<th>Theme 3: The right to exercise legal capacity and to personal liberty and the security of person (Articles 12 and 14 of the CRPD)</th>
<th>Rated-Not initiated (N/I)</th>
</tr>
</thead>
</table>

This theme encounters that the person with a mental health disability who is using Hargeisa Mental Health Ward has no access to ‘Legal Capacity’ at all. Throughout it has been observed that this is a common practice in -Somalia that the user has no say in his/her well-being! Nonetheless it is the family who is the one instigating all the care and never do these loved ones consult with the one who is receiving the care.

Mostly the ill person is brought to the ward chained. Under no circumstances is the ill person consulted about the care and whether s/he wishes to have treatment, if this did occur the staff would be laughed at and abused. All in all the family takes the lead role in the care.

Thereby no support agencies are available for the service user and currently there is no attempt to provide the user with any living accommodation. Greatly encountered examples are if the family is not happy with the user’s behaviour they then in turn force the user to live on the street. Taking into consideration all encountered, the team has rated this theme as- Not Initiated.

**Theme 4 addresses Freedoms from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse (Articles 15 and 16 of the CRPD)**

<table>
<thead>
<tr>
<th>Theme 4: Freedoms from torture or cruel, inhuman or degrading treatment or punishment</th>
<th>Rated-Not initiated (N/I)</th>
</tr>
</thead>
</table>
and from exploitation, violence and abuse
(Articles 15 and 16 of the CRPD)

Theme 4 sees freedom from torture or cruel, inhuman or degrading treatment as being non-visible. Unhappily, the staff and family alike use ‘Chaining’ as a way of containing the person. This does concur with Article 15 & 16 of the UN-CRPD as being violated to an extreme extent. As identified by the team preparing the assessment, the staff members of the ward do not treat service users with humanity, dignity and respect by means of ensuring their safety and security.

An overall impression expressed by all was that the users are not treated well, and any person who is mentally ill is not provided with human rights even when h/she recovers. It is believed that this rationale is due to the lack of information and knowledge about the rights of the users. Another perception is that literacy and ignorance combined with cultural misbehavior are common among all the community members thus empowering ‘Discrimination and Stigma’.

Even though previously WHO had initiated the ‘Chain Free Initiative’ it has been encountered within Hargeisa Group Hospital, Mental Health Ward but not maintained. Providentially there is an established direction to discontinue seclusion and restraint practices and replace these practices with de-escalation tools and techniques however this has not yet been achieved.

Currently, there are no documentation/records kept about seclusion or restraint coupled with no limitation in relation to time and/or duration. In addition no provision for privacy is present and the user is locked in continuously without access to the open air compound. As for a treatment plan being present it is non-existent. Within this Hospital there is no Electro-Convulsive Therapy (ECT), Psycho-Surgery and/or Medical/Scientific Experimental Surgery practiced!

Identifiably service users do not have the opportunity to have input into the running of the ward. Even if the service users want to discuss their concerns and provide inputs on the running of the ward, this opportunity is not available. Sadly to say no one has ever asked the users for his/her input so there is no fear of repercussions ever occurring. In addition, no regular meetings occur between service users and staff, sometimes an impromptu discussion may occur between the two, although service users are encouraged to speak to senior staff about any concerns.

If you ask if the service users are informed of their rights- the answer is clearly NO! Also if a user want to go about making a complaint at the facility, how could they if ‘NO’ procedures are in place for a user to make this complaint? As well, there is no access to any Legal Assistance provided.

Presently, the facility is monitored by GRT whilst reporting to the MoH. As a result, GRT’s presence in the ward daily is acknowledged by all, staff and family alike while at the same time maintaining a strong collaboration with MoH is deemed imperative. Hence this in turn empowers the findings and recommendations of GRT thus creating respect and action. Consequently a major reinforcement of GRT is ensuring teaching and promoting of human rights to all who enter
the mental health ward is constant and consistent. So for Theme 4, we believe that the rating deserved here after reviewing the findings is –Not Initiated

**Theme 5 addresses the right to live independently and be included in the community (Article 19 of the CRPD)**

<table>
<thead>
<tr>
<th>Theme 5: The right to live independently and be included in the community (Article 19 of the CRPD)</th>
<th>Rated-Not initiated (N/I)</th>
</tr>
</thead>
</table>

Lastly Theme 5 discusses the possibility of the service user being able to live independently in the community. I am so sorry to say that this right is not even close to achievement in Somalia. Presently, there is no Legislation in place for any of these rights to occur. In the past the mental health ward has been used as a place for families to dump their loved one and leave hoping that this person would never return again, because it was all too hard at home.

Upon entering the ward GRT encountered that there were over one hundred patients that were living here with no or little access to sustainable treatment and care. From the very beginning of the Project, GRT assessed every person that was on the ward and re-established the connection between user and family. Some families were happy at the stabilization of the loved one; some were angry and refused to have him/her return home.

At this time the Government is progressing through enormous change and Legislation is at the forefront. Whereby I believe that with the current influx of ‘Developmental Aid Agencies’ into the Country you will see this service being changed in the near future.

In addition the current trend is the lack of providing education and/or opportunities for employment to the mental health service user. Formerly and presently the constant struggles in regards to stigmatization and discrimination are overwhelming for all concerned.

Even though numerous awareness campaigns have been conducted the persistent struggles against the myths is overpowering. More time will be needed to break down the barriers and belief system that haunts the Somalis so that the person with a mental health disability receives a fair chance in life by receiving education and employment rights, equal to all.

Being a strictly Muslim Culture and Belief System, the service user does not have the right to freely choose his belief preference. It is embraced as ‘Muslim’ regardless of what you wish or believe. During the users stay in the ward there is no additional transport service offered for the person to visit to the Mosque. Thereby if the families do not present then the person does not attend unless he chooses to take himself.

In regards to any Political, Religious, Social and Disability Organizations offering activities within the facility, none are provided. Albeit that the staff remain the entire length of duty in order to provide these activities/services and/or arrange transportation for the user to another place.
Hence for the purpose of this assessment in ‘Theme 5’ the team rates it-Not Initiated attributable to the lack of ‘Legislation and Community Involvement’.

**DISCUSSION**

In line with the Convention CRPD (2006) that promotes human rights and standards for persons with disabilities a guiding principle that is not reflected and/or respected on the ward is respect for inherent dignity, individual autonomy including the freedom to make one's own choices, accessibility, and independence of persons in a non-discriminatory manner.

Other guiding principles that necessitate respect are full and effective participation and inclusion in society, respect for difference and acceptance of persons with disabilities as part of human diversity and humanity, and equality of opportunity between men and women.

By elaborating in detail the rights of persons with disabilities and setting out a code of implementation for that reason I believe that the below discussion attempts to address these rights in the Hargeisa, Mental Health Ward. Whereby I begin my discussion by commenting on the condition and status of the mental health ward indicated as the overall content of Theme 1.

For me as a human being Theme 1 was the most fundamental of all the rights. All of us want to believe that we have in our lives the right to adequate standard of living. To be more precise Article 28 of the CRPD (2006) states that ‘it is the right of persons with disabilities to have an adequate standard of living for themselves and their families, including adequate food, water, clothing and housing, and to the continuous improvement of living conditions, and shall take appropriate steps to safeguard and promote the realization of this right without discrimination on the basis of disability’. For the service users in Hargeisa Mental Health Ward, this was not the case after qualitative findings where established. It was evident by the results that the MoH currently was not addressing this concern.

Let’s start by highlighting the standards in Theme 1; firstly the physical condition of the ward which is demonstrated in the below picture requires attention 10 fold. Albeit to observe the buildings remain with holes, doors were off, and no shutters were in place so as to prevent the wind coming in during the windy season. The building was definitely identified in accordance with the CRPD (2006) as not in good standards suitable to treat and house those persons with a Mental Health Disability.

The sleeping area allocated for where to rest your weary head was identified as a piece of the floor. No sleeping attire/equipment was distributed and it was evident after talking with the staff that no one provided any input into
where the user slept, as for comfort and privacy this did not occur or was it expectant.

As observed during the assessment, the hygiene and sanitary requirements were not met and nor was it observed as a reinforcement from the staff as a normal activity of daily living. In regards to the food and drinking water this was provided by the hospital and conversely new cloths were provided after donations from visiting Diaspora and/or Community Groups. Especially during Ramadan this practice was a current occurrence. Unfortunately, it was observed that these clothes remained on the user until they almost dropped off because of the uncleanness’ of the garment.

Nowhere in this facility was it identified that there was an allocated private space for the user to communicate freely and/or have s/he’s right to privacy respected. Accenting on the appealing welcomes of the ward, it’s comfortable and stimulation environment was not to be seen. The surrounding was large but it was overrun with plastic bags, faeces and trash. This facility did not appear and/or present itself to be conducive for active participation. As for the service users enjoying a fulfilling social and personal life engaged in community life and activities was non-existent.

The limitations experienced here were that no-one even including the MoH had spent time and energy addressing the ongoing needs of this vulnerable population as displayed during the assessment. Mental Health has been an area that has been sadly neglected for so many years even though it touches all of us throughout our life’s journey.

Having considered Health and Human Rights (2010) and by keeping in mind that the Constitute of the World Health Organization establishes a basic international principle whereby “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition”(Document CD50/12). This resonates with the principles of the CRPD (2006) and is embraced within this project.

Lastly ‘it is important to note that basically no financing could be traced for non-communicable diseases. While this may be understandable because of the prevalence of communicable diseases in Somalia, it is hard to ignore Mental Health and Disability Problems in a Country that has been affected by almost two decades of conflict’-World Bank Working Paper No.210, A decade of Aid to the Health Sector in Somalia 2000-2009.World Bank, Washington, 2011.page 35. Therefore I embrace the rating of ‘Not Initiated’ for this Theme 1.

In Theme 2 the focus is on ‘the right to the enjoyment of the highest attainable standard of Physical and Mental Health’ indicated in Article 25 CRPD (2006) and that ‘persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons’. So let’s reflect back on this theme and how it presented itself during the assessment. Our findings revealed that all who required treatment received it whilst at the same time support is adequate.
Although during our assessment the quality of care observed was much to be desired. The staffs have worked on this ward for a number of years, and even with receiving numerous training from WHO on ‘Clinical Management’ over the past decade as well as trainings from other International Organizations such as Tropical Health and Education Trust (THET), nothing has appeared to be displayed in their work practice on the long-term.

THET has been involved in incorporating mental health into the training curriculum for a wide variety of health practitioners but sad to say the level of care observed here needed much more input and strengthening. In fact this phenomenon could be due to the number of admitted users on the ward and the fact that the staff had no knowledge of who they were treating as evidenced by no medical records being kept as well demonstrated along with the unprofessionalism of their approach.

An example of dispensing the medication by the nurse was that s/he had no idea who was who and that she was so fearful for these users that s/he would stand from afar and throw the medication to the person thus not ensuring that the right medication was received by the right person, at the right time, and/or by the right route. This is an indication that the nurse is afraid and is not well trained to manage the person with a mental illness. Also it is questioned if there is enough resources-staff available in the ward to provide quality service?

Albeit that in the medical ward there is no observed proof that the practices are any better than the mental health ward. As a result it is believed that no lessons can be learned from the staff practicing in the rest of the hospital plus the hospital management has not intervened and/or been forthcoming with the provision of direction. Prior to the beginning of the Project this practice of care was never questioned by anyone and was accepted by all within this facility even including the families. At the moment there are no Health and/or Mental Health Policies in place to prevent this occurrence.

As mentioned above there were no treatment plans and/or medical records in place for each user therefore linking to other support networks was difficult to proceed with. Consequently the service user, after being placed in the facility by the family was not expected to return home and come to think of it, many statements such as “We don’t want her/him at home, we cannot look after her/him and s/he is too angry for us to control” were forthcoming from many family members. It is considered a common occurrence that these above statements are a worldwide phenomenon when no continuous medication and family education and support are provided. Nonetheless these kinds of statements were repeated by many of the families/loved ones that deposited the user in the ward.

Thus the expectation was that now the user was in the ward that s/he would stay for a long time, even indefinitely never to return to the community and/or home. Yet again, there is an emphasis on hospital admission and treatment without looking at the community that generates these users is doomed to an unhealthy life-style. Endless community awareness and education will be required if Somaliland would make a concerted effort in reducing this burden of disease and disability.
In addition, Jaranson et al (2004) believes that Somali individuals often need advocacy within their family and community in order to reduce stigma and prevent social isolation. Moreover, it is crucial to educate both users and their families about the mental health and mental health illness. This is important to promote adequate monitoring of treatment compliance and side effects. Because of the strength of Somalis’ connection to family, families play an important role in providing the needed support and encouragement to make treatment successful. Without this support, Somalis with mental illness may feel alone, adding to existing feelings of hopelessness and worthlessness.

With the provision of psychotropic medications coming from various sources and not being required to be in line with any particular essential drug list, the availability was sporadic. As time goes on in Hargeisa there are more and more private pharmacies establishing themselves and these are providing many kinds of psychotropic drugs, however the quality and costing is not monitored by any regularity body. Even though the staffs of the ward have received numerous trainings from WHO on ‘Clinical Management’, they are observed and still unwilling or one could say resistant to prescribe and dispense as trained.

Sadly it was observed that other wards within the hospital are reluctant to accept the user with a mental health disability. One time I observed a 36 week pregnant woman being admitted into the mental health ward for treatment only to be being refused care from the staff of the maternity ward. In addition Article 25 CRPD (2006) recognizes that persons with disabilities have the right to the highest attainable health care including the area of sexual and reproductive health.

Needless to say this woman did not receive this right and therefore gave birth in the mental health ward with no assistance from trained midwifery staff. Throughout the hospital it is an acknowledged common practice for the wards to deny treatment and care for a mental health service user. Our teams’ rating for ‘Theme 2’ is Not Initiated.

Focusing on ‘Theme 3’ which is the service users ‘right to exercise legal capacity and to personal liberty and the security of person on an equal rights with others’ identified in Article 12 and 14 CRPD (2006). In addition Article 14 CRPD (2006) states that ‘persons with a disability are not deprived of their liberty through any processes.

My first impressions and what the team observed and also previously experienced in relation to ‘Independent Living’ in the community were non-existent for these users. I observed the family bringing the user to the ward and then abandoning them, hoping never to see them again. The decisions for admittance to the ward have been the sole responsibility of the family and not the user even as the treatment regime is never discussed with the user.

As far as having informed consent for the user, this does not emerge. Regrettably as observed on many occasions the user is brought into the mental health ward usually in ‘Chains’ with no say in what is happening to him/her. It is expected and sometimes verbalized by the family that the user should be detained here for as long as it can be. At times, the user refuses to stay in the facility so
s/he escapes over the wall and even at times I have seen the user end up with fractured limb injuries.

Alas to the extent that the user exercises his/her Legal Capacity in order to protect him/her self it is not in place. Unfortunately during the assessment the team identified that nowhere is there any support forthcoming for the user. S/he is on her/his own to fend for her/himself.

Within this theme, we discuss the right to confidentiality and access to personal health information and for the mental health ward being that there is no medical records maintained therefore there is no access to personal health information. On many occasions the issue of confidentiality has been reinforced; however, a common practice of the local Somali person is that s/he wants to know all that is happening to everyone so insisting on privacy and confidentiality is such an ongoing struggle, as stated by the staff. As a result of the observations and experiences the teams’ rating for ‘Theme 3’ is Not Initiated.

As we move onto ‘Theme 4’ which addresses Article 15 and Article 16 CRPD (2006) stating that ‘freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse’ our team reports that verbal, mental, physical and sexual abuse is rampant within the mental health ward. An example that was observed is the case of a 15 year old Ethiopian boy who suffered with seizures and had been previously left on the street. The local police carted him off to the mental health ward thus neglecting and deserting him there. As reported by the staff ‘there was never any investigation to look for his family or was there any care or consideration taken with him’.

While on the ward he experienced many occasions of sexual abuse, even the staff were aware of this situation and did not lift a hand to protect or rectify the issue, as the story told goes. After, much discussion with the Ethiopian Embassy and a lot of determination on the part of me and a team doctor, our boy was finally taken back to his family in his own country. Even after discussing this issue extensively with the staff from the ward no-one was prepared to go that extra mile to assist this young boy. Consistently, I witnessed the negative effects of emotional neglect portrayed in this boy.

In Somalia seclusion and restraints come in the form of a ‘Chain’ no other method is used or embraced. This method is used by Public and Private Facilities alike. As well it is the common form of restraint for the community and families. No other method has been reported by any of the workers within the mental health arena.

Hargeisa Mental Health Ward 2011
Elector-convulsive Therapy (ECT), Psychosurgery, or other Medical Procedures that have permanent and irreversible effects, are not applicable in Somaliland. As noted on many occasions there are no safeguards in place such as policy to prevent torture or cruel, inhuman or degrading treatment or other forms of ill-treatment and abuse. Although currently, the MoH in collaboration with GRT and other stakeholders are developing a Mental Health Policy in order to advocate and promote ‘Human Rights’ for persons with a Mental Health Disability. Our overall team score for ‘Theme 4’ is Not Initiated.

Lastly we summarize and report on ‘Theme 5’ highlighting Article 19 CRPD (2006) ‘which is the right to live independently and be included in the community’. As documented in the assessment this right is not respected nor accepted by any member of the community even including the family of the user.

The team has noted and observed on countless occasions many of the mental health users once s/he is discharged from hospital that they end up on the street with nowhere to go, even it is reported that the family shun them. These people are seen wandering the streets begging for money and food.

David McGraw Schuchman and Colleen McDonald (2004) support the idea that many Somalis with mental illness are socially isolated. The pain of this isolation is felt especially intensely because Somali culture is traditionally communal and family oriented. While people with mental illness maybe ostracized from the community, their fear of stigma maybe even more powerful.

Frequently interviewees expressed a fear that there would be rumours about madness or spirit possession if it became known that one sought help for mental health illnesses from Biomedical Health Care Services. Those sufferers that are instituted by the family are seen as ‘mad’ and that there is no hope for them to return back into the community. On the other hand social isolation is created for the service user leaving them to fend for him/her self while it is recognized that abandonment prevails foremost on the side of the family.

Whether the ostracism is created by the community or is self-imposed due to anticipated negative responses, the social isolation creates a profound worsening of the mental illness. This social isolation can be very disorientating and can make the process of healing very difficult. In fact, even without prior mental health disabilities, isolation from community alone can contribute to the development of a mental illness.

When discussions transpire among the staff, families and community about the user having access to employment and education it is strictly denied. So much stigmatization and discrimination surrounds the user of mental health services in Somaliland. Even the assessment team can talk about their own experiences in relation to assisting someone to obtain a job. It is stated by one member ‘the struggle is tremendous and hard going for those persons working for and living with Mental Health Disabilities in our community, none of them will ever get a job’.
Additionally it is considered improper to recommend that someone seek psychiatric care or psychological help as this could easily cause feelings of shame, frighten the person, and affirm the s/she actually had become ‘crazy’. Furthermore in the eyes of the employer and community the taking of medication also ‘confirms/ a state of madness’.

Throughout Somaliland it is not accepted that the mental health service user participate in political and/or public life, albeit that the user is minimally accepted for who they are, let alone be accepted into political life. Also, to be supported to take part in social, cultural, religious, and leisure activities is something that is missing from the Hargeisa Group Hospital, Mental Health Ward and the community at large.

For treatment to be effective, Trisha Stark (2003) suggests it must be understood by the user from a personal religious and cultural perspective. If a treatment is recommended that has negative cultural associations, the user will not accept it. If, on the other hand, the treatment is consistent with cultural and religious beliefs, the user will more likely be an active participant and the treatment will be more successful. Thereby after the discussion about ‘Theme 5’ concluded the team agreed on the rating as Not Initiated.

CONCLUSION AND RECOMMENDATIONS

In conclusion, this assessment has brought to light a certain mistrust and lack of understanding between MoH care personnel and the Somali population concerning the origin and treatment of a mental health illness. Many Somalis believed that the medical personnel often dismissed physical pain as psychological or social ‘stress; which, in turn, made their symptoms seem less valid. Often they felt that their complaints about their loved one were not taken seriously.

Into the bargain Doctors’ and Nurses’ on the ward were said to overemphasize and misuse medical/drug treatments with the intention of subduing and/or deescalating the user. At the same time the lack of understanding for one’s human rights plus the non-biomedical form of restraint ‘Chaining’ was persistently imposed.

Undisputedly for me coming from a practice and culture of now high standards in Mental Health Care being in Somaliland/Somalia has been an eye opener. After observation, interviews and meetings the general consensus of the situation on the ward is alarming to say the least, even though I have worked and lived in many countries in the world I have never experienced such resentment and animosity towards ones loved family member/s.

Unanimously the team feels that because of the ‘Humanitarian Situation’ experienced in Somali for so many years, many people have forgotten how to love and care for someone who needs that extra bit help, this being our vulnerable group of those Persons with a Mental Health Disability. Needless to say and essentially noted the ‘Human Rights’ situation is nonexistent and it takes someone with determination and staying power to come in and lead the way.
In so doing it is anticipated that much effort will be required and that many areas of care will be need to be addressed. For that reason as GRT Project Manager, I am blessed with the task of instigating change. So I consider myself to be a person with strong will power and a dedication in helping these vulnerable people.

Recommendations to improve quality based on the results

In conjunction with the teams’ specific recommendations based on the specific results from the assessment the first step will be to address the structure of the facility and provide renovations so that at least to start with the buildings will be intact. Then it is about providing mattress and linen while ensuring that all the users receive a bed s/he can call his/her own. These will all transpire in unison with the re-assessment of each user whereas ensuring that each person is not retained any longer than is necessary and that each person receives the required treatment and quality care. Immediately, the cleaning of the wards, bathroom facilities and the surrounding grounds will be addressed. Focusing will be medication, sanitation and hygiene improvements.

Our team identified the areas that require instantaneous help, these being staff organization of activities, capacity building, family education, rehabilitation of the buildings, identification of staffing needs, responsibilities and human rights, documentation, job descriptions, community education and promotion on ‘Human Rights’ in the form of Awareness Campaigns to be conducted throughout the 2 year GRT Project.

The manual on Minimum Standard of Service Delivery will be compiled and presented to WHO Nairobi Office for the publication. It is believed that the indicators in the manual which are taken from the ‘Quality Rights Toolkit’ will concentrate on the human rights violations occurring on the ward. As the result of the assessment the ‘Best Practice of Minimum Standards & Service Delivery Manual’ will provide the indicators and direction to follow as set down in the recommendations by the Assessment Team.

Accordingly I embrace that this manual provides the essential direction and guidance required to work with the staff of Hargeisa Group Hospital, Mental Health Ward, including the users and family in order to achieve improved ‘Standards of Care Delivery’ with the main focus being on ones ‘Human Rights’.

Broader recommendations

As mentioned within the above report that there is no Somaliland Mental Health Policy in place so part of the GRT Project is to encourage and support the MoH in this development. Below is listed the anticipated way forward in order to achieve this goal. I believe that in hindsight of this strategy the Mental Health Ward will indirectly achieve its challenge of being ‘Chain and Human Rights Violations Free’ by:
Finalization of the Mental Health Strategy with integration into the National Health Sector Strategic Plans for Somaliland to be developed by November 2012 and followed up by MoH plus calling upon support Partner’s involvement.

- Include Mental Health into the Community Based Health Workers Intervention (screening, first aid, referral and follow-up);
- Pilot test integration of Mental Health into Primary Health Care Facilities- Diagnosis, Treatment and Support (including medicines);
- Analysis of Mental Health Information from Public and Private Mental Health Facilities;
- Public Mental Health Education/ Family Support, aiming to reduce Stigma;
- Ownership by MoH (Focal Point Person)
- Advocacy with Donors/Partners/Diaspora

In the mid-term the teams’ goals are that of:
- Integration extension of Mental Health into Primary Health Care in all areas;
- Mental Health into Curricula of Pre-Service Training;
- Human Resources- Mental Health Professionals’ Training;
- Life skills education for Children-in school and out of school;
- Public Mental Health Education/ Family Support;
- Drug dependence Care Facilities in existing Hospitals

In the realm for recommendations to be initiated in the long-term are those:
- Mental Health Wards in the Public and Private Sector to be used solely for acute stabilization;
- Community Mental Health Out-Patient Centers be established (MoH) ;
- Specialist Medical and Non-Medical Professionals-Multi Disciplinary Teams (MoH & Private Sector);
- Mental Health Legislation & Policy Development (Govt. & Stakeholders);
- Rehabilitation- Welfare support for the Person with a Mentally Health Disability and their Families (Govt.)

A positive change on the ward, August 2012
REFERENCES


Somaliland Population Committee estimated the population 3.4 million in 2006, see annex 1 for different estimations, sources and dates


50th Directing Council 62nd Session of the Regional Committee Washington, D.C., USA, 27 September-1 October 2010- Document 50/12-Annex D