IMC Ethiopia

Baseline Mental Health Situational Analysis

Dollo Ado Somali Refugee Camps

January 10th, 2013
Table of Contents

1. Assessment Goals

2. Assessment Methodology
   2.1. Desk Top Review
   2.2. Site Visits, Interviews and Focus Group Discussions
   2.3. Assessment Instruments and Analysis

3. Assessment Results
   3.1. General Background and Context
   3.2. International Medical Corps in Dollo Ado
   3.3. Prevalence of Mental, Neurological and Substance Abuse Problems and Psychological Distress

3.4. Local Concepts of Mental Illness and Expressions of Distress

3.5. Mental Health Services in Dollo Ado

4. Conclusions and Recommendations
   4.1. IMC Mental Health Curriculum and Training
   4.2. IMC Mental Health Services and Coordination
   4.3. Further Programming Needs and Opportunities

Appendixes
   Key Informant Interview Format

Acronyms

ARRA Administration for Refugee/Returnee Affairs
FGD Focus Group Discussion
GBV Gender Based Violence
IASC Inter-Agency Standing Committee
MHPSS Mental Health and Psychosocial Support
RCC Refugee Central Committee
UNHCR United Nations High Commissioner for Refugees

Acknowledgements: This report would not have been possible without the efforts and support of IMCs national mental health team: Dr. Haile Esubalew, Jalle Teferi, Jamal Ibrahim, Zewdu Shewangza, Tadu Bezu, Ashalew Zebene, and Abdulwas Yusufi. We also want to thank all our key informants and Focus Group Participants for sharing their knowledge, insights and experiences with us.

For questions or to learn more about this assessment, please contact: Dr. Inka Weissbecker, IMC Global Mental Health and Psychosocial Advisor, iweissbecker@InternationalMedicalCorps.org
1. Assessment Goals

The overall goal of this situational analysis was to inform planning of the new BPRM funded IMC mental health program including:

1. Mental health capacity building and curriculum development for ARRA health center staff
2. Overall coordination and delivery of mental health services and activities
3. Mental health outreach, advocacy and awareness raising activities

Data was collected on the mental health context (e.g. expressions of distress and local concepts of mental health, coping and community sources of support; attitudes towards people with mental illness and help-seeking patterns); and on currently existing mental health and psychosocial services. This assessment focused on identifying needs as well as resources. The situational analysis concludes with recommendations aimed to inform IMC program implementation and shed light on further program needs and opportunities.

2. Assessment Methodology

The assessment was conducted from December 9th 2012 to January 4th 2013 in Boqolmayo, Melkadida and Kobe refugee camps. Brief assessment visits were also conducted in Buramino and Hiloweyn camps (Dec 29th) and Filtu regional hospital (December 14th). Data was collected by the IMC Ethiopia Mental Health and Psychosocial Support (MHPSS) team including the MHPSS program manager and deputy program manager, as well as three mental health officers and two psychosocial officers. The IMC Global Mental Health and Psychosocial Advisor provided technical support, analyzed the data and wrote the assessment report.

2.1. Desk Top Review

A desktop review of previous mental health and psychosocial assessments in Dollo Ado camps and relevant literature included:

- MSF (January 2011) Presentation of MSF-Spain Mental Health Assessment and Project Proposal in Liben Zone Somali Refugee Camps of Bokolamyo and Malkadida and Dolo Ado Transit Camp.
- UNHCR (August 2012) Rapid Mental Health and Psychosocial Assessment.

2.2. Site Visits, Interviews and Focus Group Discussions

Key Informant Interviews

**Refugee community key informants:**
- RCC members (Secretary, Disability Chairman, Women’s Association Chairman, Youth Association Chairman, Disability Leader)
- Religious Leaders

**Camp Administration and Service providers:**
- ARRA Camp Coordinator
- General Health Staff (Medical director, Nurse)
- SGBV Staff (2)
- Psychologist (2)
- Counselor (2)
- Community Incentive Worker

**Focus Groups Discussions** (5-10 participants)
- Refugee incentive workers (former MSF mental health and new workers) in Bokolemayo and Melkadida
- GBV refugee incentive workers in Kobe

**Coordination meetings and visits with other agencies**
- Camp level coordination meetings
- Meetings with RCC representatives in Melkadida, Bokolemayo and Kobe
- Meetings with former MSF national and expat psychosocial counseling staff
2.3. Assessment Instruments and Analysis

International Medical Corps used the WHO/UNHCR (2012) “Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings”\(^1\) including an IMC specific comprehensive version of the “Checklist for integrating mental health in primary health care (PHC) in humanitarian settings” as well as the “Participatory assessment: perceptions by general community members” (see Appendix for assessment tools used). The data were entered and analyzed using Microsoft excel software. All qualitative data from key informant interviews and FGDs was theme coded and grouped for analysis.

3. Assessment Results

3.1. General Background and Context

The Somali region in Ethiopia has been experiencing an increasing influx of refugees fleeing from ongoing political and civil unrest and famine in Central and Southern Somalia. UNHCR and ARRA established Boqolmayo Camp in February 2009, followed by Melkadida (2010), Kobe (2011), as well as Buramino and Hilaweyn Camps (2012). A sixth camp is currently planned to accommodate the continuous flood of refugees. As of January 5\(^{th}\), 2013 there are 181,419 refugees in all camps. During the week of December 22–28\(^{th}\), 2012, the daily arrival rate of registered individuals was 151.3\(^{3}\). The majority of Somalis are Sunni Muslims. Most are pastoralists (livestock herding: goats, camels, cows, sheep and donkeys) while some are professionals (mostly teachers and some business men) from Mogadishu.

3.2. International Medical Corps in Dollo Ado

International Medical Corps is currently the largest implementing partner for ARRA and UNHCR in the Dollo Ado camps, and has been conducting programs in the areas of nutrition, WASH and GBV. Starting in November of 2012, International Medical Corps has been implementing community based mental health and psychosocial support services in Boqolmayo, Melkadida and Kobe Camps with support from BPRM. The project is integrating comprehensive clinical mental health and psychosocial services with ARRA health clinics in all camps and has the following components:

→ **Building capacity of ARRA health clinic staff in mental health**: Provision of training and on the job supervision to ARRA health staff using the WHO mhGAP guidelines and focusing on the 3 priority conditions chosen at the national level (epilepsy, depression, psychosis). The training is consistent with national guidelines and will build capacity in the longer term. One additional mental health condition will be chosen depending on needs and priorities in the camps determined by this situational analysis.

→ **Providing comprehensive mental health and psychosocial services**: Mental health officers (1 in each ARRA clinic) provide both pharmacological and non-pharmacological treatment of mental disorders. They are supported by psychosocial officers who are engaged in mental health case management and counseling. Refugee-incentivized volunteers work closely with the psychosocial workers in conducting home visits and community outreach activities. Community outreach efforts and psychosocial activities do not only benefit refugees as a whole but also build mental health promotion skills among refugee incentivized volunteers. Knowledge, attitudes and practices around mental illness among Somali refugees explored in this situational analysis will inform these activities.

→ **Psychosocial activities**: Psychosocial workers and volunteers organize psychosocial activities in each camp which to promote general well-being and social support.

---

3.3. Prevalence of mental neurological and behavioral problems and psychological distress

The difficult living conditions in the camp and past stressful experiences can contribute to psychological distress and mental disorders. MSF (2011) reported that refugees have lost family members and personal belongings as well as jobs and livelihoods in Somalia and some have witnessed violent conflict. According to UNHCR however, the majority of current new arrivals fleeing due to food insecurity rather than conflict (Reasons for flight: 94% food insecurity, 5% other, conflict and food security >1%, 0% conflict only)². IMC key informants reported that stressors in the camp include insecurity, uncertainty, GBV and limited access to needs and opportunities such as jobs and livelihoods. The World Health Organization (WHO) estimates that rates of common mental disorders such as anxiety disorders and depression double in the context of humanitarian emergencies from a baseline of about 10% to 20% while people with severe mental disorders (2-3%) are especially vulnerable in such contexts and needs access to care. This has important public health implications as mental health problems interfere with a person’s functioning and daily living which typically impacts the whole family.

Prevalence of mental health related symptoms

A previous IMC assessment of symptoms of severe distress (using the WHO/UNHC 2012 Toolkit, “Assessment of serious symptoms of distress in humanitarian settings”) was conducted in 2011 including total of 1980 participants, 942 from Boqolmayo and 1038 from Melkadida camp. Of those participating, 77% were female and 23% male (Figure 1). Survey results showed that a high number of participants is reporting severe symptoms of distress and that at least every fifth person suffers from mental health difficulties that impact day to day functioning. This is consistent with general WHO estimates.

Especially notable is the high number of people (67.8%) avoiding reminders of distressing events, which is an indication of the severe hardship and stressors the affected population has experienced.

Key informant interviews with service providers who have been engaged in psychosocial support and counseling in the camps suggest that common problems include depression, stress and anxiety, non-specific somatic complaints and epilepsy. IMCs past FGDs (2011) in Melkadida and Bokolmayo (14 groups total) found emotional problems related to the refugee situation including fear, sleeplessness, being demoralized, being forgetful, difficulty managing children, relationship problems, lack of patience, feelings of loneliness and thoughts of suicide. As a result of those problems, it was reported that people would have difficulties in their day to day activities such as keeping personal hygiene, doing well in school or remembering things, and accomplishing work and livelihood activities. Such problems reportedly led to potentially destructive behaviors such chewing chat, smoking cigarettes, drinking too much alcohol, and stealing

Frequency of mental health problems identified in general health clinics

IMC collected data on the approximate number of mental health cases as ARRA clinics (see table below). Melkadida identified the most cases of mental disorders (47) followed by Bokolmayo (28) and Kobe (8). Psychotic disorders were most common followed by epilepsy and medically unexplained somatic complaints.
3.4. Local concepts of mental illness and expressions of distress

Key informants were asked about local concepts of mental illness including perceived causes, consequences and ways of help seeking. Key informants often had their own ways of categorizing mental illness and there are various expressions for different types of mental problems in the Somali language (for a summary from key informant interviews see Table 1 below). Several key informants noted that there are two types of mental illness, one that can be identified by looking and the other cannot. Another community leader key informant distinguished between people with mental illness who live harmoniously with the community and those who are in repeated conflict with the community. The first group lives with the community by taking a part in different social activities but their role is limited whereas the second group is chained at home, considered as harmful and not involved in social roles.

<table>
<thead>
<tr>
<th>Mental Health Problem</th>
<th>Symptoms</th>
<th>Perceived Cause</th>
<th>Ways of help-seeking and coping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waali (possible psychosis)</td>
<td>Appearance: Very dirty, dressed inappropriately Emotional: Nervousness, intense fear, irritability Disorganized behaviors: Wandering through the streets aimlessly, disorientation, taking off one’s clothes in public, walking naked, collecting garbage Violence and aggression: Aggressiveness, violent behavior toward others, beating others or screaming at someone else randomly and unpredictably Eating: Not eating, eating rubbish Sleep: Bad dreams Speech: Talking alone, mumbling, not talking at all, illogical talk/ disorganized speech, nonsense words, talking like a child, others are unable to understand them Memory and concentration: Inability to remember and to concentrate</td>
<td>Spiritual: Spirits, ghosts, or a curse (e.g. Gini-supernatural beings or spirits created by God)</td>
<td>Qur’an Recitation by religious leader (individual session) Taking the person to the bush and letting them talk about what he feel</td>
</tr>
<tr>
<td>Qoof waalan (possibly psychosis)</td>
<td>Behavioral: Clothes very untidy, uncut nails and hair, carrying things that are not useful such as stones, walking around, asking to for food and eating whatever they find, sleeping wherever, sometimes burning houses Cognitive: Cannot identify children, wife, relatives, always goes out, controlled by another person Harming self or others: Harming people or themselves, (e.g. some may take children to the bush and leave them there).</td>
<td>Biological: Can be present at birth Traumatic events (e.g. car accident, bomb, loss of wealth) Can also be caused by a lot of wealth or isolation from people</td>
<td>Physical restraint (e.g. tying person), giving an injection from a shop in the camp (shop receives it from Nairobi, likely an antipsychotic)</td>
</tr>
<tr>
<td>Murug (possibly depression)</td>
<td>Emotional: Feelings of “everyday” sadness, stress, feeling disappointed, crying Behavior: Self-neglect Social: Isolation, poor communication, poor social interaction, staying at home, lack of interest in social activity Cognitive: having flashbacks Somatic: Headache, muscle aches and pain, nausea, loss of</td>
<td>Stressors: Stressors in Somalia, trauma, domestic violence, financial pressure because of disability in family</td>
<td>This problem is confidential and often not talked about Others try to talk to affected people and advise them Talking to friends or family</td>
</tr>
<tr>
<td>Case</td>
<td>Symptomatology</td>
<td>Stressors</td>
<td>Ways of help-seeking and coping</td>
</tr>
<tr>
<td>------</td>
<td>----------------</td>
<td>-----------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td><strong>Mashqool</strong> (possibility depression)</td>
<td>Being worried, staying at home, loss of interest in daily activities, lack of communication</td>
<td>Loss of property or loved ones</td>
<td>Family and relatives and neighbors can help. Giving them back what they lost, making stories and consulting with the person.</td>
</tr>
<tr>
<td><strong>Walida dhaqanta</strong> (possibly manic-depression)</td>
<td>Behavior: Behaving like a normal person (e.g. wearing clothes, cleaning himself, eating like a normal person), the person may now know that he has a problem. His relatives will report he is behaving differently. The person can change in one hour and the next hour they are normal or from one week to the next week. Memory: being forgetful, memory loss (e.g. person does not remember that he had school education or classes) Cognitive: Person talks about strange ideas (e.g. saying he will fly to the USA tomorrow or will marry the daughter of the bush), believing negative things others say about them (e.g. them being stupid or careless) Talkativeness: Sometimes talking without stopping</td>
<td>Physical trauma (e.g. person fell from a tree) Loss (e.g. someone’s wife has died, losing a loved one, or property has been taken, loss of opportunity to go abroad) Witnessing traumatic event (e.g. seeing someone raped or killed)</td>
<td>Religious ceremonies, prayers, going to the mosque, admitting their mistakes, injections bought from shop in the camp (Note: likely antipsychotics which can also be affective for manic episodes)</td>
</tr>
<tr>
<td><strong>Haasuus</strong> (Possibly PTSD)</td>
<td>Flashbacks, lack of communication, nightmares and isolating themselves</td>
<td>Past stressful events</td>
<td>No treatment because “thinking and worrying about the past is not accepted in Islamic faith and God has a plan to do everything”. Reading Qur’an for exceptional persons</td>
</tr>
<tr>
<td><strong>Wareer or mirdaabool</strong> (Possibly epilepsy/ seizures)</td>
<td>Falling down, being shocked, being awake at night from sleep shouting, talking in sleep</td>
<td>Gini</td>
<td>Reciting Qur’an Borena (Ayana)</td>
</tr>
<tr>
<td><strong>Mirlaan</strong> (Possibly Dementia or aging)</td>
<td>Loss of memory, becoming irritable when they forget where they put something</td>
<td>Gini, witchcraft, curse, punishment from Allah</td>
<td>Reciting Qur’an Traditional healers such as Borena, Shera practices Health facilities</td>
</tr>
<tr>
<td><strong>Mala’awal</strong> (an imaginary belief)</td>
<td>Suspiciousness, absent mindedness, anxiety</td>
<td>Gini</td>
<td>Reciting Qur’an</td>
</tr>
<tr>
<td><strong>Psychologic al Distress</strong></td>
<td>Irritability, preferring to be alone, weakness, muscle tension, sleeping problems, communication problems</td>
<td>Witnessing or experiencing traumatic situations (e.g. war, drought) Loss of belongings such as animals</td>
<td>Consulting friends and relatives, making stories Refunding belongings (e.g. money collected from the community as replacement for the loss) Participation in group activities such as singing and dancing Consulting religious leaders</td>
</tr>
<tr>
<td><strong>Shido</strong> (Possibly stress)</td>
<td>Emotion: Worry Behavior: Frustration, aggressiveness Appetite: Lack of appetite Sleep: Sleeplessness, nightmares Thoughts: Thinking about how life in Somalia was better and they could have more than this, longing for Somalia to be peaceful</td>
<td>Biological causes Uncertainty: Waiting for results of refugee interview or of HIV test No access to opportunity: Missed opportunity, feeling discriminated against</td>
<td>Someone who has strong faith can accept and adapt to the situation (e.g. become donkey cart rider even if they have been a pilot before) Accept advice from the family and leave the rest to God</td>
</tr>
</tbody>
</table>

- Distress
- Anxiety
- Biological
- Psychological
- Emotional
- Behavioral
- Cognitive
- Physical
- Sleep
- Thought
- Appetite
- Family
- Relative
- Neighbor
- God
- Quran
- Worry
Impact of Mental Illness

When asked about how mental illness would impact those affected, key informants named a wide range of impacts, which included the effects of the mental illness itself as well as wider consequences due to the response from the family or community. Severe social stigma exists regarding those affected by mental illness. Key informant interviews suggest that people with severe mental disorders such as psychosis are stigmatized in the community and are at high risk for violence and abuse. Key informants also noted ways in which families of those with mental illness would be affected (see Table 2 for details).

Table 2.

<table>
<thead>
<tr>
<th>Impact of mental illness on the person</th>
<th>Family and Community Aspects of Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Daily Functioning</strong></td>
<td></td>
</tr>
<tr>
<td>Impaired daily functioning</td>
<td>Considered as unable to function</td>
</tr>
<tr>
<td>• Impaired daily task and routine activities</td>
<td>• Considered as harmful to society and incapacitated by community</td>
</tr>
<tr>
<td>• Can’t survive by themselves and dependent on family</td>
<td></td>
</tr>
<tr>
<td>Reduced role Functioning</td>
<td>Physical restraint and exclusion</td>
</tr>
<tr>
<td>• Involved in some activities but very limited involvement in social and other roles</td>
<td>• Chained and closed in private room at home</td>
</tr>
<tr>
<td><strong>Social Functioning</strong></td>
<td></td>
</tr>
<tr>
<td>Isolation</td>
<td>Being excluded by community</td>
</tr>
<tr>
<td>• Sitting alone, staying in bed, staying at home, isolating them selves from society</td>
<td>• Avoided by the community and isolated/restricted</td>
</tr>
<tr>
<td>Lack of interest in participation</td>
<td></td>
</tr>
<tr>
<td>• Lack of interest to participate in social activities (e.g. wedding ceremony, mourning, religious holiday ceremony and etc.)</td>
<td>• “Restriction from society because the society expects they are crazy and not able to perform properly and are destructive as they don’t have motivation and are incapacitated”</td>
</tr>
<tr>
<td></td>
<td>• People change the side of the street or run away from persons with mental illness because they feel it is communicable</td>
</tr>
<tr>
<td><strong>Relationship Functioning</strong></td>
<td></td>
</tr>
<tr>
<td>Difficulty maintaining or initiating marriage</td>
<td>Excluded from marriage prospects or break up of marriage due to mental illness</td>
</tr>
<tr>
<td>• Relationship problems, lack of marriage</td>
<td>• Avoiding marriage with those who are mentally ill</td>
</tr>
<tr>
<td></td>
<td>• Breaking up of marriage (divorce, separation; common practice among ‘Maymay speakers’ especially if wife is mentally ill, it is easy for her husband to separate/divorce)</td>
</tr>
<tr>
<td></td>
<td><strong>Not being supported by family</strong></td>
</tr>
<tr>
<td></td>
<td>• No supportive communication with family, lack of primary support group</td>
</tr>
</tbody>
</table>
Getting into conflict
• Easily getting into conflict, can disturb his/her neighborhood, quarrel with the community, throw stones.

Being subject to stigma and discrimination and abuse
• Both family and the person affected are prone to stigma and discrimination- (e.g. people run away or throw stones using nicknames such as ‘wallo’=crazy)
• “Some people in the community intentionally provoke individuals with mental illness by calling them “kewus” which means ‘crazy’”

Educational and Employment Functioning

Unable to attend education
• Unable to attend school or take advantage of educational opportunities due to mental illness

Restricted access to education
• Loss of access to education (e.g. a child with seizure disorder may leave school because of fear or pressure from his/her class mates)

Unable to perform job
• Economic impact
• Loss of job or income generating capability,
• Loss of job (due to effect of mental illness such as poor concentration)

Loss of job due to discrimination
• Loss of job due to discrimination (e.g. in Kobe, refugees with epilepsy cannot be selected for incentive worker positions)
• Engaged in labor but within limited role and without compensation

Effects on the Family

Impact on family well being
• Loss of parental caregiving (e.g. if father or mother is mentally ill he/she is unable to give proper and expected care for children)
• Family may be depressed
• The person with mental illness may act violently towards somebody and this another burden for family

Social and Community Aspects of Impact

Discrimination towards family by Community
• People in the community may say ‘….that/this son/daughter belongs to that crazy man’

Economic and caregiving hardship on family
• Reduction in family income because more time is spent with the person with mental illness (e.g. family may need to stay with them to protect from harm)
• Lost income if the affected person is the one responsible for family income
• Need for buying expensive medicines

Family may be restricted from social services

Harm to self
• Suicide or self harm due to mental illness

Suicide due to experience of stigma

Harming others
• Harming others and homicide

Treatment and care seeking for mental illness

Chronic or severe problems

Key informants were asked how people affected by mental illness and their families cope with mental health problems. The most frequent response included religious practices. Recitation of the Qu’ran is performed at the individual level or in groups. The religious leader may be requested to come to the residence of the ill person or the individual may be taken to the religious place. This practice is common for severe mental health problems because there is a belief that such problems are caused by ‘evil spirits’ locally termed as ‘Sheitan/Gini’. Some also have an ‘Ayana’ performed, which is a traditional ceremony. The “Ayan seer” who is leading the ceremony asks the individual or his/her family to bring goat or sometimes chicken on the ceremony date. The preferred color of goat/chicken is mostly black or white. The “Ayan seer” prays for the individual and provides some traditional medicines prepared from leaves or roots of tree. Seeking out health facilities for severe mental and neurological disorders is rare and often a last option. It is a common belief no medication can cure mental disorders but that medications can help affected people sleep and calm down. Key informants also reported that many refugees believe that severe mental illness is incurable and not preventable.

Indeed, when asked where they would refer people with mental illness the majority of Somali key informants said they would send them to traditional healers or religious leaders (or chain them). Key informant service providers...
who were also implementing partners in the camp were more likely to report that they would refer to ARRA or MSF.

Previous MSF psychosocial counselors reported that clients who were prescribed medication from ARRA for chronic conditions such as epilepsy often did not comply with medication regimens. They frequently stopped medication prematurely and expected to see effects immediately or they were worried about dependence. It is also likely that affected persons and their families did not receive enough explanation and follow given the previous lack of clinical mental health specialists and lack of outreach by such professionals. Psychotropic medication (likely antipsychotics) is also reportedly sold unofficially in shops and used to treat episodes of psychosis and mania.

Common mental health problems

Key informant interviews and the relevant literature suggests that common mental health problems such as depression and anxiety are not conceptualized as mental illness but rather as normal reactions to the stresses and pressures of the environment. Somalis typically seek to resolve these issues through religious practices and by seeking support and advice from family and community members. If loss of belongings is involved as precipitating factor, the community may also come together to replace the loss. Most would not consider seeking care for such problems at health facilities. However, those affected may seek out health clinics for stress related problems such as non-specific somatic complaints. There is also a belief that depression is very common and that people recover easily.

MSF counselors reported that they often had difficulties engaging clients with common mental health problems and somatic complaints in treatment. They reported that those clients were often seeking out medication treatment instead of counseling and that the majority dropped out of treatment.

<table>
<thead>
<tr>
<th>Care seeking for chronic or severe mental health problems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Religious practices</strong></td>
</tr>
<tr>
<td>✓ Going to a religious leader</td>
</tr>
<tr>
<td>✓ Reading the Quran</td>
</tr>
<tr>
<td>✓ Going to a mosque</td>
</tr>
<tr>
<td>✓ Praying</td>
</tr>
<tr>
<td><strong>Restraint and punishment</strong></td>
</tr>
<tr>
<td>✓ Chaining</td>
</tr>
<tr>
<td>✓ Isolating affected persons in a private room</td>
</tr>
<tr>
<td>✓ Chaining them and moving them away from home to the forest</td>
</tr>
<tr>
<td><strong>Health care facilities (rare)</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Coping with psychological stress and common mental health problems

- ✓ Helping each other morally and economically
- ✓ Praying
- ✓ Going to mosque
- ✓ Acceptance
- ✓ Rest
- ✓ Sleep
- ✓ Self-isolation
- ✓ Recreational activities
- ✓ Enjoying time with friends
- ✓ Chewing chat, drinking tea
3.5. Mental Health Services in Dollo Ado

According to the WHO optimal mix of services, health systems should provide multi-layered services to support the mental health and psychosocial well-being of the community (see pyramid). Significant gaps exist in the Somali region as a whole and in remaining camps.

1. Inpatient Psychiatric Facilities

There is no inpatient psychiatric capacity in the Dollo Ado camps or the Somali region. Patients requiring specialized mental health care and hospitalization are referred to Emmanuual mental hospital in Addis Ababa, which is about 3 hours by road and one and a half hours by plane.

No specialized mental health providers (e.g. psychiatrists, psychiatric nurses, MH Officers) are available in the Somali region, resulting in a significant gap in mental health service provision.

2. General hospitals and Community Mental Health

**General hospitals:** The nearest referral hospital is Filtu Hospital, which can be reached by road in two to three hours. According to an assessment visit by IMC in December 2012, staff for Filtu includes 5 GPs, 4 HOs, 25 nurses, 7 midwives and 2 social workers as well as one surgeon. Filtu hospital does not have a psychiatric inpatient unit and the staff has not received mental health training. However, Filtu usually has some psychiatric medication available, which includes antidepressants, anti-anxiety medication, anti-epileptic medication. There are no anti-psychotics available and only occasionally mood stabilizers (generic bipolar disorder medication) are in stock. Laboratory tests available include complete blood count, rapid blood sugar test and toxicology screening test (Urine Analysis). Over the past month, it was estimated that there have been 2 persons of depression and 5 persons with epilepsy who have received treatment. There were no cases of psychotic disorders and 4 cases of alcohol and drug use disorders. Persons who need specialized mental health treatment are referred to Emmanuual hospital in Addis Ababa but such referral occurs only rarely.

**Community mental health:** Community mental health services in the 3 camps had been previously (until December 31st 2012) assigned to MSF-Spain. MSF staffing included psychologists as well as lay counselors and community outreach volunteers. MSF provided psychosocial group and individual counseling for clients presenting with mental health problems as well as community outreach and general education about psychological stress, positive coping and seeking care. However, the program did not include clinical treatment for those requiring more specialized services (e.g. patients with psychosis, epilepsy) and psychiatric medication. Such cases were referred to general ARRA clinics whose staff had only very limited training in identification and management of mental and neurological disorders.

RADO (Rehabilitation and Development Organization) has psychologists on staff and is engaged in services and activities for people with mental and physical disabilities such as counseling and psycho-education, psychological first aid, support groups (e.g. for mothers with children with disabilities) and facilitating access to basic needs in all camps. They also provide materials and supplies (e.g. wheelchairs, eye glasses). However, RADO does not have the capacity to address more specialized mental health problems that need medication management.

Safe the Children is providing child friendly spaces, Early Childhood Education (ECD) as well as psychosocial and life skills activities for children, including children with disabilities (Melkadida). The IMC GBV program includes psychosocial support and recreational activities in Melkadida and Kobe. Psychosocial activities such as sports for
youth are provided by JRS in Melkadida.

IMC is currently providing pharmacological as well as non-pharmacological treatment for mental disorders and building the capacity of ARRA and other national staff (see section 3.2. for details).

### 3. Mental Health Services through General Health Clinics

According to national guidelines in Ethiopia, mental disorders such as epilepsy, psychosis, depression should be managed at the PHC level. The government of Ethiopia is currently working in partnership with WHO to integrate mental health in primary health care in select provinces. However, the Somali region or ARRA clinics have not been included in those efforts so far.

**Mental health in ARRA clinics in Bokolmayo, Melkadida and Kobe:** IMC assessed mental health capacity and integration in ARRA clinics located in the three camps using the IMC PHC Integration Checklist.

**Staffing:** General health care in all three camps is provided by ARRA through 3 clinics, each of which have one medical director who is a doctor. Health facility staffing is shown below.

#### Psychotropic medications: WHO essential medications for managing mental disorders are generally available in all camp clinics (except for antiparkinsonian medicine for side effects from antipsychotics) and include generic antidepressants, anti-anxiety, anti-psychotic, anti-epileptic and bipolar medication. Psychotropic medication is frequently supplied through donations. However, the staff lacks capacity and skills in pharmacological management if mental illness and in monitoring and following up with mental health cases effectively.

**Mental health training and capacity:** None of the health staff at ARRA clinics has received training and supervision in mental health in line with to national and WHO guidelines. In Melkadida and Kobe, less than 5 staff has attended an MSF 2-day training in prescribing psychotropic medications (based on MSF guidelines). MSF had not provided any supervision or follow up after this training. ARRA clinic staff in all camps stated that training and supervision in appropriate identification and management of mental health cases was a significant need and that patients were not receiving adequate mental health care.

**Case Identification, management and referral:** The assessment team found that very limited mental health care is currently being provided in ARRA clinics. Case identification is low and staff reported that they felt that those presenting with mental health problems were not properly identified. Psychotic cases were the most common, followed by epilepsy and medically unexplained somatic complaints. Given the lack of sufficient training and skills, the management of mental health cases is very limited. ARRA doctors provide basic medication management for depression and psychotic disorders. Un-explained somatic complaints are also often managed with medications...
(although this is not recommended by WHO mhGAP guidelines). Clinic heads reported that patients often do not return for follow-up. Furthermore, there is no referral point for people with mental health problem inside or outside the camp. The only referral option for severe cases needing hospitalization is Addis but such referral rarely occurs and is logistically challenging.

**Community Referral links:** Links between ARRA clinics and formal and informal community services and supports (e.g. community workers schools, social services and other community social supports, traditional /religious healers) only occurs rarely or never in Bokolmayo and Melkadida and more frequently to some providers (MSF, CHWs, Save) in Kobe.

**Health Information System (HIS) reporting:** Bokolamyo and Melkadida clinics report mental health cases to UNHCR using one category (for Mental, Neurological and Substance Use Disorders) while Kobe uses the comprehensive 7 categories recommended by UNHCR and WHO globally.

### Mental health services in Buramino and Hiloweyn Camps

A brief assessment carried out in Buramino and Hiloweyn camps (where IMC is currently not operating) found that there is a significant need for training and capacity building in mental health. WHO essential medications for managing mental disorders are generally available in ARRA health clinics but the staff lacks capacity and skills in managing and following up with mental health cases effectively. Case identification is extremely low with both health centers reporting no more than 15 cases in the last month, which include epilepsy, depression, bipolar disorder, psychotic disorders, attention deficit disorder and non-specific somatic complaints. Given the lack of sufficient training and skills, the management of mental health cases is very limited. Both ARRA health clinics reported that there was a training need for mental health among staff and that cases were not receiving appropriate care.

Furthermore, The assessment team found that only very limited psychosocial support and mental health care has been provided in Buramino and Hiloweyn. RADO (Rehabilitation and Development Organization) is engaged in services for people with mental and physical disabilities such as counseling and facilitating access to basic needs in both camps but does not have the capacity to address more specialized mental health problems that need medication management. MSF psychosocial counseling and outreach had been limited to Bokolmaya, Melkadida and Kobe and did not reach Buramino and Hiloweyn. In Hilaweyn, ACF previously had a psychologist on staff to provide psychosocial support for beneficiaries of their nutrition programs. In summary, there is a significant need to cover mental health care in Buramino and Hiloweyn.

### 4. Summary and Recommendations

This assessment has provided direction for IMC programming in the Dollo Ado camps in line with current project objectives of ARRA staff training, clinical mental health service provision and outreach as well as mental health advocacy and awareness raising.

#### 4.1. IMC Mental Health Curriculum and Training

**Training of ARRA Health Staff in Mental Health:**

- **National priority mental health conditions:** Based on existing data from ARRA clinics, MSF and information shared by key informants, the priority mental health conditions identified to be integrated with general health care in Ethiopia at the national level (depression, epilepsy, psychosis) are relevant in the camps as well. According to ARRA clinic staff, psychotic disorders and epilepsy are the most frequently seen mental health conditions but there has been no capacity to provide appropriate treatment in line with national and global guidelines. The new IMC project to build ARRA staff skills in this regard would fill an important service gap in the longer term. This assessment also showed that depression is typically addressed through family and community support and will be important to engage such supports as part of psychosocial treatment and advice.

- **An additional mental health priority condition to be included in the IMC training of ARRA health professionals identified in this assessment are non-specific somatic complaints. Such complaints are very**
common at the clinic level and are often managed inappropriately with medication. Building ARRA staff skills in this area is also important given that Somalis with common mental disorders such as depression often present with somatic complaints. IMC plans to include identification and management of non-specific somatic complaints based on the WHO mhGAP intervention guide in the training of ARRA health staff as well as of IMC psychosocial officers and refugee incentivized volunteers.

4.2. IMC Mental Health Service Provision

Mental Health Service and Coordination

- No other agencies in the camps provide ongoing and specialized clinical mental health care, which include pharmacological management. Significant gaps in mental health service provision and capacity have existed previously in all Dollo Ado camps. MSF has only provided psychosocial counseling through training and supervision of local staff and refugee volunteers. Rado has provided rehabilitation services and occasional psychiatric care. This gap in specialized mental health services including medication management had also been noted in conversations with key stakeholders such as UNHCR, ARRA and the RCC as well as in a previous rapid UNHCR mental Health and Psychosocial Support Assessment (August 2012). IMC is filling this gap by providing specialized mental health services including capacity building of ARRA health staff in all 3 camps but a significant needs remain in Buramino and Heloweyn as well as in the planned 6th camp. ARRA and UNHCR have requested for IMC to provide services in both additional camps as well but funding has yet to be identified.
- Other agencies and implementing partners in the camps provide important services, which are also relevant for people with mental disorders and their families (e.g. protection, shelter, health, rehabilitation, etc.). Community support structures such as the RCC (e.g. disability, youth chairs) and other supports (e.g. religious leaders) also play important roles in the camps. Building links for cross referral would be an important part of IMC mental health case management.

Identification and treatment of persons with mental illness

Persons with severe or chronic mental illness and their families may be reluctant to seek care at clinics since causes and solutions are seen as spiritual. Those affected may also not expect medications to be helpful. Somali refugees do generally not conceptualize common mental disorders as mental illness but rather as normal reactions to environmental stressors. Going from house to house for educating people about mental illness and available treatment (as done previously by another organization) may not be the most effective and acceptable way to reach those affected. Instead, it would be advisable to create a network of referral links, which makes use of both formal and informal services and supports.

Persons suffering from severe and chronic mental illness

- Religious leaders and traditional healers are often the first point of contact for people with severe mental illness. Building relationships and working collaboratively with those groups where possible would be instrumental in reaching those affected. This should be done in a sensitive and respectful way as to not encourage harmful practices (e.g. burning) but allowing for clients and their families to choose what is most helpful to them (e.g. rituals) in addition to clinical mental health care. Community leaders (e.g. RCC) can also play an important role in facilitating supportive relationships between IMC and informal service providers.
- Medication adherence may be a challenge given belief about spiritual causes and mis-conceptions about medication (e.g. rapid effects). Comprehensive psycho-education by mental health staff as well as continued follow up and outreach by refugee workers will be needed to support medication compliance. Community leaders (some of which have expressed appreciation for IMC providing clinical mental health services) can also play an important role in encouraging families and clients to take medication as prescribed.

Persons suffering from common mental disorders

- People with common mental disorders such as depression place emphasis on social and economic causes, which can indeed play a key role in the etiology of such mental health problems. Those individuals are also likely to present with somatic complaints at ARRA clinics. It would be important not to stigmatize those affected but to provide services that are client centered and holistic. IMCs mental health case management model which is currently implemented in the camps, works with clients to develop a care plan which takes multiple and complex needs into account and helps clients and families take small steps to achieve realistic
goals. This approach is also strength based and helps affected persons identify and make use of their resources and supports - at the individual, family and community levels. Refugee workers also play an important role in engaging those individuals (e.g. in structured activities) and in following up to provide support.

**Mental Health Advocacy and Awareness**

Severe and chronic mental disorders are heavily stigmatized among Somali refugees and those affected do not only suffer from debilitating symptoms but are also often excluded from their families and communities. They consequently do not have access to opportunities for social supports, structured roles or education. They may be chained and experience physical and verbal abuse. Furthermore, their families may be stigmatized and excluded as well. Intervention should not only address mental health care needs and access to other services and supports (e.g. medical, protection) but also promote a more supportive environment. Advocacy and awareness should take a comprehensive approach and involve community leaders as well as affected persons and their families themselves. Research and IMCs experience have shown that mental illness stigma is best addressed by involving affected people recovering from mental disorders along with other key community members and showing that they can take on functional roles contribute to the community. IMCs project would not only provide clinical and case management which would show community members that it is possible to recover from mental illness, but would also assist those affected in accessing opportunities in the camps (e.g. skills building).

**4.3. Further Programming Needs and Opportunities**

*Mental health services in the region:* Challenges for mental health service provision in the longer term include the lack of qualified mental health staff (e.g. psychiatrist, psychiatric nurse, mental health officer) in the Somali region. Furthermore, the referral point for inpatient mental health needs is in Addis, which is not easily accessible. Donors and governments may consider allocating resources for shifting at least one qualified mental health staff to the Somali region, which would also be consistent with other regions such as Amhara, Tigray, Oromia, and SNNPA. It should also be considered to build the capacity of one hospital in the region for short-term acute psychiatric inpatient admission.

*Mental health services in the other camps:* A significant gap in comprehensive mental health service provision and capacity of ARRA health staff still exists in Buramino and Hiloweyn camps. Based on WHO projections, it is likely that every fifth person may experience common mental disorders while 1-3 % of the population suffers from severe mental disorders. Based on experiences in other camps, people with such severe disorders are frequently subjected to neglect and abuse in addition to lacking access to appropriate mental health care and to basic needs and opportunities. Access to appropriate care and support for those affected should be prioritized by donors.

In sum, this situational analysis provided important guidance for project implementation including local concepts of mental illness, coping and help seeking behaviors as well as mapping of formal and informal service providers. The assessment also highlighted challenges, which include lack of access to mental health services in the remaining camps and in the region.
APPENDIX: Key Informant Interview Format

IMC Ethiopia 2012 MHPSS Situational Analysis Tools

Key Informant Questions

Informed consent
It is important to obtain informed consent before doing any interviews. An example is provided here.

Hello, my name is ______ and I work for International Medical Corps. We are planning a project that will provide mental health services in the three Dolo Ado camps. Currently, we are talking to people who live or work in the camps. Our aim is to know what kind of problems people in this area have, to decide how we can offer support. We cannot promise to give you support in exchange for this interview. We are here only to ask questions and learn from your experiences. You are free to take part or not.

If you do choose to be interviewed, I can assure you that your information will remain anonymous so no-one will know what you have told us. We cannot give you anything for taking part but we would greatly value your time and responses. Do you have any questions?

Would you like to be interviewed? 1. Yes 2. No [please record number of times people say no]

Name of interviewer: ____________________________ Date: ____________________________
Interview Number: ____________________________ Key informant type (e.g. religious leader etc.): ____________________________
Gender of participant: O Male O Female Age: ____________________________

1) Local concepts of mental health and psychosocial problems
[Adapted from WHO/UNHCR tool 11, C3]

Listen for problems related to:
• feelings (for example feeling sad or fearful);
• thinking (for example worrying); or
• behaviour (for example drinking).

1.1. How would I as an outsider recognize a person with mental health problems?
   a. What does the [person] look like?
   b. How do they behave?
   c. Are there different types of mental illness? What are they?
   d. How can I distinguish between [NAME ANSWER FROM ABOVE]?

1.2. How would I as an outsider recognize a person who is emotionally upset/distressed?
   a. What does the [person] look like?
   b. How do they behave?
   c. Are there different types of being upset? What are they?
   d. How can I distinguish between [NAME ANSWER FROM ABOVE]?

2) Impact of mental illness
How does mental illness impact the lives of those affected?
- Probe: their relationships, their daily tasks, their opportunities for education, livelihoods
- Probe: Tasks that they do for themselves, their families, their communities

3) Coping and Support
[Adapted from WHO/UNHCR tool 10, 3.2.]

What kind of things do people affected and their families or communities do to deal with such mental health and psychosocial problems?
- E.g., things they do by themselves, things they can do with their families or things they do with their communities? “Does doing that help with the problem?”

4) Local attitudes and practices towards people with mental illness
[Adapted from WHO/UNHCR tool 11, C5]

4.1.) What do people in this community think about those with mental illness?

4.2.) How do people in this community treat people with mental illness?

5) Local help-seeking behaviors
[Adapted from WHO/UNHCR tool 11, C5]

Where do people with mental health problems seek help?

6) Knowledge of referral pathways

If you knew someone with mental illness in this community where would you send them?