An innovative approach to integrating mental health into health systems: strengthening activities in Somaliland

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Somaliland, in the Horn of Africa, declared independence from Somalia in 1991, but is yet to be internationally recognised as a sovereign state. The region has a significantly weak health sector, with poor service provision and scarce human resources for mental health, despite huge mental health need. Therefore, mental health care has been incorporated into an international health link (long term, mutually beneficial partnerships) between Kings College London and institutions in Somaliland, known as KTSP (Kings THET Somaliland Partnership). In addition to strengthening mental health skills and competencies within Somaliland, in the absence of any practising psychiatrists or specialist mental health nurses in the public sector, KTSP has promoted selected junior doctors (interns) to be mental health representatives in order to actively integrate mental health care into the existing health systems. This paper describes, in detail, the recruitment, roles, strengths and pitfalls of this strategy.

Keywords: capacity building, mental health, Somaliland, strengthening health systems

Background

Somalia, located in the horn of Africa, has historically suffered as a result of violence, civil war and famine, for decades. This has led to a lasting humanitarian crisis and subsequent high levels of mortality and morbidity (World Health Organization, 2005). Recently, extreme drought led to the *'worst humanitarian crisis in the world today'* (http:www.unhcr.org/pages/4eff4b06.html) and led to mass migration into Kenya.

Somaliland is a Sunni Muslim, clan based society that declared independence from Somalia in 1991, but is yet to be internationally recognised. It has an estimated population of 2–3.5 million people (Jarabi, 2007) with a large nomadic population and high numbers of internally displaced people. Somaliland remains a fragile state with poor levels of governance, coordination and infrastructure.

The health sector

The region's health sector is unregulated and, other than the comparatively few graduates of the recently opened medical schools, existing health professionals are unlicensed. Most doctors work exclusively in the private sector and, until recently, have not received any ongoing professional development. The country's health care budget is $750,000, for the entire region, per year (Syed Sheriff et al., in press).

Mental health need

There are no national epidemiological studies on mental health, however, a survey in the capital Hargeisa indicated that 21% of households care for at least one family member with a severe mental health problem (Odenwald et al., 2005). In addition, khat consumption and the impact of high rates

of female genital mutilation (Gulaid, 2008) contribute to the high burden of mental illness in the region. In addition, psychiatry is heavily stigmatised in Somaliland by both the general public and the medical community. Religious or traditional healers are often the first port of call for those suffering from mental health problems.

Mental health service provision

Primary health care is very limited. Until recently, neither psychotropic medications nor specialist psychiatric staff were available, in either primary or secondary health care services (including maternal and child health centres and health posts). Until recently, specialist mental health services were confined to two inpatient units; one at Hargeisa Group Hospital (HGH) with a 110 bed capacity, and one in Berbera Mental Hospital on the coast, with approximately 42 beds. These have operated largely with untrained nursing staff and access to only one general physician in Berbera. Many patients on the ward in the Hargeisa Group Hospital were found to be restrained with chains (Syed Sheriff et al., 2010).

The Kings College Hospital, THET, Somaliland Partnership (KTSP)

International health links are long term, mutually beneficial partnerships between UK health institutions and their counterparts in developing countries. (Leather et al., 2010). Such a link was set up between KCH (Kings College Hospital, London), THET, an international development organisation and the Edna Aden Maternity Hospital in Somaliland in 2000. This link is known as KTSP (the Kings THET Somaliland Partnership). In the early years, the link expanded to incorporate the two new medical schools (Hargeisa University and Amoud University in Borama) and the main government hospital in Hargeisa, HGH (Hargeisa Group Hospital) and focused on health sector capacity building and human resource development (Leather et al., 2006). The Kings THET Somaliland Partnership (KTSP) now includes four nurse training institutions, two medical schools, two professional associations, the health professional's council, some public hospitals and regional health boards, and involves close collaboration with the Ministry of Health and Labour. The primary working method of KTSP is a multi-pronged approach, strengthening primary health care systems to include mental health care in Somaliland. This is done by focusing on strengthening human resources through training, as well as salary support, mentoring, and support of leadership and governance in training institutions and professional organisations. Lack of mental health professionals, on either side of the link, meant that mental health was not incorporated into the activities of the link until 2007.

The two medical schools in Somaliland, the University of Amoud in Boroma and the University of Hargeisa, opened in 2000 and 2005, respectively. Graduates of the two medical schools automatically qualify for a two-year internship programme that provides a structured training environment. The Somaliland Medical Association, along with the two medical schools, administers the internships, with support from KTSP. Within this system, interns receive salary support from KTSP, conditional on their working full-time in the public sector. The programme is run jointly between the medical schools.

In 2007, the first medical students to graduate in Somaliland did so without formal training in mental health care. As a result

of concerns raised, regarding this lack of mental health training, the KTSP multidisciplinary mental health group (mentioned above) was set up.

At this time, there was also a brief appraisal of the situation concerning mental health care by KTSP. Also, in 2007, the main advocates for mental health care in Somaliland were local nongovernmental organisations (NGOs), such as the General Assistance and Volunteer Organisation (GAVO), as the Ministry of Health and Labour was vastly under resourced. Although the Deans of the Medical schools, the heads of the nursing institutions and leaders of professionals organisations wanted to include mental health care as part of the basic training of all health professionals, it was also clear that there were no mental health faculty members, psychiatrists nor specialist mental health nurses to advocate for this, or to provide training or supervision. Following this appraisal, it was decided that strengthening mental health skills and competencies in Somaliland would need to be an important component of a comprehensive strategy to strengthen mental health care within the existing health care system (Syed Sheriff et al., 2010). In 2008, the idea of competitively selecting promising interns and students to becoming KTSP mental health representatives (MHR) was devised.

KTSP mental health representatives

Original aims

- To be a local mental health care contact for those overseas, and for other mental health stakeholders in Somaliland
- To support the acquiring of teaching skills for local professionals and to improve sustainability of teaching and exams
- To improve local capacity by providing the MHRs with mentoring and supervision in psychiatry, and other skills, such as leadership capacity.

Description

The MHR system is based on a one-year post, undertaken while participating in the internship programme, and without additional financial remuneration. It is supported by the Deans of both medical schools, KTSP and the internship programme. A MHR is recognised as a position that carries both responsibility and prestige. They are selected from interns, to work closely with the KTSP mental health group, and to promote and sustain mental health care in Somaliland. Additional support from the KTSP involves several face-to-face meetings with the MHRs annually, as well as regular email, video conferencing and text-based, online meetings. In this way, the representatives receive regular supervision and mentoring in their role.

In 2008, the pilot recruitment criteria were partially based on an essay competition, in which all final year students and interns participated. Two male interns, one from each medical school, were selected on the basis of the essays and exam performance, and were endorsed by the Deans of both Medical Schools. Since the pilot, recruitment has been through a letter of application. The selection panel consists of psychiatrists in the UK, in addition to Somaliland colleagues, with applications processed anonymously. In 2009, 12 new interns applied for the two posts and one MHR was chosen from each medical school. In 2010, a dearth of applicants (reflecting a smaller than average graduating year) meant that there were only two applicants, both female and from the same university. As their applications were very strong, a decision was made, jointly with Somaliland

colleagues from both universities, to recruit them both.

One of the main duties of the MHRs has been to contribute to the annual KTSP undergraduate psychiatry course for final year medical students. Over 50 students have now completed this course. As KTSP has evolved to now provide distance learning via Medicine Africa, a medical education website designed to deliver real time, clinical, case based education to Somaliland from the UK (Finlayson et al., 2010). Since then, the MHRs have been taking an active role in coordinating online teaching (available to all interns and final year students). In addition, they also coordinate student, peer-to-peer mentoring (over 25 UK–Somaliland student pairs have completed the course), and an intern clinical supervision pilot (13 junior doctors in Somaliland are taking part). As the teaching delivered by KTSP has widened since 2008, the MHRs have taken on new roles assisting in teaching mental health care to over 40 nursing students. Another key role of the MHRs has been to develop the psychiatry exam in medical school finals, which has been compulsory since 2009. The MHRs, under the supervision of senior UK psychiatrists, have developed and coordinated the exams with the support of an external examiner from the UK, in the country during the actual exams.

Two former MHRs have continued to work within mental health care in Somaliland, following their internship. One is currently working as a doctor on the psychiatric ward in HGH, supported by an Italian NGO, the Gruppo per le Relazioni Transculturali (GRT) and remains in regular contact with KTSP for continuing clinical supervision. The ward, previously, did not have access to regular medical input and recent visits have shown that ward conditions have improved both in terms of documentation and a reduction in the incidence of chaining on the ward. Over the last year, another former MHR has set up a mental health outpatient service in Boroma, a city that had no psychiatric nor mental health services previously, with support from the KTSP.

Strengths

This was a grass roots initiative that relied on the enthusiasm of the interns and their willingness to take on a volunteer role. Its strength is that it knits psychiatry into existing structures, the medical schools and internship programmes, which are already at the heart of a strengthening programme for the health care system. This has enabled mental health care to become a prominent part of activities that were already supported by KTSP, thereby adding sustainability to the project.

The benefit of having a consistent, locally based member of a teaching team is multifold, including improvement of the cultural sensitivity of the teaching and enabling clinical teaching on the psychiatric wards. In a region without mental health care specialists, it is vital that medical students and interns receive a grounding in psychiatry, and general health care doctors feel supported in undertaking assessment and treatment of mental illness. The MHR project has gone some way to achieving these goals.

The MHRs have also proven to be proactive and enthusiastic advocates for mental health care and have enabled the integration of mental health care into the internship of junior doctors. There has also been work by the MHRs on developing new forms of documentation on the wards of HGH to standardise and improve the diagnosis and treatment of psychiatric patients. Not only

is this a breakthrough for service provision, but has also empowered interns to be enthusiastic about mental health care. This has impacted improvements in the recognition and treating of mental health conditions within the hospital, and in the community. All interns are offered clinical supervision from UK psychiatrists via Medicine Africa. Not only were the effects of introducing MHRs immediate, but also unexpected and far reaching. As a result, the MHRs have raised the profile of psychiatry among the general medical community. By creating an MHR role, with strong local support, the standing of mental health care has improved.

The provision of teaching and leadership training for the MHRs, and ongoing supervision and mentoring, has allowed important capacity building. The MHRs are now able to teach medical students and interns, independently, thereby promoting teaching and leadership skills that can have a lasting impact on the ability of those within Somaliland to provide their own training in the future.

Pitfalls

The role of MHR is associated with considerable responsibility for a newly qualified doctor, and there have been concerns as to whether this was too much to ask, particularly around final exams, as well as challenging other doctors to advocate for mental health care within the medical community. Feedback from MHRs and the intern body, however, has been that the level of responsibility is comparable to other roles expected of the interns, who face huge challenges in the largely unregulated and understaffed public health sector.

Several former MHRs have commented that they did not receive prior training specifically for this role of MHR. We recognise that the training is experience based, *'on the job'* training and as such is more of a mentorship than a standardised training that can be received prior to the commencement of the role. Another drawback is that, although the role has the support of Somaliland institutions, it is a voluntary role, therefore the MHRs are putting in a lot of extra work with a lack of financial remuneration. As a result, this may bias the applications towards those who are better off. Additionally, one of the female MHRs stated said that the role was particularly challenging for a female MHR because of a perceived lack of female authority, making her feel undermined. An unforeseen problem arose during the Medical School final exams in 2009, when one of the MHRs was threatened by a student he had previously examined, who went on to fail finals. However, the MHR felt the situation was resolved with the strong support from the UK external examiner. This has highlighted the issue that when problems arise, it is an almost insurmountable challenge to ascertain sensitively whether problems are due to clan based rivalry, personality clash, or women and young doctors taking on roles of authority.

The authors did not expect the MHRs to become psychiatrists, but hoped that their experiences as MHRs would allow them to retain some skills in mental health care and advocacy. Due to the lack of postgraduate education for most specialties in Somaliland, it has been essential for many of the former MHRs to leave the country to continue their education. However, it is hoped that strengthening the health care systems (including mental health) within Somaliland will provide adequate working conditions, within the public sector, for those who wish to return. Yet, there remains the

risk of those with additional, desirable skills leaving the region, and pursuing careers elsewhere.

Conclusions

The scarcity of human resources in mental health care led to the innovative piloting of the MHR programme with interns in Somaliland. The authors did not realise at the time how successful and far ranging the benefits would be, nor how this would become an integral part of a multi-pronged approach to strengthening mental health care within the health sector. The recruitment of MHRs has relied upon the strength of the KTSP internship programme, including salary support, to keep them in post as (paid) interns, and the retention of the interns within the public sector. The importance of close collaboration and local ownership has as always been essential to the survival of the project. This was one reason why the decision was made to actively recruit MHRs from both medical schools, at the request of their deans and the intern body.

As the role has evolved and numbers of MHRs have increased, the importance of continuing support for alumni, to improve capacity building, has become apparent. Additionally, incorporating ongoing mentoring for this cohort is a priority. In the absence of local mental health care leaders, the MHRs fill a gap in local medical education and service delivery. In the future, the aim is to also focus on nonclinical skills, including ethics and leadership, which are necessary to fulfil this role and establish a cohort of future mental health care teachers and leaders.

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References

Finlayson, A., Baraco, A., Cronin, N., Johnson, O., Little, S., Nuur, A., Tanasie, D. & Leather, A. (2010). An international, case-based, distance-learning collaboration between the UK and Somaliland using a real-time clinical education website. *Journal of Telemedicine and Telecare, 16*, 181-184.

Gulaid, U. J. (2008). The Challenge of Female Genital Mutilation in Somaliland Finnish. *Journal of Ethnicity and Migration, 3*(2), 90-91.

Jarabi, B. O. (2007). *Review of Various Population Estimates for Somaliland.* Puntland and South-Central Somalia: Independent Consultancy Mission.

Leather, A., Ismail, E. A., Ali, R., Abdi, Y. A., Abby, M. H., Gulaid, S. A., Walhad, S., Gulaid, S., Ervine, I., Lowe-Lauri, M., Parker, M., Adams, S., Datema, M. & Parry, E. (2006). Working together to rebuild health care in post-conflict Somaliland. *Lancet, 368*, 1119-1125.

Leather, A., Butterfield, C., Peachey, K., Silverman, M. & Sheriff, R. (2010). International Health Links movement expands in the United Kingdom. *International Health*, 2:3, 165-171.

Odenwald, M., Neuner, F., Schauer, M., Elbert, T., Schauer, M., Elbert, T. R. & Rockstroh, B. (2005). Khat use as risk factor for psychotic disorders: a cross-sectional and case-control study in Somalia. *BMC Medicine, 3*, 5.

Syed Sheriff R, J., Baraco, A., Nour, A., Warsame, A., Peachey, K., Haibe, F. & Jenkins, R.,

(2010). Improving Human Resource Provision for Mental Health in Somaliland. *Psychiatric Services*, 61, 225–227.

World Health Organization (2005). *The World Health Report (WHO)* 2005. Geneva, World Health Organization, 2005.

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