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Jibril Handuleh

The author of this personal reflection is a junior doctor from Somaliland, a country that has suffered from civil war. He studied medicine there, and became interested in mental health care. This aspect of heath care is among the most neglected in the horn of Africa. However, with the support of British psychiatrists, the author has established educational training in psychiatry. He has also subsequently initiated mental health services in his hometown of Borama. Within a few years, an inpatient psychiatric unit, an outpatient department and community mental health outreach were also created. Key to his success was intensive cooperation and collaboration with the community, resulting in broad support for mental health programmes. He has also attempted to collaborate with traditional healers, but remains hesitant of their role.

Keywords: community involvement, mental health, service development, Somaliland, teaching psychiatry

Somaliland is an area in northern Somalia that declared independence from Somalia in 1991. It is a democratic, and relatively peaceful, country that is not yet recognised as an independent state. The civil war, two decades ago, significantly affected the delivery of health services within Somaliland. The infrastructure of the health care system had been destroyed during the war, and many health care professionals left the country. Mental health issues are neglected, while the needs are huge. Due to the past violence, many people became internally displaced, or refugees in neighbouring countries. Violent experiences, family separation, and loss of property and livelihood have all negatively impacted the mental health status of the population. Additionally, excessive intake of the stimulant *khat*, which is used extensively in the country, increases the risk of psychosis (Odenwald et al., 2005).

Choosing psychiatry as a profession

I grew up, in exile, in Saudi Arabia, only returning to my home country when it was time to begin medical studies. At medical school, in Somaliland, there were no local teaching staff, nor exams, in psychiatry. I graduated, as a general physician, from Amoud University in Borama, Somaliland in 2009, with no experience of mental health care. In fact, I thought that people with mental disorders were very difficult to handle.

By that time, medical institutions in the United Kingdom had been supporting general health institutions in Somaliland since 2000 (Leather et al., 2006), and in 2008 mental health care was added to this partnership (Syed Sheriff & Whitwell, 2012). In 2009, a group of British psychiatrists were looking for mental health representatives (MHR) to work with the local medical schools. I applied and was selected. At this stage, I still had no experience in mental health care

and applied more out of curiosity, than anything else. I had seen some of my classmates in college, who had developed severe mental illnesses, and observed that no one had been able to help them.

Community attitudes towards psychiatry were not good, and often this attitude was also expressed as negativity towards mental health care professionals. Many people, including general health care professionals, could not understand why I would choose to specialise in psychiatry. I was told; '*you are already crazy if you treat these patients, or on the verge of becoming crazy*'. This was very painful to me. Sadly, even some of my close family members were among the people who fiercely opposed my choice. In the end, however, they realised the services I was able to offer made a real difference, and they encouraged me.

The British psychiatrists, who were supporting the MHR programme, did strongly encourage local, junior doctors to become teachers, and to develop services. As an MHR, I worked as an assistant lecturer in psychiatry and coordinated the exams in mental health. I also became involved in initiatives for tele-learning (Finlayson et al., 2010). My experiences as an MHR have made me an advocate for mental health care in Somaliland.

Starting mental health services in Borama

In 2010, I developed a plan to establish mental health services in Borama. The Tropical Health and Educational Trust (THET), a British international nongovernmental organisation (NGO), made a small, financial contribution to the programme. Mental health services in Borama started in May 2011, with an outpatient department and outreach programmes to advocate for mental health care in the community. The pilot phase ended in late 2011, and as a result, the local community decided to fund a psychiatric ward in the local, Borama hospital. The urgent need for an inpatient mental health unit in Borama had been obvious for a long time. Patients with mental disorders often became a huge burden to their families, as relatives did not know how to effectively deal with acutely disturbed or violent patients. The few options they had included chaining them up, or putting them into prison, in order to control them. Local residents from Borama, and Somali refugees now residing in Norway and Denmark, raised money to establish a small, acute stabilisation unit for people with severe mental disorders.

Before the project took off, for three months, we did extensive work to get community support and commitments from various groups. We spoke with everyone. We went to the community leaders in every quarter of town, and the neighbouring villages, to explain what we wanted to accomplish. In general, people were very positive. The elders of the clan told us they saw how many people, especially the young ones, were affected by mental disorders. It helped that the elders knew my family well, and that my father is a respected community leader.

We also went to the religious leaders (the *sheikhs),* to get their support, and found most of them very open. Sometimes, traditional people think that psychiatric disorders are caused by *jinns* (spirits). Three sympathetic sheikhs gave me a lot of support, they went with me to community meetings and explained that psychiatric disorders are different from *jinns.* We also organised meetings with local women leaders. I went to these meeting with a female nurse who works closely with me. We also secured the support of the local government, and from the health care authorities.

I recommended that the mental health unit not be placed outside, but inside the hospital, because then patients would have access to other hospital services. The hospital director was very supportive, especially as it is the training hospital for the university. It was important to the university to have a good psychiatric unit available where the students could learn about psychiatry. As a result, the university took the lead in building and running the facility. The deans of the medical and nursing schools, and the director of Borama hospital, a gynaecologist, helped me to establish this service.

We spent a lot of time training the general medical staff. It was important that the female nurses and midwives, working in the obstetrics and gynaecology departments, also had a good understanding of mental health disorders. To accomplish this, we organised several three-day workshops for them. We also trained community health workers so that they could identify and refer people from the communities. In the inpatient unit, we work with six dedicated nurses who have gradually become experienced, mental health care nurses.

Setting up services in the community and working with traditional healers

Each day I hold mental health consultations in the outpatient department of the hospital. In the inpatient unit, with 20 beds, we see mainly patients with *khat* induced psychosis, schizophrenia, acute mania, and those with suicidal tendencies. Patients are stabilised in the hospital, and then followed up in the community by our nurses, or through social workers from a local NGO for community services. This is very important. Every Monday I visit the communities. We have divided our target area into four, and each week we visit another area. We go to the homes of patients, and speak with them. The social workers provide medication, if required. The nurses and I often offer home visits, particularly to acutely ill patients that needed urgent treatment. Such patients cannot wait in the regular outpatient department.

I have also made contact with some of the local, traditional healers and went to see their practice. I was curious to know what to they did for their patients, and to find out why people choose to see them, instead of psychiatrists. Quite honestly, I was not very impressed. They claim to treat people, but I feel that some practices amount to torturing patients. I have witnessed scenes where the healer would force the head of a patient repeatedly into a bucket of water, until they are almost drowned. This was thought to be the right thing to do as they believe mental illness is caused solely by *jinns,* or magic. I tried to explain to them that these techniques were inappropriate, but they showed no interest in changing their methods. They regarded me as too westernised. Fortunately, they did agreed that some patients could receive psychiatric medication, and eventually some of the traditional healers referred cases to my outpatient unit. Since then, some families have decided to take their family members away from the traditional healers, and to work with my team. They now acknowledge that mental illness is treated through psychopharmacology, or talking therapies, instead of herbs or beating. However, they still believe readings from the Koran can have strong healing effects, and believe this to be a form of talking therapy with a Sheikh. There are patients who were ill for many years and had never been treated with psychiatric medication. Some of the chronically ill mental patients have responded well to

this form of treatment. There are even several patients who are now well enough to run small businesses. Unfortunately, not all patients responded as well.

Continuing challenges

I have seen dozens of patients with bipolar disorder, or schizophrenia, who had been told they had typhoid fever. In Somalia, people often believe they suffer from endemic fever while in reality they have a mental disorder. They are mistakenly given a high dosage of a broad spectrum antibiotic, which is very expensive, but leads to nothing. One example was a poor man who was living in a tent, and suffering from chronic psychosis. After I saw him and made a careful assessment, I gave him suitable antipsychotic medication. Fortunately, he reacted well to it and he is now working for his family.

Another challenge is that many people, often women, who suffer from depression and other anxiety disorders, or psychosomatic complaints, are not given any psychiatric treatment. One example is a university graduate who was unemployed for two years, and severely depressed for more than one. Her family thought she was involved in a love affair, and that was the reason for her low mood. They thought becoming depressed could not happen to people who are '*real Muslims*', and they denied her medication. However, her sister was a student nurse who had learned about depression at nursing school, she asked if I could help her sister, and I did.

Surviving as doctor in psychiatry

I love my work, but sometimes it is very hard. The numbers of patients are very high; we have a current caseload of 1500 patients a year, in a total population of around 150,000. I easily work 12 hours or more, each day. Initially, there were only a few nurses who assisted me, but their number is increasing. I also have worked with a younger doctor, who is now assisting me, so the work can be shared. Medication supply was also initially a challenge, but medication import companies in Somaliland have now agreed to supply us, so we have a good stock, including the psychotropic medication from the World Health Organization essential list of medications.

As a junior doctor I feel privileged that, while preparing for residency, I could make a real difference. It is, of course, not always easy. In fact, I left my paid job with Doctors without Borders in another part of Somaliland, and returned to Borama to work as a volunteer, in order to set up the mental health care system. There are many challenges ahead, but I am really proud that, within a year my hometown has an inpatient mental health unit, an outpatient psychiatric service and a dedicated community based psychiatry service.

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Jibril Handuleh is a medical doctor. He is director of the psychiatric unit in Borama Hospital and a clinical lecturer in psychiatry at Amoud University School of Medicine, Borama, Somaliland, Northern Somalia. He is the Somaliland lead in the web portal of www.medicineafrica.com that provides clinical e-learning in psychiatry, and other fields of medicine, for Somaliland interns and medical students.
email: jibriil.mahamed@gmail.com.