

WHO-AIMS

**WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN ERITREA**



**World Health
Organization**



**MINISTRY OF HEALTH
ERITREA**

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MENTAL HEALTH SYSTEM
IN ERITREA

*A report of the assessment of the mental health system in Eritrea using
the World Health Organization - Assessment Instrument for
Mental Health Systems (WHO-AIMS).*

Asmara, Eritrea

2006



**MINISTRY OF HEALTH
ERITREA**

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Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website.

http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

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WHO-AIMS REPORT FOR ERITREA

1.0 INTRODUCTION

The mission of the WHO in the area of mental health is to reduce the burden associated with mental and neurological disorders including substance abuse and to promote mental health of the population worldwide. In order to improve mental health systems, base line information is essential. In line with this, the WHO developed the World Health Organization Assessment Instrument for Mental health Systems (WHO-AIMS).

WHO-AIMS has been developed to assess key components of a mental health system and thereby provide essential information to strengthen these systems. The mental health systems have been grouped into 6 domains that are interdependent, conceptually interlinked and somewhat overlapping. All 6 domains, namely policy and legislative framework, mental health services, mental health in primary health care, human resources, public education and linkages and monitoring and evaluation are to be assessed in order to get a complete picture of the mental health system of the country.

1.1 Background

Eritrea is situated in the Horn of Africa and has an area of 124,000 square kilometers. To the east the country is bordered by the Red Sea. Djibouti borders the country to the southeast, Ethiopia in the south, and the Sudan in the north and west. Administratively the country is divided into six Zobas or regions.

No population census has ever been carried out in Eritrea. As a result, there are no reliable estimates of the population currently residing in Eritrea or the population of Eritreans living abroad, many of whom are potential returnees. However, based on a population count, the Ministry of Local Government estimated the total population of Eritrea to be about 3.6 million in 2005. The population is made up of 9 ethnic groups – Afar, Bilen, Hedareb, Kunama, Nara, Rashaida, Saho, Tigre and Tigringya.

Eritrea is a land of geographical contrasts with land rising from below sea level to 3,000 meters above sea level. There are three major physiographic zones: the Western Lowlands, the Central and Northern Highlands, and the Eastern Lowlands. Rainfall in Eritrea ranges from less than 200 mm per annum in the eastern lowlands to about 1,000 mm per annum in a small pocket of the Escarpment.

Because of Eritrea's strategic position on the Red Sea, it has fallen victim to many invaders and colonizers. More recently the country was engaged in three decades of struggle for self-determination from Ethiopia, which culminated in formal independence in 1993.

Agriculture and pastoralist activities are the main sources of livelihood for about 80% of Eritrea's population. The agricultural sector depends mainly on rain, with less than 10% of the arable land currently irrigated. Consequently, productivity is low and the agricultural sector, including livestock and fisheries, accounts for only one-fifth of the Gross Domestic Product (GDP).

Eritrea is one of the poorest countries in the world with a GDP per capita of about US\$ 200, well below the average of US\$ 270 for less developed countries (UNDP, 2001).

1.2 Health Services

Since independence, the Ministry of Health (MoH) has made significant progress in ensuring access to health care services through restoration of health facilities damaged during the war, the provision of adequate supplies of drugs and equipment, the expansion of available health services to communities where they are lacking, construction of new facilities, and the training of qualified health personnel.

The health strategy of Eritrea focuses on primary health care, and this is achieved through the development of basic health services at the local level to reach more people. The Demographic Health Survey (2002) findings indicate that access to health services has improved since 1995. Infant mortality rate is 48 per 1000 live births and under-5 mortality is 93 per 1000 live births. Maternal mortality rate has reduced from 998 per 100,000 to 630 per 100,000.

Currently, the MoH is operating 25 Hospitals, 50 Health Centers and 177 Health Stations, most of them Government owned (HMIS 2004 report).

1.3 Mental health services in Eritrea

Psychiatric services were introduced during the Italian colonization along with all other medical fields. It was first delivered within the Regional Elena Hospital in a special ward. In 1971 the government built a special neuro-psychiatric hospital in southwest Asmara, called St. Mary's Hospital. This hospital was planned to provide 120 beds, a number that increased significantly in time to a today's number of 160 beds. The wards have since been changed from big sleeping hallways of 36 beds, to smaller compartments with 4 to 6 beds. The hospital now consists of several wards, which make up the inpatient department, as well as an outpatient department.

Since 1987, psychiatric nurses and national physicians have been assigned to deliver mental health care. In 2005, the mental hospital staff consisted of one psychiatrist/director, one matron, one administrator, four head nurses, eight psychiatric nurses, one psychology graduate, eleven general nurses and twenty-two health assistants, supported by a laboratory and a pharmacy. These numbers reflect the most up-to-date situation on human resources and can give insight into the newest developments since the assessment for this report. This report is based on data from

the year 2004; data have been collected from the 31st October to the 30th November 2005.

The hospital is operating with around 160 beds. There are two wards for male patients (one for civilians and one for military patients) and one for female military and civilian patients. Until now, the only way to restrain patients has been to chain them to their beds by their ankles. About one-third or more of all patients are chained. Since about one year ago there is an activity room for patients. In 2004 about 966 patients have been admitted to the wards. Chronic patients (patients with a chronic disorder, with many re-admittances or long durations of admittance) occupy about 30-40% of all beds. The average length of stay is 50 days, but in the active beds (for non-chronic/acute) patients generally stay 2-3 weeks.

The dominant admission diagnoses (ICD 10) for the year 2004 were: schizophrenia (32%), disorders of adult personality and behaviour (25%) and affective disorders (21%)

The outpatient department is open 5.5 days a week. About 10 new patients are seen on a daily basis, which means about 2,700 new patients a year are served. Sometimes patients are referred, but the majority of patients refer themselves. Most patients (both in and outpatients) come from the Asmara region.

Altogether, according to the data from the Health Management Information System in 2002, there are about 33,000 “patient contacts” in the OPD per year. The diagnoses (ICD 10) of new patients in 2002 were: schizophrenia 11%, affective disorder 17%, neurotic and stress related disorder 22%, unclassified behavioral mental disorder 15%, mental retardation 3%, epilepsy 14%, dementia 4%, headache 10%, not diagnosed 4%.

In Asmara there is one residential facility for 150 chronic patients, Mai Temenai. The institution falls under the local government, not under the Ministry of Health and a few health assistants are in charge. The St. Mary’s Hospital, the psychiatric hospital, provides medication and half a day a week clinical services by a psychiatric nurse from the hospital.

During the last few years the MoH has been training around 60 primary care workers in basic mental health knowledge; physicians as well as nurses in one week training are trained to diagnose and treat the most frequent psychiatric disorders and to do follow up. These professionals come from all over the country. Although some of these professionals are able to apply their knowledge, the majority are not able to do this since there is not a good distribution system of psychotropic drugs and they do not have access to these drugs. Also the skills of these professionals are limited since the MoH is not able to provide them follow-up supervision because of transport problems.

In June 2005, the HRD department of the MoH finished the first 14 month course in post basic nursing; they trained 16 community psychiatric nurses. Three community psychiatric nurses are assigned to different Zobas associated with a referral hospital. Two of these nurses are assigned to the psychiatric hospital; 8 are employed by the Ministry of Defense or the police so do not fall under the MoH but are associated with military hospitals.

It is not certain how effective these decentralized community psychiatric nurses will be because of the limitations in the availability and the distribution system of psychotropic drugs. If they cannot use these drugs the impact of the training will be very limited.

The MoH is planning to continue the training of community psychiatric nurses but has not yet decided how soon.

2.0 JUSTIFICATION

The World Health Report 2001 provided evidence on the huge burden disease associated with mental illness and outlined the need and rationale for building community based mental and health systems and services. The availability of baseline information is essential for development of any meaningful mental health policies, plans and services.

The WHO Mental Health Atlas study reports that in 2001, more than 72% of countries did not have any system for collecting and reporting mental health information. Many other countries have information systems but these systems are limited in scope and quality.

The mental health system and services in Eritrea have not been studied and analyzed. This study is therefore necessary in order to document the baseline assessment of the mental health system and services in the country.

3.0 OBJECTIVES

The overall objective was to assess key components of mental health system in Eritrea and provide essential information to strengthen the system.

The Specific objectives are:

1. To obtain baseline information for mental health services in Eritrea
2. To identify major strengths and weaknesses of the mental health system in the country.
3. To provide essential information for relevant public mental health action.
4. Provide a benchmark for comparison with other countries

4.0 METHODOLOGY

4.1 Introduction

The study used the WHO-AIMS instruments. Information was collected on mental health systems and services covering each of the 6 domains mentioned in the WHO-AIMS documents: policy and legislative framework, mental health services, mental health in primary health care, human resources, public education and linkages and monitoring and evaluation.

The information for this study was collected at 3 levels – national, zonal and health facility levels. Data was collected from 31st October to 30th November 2005 and is based on the year 2004.

4.2 Study Design and Sample Size and Data collection:

Information was collected from the entire national Geographic zone. A national questionnaire was developed to assess policy, services and legislation. This was administered at the Ministry of Health and the Ministry of Labour and Human Welfare (MLHW).

A zonal questionnaire to assess the organization of mental health services at zonal level was administered at all the 6 zones.

Four types of health facilities were assessed:

1. One mental hospital (There was only 1 mental hospital in the country).
2. Six zonal referral hospitals that offer integrated outpatient services including mental health consultation.
3. There is one community residential facility in the country and it is in Mai-Temenay, Asmara.
4. Primary health care clinics. Mental health workers are present in all 30 primary health care facilities.

5. RESULTS

Domain 1: Policy and Legislative Framework

Mental Health Policy

Eritrea's mental health policy was last revised in 1998 and includes the following components: developing community mental health services, downsizing large mental hospitals, developing a mental health component in primary health care, human resources, involvement of users and families, advocacy and promotion, human rights protection of patients, equity of access across different groups, financing, quality improvement and a monitoring system.

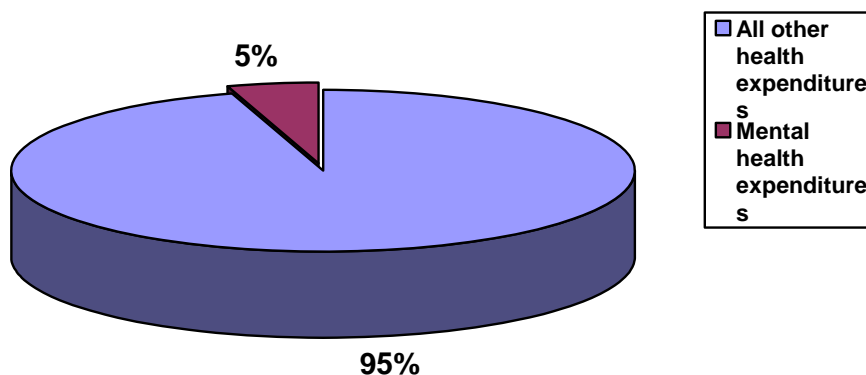
In addition, a list of essential medicines is present. These medicines include Antipsychotics, Anxiolytics, Antidepressants, Mood stabilizers and Antiepileptic drugs.

A mental health plan and disaster/emergency preparedness plan for mental health do not exist. There is no current mental health legislation.

Financing of mental health services

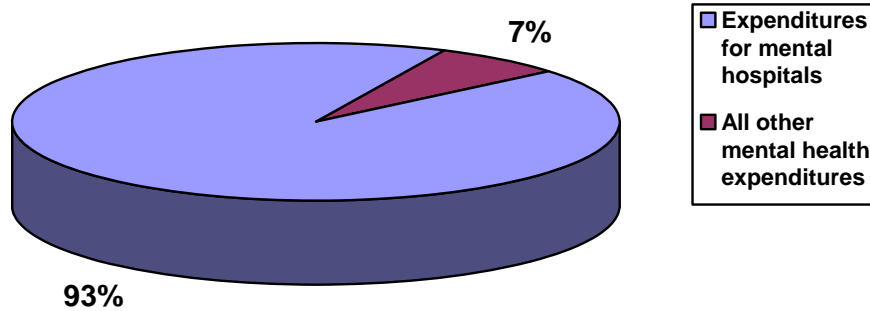
Five percent of health care expenditures by the government health department are directed towards mental health (Graph 1.1). Out of all the expenditures spent on mental health, 93% is directed towards the mental hospital (Graph 1.2).

GRAPH 1.1 HEALTH EXPENDITURE TOWARDS MENTAL HEALTH



DATA SOURCES: Finance Dept. MoH

GRAPH 1.2 MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS



DATA SOURCES: Finance Dept. MoH

It is worth noting that all mentally ill patients have free access to essential psychotropic medicines, although the distribution of psychotropic drugs is very limited.

Human rights policies

There is no national human rights review body which has the authority to oversee inspections in mental health facilities and impose sanctions on those facilities that persistently violate patients' rights.

Domain 2: Mental Health Services

Organization of mental health services

A national mental health authority exists, which provides advice to the government on mental health policies and legislation. The mental health authority is also involved in service planning, management and coordination and monitoring and quality assessment of mental health services. Mental health services are not organized in terms of catchment/service areas.

Mental health outpatient facilities

There is only one outpatient mental health facility available in the country. The facility treats about 2700 users per year (75 per 100,000 population). The data is not able to be disaggregated by gender. Users were most frequent diagnosed with

neurotic disorders (22%) and mood disorders (17%). The average number of contacts per user is 12.2. There was no program for follow up community care or mobile services. The outpatient mental health facility had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available.

Day treatment facilities and community-based psychiatric inpatient units

There are no day treatment facilities or community-based psychiatric inpatient units in the country.

Community residential facilities

There is one community residential facility in the country in Mai-Temenay, Asmara. This facility has 150 beds (4.2 per 100,000 population). One bed is reserved for patients under the age of 18 and 50.6% percent of patients are females. In 2004, the community residential facility treated 79 users (2.2 per 100,000 population). Most users have lived there since it opened in 1998.

Mental hospitals

There is only one mental hospital available in the country with 160 beds (4.44 per 100,000 population). There are no beds in the mental hospital reserved for children and adolescents only. The number of beds has remained the same in the last five years. In 2004, the hospital had 966 admissions of which 266 were females and 10 were children or adolescents. The patients admitted in mental hospitals have been diagnosed primarily with the following diagnostic categories: schizophrenia (31.9%), disorders of adult personality and behaviour (25.2%), and mood (affective) disorders (20.9%). On average patients spend 48.4 days in mental hospitals. About three quarters (74%) of patients spend less than one year in the mental hospital, 4% spend 1-4 years, 11% spend 5–10 years and 11% spend more than 10 years in the mental hospital. About 33% of patients in the mental hospital are physically restrained at any time.

Only 12 mental patients (1.2%) had received one or more psychosocial interventions in the mental hospital in 2004. The existing mental hospital, St. Mary, had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility in 2004.

Human Rights and Equity

Thirty-six percent of admissions to the mental hospital are involuntary. Also, over 20% of the patients in the mental hospital are secluded or restrained. Twenty-two percent of the patients have been in the hospital over 5 years.

All of the mental hospital beds are located in or near the largest city. This distribution of beds limits access for rural users.

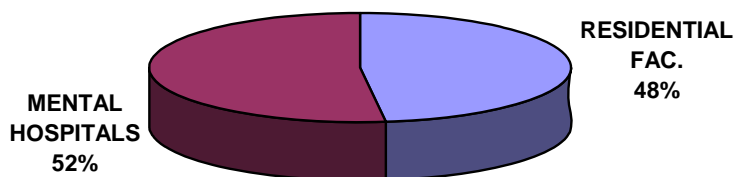
Forensic and other residential facilities

There are no forensic inpatient units in the mental hospital or “other residential facilities” within or outside the health system that provide care for people for mental disorders.

Summary Graphs

The psychiatric beds in this country are in the mental hospital and the community residential facility (Graph 2.1).

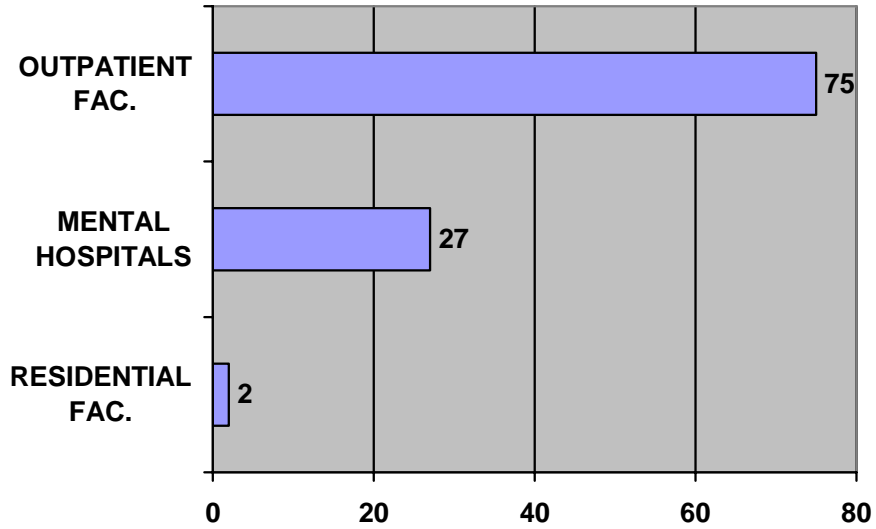
GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES



DATA SOURCES FOR GRAPH 2.1: MoH

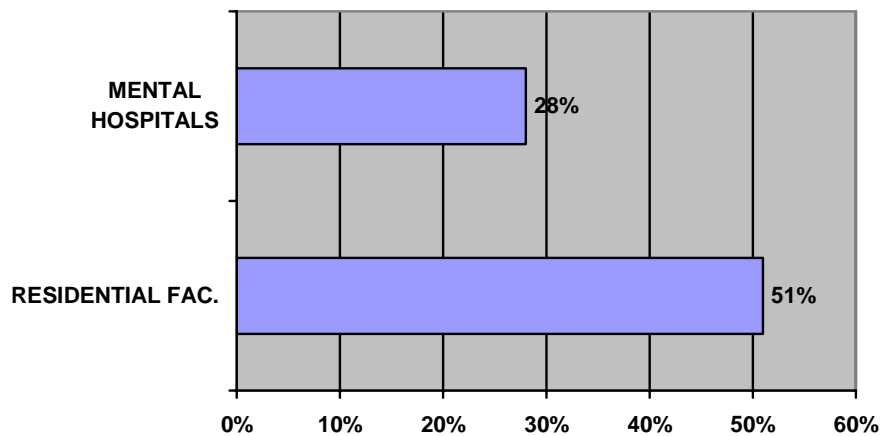
The majority of the users were treated in outpatient facilities (Graph 2.2).

GRAPH 2.2 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES (rate per 100.000 population)



Female users make up about 40% of the population in all mental health facilities in the country. The proportion of female users is highest in the residential facility and lowest in the mental hospital. There is no data for the outpatient facility (Graph 2.3).

GRAPH 2.3 - PERCENTAGES OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES

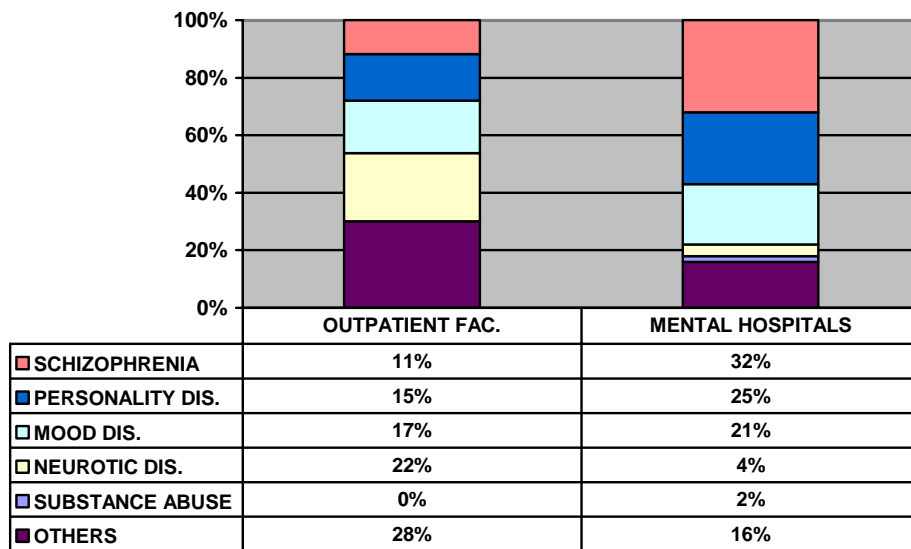


DATA SOURCES FOR GRAPH: MoH, Mental Hospital

The percentage of users that are children and/or adolescents is about 1%. The number of children and adolescents treated in the outpatient facility is unknown.

The distribution of diagnoses varies across facilities: in outpatient facilities mood disorders and neurotic disorders were most prevalent, whereas, in mental hospitals schizophrenia and personality disorders were most frequently diagnosed. (Graph 2.4).

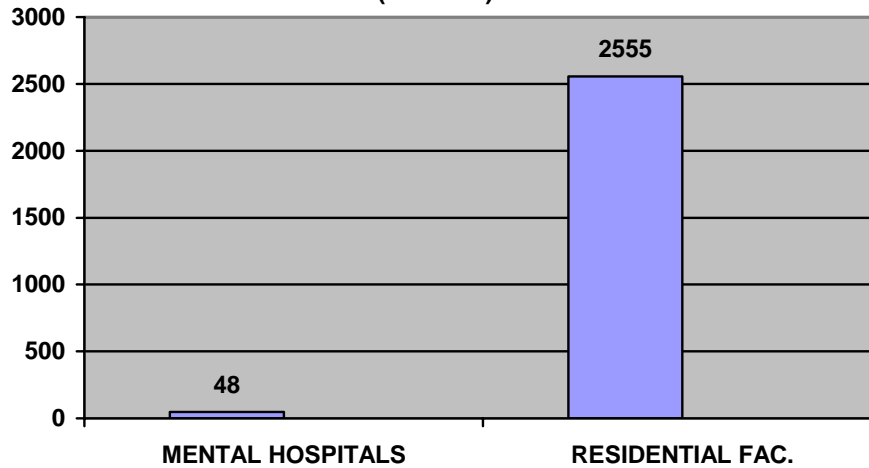
GRAPH 2.4 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS



DATA SOURCES FOR GRAPH 2.4: Mental Hospitals (2002 data)

The longest length of stay for users is in the residential facility (Graph 2.5).

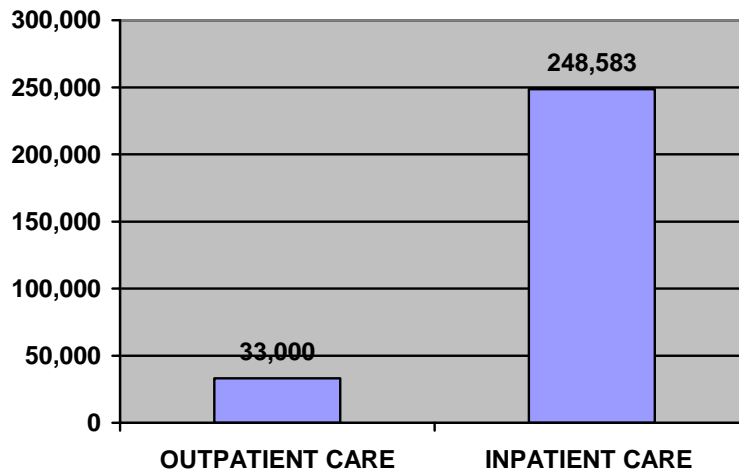
**GRAPH 2.5 - LENGTH OF STAY IN INPATIENT FACILITIES
(IN DAYS)**



DATA SOURCES FOR GRAPH 2.5: Facilities

The ratio between outpatient contacts and days spent in both inpatient facilities (i.e., the mental hospital and residential facility) is an indicator of community care: in this country the ratio is 1:7.5 (Graph 2.6).

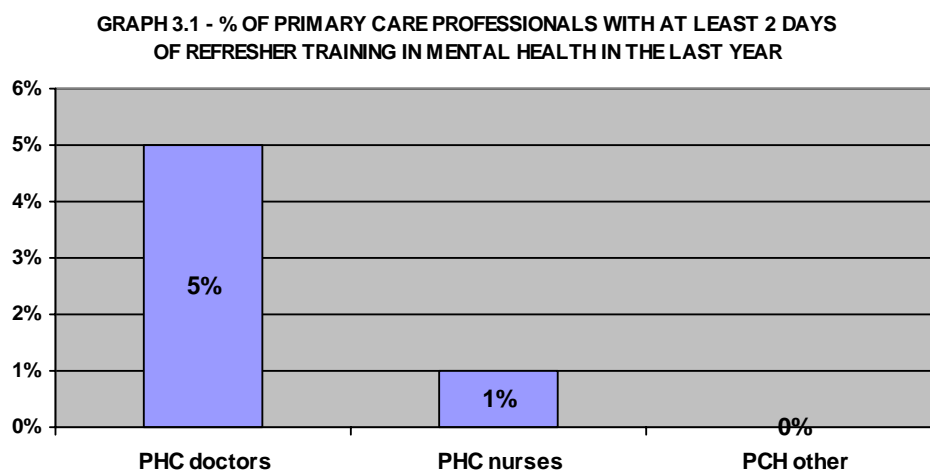
**GRAPH 2.6 INPATIENT CARE VERSUS
OUTPATIENT CARE**



Domain 3: Mental Health in Primary Health Care

Training in mental health care for primary care staff

One percent of the training for medical doctors is devoted to mental health, in comparison to 4% percent for nurses and 2% for non-doctor/non-nurse primary health care workers. In terms of refresher training, 5% of primary health care doctors have received at least two days of refresher training in mental health, while 1% of nurses and no non-doctor/non-nurse primary health care workers have received such training in the year 2004 (Graph 3.1).



DATA SOURCES FOR GRAPH 3.1: MoH, Hospitals

Mental health in primary health care

In general, there are no “physician based primary health clinics”. All clinics are run by a health assistant (associate nurse) whereas health centers are run by nurses. The only facilities run by physicians are hospitals and mini-hospitals with fewer beds and only one physician. In 2004, no primary health care clinic had assessment and treatment protocols for mental health conditions available. A few primary health care doctors (less than 20%) and a few non-physician providers (less than 20%) made at least a monthly referral to a mental health professional. None had interacted with an alternative/traditional practitioner.

Mental health service is provided as part of the routine integrated services without a specialized mental health unit within the health facility.

Prescription in primary health care

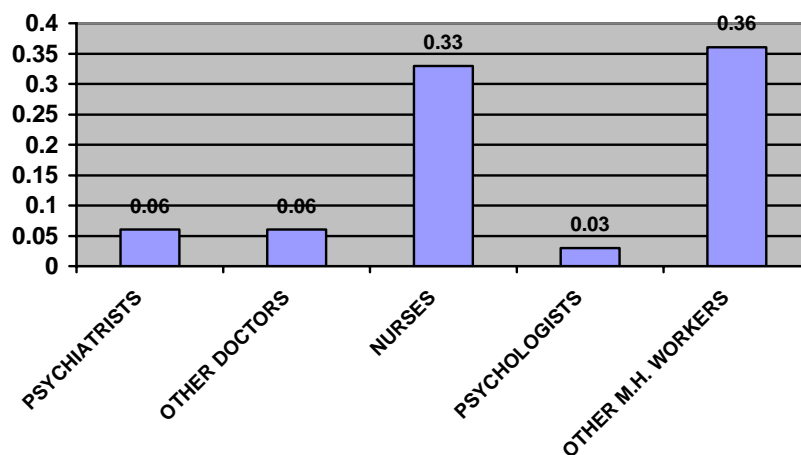
Non-doctor/non-nurse primary health care workers are not allowed to prescribe psychotropic medications, whereas primary care nurses are allowed to prescribe with some restrictions (i.e. in facilities where there are no physicians). In contrast, primary health care doctors are allowed to prescribe without restriction.

Domain 4: Human Resources

Number of human resources in mental health care

According to the data for the year 2004, the total number of human resources working in mental health facilities or private practice is 0.83 per 100,000 population. The breakdown per 100,000 population according to profession is as follows: 0.06 psychiatrists (2 psychiatrists), 0.06 other medical doctors (2 medical doctors not specialized in psychiatry), 0.33 nurses (12 nurses), 0.03 (1 psychologist), but no social workers or occupational therapists. Additionally, there are 0.36 per 100,000 other health or mental health workers (13 in total which includes auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors) (Graph 4.1).

GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100.000 population)



DATA SOURCES FOR GRAPH 4.1: MoH, Health facilities

Both psychiatrists, the 12 nurses, and the doctors (not specialized in mental health) work in the public mental hospital and the mental health outpatient facility. The psychologist works full-time in the mental health outpatient facility, while the 13 other health workers work in the mental hospital. In terms of staffing in mental health facilities, there are 0.01 psychiatrists per bed in mental hospital. As for nurses, there are 0.04 per bed in the mental hospital. Finally, there are 0.08 other mental health workers per bed in the mental hospital. It is worth noting that there is no psychiatrist working outside the capital city and in 2004 all of the psychiatric nurses were assigned in the Central Zone.

Training Professionals in mental health

There is no psychiatrist training program but 93 nurses (2.58 per 100,000 population) were trained in the previous year. No training programs exist for other mental health workers.

Consumer and family associations

There are no users/consumers associations, no family associations and no NGOs involved in mental health activities.

Domain 5: Public Education and Links with other Sectors

There is a coordinating body to oversee public education and awareness campaigns on mental health and mental disorders. Government agencies and some NGOs have promoted public education and awareness campaigns in the last five years. These campaigns have targeted mainly the general population. In addition, there have been public education and awareness campaigns targeting professional groups including the complimentary/alternative/traditional sector, teachers, social service staff, leaders and politicians, healthcare providers and other professional groups linked to the health sector.

The following legislative provisions exist to provide support for users: (1) provisions concerning a legal obligation for employers to hire a certain percentage of employees who are disabled, and (2) provisions concerning protection from discrimination (dismissal, lower wages) solely on the account of a mental disorder. Both of these provisions exist but are not enforced. In addition the following legal provision exists - provisions concerning priority in state housing and in subsidized housing schemes for people with severe mental disorders – which is enforced. There are no legislative or financial provisions concerning protection against discrimination in allocation of housing for people with mental disorders.

In addition to legislative and financial support, there are formal collaborations with the Health Services Department of the Ministry of Health which is responsible for primary health care/community health, HIV/AIDS, reproductive health, child and adolescent health. Furthermore, there are formal collaborations with the Ministry of Labour and Human Welfare, which is in charge of substance abuse, child protection, education, employment, housing, welfare, criminal justice and the elderly.

Regarding mental health activities in the criminal justice system, the percentages of persons with mental retardation and psychosis in prisons are unknown. Similarly, the number of prisons with at least one prisoner per month in treatment contact with a mental health professional is unknown. As for training, some police officers (less than 20%) and no judges and lawyers have participated in educational activities on mental health in the last five years.

In terms of financial support for users, no mental health facility provides access for their patients to employment programs outside the mental health facility.

Domain 6: Monitoring and Research

A formally defined list of individual data items that ought to be collected by all mental health facilities exists. This list includes the number of inpatient admissions, length of stay, and patient diagnoses. The government health department received data from the mental hospital. Based on this data, a report was published but did not include comments on the data.

Of the 36 health publications written about Eritrea between 1999 and 2004, there were only 2 publications (6%) on mental health: "Factors that mitigate war induced anxiety and mental distress" (J Biosoc). Sci 2004 Jul; 36 (4), 445 -61) and "Maternal psychosocial well being in Eritrea: application for participatory methods and tools of investigation and analysis in complex emergency settings" (Bull World Health Org. 2003; 81 (5): 360 – 6).

DISCUSSION:

The existence of a mental health policy is a positive development for mental health in the country. However, since the policy was formulated, 8 years have passed without review. In this period there have been important developments in the area of mental health. The country itself has undergone important socio-economic changes including a border war. The policy therefore needs to be reviewed. The lack of mental health improvements since the health policy was developed cast some doubt as to the implementation of some aspects of the policy.

The percentage of the general health expenditure by the Ministry of Health spent on mental health is low (5%) but comparable to more than 35% of the African Countries. It is worth noting that more than 93% of this expenditure is spent on the one clinical mental health facility. This expenditure pattern will raise concern about the sustainability of the practice of free access to antipsychotic drugs. This may be particularly difficult in light of the competing priorities both within and outside the health sector. A viable and sustainable plan for mental health financing therefore needs to be developed.

The mental health services mostly revolve around the only mental health hospital and its only outpatient unit complemented by the only community residential facility. All these facilities are based at the capital city of Asmara. Consequently, access to services could be a problem for many users, considering the difficult terrains in the country.

The number of psychiatric hospital beds at 4.4 per 100,000 population is higher than 80% of the African countries. However, the number of psychiatrists and nurses (0.06 and 0.3 per 100,000 population respectively) are low.

Considering that there are relatively few mental health facilities in the country and that they are concentrated in the capital city, providing mental health services in primary health care could be one of the best options for increasing the availability of mental health services. However, this aspect seems to be difficult, because the primary health care training is behind schedule.

Training of mental health personnel also needs to be given priority in order to fill the existing gaps.

Mental health research is another weak area and needs to be strengthened.

CONCLUSIONS

The mental health assessment has provided insight into the status of mental health services in Eritrea.

The strong points of the mental health services included the existence of a mental health policy, existence of a mental hospital and free access to psychotropic drugs.

Some of the areas that need improvement include revision of the mental health policy, development of a strategic plan, development of mental health in primary health care, human resource development and mental health research.

RECOMMENDATIONS:

1. Immediate review of the mental health policy.

An interdisciplinary and inclusive approach should clearly be reflected in the policy. The policy should also include the need for mental health legislation, school mental health, rehabilitation of the severely ill, etc. Mental health should not be the exclusive responsibility of the MoH. Other Ministries should be involved (education, welfare, justice).

2. Development of a national strategic plan for mental health

The development of a national strategic plan for mental health needs to be a priority. "The National Plan for Mental Health and Psychosocial Care in Eritrea" written in 2004 by Healthnet TPO (an international NGO) and the MoH can act as a guiding

document. A strategic plan for the coming 10 years should be developed. The below mentioned recommendations will be incorporated in the plan. The development of an emergency/disaster plan should be part of this plan.

3. Improving the access and use of psychotropic medicines in the country.

Though psychotropic drugs are free, the access to psychotropic drugs for most people in the country is still very limited. Drugs are only available in the psychiatric hospital in Asmara and in a few other places in the country and at times there are no medications available. The procurement and distribution system for psychiatric drugs should be evaluated and improved. An alternative mental health financing scheme could be considered to improve the accessibility.

4. Strengthening mental health in primary health care.

Treatment for mental health disorders should be available in primary care. Therefore primary care workers have to be trained in the necessary skills to diagnose and treat patients; medical staff have to be trained to recognize mental disorders, to treat mental health disorders, and how to refer people with mental disorders. The existing MoH efforts should be strengthened. It should be mentioned that an adequate distribution system of psychotropic drugs is essential. Outpatient psychiatric facilities should be available in general hospitals as well as some beds for short-term patients. Mental health services should become decentralized.

5. Develop community mental health structures.

Primary care professionals should cooperate with other professionals like teachers, social workers, community rehabilitation workers to set up community mental health structures. This involves cooperation with all kinds of community members and traditional healers.

6. Human resource development for mental health.

The number of mental health professionals in Eritrea is extremely limited. At the time of the data collection in 2004 there were only two psychiatrists including one attached to an international NGO, temporarily assisting the MoH and the St. Mary's hospital. One or two Eritrean physicians should be trained as a psychiatrist; and some physicians should receive 6-12 months of training in community mental health in a center of excellence abroad. When they return they can improve the care in the psychiatric hospital and be active in community facilities. They can bridge the gap in the coming years until fresh Eritrean medical doctors will be graduated. Some of these doctors should specialize in psychiatry.

The training of community psychiatric nurses should continue. The community psychiatric nurses are crucial to make decentralization of mental health facilities possible. HealthNet TPO, an international NGO assisting the MoH, together with

DIA (Dutch Interchurch Aid) are starting a project called Healthy Mind aimed at setting up community mental health structures in two regions of Eritrea. This project can support the MoH with trainers. Mental health upgrading courses should become part of the continuous education program of the MoH. The staff of the psychiatric hospital should have access to refresher trainings. They should be assigned for a longer period to St. Mary's hospital and they should not be rotated every few years to another hospital. A system of salary increases tied to years of experience and training should be developed.

7. Strengthening of mental health research.

Research should be conducted - especially epidemiological research in communities and research relevant for further policy development. Research should focus on vulnerable groups, such as children, women, and demobilized soldiers. Cooperation should be sought with the CBR program of the MLHW, a program covering 40% of the country and which has a lot of data about communities and different groups. Programs should be developed in particular for people who are suffering from psychiatric disorders as a result of the various wars experienced by the people of Eritrea.

8. Improving the quality of care in the psychiatric hospital.

The hospital has been functioning many years with a very limited number of staff with no regular supervision by a psychiatrist, and with no additional staff training for many years. This is reflected in a very limited quality of care for patients. There are no different wards for acute and chronic patients and many patients are restrained.

It is essential the hospital gets professional assistance to change this situation. In Eritrea mental illness is strongly associated with the Neuro Psychiatric hospital and this hospital sets an example of how to treat mental patients.

The patients often suffer because of inhumane conditions. Some of them are chained for many years because there are no rehabilitation facilities.

However, these conditions cannot be attributed to the unmotivated or careless attitudes of staff members. Since there is only one mental hospital in the country in which all nurses and physicians conduct their practice, they often experience the current condition in this hospital as the normal way of treating mentally ill patients and lack better examples. The bad conditions in the mental hospital are therefore the result of insufficiently trained staff, who do not receive appropriate guidance and often lack expert knowledge.

One priority is to develop a system to reduce the chaining of patients and to develop alternatives.

Another priority is to develop rehabilitation facilities for chronic patients; these could be residential as well as day centers.

Annex: DATA COLLECTION INSTRUMENTS

Questions for the mental hospital

Interviewee: Director Hospital (1) or head OPD (2) or administrator (3) for all questions except 6.1.5

Human rights

1.4.2

Does this hospital have at least one yearly external review/inspection of human rights protection of patients?

An external review/inspection refers to a review that is conducted by an external body that is independent from the mental health facility.

1.4.4

Has this hospital had at least one-day training, meeting or other type of working session on human rights protection of patients in the last 2 years?

Integration of facilities

2.1.3

Is your hospital organizationally integrated with mental health outpatient facilities?

The two facilities are organizationally integrated if both of the following 2 conditions exist

- a. Referral system between the two types of facilities is utilized to facilitate continuity of care
- b. Mental hospitals and mental health outpatient facilities work in a coordinated manner

Beds, patients and use of mental hospitals

2.6.1

How many mental health hospitals are available in the country?

2.6.2

What is the number of beds in the mental hospital?

Bed: A bed that is continuously available for use by people with mental disorders for round the clock (day and night) care.

2.6.3

Has there been a decrease/increase of the number of beds in the mental hospital in the last five years? (compare 2005 with 2000)

2.6.4

What is the number of patients treated in your hospital? (inpatients)

What is the number of female patients treated in your hospital? (inpatients)

What is the proportion of female patients treated in your hospital?

Number of patients treated in a mental hospital: (a) the number of patients in the mental hospital at the beginning of the year plus (b) the number of admissions during the year.

2.6.5 What is the proportion of patients treated in your hospital the last year (2004) by ICD-10 diagnosis?

1. Mental and behavioural disorders due to psychoactive substance use (F10-F19)
2. Schizophrenia, schizotypal and delusional disorders (F20F29)
3. Mood [affective] disorders (F30F39)
4. Neurotic, stress related and somatoform disorders (F40F48)
5. Disorders of adult personality and behavior (F60F69)
6. Other (e.g., epilepsy, organic mental disorders, mental retardation, behavioral and emotional disorder with onset usually occurring in childhood and adolescence, disorders of psychological development)
(UN = unknown; NA = not applicable)

2.6.6

What is the proportion of involuntary admissions to your hospital?

What is the number of involuntary admissions to your hospital?

Involuntary admissions refer to admissions to mental health facilities that occur without the voluntary consent of the individual. Involuntary admissions are typically permitted in situations where a person with a mental disorder is likely to cause self-harm or harm to others or suffer deterioration in condition if treatment is not given. Involuntary admissions are typically ruled by mental health legislation.

Number of admissions: The number of admissions in one year is the sum of all admissions to the facility within that year. In WHO-AIMS, this number is a duplicated count. In other words, if one user is admitted twice, it is counted as two admissions

2.6.7

What is the proportion of long-stay patients by length of stay on 31st of December of the last year in your hospital?

1. more than 10 years
 2. 5-10 years
 3. 1-4 years
 4. less than 1 year
- (UN = unknown; NA = not applicable)

Time spent in mental hospitals

2.6.8

What is average number of days patients spent in your hospital?

What is the number of patients treated in your hospital?

What is the cumulative number of days spent in your hospital? (Total of all patients)

Number of patients treated in a mental hospital: (a) the number of patients in the mental hospital at the beginning of the year plus (b) the number of admissions during the year.

2.6.9

What is the occupancy rate in your hospital? (how many beds are used from all the available beds)

Cumulative number of days spent in mental hospitals (total of all patients) divided by beds of the hospital times 365 (#)

2.6.10

What is the percentage of patients who were physically restrained or secluded at least once in the last year in your hospital?

- Percentage of patients who were physically restrained or secluded patients at least once in the last year in mental hospitals:
- A = Over 20% of patients are restrained or secluded
 - B = 11-20% of patients are restrained or secluded
 - C = 6-10% of patients are restrained or secluded
 - D = 2-5% of patients are restrained or secluded
 - E = 0-1% of patients are restrained or secluded
- UN = unknown

- *A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the user's body, which he or she cannot easily remove. Using force to hold a user and restrict movement constitutes restraint. Seclusion refers to the practice of placing a user in a confined space alone e.g. in a locked room.*

- *Include all the users who are physically restrained or secluded, irrespective of the duration of the restraint or seclusion*
- *In 'comments' column, either (a) indicate data source or (b) write 'BE' if response is based on a Best Estimate:*

2.6.11

What is the proportion of children and adolescents among the patients treated in your hospital?

Count patients under 17.

2.6.12

What is the proportion of beds in your hospital that are for children and adolescents only?

2.7.2

How many forensic beds do you have in your hospital? (what is the proportion?)
 Do you have a forensic unit in your hospital? (how many beds/proportion of all beds)
 Do you have prison mental health treatment facilities? (how many beds?)

Beds in forensic inpatient units by type of facility

Proportion of beds in forensic inpatient units by type of facility :

MEASURE	1) mental hospitals 2) forensic units in mental hospitals 3) forensic units in general hospitals 4) prison mental health treatment facilities Proportion; UN = unknown; NA = not applicable
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Psychosocial interventions

2.9.1

What is the percentage of inpatients who received one or more psychosocial interventions in your hospital in the past year?

Percentage of patients who received one or more psychosocial interventions in mental hospitals in the past year : A = none (0%) B = a few (1 - 20%) C = some (21 - 50%) D = the majority (51 - 80%) E = all or almost all (81 - 100%) UN = unknown; NA= not applicable
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Psychosocial interventions sessions should last a minimum of twenty minutes to be counted for this item. Examples of psychosocial treatments include psychotherapy, provision of social support, counseling, rehabilitation activities, interpersonal and social skills training, and psycho-educational treatments. Do not include intake interviews, assessment, and follow-up psychopharmacology appointments as psychosocial interventions.

Availability of medicines in mental hospitals

2.10.1 In your hospital is at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) available all year long?

Psychiatry beds located in or near the largest city

2.11.1 What is the number of psychiatric beds in or near Asmara? (in community based psychiatric inpatients units and mental health hospitals)

Community-based psychiatric inpatient unit: A psychiatric unit that provides inpatient care for the management of mental disorder within a community-based facility. These units are usually located within general hospitals, they provide care to users with acute problems, and the period of stay is usually short (weeks to months).

- *Includes: Both public and private non-profit and for-profit facilities; community-based psychiatric inpatient units for children and adolescents only; community-based psychiatric inpatient units for other specific groups (e.g., elderly).*
- *Excludes: Mental hospitals; community residential facilities; facilities that treat only persons with alcohol and substance abuse disorder or mental retardation.*

Ethnic and religious minority group admissions to mental hospitals

2.11.5 What is the proportionate number of ethnic and religious minority group admissions to the mental hospital in comparison to their relative population size?

We have to include the percentages in the general population.

In comparison to their relative population size, ethnic and religious minority groups make up:

- A = Substantially larger proportion of admissions to mental hospitals
- B = Roughly equal proportion of admissions to mental hospitals
- C = Substantially smaller proportion of admissions to mental hospitals
- UN = unknown; NA= not applicable

Human resources in mental health facilities

4.1.1 What is number of human resources working in or for mental health facilities or private practice by profession?

- UN = unknown
1. psychiatrists
 2. other medical doctors, not specialized in psychiatry,
 3. nurses
 4. psychologists
 5. social workers
 6. occupational therapists
 7. other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors)

Nurse: A health professional having completed a formal training in nursing at a recognized, university-level school for a diploma or degree in nursing.

Occupational therapist: A health professional having completed a formal training in occupational therapy at a recognized, university-level school for a diploma or degree in occupational therapy.

Staff working in or for mental health outpatient facilities

4.1.4

What is the number of full-time or part-time mental health professionals working in or for outpatient mental health facilities?

1. psychiatrists
 2. other medical doctors, not specialized in psychiatry,
 3. nurses
 4. psychologists, social workers, and occupational therapists
 5. other health or mental health workers
- Number; UN = unknown
Include mental health staff working in government-administered outpatient facilities, NGO outpatient facilities and for profit mental health outpatient facilities. Exclude professionals engaged exclusively in private practice.

Mental health information systems in mental hospitals

6.1.2

Do you have in your hospital a system by which you routinely collect and compile data? (by type of next information)

1. Number of beds
 2. Number of inpatient admissions
 3. Number of days spent in hospital
 4. Number of involuntary inpatient admissions
 5. Number of users who are physically restrained or secluded
 6. Diagnoses
- UN = unknown; NA = not applicable (e.g. no mental hospitals exist)

Routine collecting and compiling data means that data are collected, compiled, and are available at one place in the hospital all year long.

Data transmission from mental health facilities

Interviewee: somebody in the MoH, Dr. Goitom?

6.1.5

From which mental health facilities did the government health department received data in the last year?

1. Mental hospitals
 2. Community-based psychiatric inpatient units
 3. Mental health outpatient facilities
- UN = unknown; NA = not applicable

Community residential facilities. (Mai Temenai)

To be considered if residential facilities through the MLHW meet the criteria.

Interviewee: head nurse of Mai Temenai

- *Community residential facility: A non-hospital, community-based mental health facility that provides overnight residence for people with mental disorders. Usually these facilities serve users with relatively stable mental disorders not requiring intensive medical interventions.*
- *Includes: Supervised housing; un-staffed group homes; group homes with some residential or visiting staff; hostels with day staff; hostels with day and night staff; hostels and homes with 24- hours nursing staff; halfway houses; therapeutic communities. Both public and private non- profit and for-profit facilities are included. Community residential facilities for children and adolescents only and community residential facilities for other specific groups (e.g., elderly) are also included.*
- *Excludes: Facilities that treat only persons with diagnosis of alcohol and substance abuse disorder or mental retardation; residential facilities in mental hospitals; generic facilities that are important for people with mental disorders, but that are not planned with their specific needs in mind (e.g. nursing homes and rest homes for elderly people, institutions treating mainly neurological disorders or physical disability problems).*

1.4.3

Does this facility have at least one yearly external review/inspection of human rights protection of patients?

An external review/inspection refers to a review that is conducted by an external body that is independent from the mental health facility.

1.4.5

Has this facility had at least one-day training, meeting or other type of working session on human rights protection of patients in the last 2 years?

2.5.1

What is the number of community residential facilities in the country?

2.5.2

What is the number of beds/places in your community residential facility?

2.5.3

What is the number of users treated in your community residential facility?

Number of users treated in a community residential facility: (a) the number of users in the facility at the beginning of the year plus (b) the number of admissions to the facility during the year

2.5.4

What is the proportion of female users treated in your community residential facility?
How many female users are treated in your community residential facility?

2.5.5

What is the average number of days spent in your community residential facility?

Cumulative number of days spent in community residential facilities in the previous year (total of all users) divided by number of users treated in your community residential facility.

Children and adolescents treated in community residential facilities

2.5.6

What is the proportion of children and adolescents among users treated in your community residential facility?

Count users aged 17 years and younger treated in both adult and specialized child and adolescents facilities.

2.5.7

What is the proportion of beds/places in your community residential facilities that are for children and adolescents only?

What is the number of beds/places in community residential facilities for children and adolescents only?

4.1.1

What is number of human resources working in or for community residential facilities or private practice per by profession?

UN = unknown

1. psychiatrists
2. other medical doctors, not specialized in psychiatry,
3. nurses
4. psychologists
5. social workers
6. occupational therapists
7. other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors)

Mental Health Outpatient Facility Questionnaire:

Question Number	Question	Response	Remarks
OP1	<p>How many patients were treated in this facility in 2004?</p> <p style="text-align: right;">Male</p> <p style="text-align: right;">Female</p> <p style="text-align: right;">Total</p>	<p style="text-align: center;"><input type="text"/></p> <p style="text-align: center;"><input type="text"/></p> <p style="text-align: center;"><input type="text"/></p>	<p>2.2.2</p> <p>2.2.3</p>
OP2	<p>How many patients were treated for the following diagnoses?</p> <p style="text-align: center;">Mental and behavioral disorders from substance abuse</p> <p style="text-align: center;">Schizophrenia, schizotypal and delusional disorders</p> <p style="text-align: center;">Mood (affective disorders</p> <p style="text-align: center;">Disorders of adult and personality disorders</p> <p style="text-align: center;">Neurotic, stress and somatoform disorders</p> <p style="text-align: center;">Others (epilepsy, mental retardation etc)</p>	<p style="text-align: center;"><input type="text"/></p> <p style="text-align: center;"><input type="text"/></p> <p style="text-align: center;"><input type="text"/></p> <p style="text-align: center;"><input type="text"/></p> <p style="text-align: center;"><input type="text"/></p> <p style="text-align: center;"><input type="text"/></p>	<p>2.2.4</p>
OP3	<p>How many patients were treated in these age groups in 2004?</p> <p style="text-align: right;">> 17 years</p>		<p>2.2.6</p>

	0 – 17 years	<input type="text"/>	<input type="text"/>
OP4	Is routine follow up community care provided?		2.2.8
	Yes	<input type="text"/>	<input type="text"/>
	No	<input type="text"/>	<input type="text"/>

OP5	Is there a mental health mobile clinic that conducts regular outreach services?		2.2.9
	Yes	<input type="text"/>	<input type="text"/>
	No	<input type="text"/>	<input type="text"/>
OP6	How many users received one or more psychosocial interventions in 2004?	<input type="text"/>	2.9.3
OP7	How many patients were treated from urban and rural groups?		2.11.2
	Urban	<input type="text"/>	<input type="text"/>
	Rural	<input type="text"/>	<input type="text"/>
OP8	Which languages do the mental health workers in this facility speak fluently?	<input type="text"/>	2.11.3
		<input type="text"/>	<input type="text"/>
		<input type="text"/>	<input type="text"/>
		<input type="text"/>	<input type="text"/>

OP9	Availability of psychotropic medicines			2.10.3
	Category	Types available	Where available	
	Anti psychotic			
	Anti depressant			
	Mood stabilizer			
	Anxiolytic			
	Anti epileptic			

Questionnaire on Mental Health in Primary Health Care (PHC)

3.1 Physician Based PHC

3.1.1 How many hours were devoted to psychiatry and mental health related subjects in the undergraduate training of medical doctors? (Interviewee – Physicians)

3.1.2. Did you have at least two days of refresher training course in psychiatry/mental health in the last year (Interviewee – PHC doctors)

3.1.3. Are there assessment and treatment protocols for key mental health conditions in the physician based PHC? Interviewee – ZMD, National Medical Officer)

- a) data source b) best estimate

3.1.4. How many of the full time PHC doctor in the HF make on average at least one referral per month to a mental health professional

- a) data source b) best estimate

3.1.5 How many of the PHC doctors in the HF interact with a mental health professional at least monthly in the last year?

- a) data source b) best estimate

3.1.6 Prescription by Primary Health Care Doctors:

Does the Health Regulations authorize PHC doctors to prescribe and/or to continue prescription of psychotropic medicines?

Interviewee = Zonal medical Officers,

3.1.7. Does the Physician based PHC clinic has at least one psychotropic medicine of each therapeutic category (anti psychotic, anti depressant, mood stabilizer, anxiolytic and anti-epileptic medicines) in the facility or in a nearby pharmacy all year long

3.2 Non-Physician-based PHC

3.2.1 How many hours are devoted to psychiatry and mental health-related subjects in under graduate (first degree training) at the nursing school (Interviewee = Nursing Schools)

3.2.2 How many hours are devoted to psychiatry and mental health-related subjects in non doctor/non-nurse PHC workers in colleges/vocational schools (Interviewee = Non Doctor/Non nursing colleges/vocational schools)

3.2.3 How many of the PHC nurses within the facility had at least two days of refresher training in psychiatry/mental health in the last year? (Interviewee – Health Facilities)

3.2.4 How many of the non doctor/non nurse PHC workers within the facility had at least two days of refresher training in psychiatry/mental health in the last year? (Interviewee – Health Facilities)

3.2.5 Does the non physician based PHC have an assessment and treatment protocols for key mental health conditions? (Interviewee – ZMO)

3.2.6 How many of the non physician based PHC clinics make on average at least one mental health referral to a higher level of care per month? (Interviewee – ZMO, HC or HS heads)

3.2.7 How many of the non physician based PHC clinics have at least one psychotropic medicine of each therapeutic category (anti psychotic, anti depressant, mood stabilizer, anxiolytic and anti-epileptic medicines) in the facility or in a nearby pharmacy all year long? (Interviewee – ZMO, HC or HS heads)

3.2.8 Does the Health Regulations authorize PHC nurses to prescribe and/or to continue prescription of psychotropic medicines? (Interviewee = Zonal medical Officers)

3.2.9 Does the Health Regulations authorize non-doctor/non nurse PHC workers to prescribe and/or to continue prescription of psychotropic medicines?

- 3.3.1 Does the Physician based PHC clinic interact with complimentary/alternative/traditional practitioners at least once in the last year?
- 3.3.2 Does the Non-Physician based PHC clinic interact with complimentary/alternative/ traditional practitioners at least once in the last year?
- 3.3.3 Does the mental health facility interact with complimentary/alternative/traditional practitioners at least once in the last year? (Interviewee = Zonal medical Officers.

The WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in the Eritrea including the policy and legislative framework, mental health services, mental health in primary health care, human resources, public education and links with other sectors, and monitoring and research. The goal of collecting this information is to enable policy makers to develop information-based mental health plans with clear base-line information and targets.

The network of mental health facilities in Eritrea consists of a mental hospital, a mental health outpatient department, and a community residential facility. There are 0.83 human resources working in mental health per100,000 population. Most resources for mental health are concentrated in the capital city Asmara. There is a mental health policy (1998) in Eritrea but no mental health plan or legislation. Mental health provision in primary care is weak and access to psychotropic medication is limited.

Important steps in strengthening the mental health system in Eritrea include: (1) increasing the capacity of primary health practitioners to provide mental health services in primary care, (2) revising the mental health policy, (3) development of a mental health plan and legislation, (4) increasing the number of mental health professionals and strengthening their training, and (5) increasing access to psychotropic medicines.