

WHO-AIMS

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



**World Health
Organization**



**MINISTRY OF HEALTH
ETHIOPIA**

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MENTAL HEALTH SYSTEM
IN ETHIOPIA

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

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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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The WHO-AIMS project is coordinated by Shekhar Saxena.

Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Ethiopia. Ethiopia is in the process of developing a national mental health policy. There is no disaster/ emergency preparedness plan for mental health. Approximately 1.7% of the national health expenditure for 2004 was spent on mental health. There is no external reviewing of the mental health facilities regarding human right issues. The country's only mental hospital also acts as the national coordinator of mental health services.

The country has 53 psychiatric outpatient facilities, 6 inpatient facilities and one mental hospital. There is only one residential facility in the country for the chronically mentally ill and several other residential facilities, which have mentally ill clients among their beneficiaries. There are three day-treatment facilities. There are 0.35 mental hospital beds and 0.14 community psychiatric inpatient beds per 100,000 populations. The majority of users of mental health facilities are males. All facilities lack special programs for children and adolescents. There are no separate forensic units

In terms of training, 2% and 3% of the trainings of medical doctors and nurses respectively are devoted to mental health. Curriculum on mental health was prepared for Health Extension Workers. There are no mental health assessment and treatment protocols for primary health care workers. About 50% of physician-based primary care clinics and few non-physician-based primary care clinics made referrals to mental health workers. Few interactions were made between mental hospital and traditional/ alternative practitioners.

Primary care physicians are allowed to prescribe psychotropic medicines without restrictions while there are some restrictions for primary care nurses. Half of the physician based primary health clinics (PHC) have at least one psychotropic medicine of the antipsychotic, antidepressant, anxiolytic and antiepileptic categories available, whereas none of the non-physician based PHC had these medicines available.

There are 0.02 psychiatrists, 0.3 psychiatric nurses and 0.4 psychosocial staff per 100,000 population of the nation. All of the psychiatrists work in the capital city of the country. The density of nurses is eight times greater in the capital city than the rest of the country.

Few mental health professionals graduated in 2004, making 2.7 nurses and 0.003 psychiatrists for every 100,000 people. 15 residents were following training in the newly started psychiatry postgraduate program. 18% of the nurses but none of the other professionals in mental health had refresher courses.

There is no formal coordination of public health education in mental health. Although the mental health facilities worked closely with many departments in different sectors, there was no formal collaboration with the other sectors. There are two family associations working for the mentally ill while there are no user/ consumer associations. No legislative

or financial provisions exist to protect mentally ill persons against discrimination in work place or to provide housing for the homeless who are severely mentally ill.

There is a formal data collection mechanism for mental health data but the department of health had not published any document using the data. 18% of local health publications were in mental health, mainly epidemiological reports.

The results are used to discuss the status of the various aspects of mental health services in the country. The report recommends the development and implementation of a national mental health policy and a mid-term action plan as a priority for Health Sector Development Programme of Ethiopia.

INTRODUCTION

Ethiopia is a country with an approximate area of 1,104,000 sq.km. (UNO, 2001). Its population in 2004 was 72.42 million and the sex ratio (men per hundred women) is 99 (UNO, 2004). The proportion of population under the age of 15 years is 45% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004). 85% of the population lives in rural areas. The literacy rate is 49.2% for men and 33.8% for women (UNESCO/MOH, 2004).

The main languages used in the country are Amharic, Oromo and Tigrinya. The country is home to over 80 ethnic groups. Oromo and Amhara are the two largest ethnic groups. Tigre, Somale, Gurage, Sidama and Walayta are the main minorities. The main religious groups are Islam and Ethiopian Orthodox Christianity. Other forms of Christianity and different endogenous worships are also widely practiced.

The country is a low-income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.6%. . The per capita total expenditure on health is 14 international \$, and the per capita government expenditure on health is 6 international \$ (WHO, 2004).

The life expectancy at birth is 46.8 years for males and 49.4 years for females (WHO, 2004). The healthy life expectancy at birth is 41 years for males and 42 years for females (WHO, 2004). The literacy rate is 49.2% for men and 33.8% for women (UNESCO/MOH, 2004)

The public health care system is underdeveloped. Only 64% of the total population is served by the public health care system. In terms of primary care, there are 1,145 physician-based primary health care clinics in the country. 581 of these are in the public sector while the rest are in private or other non-governmental ownership. There are also 5,495 non-physician based primary health care clinics (4,337 in the public sector and 1,158 run by private and or other non-governmental ownership). A total of 15,108 beds are available in all physician based primary care institutions. 13,469 of these beds are in hospitals while the rest are in health centres. The proportion of beds in private hospitals is not known. There are 2.8 physicians per 100,000 populations.

Domain 1: Policy and Legislative Framework

Policy, plans, and legislation

Ethiopia does not have a mental health policy. However, a national mental health policy is currently under development. It is expected to be finalized and endorsed in 2006. Psychotropic medicines are included in the national list of essential drugs. These medicines include antipsychotics, antidepressants, anxiolytics, mood stabilizers and antiepileptic drugs. A mental health plan does not yet exist for Ethiopia. However, a mental health plan will be a component of the national mental health policy. This draft

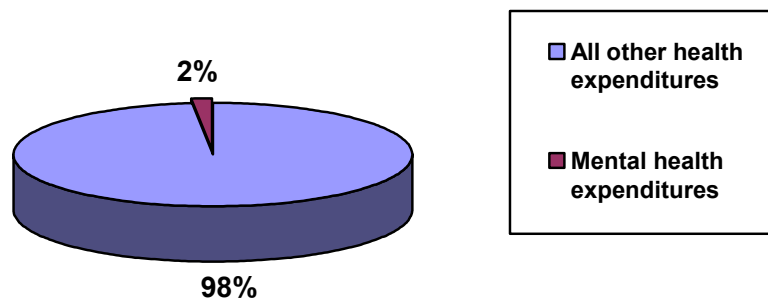
plan will contain the following components: developing mental health services at the primary health care units, reforming the mental hospital to provide up-to-date and comprehensive services, advocacy, and promotion. In addition, the draft plan will set strategies with specific priority goals for the period 2007-2009. This period is part of the duration for the Third Five year health Sector Development plan which extends from 2005-2009. Development of integrated mental health services at all tiers of the health care system and mental health education activities will be among the top priorities of the plan. A time frame for the priority activities will be set for the period 2007-2009. The country does not have a disaster/emergency preparedness plan for mental health. There is no mental health legislation.

Financing of mental health services

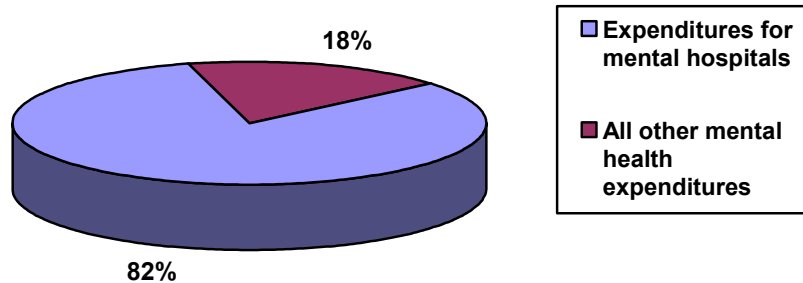
Of the total national health expenditure in 2004, 1.7% was spent on mental health. Eighty-three percent of mental health care expenditures by the government were directed towards the mental hospital.

Sixty-five percent of those who attend public mental health services have free access (at least 80%) to essential psychotropic medicines. For those that pay out of pocket, the cost of antipsychotic medication (chlorpromazine 100mg) is 0.03 birr (3% of the daily minimum wage) and antidepressant medication (imipramine 25mg) is 0.54 birr (6% of the daily minimum wage). There are no social insurance schemes for health coverage.

GRAPH 1.1 HEALTH EXPENDITURE TOWARDS MENTAL HEALTH



GRAPH 1.2 MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS



Human rights policies

There is no separate national human rights review body, which has the authority to oversee mental health facilities and to ensure patients' rights. The only mental hospital in the country is not reviewed or inspected for human rights protection of patients by any human rights body other than the ministry of health. The same is true for all community-based psychiatric inpatient units and community residential facilities. Mental health legislation does not exist and thus does not make such reviews mandatory for all mental health facilities. In terms of training, all mental hospital staff, 30% of community-based outpatient and 16% of community based inpatient unit staff have had at least one-day workshop/ session on human rights in 2004.

Domain 2: Mental Health Services

Organization of mental health services

The country's mental hospital, which is under the ministry of Health, is also the national mental health authority. In this capacity, the mental hospital supervises mental health services in Ethiopia. The mental hospital provides advice to the government on mental health service needs. The hospital is also responsible for the organization of the ongoing National Mental Health Policy development. It is also involved in service planning and monitoring the quality of mental health services. Mental health services are currently not organized in terms of catchments/service areas.

Mental health outpatient facilities

There are 53 outpatient mental health facilities available in the country. There are no outpatient facilities that serve children and adolescents only. These facilities treat 84 users per 100,000 populations. Of all users treated in mental health outpatient facilities, 36% are female and 6% are children or adolescents. The users treated in outpatient facilities were primarily diagnosed with schizophrenia (41%). Mood [affective disorders]

made up 13% of diagnoses, while neurotic, stress related and somatoform disorders made up 11% of diagnoses.

The average number of contacts per user in community based outpatient facilities is unknown. None of the outpatient facilities provide follow-up care in the community. There are no mobile mental health teams. Approximately half of outpatient facilities have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility or at a near-by pharmacy all year long.

Day treatment facilities

There are three day-treatment facilities in the country serving a total of 774 beneficiaries. Two of these facilities are for persons with mental retardation who also suffer from additional behavioural problems. One is devoted primarily to help children with autism.

Community-based psychiatric inpatient units

There are 6 community-based psychiatric inpatient units available in the country for a total of 0.14 beds per 100,000 populations. None of the beds in community-based psychiatric inpatient units are reserved for children and adolescents. Thirty-six percent of patients are female and 5% are children or adolescents. The rate of admissions in these facilities is 0.3 per 100,000 populations. However, data are not available regarding the diagnoses of admitted patients in most community based inpatient units. Similarly, there are no data about the duration of time patients spent in community-based psychiatric inpatient units or the proportion of patients who received psychosocial interventions in 2004. 100 % percent of community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility.

Community residential facilities

There is one community residential facility available in the country. This facility serves the population of chronically mentally ill persons and treats 0.2 patients per 100,000 populations. There are no beds in community residential facility reserved for children and adolescents only. Thirty-two percent of patients are female. Children and adolescents were not treated in this facility in 2004. All of the residents spent the whole of 2004 in the community residential facility.

Mental hospitals

There is only one mental hospital in the country with 0.35 beds per 100,000 populations. The number of beds decreased by 30% in 2004 due to demolition of some blocks during a process of expansion. The expansion will enable the hospital to acquire separate wards for specific groups like children, the elderly and forensic cases, all of which have been served in the same wards. The number of adult beds will in fact be less than what it used

to be before expansion. This hospital is organizationally integrated with mental health outpatient facilities. None of the beds in the hospital are separately reserved for children and adolescents. The patients admitted to the mental hospital were given primarily the following diagnoses: schizophrenia (60%) and mood disorders (25%). The number of patients in the mental hospital in 2004 was 1,235 (1.7 per 100,000). Thirty-one percent of patients treated were female and 7% were children or adolescents.

The average number of days spent in the mental hospital is 63: 92% spend less than one year in the hospital; 5% of patients spend 1-4 years; 0.21% spend 5-10 years; and 0.42% of patients spend more than 10 years in the mental hospital.

Almost all patients in the mental hospital received one or more psychosocial interventions in 2004. At least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) was available in the mental hospital.

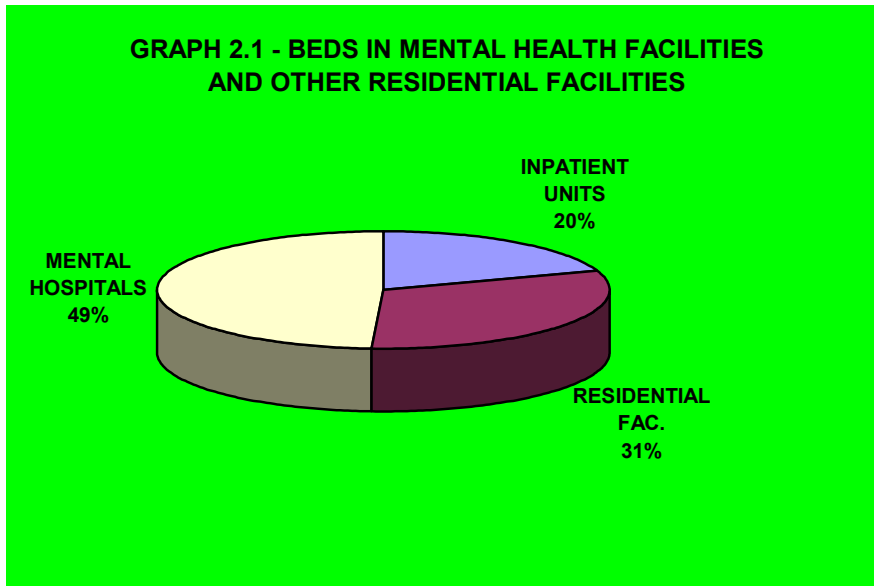
Forensic and other residential facilities

There are no separate forensic inpatient units in the country. Patients requiring forensic mental health assessment received such assessment in the mental hospital. Twelve out of the 360 beds (3%) in the mental hospital are used for forensic purposes. The maximum stay of forensic patients in the hospital is 6 months.

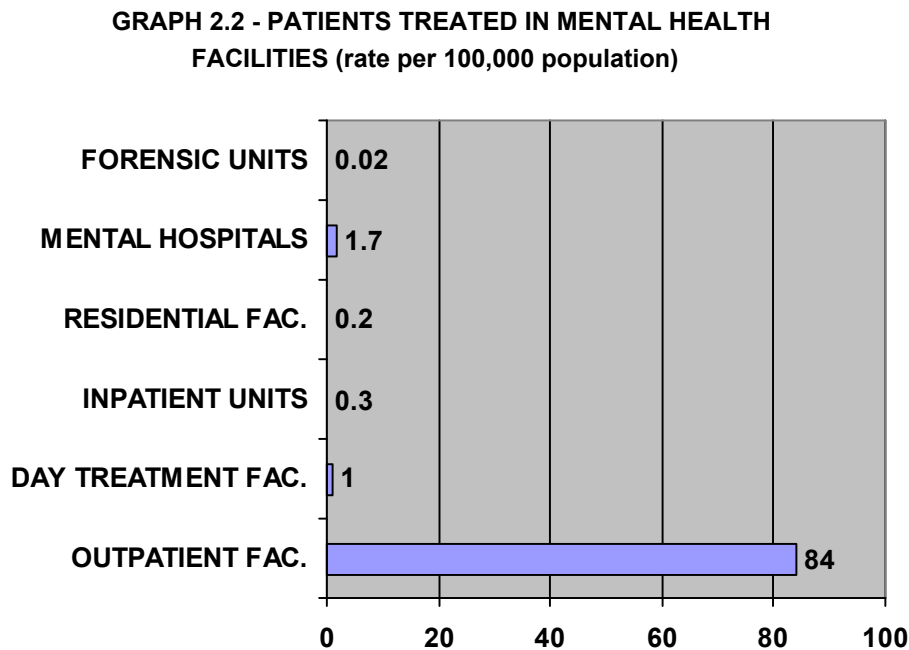
Human rights and equity

There are no data regarding the number of involuntary admissions to community-based inpatient psychiatric units or to the mental hospital. Two to five percent of patients admitted in the mental hospital were restrained or secluded at least once in 2004. It is unknown what proportion of patients in community-based inpatient units were restrained or secluded.

Eighty-one percent of beds in community based psychiatric inpatient units and all mental hospital beds in the country are located in or near the largest city. Such a distribution of beds prevents access for rural users. Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is a minimal issue in the country. However, one criterion for eligibility for psychiatric nursing training is fluency in the working language of the area they work in.

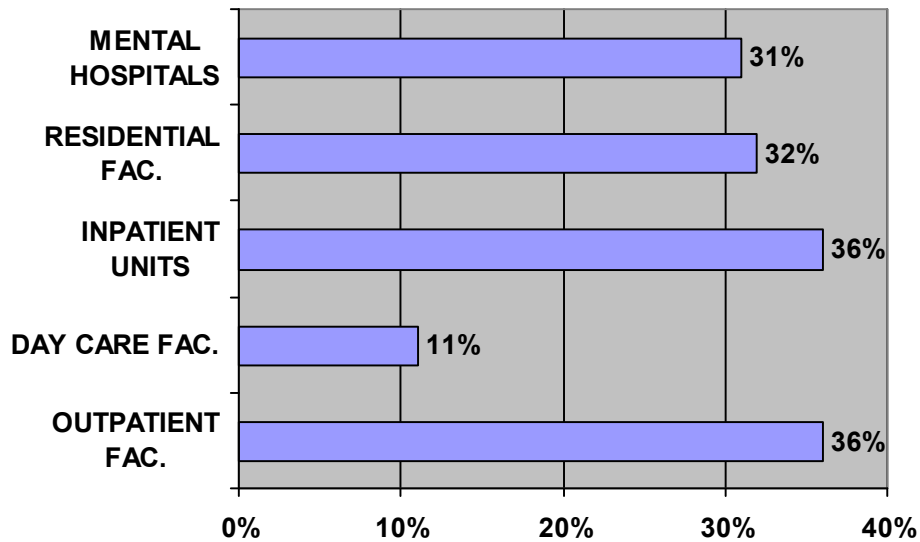


The majority of mental health beds are in the mental hospital followed by the community residential unit. There are no separate forensic units with beds.



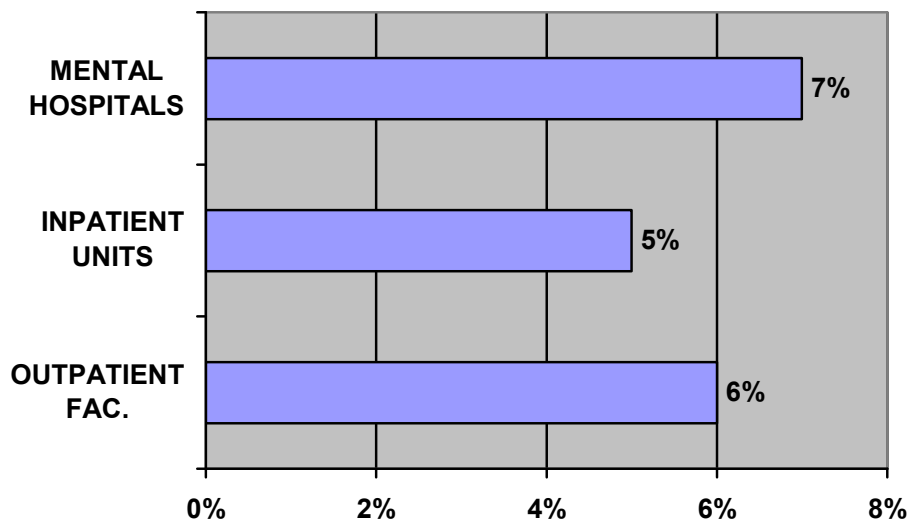
The vast majority of users are treated in outpatient facilities, including the outpatient facilities of the mental hospital. Very few patients per 100,000 are seen in inpatient units of the mental hospital, in community based inpatient units or in residential units.

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



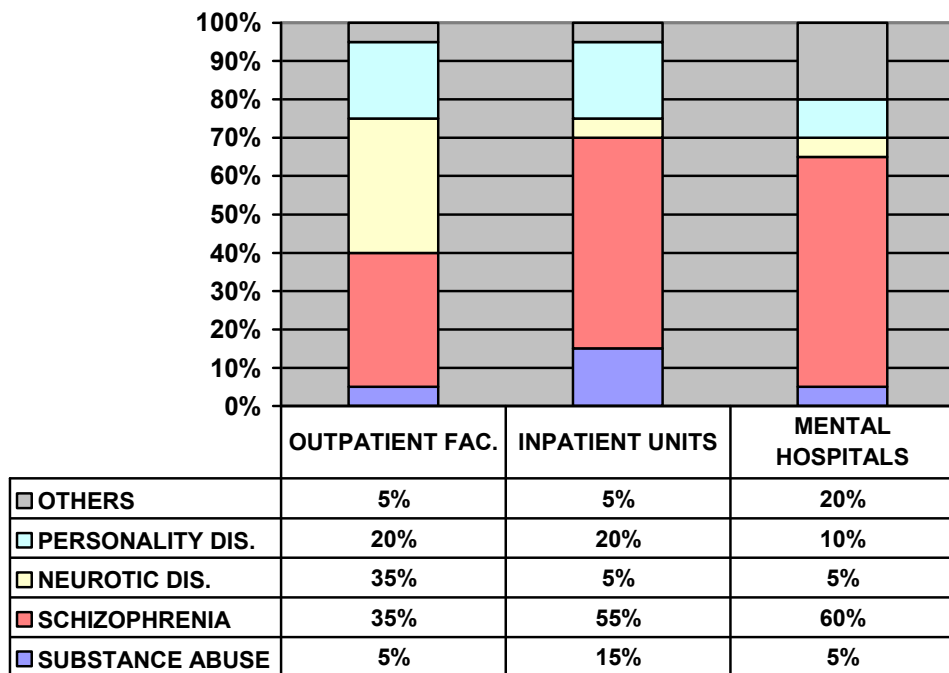
Female users make up over 30% of the population in all mental health facilities in the country. The proportion of female users is highest in outpatient facilities and inpatient units.

**GRAPH 2.4 - PERCENTAGES OF CHILDREN AND
ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES**

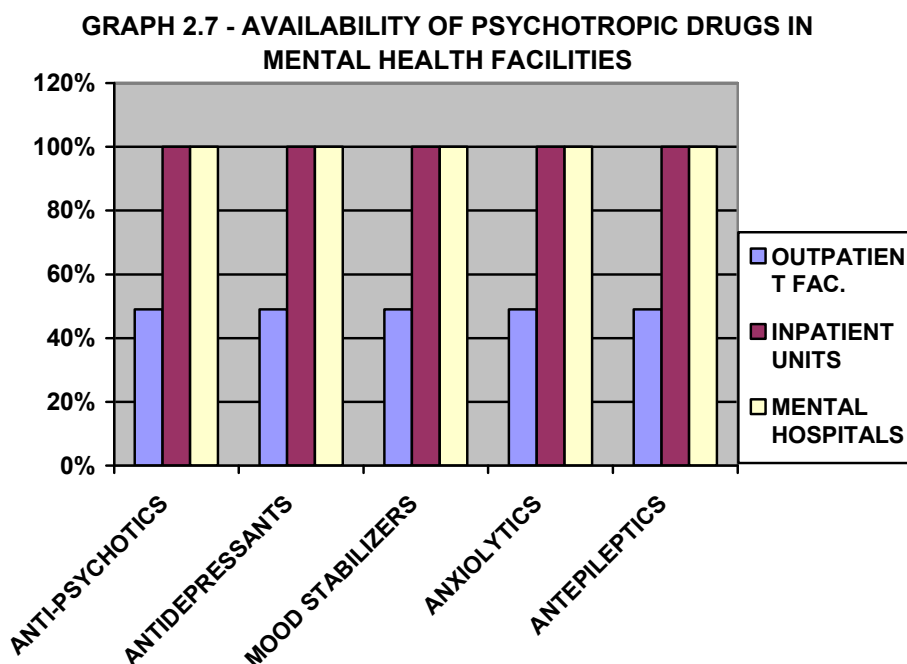


Except for residential facilities, which had not seen clients of child/adolescent age group, the percentage of users that are children and/or adolescents does not vary substantially from facility to facility. The proportion of children users is highest in the mental hospital and lowest in inpatient units.

GRAPH 2.5 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS



The pattern of distribution of diagnoses is different in outpatients and mental hospital. The most prevalent in outpatient facilities is other conditions followed by schizophrenia while in the mental hospital schizophrenia is the most prevalent diagnosis followed by others. Substance abuse disorders make for the 0.1% of diagnoses in mental hospital while such diagnosis is absent in outpatient facility. Interestingly personality disorders are not diagnosed in either facility. Inpatient facilities do not keep separate records for admitted patients who have already received diagnoses as outpatients.



Psychotropic drugs are mostly widely available in mental hospitals and inpatient units, and some times in outpatient mental health facilities.

Domain 3: Mental Health in Primary Health Care

Training in mental health care for primary care staff

2% of the training for medical doctors and 3% of training for nurses is devoted to mental health while there is no training in mental health for non-doctor/non-nurse primary health care workers. There is no refresher training in mental health for primary health care doctors, primary care nurses or non-doctor/non-nurse primary health care workers.

In October 2004, training in mental health was also provided by the mental hospital to 215 trainers of Health Extension Workers (HEW). The HEW is a new type of frontline non-physician, non-nurse primary health care worker. HEWs are female high school graduates trained for one year on various basic health care issues including mental health. The Ministry of Health has a national plan to train and employ two HEWs per every 5,000 general population to do the following duties: health education, demonstration, supervision and support. The mental hospital has produced a very simple training package to enable HEWs to identify and educate the community on common mental health signs and symptoms. It is expected that HEWs will identify and refer cases of mental disorders.

Mental health in primary health care

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. None of the physician-based primary health care clinics have assessment and treatment protocols for key mental health conditions available. Neither do non-physician-based primary health care clinics.

Some physician-based primary health care clinics (21-50%) and a few non-physician-based primary health care clinics (1-20%) make on average at least one referral to a mental health professional per month.

As for professional interaction between primary health care staff and other care providers, a few primary care doctors (1-20%) have interacted with a mental health professional at least once in 2004. There are no data on the percentage of physician-based and non-physician-based PHC facilities that had interaction with a complimentary/alternative/traditional practitioner in 2004. A few mental health facilities (1-20%) had some interaction with complimentary/alternative/traditional practitioners at least once in 2004.

Prescription in primary health care

Primary care doctors are allowed to prescribe psychotropic medications in any circumstance. Primary care nurses are allowed to prescribe psychotropic medications but with some restrictions. Non-doctor, non-nurse primary health care workers are allowed to dispense psychotropic medicines but are not allowed to prescribe.

Fifty to eighty percent of physician-based PHC institutions have at least one psychotropic medicine of each therapeutic category available (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) while none of the non-physician-based primary health care clinics have such medicines available.

Domain 4: Human Resources

The total number of human resources working in mental health facilities or private practice per 100,000 populations is 1.2. The breakdown according to profession is as follows: 0.02 psychiatrists, 0.02 other medical doctors (not specialized in psychiatry), 0.3 nurses, 0.4 psychologists, 0.4 social workers, no occupational therapists, and 0.02 health assistants.

Regarding the workplace, 3 psychiatrists (21.4%) work in community-based psychiatric inpatient units, 9 psychiatrists (64.3%) work in the mental hospital, and two psychiatrists (14.3%) work in private practice in the capital city. Although exact figures are not known, the majority of these also do moonlighting work in other facilities. Nine medical doctors not specialized in mental health (75%) work in the mental hospital while 3 (25%)

work in community-based psychiatric inpatient units. The majority of mental health nurses (111 or 58.4%) work in outpatient facilities. Thirty-nine nurses (21%) work in community-based psychiatric inpatient/outpatient units and 40 (21%) in the mental hospital. Eighty-three percent (506) of psychologists and social workers work in schools as counsellors while one social worker (.3%) and one psychologist (.3%) work in the mental hospital. The remainders work in other institutions (e.g. NGOs). There are no psychologists or social workers in community-based psychiatric outpatient facilities or inpatient units. As regards to other health or mental health workers, 17 health assistants work in the mental hospital.

In terms of staffing in mental health facilities, there are 0.03 psychiatrists per bed in community-based psychiatric inpatient units and in the mental hospital. As for nurses, there are 0.4 nurses per bed in community-based psychiatric inpatient units in comparison to 0.2 nurses per bed in the mental hospital. There are no psychologists, social workers or occupational therapists working in community-based psychiatric inpatient units. The combined professional per bed rate for psychologists and social workers in the mental hospital is 0.01.

The distribution of human resources between urban and rural areas is unfair: all the psychiatrists work in the largest city in the country (0.5 per 100,000 city population versus 0.2 psychiatrist per 100,000 for the whole country). The nurse to population ratio is also biased in favour of the largest city with 2.5 per 100,000 in contrast to 0.3 per 100,000 for the entire country.

Training professionals in mental health

The number of professionals that graduated in 2004 in academic and educational institutions per 100,000 is as follows: 0.4 Medical doctors, 2.7 nurses, 0.003 psychiatrists (two psychiatrists graduated from colleges abroad), 3.5 HEWs. No psychologists, occupational therapists, or social workers with at least one year training in mental health care graduated in 2004. 0.03 nurses per 100,000 populations graduated with at least one year training in mental health in 2004. Postgraduate training in psychiatry is in its second year with a total of 15 residents in 2004.

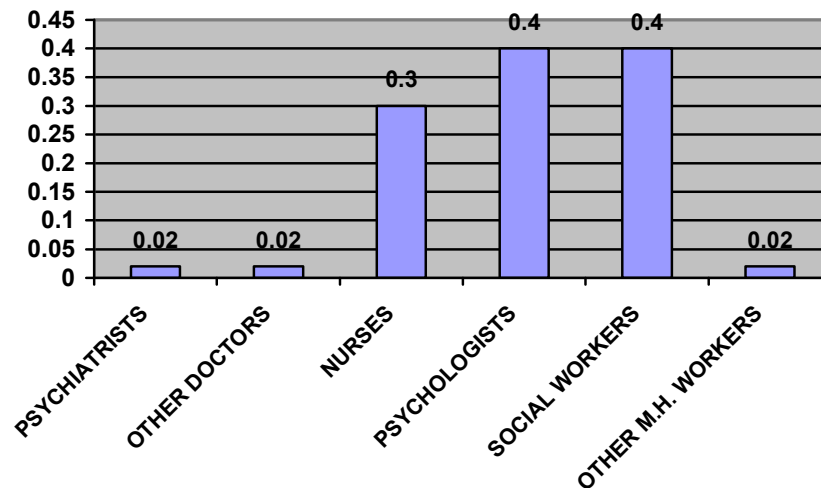
Regarding refresher training, none of the psychiatrists or non-psychiatric doctors had refresher training in mental health while 35 out of 190 nurses working in mental health facilities had refresher training on the rational use of psychotropic drugs, psychosocial intervention, and child and adolescent mental health issues. Usually, two refresher courses are given to mental health nurses annually. However, one of the courses was not given in 2004 because of lack of funds.

One psychiatrist immigrated to another country within five years of completing her training. Six psychiatrists who did their training abroad stayed in the country of training.

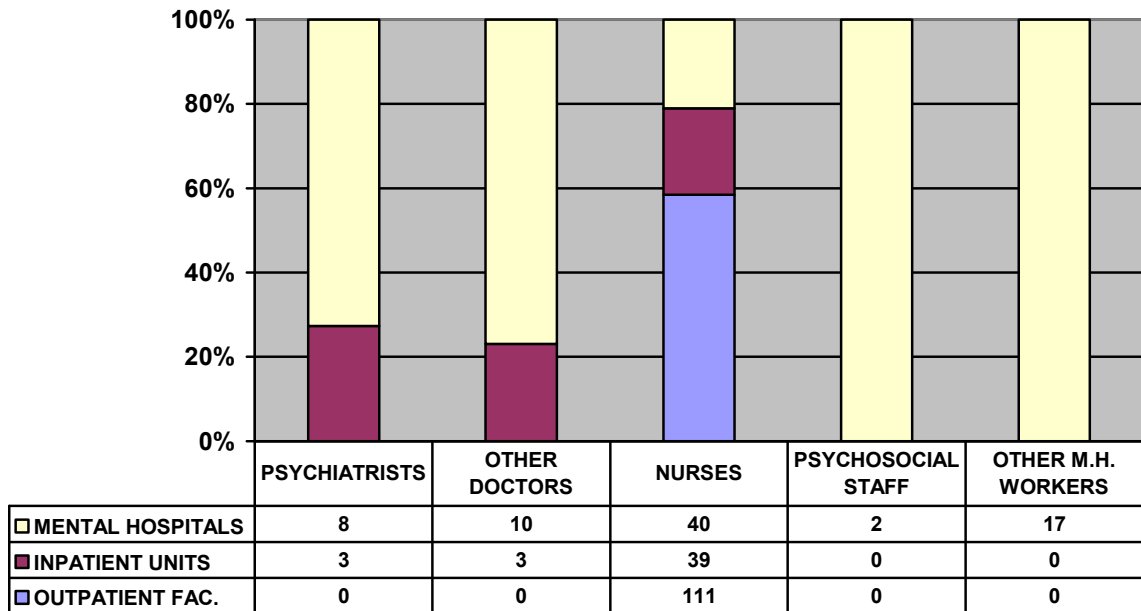
Consumer and family associations

There are no users/consumers associations in the country but there are 1,210 family members that are members of two family associations. The government does not provide economic support for family associations. Family associations have been involved in the formulation of the draft national mental health policy in the past year. A few mental health facilities (1-20%) had interactions with family associations in 2004. In addition to consumer and family associations, there are other NGOs in the country involved in individual assistance activities such as counselling, housing, or support groups. The exact number of such organizations is however, unknown.

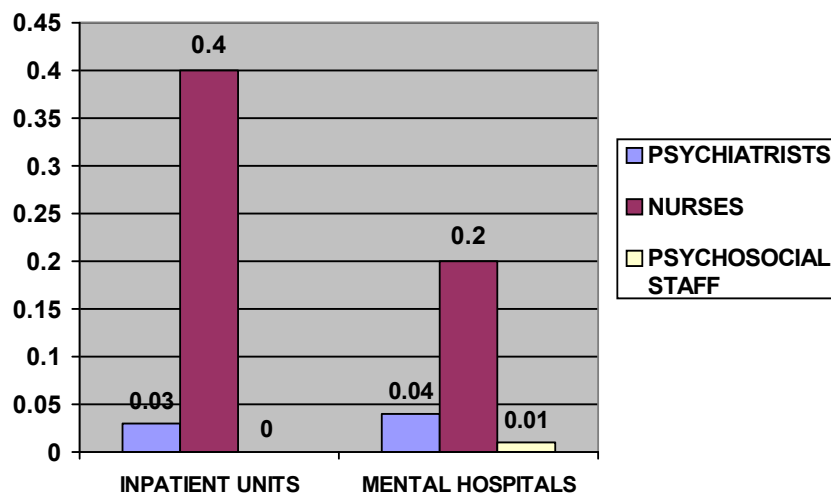
**GRAPH 4.1 - HUMAN RESOURCES IN MENTAL
HEALTH**
(rate per 100,000 population)



GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES
(percentage in the graph, number in the table)



GRAPH 4.3 - RATIO OF HUMAN RESOURCES/BEDS



Domain 5: Public Education and Links with other Sectors

Public education and awareness campaigns on mental health

There is no formal coordination of public education on mental health. However, the mental hospital occasionally arranges public education and awareness campaigns on mental health and mental disorders. Government agencies, (the mental hospital, Department of Health Education, mass media), private newspapers and magazines have promoted public education and awareness campaigns in the last five years. These campaigns have targeted the general population, children and adolescents, women and trauma survivors. In addition, there have been public education and awareness campaigns by the mental hospital targeting professional groups including health care providers, teachers, journalists, traditional healers and politicians.

Legislative and financial provisions for persons with mental disorders

There is no legislation to protect persons with mental illnesses against discrimination in the work place (dismissal, lower wages) illness. However, the testimony of a psychiatrist can reverse employer actions. There is no legislation that obligates companies to reserve a certain percentage of their vacancies to mentally disabled persons. There are no legislative or financial provisions for housing for the severely mentally ill.

Links with other sectors

There are no formal collaborations with any sector. All the same, the mental hospital works closely with the Departments of Criminal Justice, Labour and Social Welfare, the Department of Primary Health Care, Community Health Department of Addis Ababa University, the Health Education Department, HIV Department and the Department of Drug Control. Also, there are no formal links with the departments of Education, Employment, Housing or the Elderly.

In terms of support for child and adolescent health, 4% of primary and secondary schools (1-20%) have either a part-time or full-time mental health professional, and a few of primary and secondary schools have school-based activities to promote mental health and prevent mental disorders. The percentage of prisoners with psychosis and/or mental retardation is less than 2%. Regarding mental health activities in the criminal justice system, some (21-50%) of the country's prisons have at least one prisoner per month in contact with a mental health professional. No police officers participated in training activities on mental health while a few judges (1-20%) have done so.

In terms of financial support for users, none of the mental health facilities have access to programs outside the facility that provide employment for users with severe mental disorders. It is not known what percentage of people on disability benefits receives benefits due to mental disability.

Domain 6: Monitoring and Research

The Ministry of Health has a formally defined list of individual data items that ought to be collected by all mental health facilities. The extent of data collection is variable among mental health facilities. The government health department received data from the mental hospital and all community based psychiatric inpatient/outpatient facilities. However, no report was produced on the mental health data transmitted to the government health department.

In terms of research, 18% of all health publications in the country were on mental health. The research focused mainly on epidemiological studies in community and clinical samples but there were also research on drug trials and genetics.

Next Steps in Planning Mental Health Action

The information gathered using the WHO-AIMS clearly shows the limited amount of mental health services in the country. Compared to other African countries, the extent of mental health care in Ethiopia is poor in almost all aspects of services (Health Atlas 2005 at <http://www.cvdinfo.ca/mh-atlas/>). In addition to poor resources, one major factor for the low investment in mental health services is lack of awareness of the importance of mental health in the country's overall development. Therefore, to prevent the impact of neglected mental and behavioural problems, it will be necessary to get together with policy makers and other stakeholders to discuss on the significance of mental health and to decide future directions.

The most important next steps in mental health planning in Ethiopia are the development and endorsement of a mental health policy and a mental health action plan, as well as training of the PHC workers in mental health. The country is economically very poor. The presence of a policy and an action plan will ensure responsibility and accountability, and also the economic use of resources. Adequate planning for the use of additional resources is essential to ensure that there is no misuse or wastage and that additional services address the real problems of the population. Sustainable development of a mental health system can be achieved only if services are based on policy and guided by an action plan. The presence of policy and an action plan will enforce responsibility and accountability at various levels of the health care system. The policy will define the responsibilities of different relevant sectors and also the types and extent of intersectoral collaboration. The policy and plan will also enable health authorities to define levels of care and allocation of mental health staff and other resources. The Ministry of Health is now working on the final draft of a national mental health policy.

The other critical issue in the development of mental health care in Ethiopia is lack of mental health awareness and basic management skills among primary health workers. Training PHC staff will maximize the helping potential of the PHC staff, thereby reducing the suffering of patients, and increasing early recognition and timely treatment

of debilitation. There have been a lot of instances where mentally ill people come to mental health services after spending lengthy and painful periods because of being misdiagnosed and mismanaged as somatic cases by primary health care workers. Primary health care workers receive little training on mental health issues. Moreover, most of the primary health care workers in this country graduate without having any exposure to the practical management of even common mental disorders. As a result, the majority of primary health care workers are not better than the general population with regard to mental health awareness. Changing this status via a medium term plan of training will therefore be a priority in promoting mental health care in this country.

Training primary health care workers in basic knowledge and management skills of common mental disorders will have the following major benefits:

1. People will have easy access to mental health care. As few mental health professionals are currently found in and around major towns, the majority of rural people usually do not have access to mental health care
2. Misdiagnosis and mismanagement of mental disorders will be reduced.
3. Follow-up and monitoring will be facilitated. Many people seen at the cities fail to return for follow-up because of unaffordable means of transport
4. Mental health awareness in the population will be improved. Improving mental health knowledge in primary health care workers will help to educate the population regarding the nature of mental illness and the means of preventing and treating mental and behavioural disorders.
5. The cost of mental disorders will be reduced by providing interventions before patients become too disabled.

Dissemination

The report of the WHO-AIMS needs to be sent to the Ministry of health and to all regional health bureaus. In addition, all training institutions of health labor and NGOs working on health have to receive a copy of the report. The health authorities will be able to determine the gaps between what the care systems and take appropriate measures. Training institutions also will use the report to restructure their curricula so that the latter will become comprehensive and not only focusing on somatic aspect of health. NGOs play a vital role in providing access to the poor, the vast majority of this country's people. There is however, no NGO, which addresses the mental health need of its clientele. Involving these NGO's in mental health awareness campaign will help them to provide a comprehensive health service to those who need medical assistance.

The need for a mental health Planning workshop

As already stated, mental health awareness is poor in this country. Unfortunately, this lack involves policy makers and health authorities at various levels. Because of this and because of the prevailing poverty, the nation's resources allocated for health are not fairly considering mental health care. The medical diseases with conspicuous physical signs are often given priority while the slowly but surely disabling mental disorders are often

ignored. With the growing population size, with growing adversities like unemployment and poverty, this country's mental health problems can get worse.

In order to prevent the impact of neglected mental and behavioural problems, it will be necessary to get together with policy makers and other stakeholders to:

- Orient stakeholders about the patterns of mental health services vis- a -vis the continental and international situations
- Discuss the magnitude of mental and behaviour problems nationally
- Discuss facts and reasons for the so-far prevailing negative attitude towards the mentally ill and on scientific advances in mental health
- Present exemplary cases
- Discuss and decide on measures (policy, action plan)

Participants of the workshop will be invited from the following institutions:

Office of the Prime minister; The Ministry of health; Ministry of Education; Ministry of finance; Ministry of Labour and social affairs; All training institutions that train health workers; All universities with medical and mental health-related departments; NGOs working on health; All Regional Health bureaus; Police; The army; Representatives of faith organizations; Representatives of mental health professionals. The workshop will last four days.

Information was gathered about the mental health system in Ethiopia in 2004. Data were collected using the World health Organization Assessment Instrument for Mental health Systems (WHO-AIMS), a tool specially prepared for the purpose.

The assessment revealed that there are 53 outpatient facilities, 6 inpatient facilities and one mental hospital in Ethiopia. However, there are few mental health professionals and mental health services are especially limited for women, children and adolescents and people who do not live in the capital city. Also, primary care providers have little training in mental health and there are no protocols for how to treat and refer people with mental disorders.

The results are used to discuss the status of the various aspects of mental health services in the country. The report recommends the development and implementation of a national mental health policy and a mid-term action plan as a priority for Health Sector Development Programme of Ethiopia.