الصندوق الاجتماعي للتنمية
SFD

Social Fund for Development

Ministry of Health and Population

National Mental Health Strategy

2011-2015

March 2010

National Mental Health Strategy

2011-2015

Acronyms

CPD	Continuing Professional Development
DIMHC	District Intersectoral mental health committee
GHOs	Governorate Health Offices
GIMHC	Governorate Intersectoral mental health committee
GPs	General practitioners
HMIS	Health Management information system
IT	Information technology
IP	Inpatient
IPD	Inpatient department
MHS	Mental health Services
MOHP	Ministry of health and population
NGOs	Non governmental organizations
NIMHC	National I intersect oral mental health committee
OT	Occupational Therapy
OP	Out patient
OPD	0utpatient department
PHC	Primary health care
QA	Quality Assurance
SFD	Social Fund for Development
TBAs	Traditional Birth Attendants
THPs	Traditional Health Practitioners

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YEMEN DRAFT NATIONAL MENTAL HEALTH POLICY

Foreward by President

Foreword by His Excellency, Minister of Health

Vision:

To make Yemen the leading country in the region in provision of quality mental health care services.

Mission:

To provide quality promotive, preventive, curative and rehabilitative mental health care services to all Yemeni people.

Goals:

- Promotion of mental health in the general population, schools and workplaces, with special attention to prevention in vulnerable groups, and to linkages with physical health
- Treatment of people with mental disorders quickly and effectively, in local primary care services where possible, and with attention to co-morbidity with physical illnesses
- Community mobilisation through media, families, NGOs to support people with mental disorders to participate in normal life with their families and friends, and return to work, to tackle stigma and discrimination, and to protect human rights and dignity

This programme is under the auspices of the President and Cabinet, and has implications for all ministries.

Key objectives of the programme include

- Enhance the capability of the National Mental Health Programme
- Integrate mental health into primary care services
- Further decentralization and strengthening of the secondary mental health care system
- Strengthened links between primary and specialist care
- Ensuring basic supply of medications for PHCs, regional psychiatric clinics and inpatient units
- Good practice guidelines for PHCs, regional psychiatric clinics and inpatient units
- Intersectoral liaison between health, education, higher education, social development, human rights, auqaf, media, youth, legislation, planning, justice, police and prisons, NGOs etc at national, governorate/regional and district levels
- Support and establish the psychological counselling canters in the universities and local communities.
- Community mobilisation through media, support to families and NGOs, health education in schools

The other ministries will contribute to the mental health strategy as appropriate and in accordance with their respective remits.

YEMEN STRATEGIC OVERVIEW

Strengths
Challenges
Top priorities
Timetable
PHC training plan

Yemen strengths

- Decentralised PHC system
- Specialists in some governorates
- Training systems for psychiatrists and psychologists
- Situation appraisal completed for several governorates
- Already has Child and Adolescent epidemiological survey
- Some highly motivated staff willing to lead and contribute to developments

Yemen challenges

- PHC not doing mental health
- Specialists concentrated in major cities , and around half of governorates have no psychiatrists
- No properly trained psychiatric nurses
- Lack of effective intersectoral approach for mental health
- Insufficient health care for prisons
- Stigma
- No adult epidemiology
- Working day greatly curtailed by Qat!

Yemen top priorities for mental health

Governance

- Strengthen national mental health programme with additional staff, capacity building, partnership with SFD, and links to other key MoPHP departments, and other ministries
- National intersectoral committee for mental health
- Governorate and district intersectoral committees for mental health

Decentralisation

- Integrate mental health into PHC
  - CPD Training programme for PHC
  - Manual-finalise and disseminate
  - HIS-include mental health
  - Medicines-review essential list, ensure availability

        - Supervision from district level –need to train a cadre for the district level. Consider GPs to do 12 month course and/or psychiatric nurses with 24 month training
    - Each governorate to have 5 -10 beds
    - Governorate OPDs to be decentralised to districts, and staff with psychiatric nurses, GPs with one year training, psychologists and psychiatrists when available.
    - Establish governorate mental health committees, with intersectoral membership
    - Establish district mental health committees, with intersectoral membership
    - Increase numbers of psychiatrists so can have at least two in each governorate ;
        - one to support and supervise the district outpatient clinics and support to PHC;
        - and one for the governorate inpatient unit and liaison psychiatry service

Public health approach

- Intersectorality
- Promotion, prevention, treatment, rehabilitation, prevention of mortality
- Public education
- Research and audit

Quality

- Continuing education for PHC
- Continuing education for specialists
- Quality standards
- Orientation workshops for intersectoral committees

Human Rights

- Mental health legislation
- Code of Practice
- Training for legislation

Yemen Timetable of Action

2010

- Finalise policy and national strategic action plan, obtain approval from President and Cabinet
- Plan PHC training
    - Agree trainers
    - Identify budget
    - Agree timetable for Training of trainers -Jan/Feb 2011
    - Establish training programme 2011-2015 for all PHC doctors and nurses
    - Invite army , police and prisons to send people for training

- Agree PHC manual and disseminate with the training
- Facilitate medicine supply to PHC
- Agree Health Information System mental health categories
- Establish additional posts for National Mental Health Programme
- Establish and continue linkages within Ministry of Health and Population for National Mental Health Programme
- Establish National Mental Health Intersectoral Committee to enable links with other relevant ministries, and steer implementation of national strategic action plan.
- Governorate psychiatrists to consider how to establish district Outpatient clinics
- Psychiatrist representatives and Primary health care representatives to agree information needed in referral letters and discharge letters (e.g. advice to patient, advice to family, side effects, signs of relapse, when to review, when to increase/decrease medication, psychosocial support etc)
- Agree quality standards for specialist care
- Strengthen mental health services in prisons
- Construct database of existing research studies
- Plan pilot adult epidemiological survey
- Plan overall research strategy

2011

- Train PHC trainers
- Start PHC training programme, and disseminate manual /guidelines alongside
- Establish OP clinics
- Implement better referral and discharge letters
- Establish governorate mental health committees and organise orientation workshops in each governorate for their members
- Establish Continuing education programme for specialists
- Finalise mental health legislation
- Develop Code of Practice
- Plan public education campaign

2012

- Continue PHC training programme
- Establish district mental health committees and organise orientation workshops in each district for their members
- Ask each PHC to establish mental health forum
- Pass mental health legislation
- Train staff in implementation of mental health legislation

2013 -15

- Continue PHC training programme
- Establish specialised services for C and A, old age, learning disabilities
- Continue CPD programme for specialists

Yemen PHC training programme

Rationale

- Mental disorder is common , specialist help is scarce, and patients prefer to be treated close to home
- Mental disorder contributes to physical illness , and to repeat consultations in PHC

How

- A cascade decentralised system utilising and building local expertise
- Combing training with provision of manuals, HIS, medicines, supervision

Run 4 courses a year in each of the 22 governorates 5 years

Then start from beginning again, to run continuously.

Objectives, activities, outputs, time frame, indicators, required resources and potential constraints.

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
1. GOVERNANCE							

Leadership of Mental Health Programme	**Strengthen National Programme for Mental Health.**	• Complete the Program structure to be:
		  • Head of Mental Health Programme
		  • Deputy Manager
		  • Coordinators in all governorates
		  • Consider need for additional staff
		• Draw up work plans to implement mental health strategy
		• Draw up budget
		• Capacity building of the Mental Health Programme staff at the MOH and GHOs
		• Raise awareness in rest of MOHP
		• Ensure strategy is integrated with overall PHC Strategy in MOHP and with overall Health Sector Strategy
			Appointments
			
			Workplans Budgets
			
			Additional staff
			
			Implementation strategy drawn up
			
			Budget obtained
			
			Staff trained
				2010-2011
				
				One year
					Appointments made.
					Workplan and budget
					
					Additional staff appointed
					
					Progress on strategy
					
					Funds spent each year
					
					Courses attended by staff
						Cost of staff	Political will in MOH
							
							Finance
							
							Lack of training
							
							Little data available

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Policy linkages within MOH to key directorates and sections	**Establish policy linkages within MOH to enable delivery of strategic action plan**						
	Administrative/ Finance sections	• Liaise with Minister of Planning • Develop and monitor the budget for mental health services in primary, secondary and tertiary care -both secondary and tertiary, including services in governorate and district hospitals as well as in mental hospitals, and in the community. • Develop accountability mechanisms which ensure appropriate financial controls, while facilitating mental health reforms. • Identify funding mechanisms. • Develop the internal budget for Mental Health Services (MHS), • Monitor the internal budget for MHS	Budgets Work plans Funding mechanisms	2010-2011	Budgets Work plans Monitoring systems	Fund Qualified staff	
	Human Resources Development General Directorate	• Oversight of pre and in-service training • Coordination of Continuing Professional Development (CPD) for psychiatrists, psychiatric nurses, social workers • Coordination of Continuing Professional Development for primary care doctors, nurses. • Support and monitor CPD on multiaxial assessments, care planning, relapse prevention, medication management, psychosocial skills, assessment of risk, and management of violence. • Identify funding mechanisms	Effective team in post Budgets Work plans Funding mechanisms	2010-2011	Effective team in post Budgets Work plans Funding mechanisms		Resistant from the others (university… etc)

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
	Quality Assurance section	• MOHP oversight of quality improvement in primary , secondary and tertiary care in relation to mental health	Establish mental health QA indicators	2011-2012	QA indicators	Qualified consultant Fund	
	Research and Health Information General Directorate	• Strengthen research capacity for the mental health • Develop a coherent programme of research and dissemination • Liaise with university departments and hospital researchers • Liaise with research donors to ensure mental health research is prioritised. • Establish research ethics committee • Identify funding mechanisms	Meetings Budgets Work plans Funding mechanisms	2011-2015	Related research Research committee Work plans		Lack of awareness about the importance of mental health related research Rare qualified researchers
		• Review HIS data collection on mental health in specialist services • Use information collected to support mental health service in planning, monitoring and decision making. • Liaise with HIS in PHC to ensure integration of mental health data collection, analysis and use. • Prepare Annual Statistical Report on Mental Health for Ministers, for Parliament, and for consideration by National and Governorate Intersect oral Committees.	Budgets Work plans Funding mechanisms Annual Report	2011-2015	Team in post Budgets Work plans Monitoring systems Annual Report	Fund Work plan	Weakness Of HIS In most health institutions

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
	Primary Health Care Sector	• Oversight of the Mental health component of the pre- and in-service training for primary care staff. • Coordination of CPD training in mental health of primary care staff • Support quality of service delivery in primary care. • Support intersectoral linkages for mental health in primary care. • Liaison with Health Sector Reform Programme on training, basic services package, essential medicines, good practice guidelines for primary care.	Budgets Work plans Funding mechanisms	2010-2015	Training manuals Training courses Trainers trainees	Plan of work Fund Effective leaders	The stigma of this field Results of the previous experience
	Family Health General Directorate	• Establish links with the programmes within the family health programmes	Coordination Plan between programmes	2011-2015	Action plan implemented Meeting	Effective leaders	
	School Health Programme	• Agree mental health contributions to school health programme, training of teachers , school curricula and materials, occupational health for teachers	Budgets Work plans Funding mechanisms	2010-2015	Training manuals Training courses Trainers trainees	Plan of work Fund Effective leaders	

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
	Reproductive Health General Directorate	• Establish links with the reproductive health programmes	Coordination Plan between programmes	2011-2015	Action plan implemented Meeting	Effective leaders	
	The National Centre for Media and Health Education	• Increase public understanding of mental health and mental disorders • Address stigma about mental disorder • Incorporate mental health education into general health education in schools, workplaces and general community		2010-2015			
	Human Rights issues Under the responsibility of the National Mental Health Programme	• Empower and monitor patient rights • Advocacy for patients and families • Promotion of human rights as integral part of mental health legislation	Hospital reports on compulsory admissions, voluntary admissions, refused discharge, complaints, staff training on human rights, Inspectorial visits, minutes of committee meeting.	2011-2012	Approved mental health law.	Effective leaders	
	Other programmes (Reproductive Health, Communicable Diseases, Non-Communicable Diseases)	• Establish links with reproductive health, diabetes, asthma, hypertension • HIV, malaria, bilharzia • Include mental health into prevention, screening , treatment and palliative care • Peer education and teacher training	Coordination Plan between programs	2011-2015	Action plan implemented Meeting	Effective leaders	

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Links with general health sector reform processes and committees	Get mental health on agenda of new national Health Sector Plan 2010-2015	• Ensure mental health representation on all MOHP health sector reform meetings • Ensure mental health representation in all health sector reform documents	Mental health included in health sector reform	Continuous	Health Sector Reform Plan	Effective leaders	Uneven distribution of mental health services
Links with other health providers	Strengthen links with other key health providers e.g. health insurance organizations, private sector, army, universities, NGOs	• Establish systematic linkages about service provision and training at national and governorate levels • • Establish service level agreements e.g. between health and university for service provision and for training placements.	Training courses Universities conducted training	Start 2011	Number of training courses Universities participate in the conducted training	Effective leaders Budget	Shortage of high Specialist cader.
Links *between* MOH and other key ministries	Strengthen policy links with ministries of Finance, Social Affairs, Endowment and Guidance, Human Rights, Justice, Interior, Social Affairs and Labour, Education, Higher Education, Information, and Media, Mother and Child Council, Parliament, Research Study Council, Foundations and NGOs, SFD, Support mental health Programme with National Intersectoral Mental Health Council	• Addition of other key partners as (specialists &SFD& ministry of awqaf)) • Meetings with individual ministries to discuss plans for mental health in each ministry • Establish National Intersectoral Mental Health Committee (NIMHC), Chaired by the minister of Health, to include representation from key parts of MOHP (e.g. health sector reform, health information, human resources), representation from other key ministries (e.g. education, social affairs, judges, religion, interior affairs (police/ prisons); representation from universities, key NGOs, (including user and family representation), and representation from each governorate.	Individual ministry plans National intersectional mental health committee established	2010-2012	Individual ministry plans Agenda and minutes of meetings	Budget for workshops and venues	Awareness about mental health problems, need for careful planning

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Mental Health Legislation	Support draft legislation through legal process	• Consultation process to get community and professional views on draft legislation • Draft and consult, and revise • Pass new legislation • Develop Code of Practice • Training workshops for health professionals and all other sectors. • Implement Code of Practice	Revised legislation. Code of practice .training	2010 2012 continuous	Legislation Code of practice Training evaluations	Budget for training workshops	Unclarity of delegation responsibilities between different professionals
Mental Health integrating in the national medical Board	**promotion of mental health & monitoring of services**	• professional Receive and review documentation • Hear appeals • Oversee training for professionals re legislation	Activated mental health monitoring and functioning	2010-2105	Remit of board Agenda and minutes of board	Budget to meet.	None
Strengthen links between MHP and governorates	Establish governorate coordinators –done in 12 governorates Build skills and capacity of governorate coordinators	• Appoint mental health coordinators in all GHOs and training	Governorate mental health coordinators in each of 22 governorates	2010-2015	Training courses Number of coordinators	Training budget	none

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Strengthen intersectoral linkages at governorate and district level to enhance decentralisation of services and multisectoral developments to all governorates and districts.							
Governorate mental health committee	Establish and train governorate mental health committee, and make appropriate links to general governorate health bodies	1. Agree membership for governorate intersectoral mental health committee (GIMHC) and the core health team. 2. Appoint each governorate committee. Membership include PHC, nursing, psychiatry, public health, health education, social welfare, police, prisons, religion, NGOs, (including user and carer representation), university, etc. 3. Organise training for each committee	Governorate mental health committee established and trained	2011-2013	Evaluation of training	Travel, Budget for training	
District mental health committee	Establish, where and when possible, district mental health committees and make appropriate links to district general health bodies	Agree membership in principle for district intersectoral mental health committee (DIMHC) and for the core health team. Membership will include primary health care, nursing, mental health, public health, health education, social welfare, police, prisons, religion NGOs and university, employment. 1. Appoint members 2. Organise orientation workshop 3. Send representation from DIMHC to GIMHC	District mental health committee established and trained	2012 -2015	Agenda, minutes, evaluation of training	Travel, Budget for training.	Current non availability of mental health staff at this level.

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Primary health care centre intersectoral forum	Each PHC can, when it is ready, establish a local intersectoral forum with schools, police, and social welfare, NGOs, user and family representatives, religious leaders, to discuss and tackle local mental health issues of common concern, as well as to agree key primary-secondary care and intersectoral liaison issues to be passed up to the district committee for discussion and action.	1. Agree membership 2. hold regular meetings 3. Send representation to district mental health committee	Primary health care centre forum established	2012-2015	Minutes of meetings, evaluation of activities	Meeting budget	Lack of interest in PHC
Monitoring-(Appraisal of context, needs, inputs, processes and outcomes at each level in service)	Updated national mental health country profile.	• Disseminate situation appraisals and other relevant studies • Construct national annual progress report • Governorate, district and primary care to prepare their local situation appraisals /profiles-these can also serve as progress reports on service improvements.	Detailed country profile available at national and local levels Detailed progress reports available.	2011-2015	Availability of national and local mental health profiles	Budget	Needs annual updating

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
2. PRIMARY CARE							
Primary health care continuing professional development (CPD).	Integrate mental health into PHC by strengthening PHC capacity to assess and manage disorders and addictions.	• Develop timetable and training programme for PHC staff • Prepare training materials • Prepare evaluation tool • Train trainers, 2-5 for each governorate. (GP, psychiatrist, psychologist, social worker and nurse) • Train PHC staff, 4 courses per year in the largest governorates &2 courses per year in other governorates on continuous basis= 80-100 trainees per governorate per year. • Create website to facilitate exchange of expertise	PHC training programme established 50 -110 Trainers trained 1600 PHC staff trained per year PHC knowledge and skills is regularly updated every 5 years.	2011 2011 2012-2015	Curriculum Evaluation of training. Numbers of courses Numbers trained.	Budget for training workshop	Shortage of psychiatrists Availability of trainers to cover the whole country Need to choose best trainers. Geographic problems.
PHC Good practice guidelines	Strengthen good practice by use of good practice guidelines	1. review existing guidelines 2. Prepare draft guide to be piloted in the governorates 3. Pilot 4. Incorporate feedback and produce final version 5. Print and disseminate final version	Draft produced Feedback from pilot Final version printed and disseminated	2011-2015	Guide	Budget to print guidelines Budget to pilot guidelines. Budget for orientation/ training Travel	Guidelines not in use Lack of encouragement Lack of budget

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Primary Health Care information system	Add 12 categories of mental disorder/ addictions/qat use to primary health care unit information sheet	• Discuss with MOH	HMIS contains 10 or more mental health categories	2011	HMIS		
PHC supply of medicines	Ensure adequate supply of antidepressants and antipsychotics to PHC	• Psychotropic medications have been added to essential medicine list • Workshop to review essential list , and to unpick purchase and distribution blockages • Raise awareness in pharmacists and PHC staff that they can order • Audit distribution of psychotropics and re-ordering mechanisms	Primary care equipped with psychotropic .	2011-2015	PHC records. Prescriptions. Pharmacy records.	Budget	
PHC transport	Ensure PHC uses their access to transport for community outreach	• Put mental health on agenda for PHC transport • Consider available transport	PHC transport used for mental health activities	2010 onwards	PHC and Transport records	Transportation facility	Lack of funds for transport
PHC health educators	Develop their role to support mental health	• Include mental health in PHC health educator job plans. • Include mental health in PHC health educator basic training and CPD	PHC health educators trained. PHC health educators' job plans contain mental health	2011	Numbers of PHC health educators trained. Training evaluations. Job plans containing mental health	Budget for training	Unclear job description. Small numbers. Lack of support and supervision

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
PHC nurses	Develop their role to support mental health	• Include in PHC mental health training. • Include mental health in PHC nurse job plans	PHC nurses trained. . 440 per year PHC nurses' job plans contain mental health	2011-15	Numbers trained Training evaluations	Budget for training.	Unclear job description. Small numbers Lack of support and supervision
PHC quality standards	Improve quality of care in PHC	• Develop quality standards for PHC	Quality standards produced	2010-15	Quality indicators Inclusion in curriculum	Budget for printing	Funds
Basic training of doctors for PHC	Ensure medical student curriculum includes common mental disorders, psychosocial interviewing skills, assessment, diagnosis, management skills and orientation to PHC and Community. (Ensure public health population perspective as well as individual clinical perspective.)	• Link with universities to make mental health essential medical student subject. • Prepare a standard curriculum containing all the common disorders and the skills needed for practice. • Use existing good practice. • Insert key questions into exam • Establish placements for medical students in PHC	Curriculum revised	2011-2015	Curriculum Exam questions Evaluations of PHC placements for medical students	Budget for workshops Transportation	Lack of cooperation between ministry and university

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Basic training of nurses for PHC	Ensure nurse curriculum includes common mental disorders, psychosocial interviewing skills, orientation to PHC and Community (Ensure public health population perspective as well as individual clinical perspective.)	• Link with nurse training colleges. • Use existing good practice. • Insert key questions into exam • Establish placements for nurses in PHC	Nurse curriculum revised	2011-2015	Curriculum Exam questions Evaluations of PHC placements for nurse students	Budget for workshops Transportation	No unified curriculum for all universities Lack of cooperation between PHC& nursing schools
LINKS BETWEEN PRIMARY AND SECONDARY CARE							
Liaison and support	Establish supportive liaison between PHC and governorate psychiatrists .	• Introductory meeting between governorate psychiatrist and PHC • Establish regular meetings between regional psychiatrists and PHCs every 2 months • Quarterly meetings between governorate coordination office and governorate psychiatrists	Regular meetings	2011-2015	Notes of meetings Number of meetings	Budget for meetings from governorate offices of health	Lack of finance
Transport	Transport available to enable support mental health supervision	• Ensure governorate psychiatrist has access to transport to visit all PHCs regularly; hire as needed • Implementation of supervision visits	PHCs receive regular visits	Start in 2011-2015	Transport records	Transport facilities	Lack o f funds Unavailability of staff for supervision

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Communications	Ensure means of speedy communication about individual patient care.	• Make available phones, fax, email as practical. Eg consider phone groups to share, negotiate free service	PHC receive detailed letter from specialists within 7 days of consultation/ discharge	Start in 2011-2013	Patient records Availability of comms.	Budget for equipment and distribution	Lack of funds.
Referral System	Strengthen referral process by developing clear procedures.	• Establish referral criteria • Develop forms for referral and forms for feedback and downward referral, or integrate substantial mental health section into general referral forms • Include referral criteria in training for PHC	Complex cases are referred for specialist care. Both specialists and PHC teams receive the information needed to enhance patient care	2011-2015	Referral forms District outpatient data	Budget for forms.	Availability of funds

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
3. SECONDARY CARE							
Governance	Strengthen governance of intersectoral mental health services to meet the needs of each governorate, taking into account the geography of different parts on Yemen, and the availability of health care within them.	• Establish and train governorate committees, and develop their work programmes	Committees established and trained. Work programmes developed.	2011-2013(5 larger governorates) 2013-2015(other governorates)	Committee membership. Evaluation of training programme. Work programme of each committee.	Budget for training	Funds
Basic training	Strengthen mental health component in basic training of doctors, psychologists.,nurses, social workers, village health workers, sanitarians etc (see human resources part)	• Review and revise mental health curriculum for medical students, nurses and other related health professions. (Ensure public health population perspective as well as individual clinical perspective.)	Training made relevant to future population needs	2011-2015	Revised curriculum Exam questions	Budget for printing and for orientation workshops	Each university has its own curriculum.

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
District OPD	Strengthen access to specialist referral close to home.	• Establish a mental health OPD clinic in each district.	Local OPD opened in all districts E.g. each clinic will work for one day every 1-2weeks clinic in each district	2011-2015	Audits of health care provision.	Budget to establish the service	Small numbers of psychiatrists
Governorate Outpatient Department (OPD)	Decentralise OPDs to district level-see above	• decentralised OPD in each district will be distributed . • Establish liaison service to governorate hospital	E.g. 1 clinic a week for general hospital patients	2011-2015			
Governorate Inpatient Departments (IPD)	Establish small IPD (eg 5-20 beds) in all general governorate hospitals, so that people do not need to transfer to the large mental hospitals a long way from home.	• Agree with Deputy Minister of PHC • Organise space and refurbish • Establish staffing levels-needs 1 psychiatrist to run IPD and liaison service, and 1 psychiatrist to run decentralised district OPDs • Establish procedures for admission, discharge, standards etc	Psychiatric beds in each governorate general hospital	2011-2015	Numbers of beds available	Budget for beds and staff	Funds Space Availability of staff

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Mental Hospitals	Review roles of large mental hospitals in relation to Staff training Complex rehabilitation Forensic cases Other tertiary services	• Audit long stay patients and establish needs for treatment and rehabilitation • • Work with governorate and district committees to establish local services so patients can be treated in their own governorates, and to reduce need for referrals to large mental hospitals • • Continuing professional development for psychiatrists, psychologists and nurses to improve good practice. • • Develop good practice guidelines for specialists	Improved patient outcomes Increased care in own governorate	2010 2011-2015	Reduced numbers of long stay clients Reduced referrals from other governorates		
Long stay patients	Review long stay cases in preparation for active rehabilitation.	• Audit all long stay patients, prepare rehabilitation plans, review regularly and plan discharge to family and the community , using partnerships with primary health care and social welfare.	Patients rehabilitated and able to go home	2011-2015	Patient progress reports and discharges of long stay patients.	Budget for rehabilitation	Not enough rehabilitation facilities Lack of support for staff.
Admission assessment forms	Improve quality of assessments on admission	• Develop multi-axial assessment forms for all admissions • Distribute and use assessment forms	Patient care improved through improved assessments	2011	Patient assessment forms. Quality of assessments	Budget for printing and training.	
Care planning	Care planning improved.	• Develop multi-axial care planning form. • Use multi-axial care planning forms	Patient care improved through improved care planning.	2011	Care planning forms. Quality of care planning.	Budget for printing and training.	

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Case reviews	Improve patient outcomes by increasing frequency and quality of case reviews.	• Develop system for regular case reviews	Improved outcomes and shorter length of stay through improved case reviews	2011	Case review forms and case reviews.	Budget for training.	
Quality standards	Improve patient outcomes by improved quality of care	• Develop and implement quality standards for secondary care • Prepare a guideline for the daily work of nurses in psychiatric inpatient units.	Quality standards developed and disseminated	2011	Quality standards. Annual reports	Budget for orientation	Few supervisors Need to be simple rather than complex.
Good practice guidelines	Improve patient outcomes by use of good practice guidelines	• Develop, pilot, disseminate good practice guidelines for specialist care of major disorders	Schizophrenia / depression guidelines drafted	2011	Good practice guidelines	Budget for printing and training	
Psychosocial therapies	Increase access to Psychosocial treatments	• Insert psychosocial skills in basic training and continuing education	Psychosocial therapies included in curriculum	2011	Curriculum	Budget for training.	Few psychologists and others with requisite skills to teach.
Medicines(very important)	Increase availability of medicines in district and governorate IP and OP clinics Increase access of discharged patients to medicines	• Review medicine availability in governorate and district hospitals and outpatients clinics • Review capacity of person discharged from hospital to access medicines • Educate pharmacists	Medicine supply improved in hospitals and clinics and for people living at home	2011	Prescription records Client interviews	Budget for medicine and transport	

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Inpatient activity programmes	Continue to improve level of daily activities to prevent institutionalisation.	• Prepare manual on daily ward activities for nurses. • Orientate nurses to need for varied daily programmes of ward activities • (Add ward based activity programmes to standards of care for hospital settings) • Disseminate standards for ward activities to mental hospitals and governorate inpatient units	Reduction of early institutionalisation. Busy ward routines	2011	Reduced length of stay. Improved patient outcomes	Budget for training	Nurses not orientated to ward activities.
Develop home-based rehabilitation	Consider how to develop home based rehabilitation,	• Community based rehabilitation guidelines to be part of PHC and specialist training.	CBR guidelines drafted, piloted and distributed	2011-2015	Numbers of clients receiving home based CBR.	Budget for printing and training	Access to transport and staff
Rehabilitation services at district level	Review district needs and plan how to develop and fund	1. Place on agenda of district and governorate mental health committees 2. Assess needs 3. Build into forward budgetary planning 4. Find unused suitable buildings 5. Open dialogue with employers 6. Work out staffing	District rehabilitation services established	2012-2015	Audits of health care provision Patient outcomes Length of stay	Budget to develop intermediate service	Unavailability of suitable places

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Rehabilitation services at PHC Level	Ideally rehabilitation services would be distributed at this level, given the prevalence of severe disorders needing rehabilitation. PHCs may be able to liaise with the local community, (families, employers, religious and community leaders) and any available NGOs to establish social rehabilitation clubs and centres	• PHCs could start to consider their local needs for social and occupational rehabilitation, and intensive support to people living at home).	Rehabilitation services at PHC level	2013-2015	Audits of health care provision Patient outcomes Length of stay in hospitals	Human resource in different sectors	Interest of PHC staff and communities to stimulate developments

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
4. TERTIARY CARE							
Forensic services	Review needs for central and local forensic services, and improve outcomes for forensic patients	• Improve dialogue and coordination between prisons and health services at ministry level , governorate level and hospital/prison level through respective intersectoral committees and bilateral meetings • Improve the management of the forensic patients by development and use of good practice guidelines for forensic services and prisons. • Improve the quality and outcomes of forensic services • Strengthen intersectoral liaison between the forensic departments, and social welfare, criminal justice and education. • Strengthen liaison between forensic departments and the respective PHC of each patient, so that PHC staff form part of post discharge support team. • Implement mental health legislation and Code of Practice • Review and harmonise any other laws that impact on forensic patients. • Improve guidance and counselling for forensic patients • Strengthen and support family relationships of forensic patients to assist discharge planning. • Improve occupational, educational and IT skills and opportunities for forensic staff • Improve recreation and sports facilities available for forensic patients	People with mental illness in prison receive prompt care and treatment Forensic services in hospitals improved Reduced need for restraint and seclusion. Improved rates of safe discharge. Improved human rights Improved outcomes after discharge	2011-2015	Patient health and social outcomes Length of stay reduced Reduced relapses and Reduced recidivism	Meeting costs Cost of health service provision to prisons Cost of increased rehabilitation services	Barriers to intersectoral dialogue Lack of management commitment to health service input to prisons

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Services for children & Adolescents	Improve patient outcomes for children and adolescents	• Develop Child and Adolescent mental health services at governorate and district levels. (start in 5 larger governorates) • Improve referral Pathways from schools and PHCs for C&A • Form linkages between C and A services and school health professionals • Incorporate C and A practice into training of specialists and primary care • Develop good practice guidelines for C and A at specialist level and PHC level • Develop community interventions, linking with NGOs, for vulnerable e.g. street children, employed children. • Develop community interventions about parenting methods, to reduce harsh punishments. • Liaison with schools to support mental health promotion in schools, and encourage early referrals.	Improved specialist , primary care and intersectoral services for children and adolescents.	2011-2015	Child & Adolescent services Patient outcomes	Budget for training and printing of guidelines	Small numbers of trainers
Services for elderly people	Improve patient outcomes for older people	• Strengthen service delivery for older people at governorate and district levels (start in 3-5 governorates) • Implications for training • Develop good practice guidelines • Develop community awareness about needs of older people	Improved care of older people	2011-2015	Patient outcomes	Budget for training & printing of guidelines	
Liaison psychiatry	Improve mental health outcomes of people with physical illness in general health care system	• Governorate psychiatrists and psychologists to liaise with general medical and surgical teams to offer advice and consultation (start in 3-5 governorates) • Develop good practice guidelines for liaison psychiatry	Improved mental health care of general patients Improved physical outcomes	2011-2015	Patient outcomes	Budget for training & printing of guidelines	

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Drug Abuse Control	Strengthen efforts to prevent and treat drug abuse , including Qat	• Close liaison between mental health programme and The Supreme Body of Drugs on public education, epidemiology, family support, primary care guidelines and specialist services at national , governorate and district levels • Research on epidemiology and interventions • Address medical culture of tolerance to Qat hazardous use by training and advocacy programme • Establish programmes to raise awareness, educate and reduce tolerance to Qat abuse in media, schools, universities, mosques at national, governorate, district and PHC levels. • Establish alternative social activities such as clubs, parks, centres • Train drug abuse workers to carry out such programmes in each governorate • Encourage growth and marketing of other cash crops e.g. coffee • Consider bonus for all public sector workers to stay at work until 5pm.	Drug abuse included in mental health work on public education etc Reduced use of Qat Reduced rates of Qat precipitated illness	2011-2015	Campaigns, curriculum, guidelines.	Budget for research, training, printing and distribution	Political, management , professional and community attitudes
Smoking	Strengthen effort to prevent and treat nicotine addiction	• Develop legislations for reduction and banning of smoking • Identify risk factors for inception and maintenance of smoking • Develop programmes to help people quit smoking • Increase availability of support for people wishing to stop smoking, especially children and adolescents as well as adults. • Encourage enrolment in sports clubs • Create summer centres and clubs • Media campaigns against smoking • Develop referral system for smokers	Draft legislation Reduced rates of smoking Reduced rates of new smokers	2011-2015	Legislation drafted, Campaigns, curriculum, guidelines	Budget for research, training, printing and distribution	Political, management , professional and community attitudes

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Referral system between secondary and tertiary services	Strengthen referral system between secondary and tertiary services , in liaison with primary care services	• Develop agreed referral criteria for each level of care • Develop referral forms and forms for replies. • Develop shared care procedures • Pilot and review	Referral criteria HS Reform referral and reply forms are adapted to include mental health Shared care procedures	2011	Forms Procedures.	Budget for training, printing and follow up	
5. HEALTH MANAGEMENT TEAMS							
Health Management Teams	Improve capacity of health management teams to address mental health in each governorate and district.	• Place mental health as standing item on agenda of health management teams at governorate and district levels • Consider whether the mental health governorate and district committees should be subcommittees of the general governorate and district health committees and regularly report to them • Include mental health aspects in all generic workshops for health management teams	Health management teams regularly have mental health on agenda	2011-2015	Minutes of meetings	Budget for training and meetings	The teams are overwhelmed by many activities.
6. HEALTH INFORMATION SYSTEMS							
Health Information Systems	There should be an integrated MH information system between health centres and OPDs in order to assist in shared care, calculations of needs for care, needs for essential medicines, and to support MOPHP in its planning functions	• Health Management Information System to work closely with the mental health section to facilitate improved coverage of mental disorders by the HIMS. • Agree around 12 categories: depression, anxiety, somatisation, acute psychosis, chronic psychosis, childhood emotional, childhood conduct disorders, dementia, toxic confusional state, epilepsy, alcohol, drugs, Qat, learning disabilities. • Prepare a record sheet to collect the data. • Pilot the record sheet, improve and finalise, and include in overall HMIS.	HMIS includes mental health, so existence of an integrated information system at all levels in health service including PHC	2011-2015	HMIS records	Budget for printing forms, supplies and training. Health workers, records, training , data storage., data transmission	Lack of training. Lack of means of information exchange.

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
7. OTHER HEALTH PROVIDERS							
Traditional Health Practitioners (including religious and other kinds of traditional healers)	Improve mutual understanding between traditional and public sectors in order to improve patient outcomes, reduce harmful practices and encourage early referral where this would improve patient outcomes.	• Consider legislation to regulate THPs • Dialogue between health sector professionals and THPs (Alternative Medicine and religious healers) at national, governorate, district and PHC levels to reduce harmful practices • Place on agenda of national, governorate, district and PHC committees. • Consider use of diagnostic algorithms and training for THPs to ensure early referral of severe or complex cases. • Consider measures to prevent harmful practices e.g. beating, cutting, chaining.	Harmful practices reduced. Shared care more effective. Increased public awareness about avoidance of harm	2011-2015	Client and family records	Budget to improve the skills of traditional healers	Resistance from the traditional healers. Medical attitudes to traditional healers. (religious healers are accepted)
	Improve detection and treatment of postnatal depression by collaboration with reproductive health programme for TBAs.	• Mental Health Programme to collaborate with Reproductive health and evaluate the feasibility • Training programmes for TBAs should include mental health	Increased treatment rates of post natal depression		Training evaluations. Treatment rates	Budget for training	
	Improve early referral of serious cases	• Develop referral guidelines • Give diagnostic algorithms to encourage referral of serious cases e.g. cerebral malaria, epilepsy, psychosis	Increased early referrals from THPs to public sector	2011-2015	Patient records	Budget for training and printing	

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
	Assess scope for liaison	• Liaison is dependent on establishment of Traditional Medicine Legislation.	Improved opportunities for systematic liaison at national, governorate and district levels	2011-2015	Minutes of meetings	None	
	Enhance support given to chronic cases by operating shared care procedure with people living a long way from health professionals	• Assess scope for shared care of chronic cases • Develop protocols for shared care • Audit practice and outcomes	Chronic complex cases receive intensive levels of support despite living far from clinics	2011-2015	Patient records		Problems with accountability
8. INTERSECTORAL LIAISON							
Governance	Strengthen systematic intersectoral liaison on mental health	• See above sections on national, governorate and district intersectoral mental health committees • Activate the national mental health strategy, the national mental health council and the governorate and district intersectoral committees • Prepare agendas for committees • Prepare system for implementation and monitoring of agreed actions • Frequent bilateral liaison meetings as required to support the implementation programme • Prepare agendas for bilateral meetings	Patient and population outcomes improved Public sector staff motivated to achieve improved outcomes	2011-2015	Numbers of meetings of committees Minutes and workplans Monitoring of completion of activities	Budget for meetings	Bureaucratic barriers

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Liaison with social affairs and labour	Social and employment outcomes for people with mental illness improved by strengthening liaison with social welfare.	• Liaison of MOH with Ministry of Social Affairs, and Ministry of Human Rights • Publish and disseminate information collected by Ministry of Social Affairs on size of vulnerable groups e.g. street children, abused women, trafficked children • Conduct joint studies of problems • Integrate mental health issues across the Min of Social Affairs work programmes e.g. on child protection • Inclusion of social needs of people with mental illness in work plans of Ministry of Social Affairs and governorate social services. • Liaison of governorate mental health services with governorate social welfare services • Develop joint committee working and joint work plans • Develop joint guidelines for health care and social care. • Ensure doctors, psychologists and nurses are familiarised with social welfare and roles. • Include mental health in social work training and job plans	Social welfare of people with mental illness improved. Improved availability of data Joint meetings Joint guidelines Inclusion of mental health in Ministry of Social affairs policy documents	2011 -2015	Minutes and work plans Studies Publications Dissemination of guidelines Policy documents	Budget for meetings	Bureaucratic barriers

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Liaison with schools	Mental health of children and adolescents in schools improved Educational achievements of people with mental disorders improved.	• Liaison of MOH with Ministry of Education • Liaison of governorate mental health services with governorate educational services • Assess needs of teachers for training module about mental health issues • Mental health promotion in schools-see public health education • Assist education system to develop referral pathways for troubled children • Assess need of people with mental illness for educational support to improve their literacy, numeracy and other occupational skills • Improve joint educational and health services for people with behavioural disorders • Establish training courses for educational psychologists • Each large school (or 4 schools in each governorate) to have a mental health office, as in Aden, to provide mental and behavioural services to address drugs and violence	Children and adolescents with mental health problems have improved health , social and educational outcomes . Educational attainment of people with mental illness improved, leading to enhanced opportunities for economic productivity	2011-2015	Minutes and workplans	Budget for meetings Funds to develop teaching materials	Bureaucratic barriers Lack of funds

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Liaison with Police	Quality of police role with people with mental illness improved.	• Joint meetings at national, governorate, district and PHC levels between health services and police at least twice a year. • Train police in each governorate and district on how to deal with and document violent incidents and how to deal with and document people with mental disorders • Ensure police follow good practice guidelines re handling people with mental illness • Negotiate with police authorities to include mental health issues in their training curriculum • Governorate and district MH training events about handling and documenting violent incidents could involve the police. • Ensure specialist services meet police needs for training in this area • Public education with media and lawyers about people>s rights in relation to police and about mental health legislation.	Systematic liaison, good practice guidelines, training& public education. Mental health modules included in police curriculum Police invited to mental health trainings	2011-2015	Curriculum. Training evaluations Workshops. Participant lists.		Bureaucratic barriers

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Liaison with Prisons	Quality of care of people with mental illness in prison improved.	• Joint meetings at national, governorate, district and PHC levels between health services and prison service every 3 months . • Develop and use good practice guidelines for prison officers re handling people with mental illness • Develop and use good practice guidelines for health staff in prisons • Organise training sessions for prison health care staff • Prison officers and health workers need better identification skills to direct people with mental illness to health facilities • Separate adolescents from adults in prisons, by transferring adolescents to special quarters • Ensure daily availability of psychiatric staff for prisons • Transfer people with psychosis to psychiatric inpatient units • Implement law of prisons • Ensure respect for human rights	Systematic liaison, good practice guidelines, and training, to ensure transfer of people with psychosis to hospital, and prevention/ treatment of common mental disorders	2011-2015	Minutes of meetings. Records of transfers from prison to hospital. Evaluations of trainings. Psychotropics available in prisons. Prison clinic data Records of attendance by health staff		Attitudes Budgets
Religious Leaders	Enhanced understanding of mental health issues in religious leaders	• Regular liaison with religious leaders at national, governorate and district levels. • Organise orientation/training seminars for the religious leaders about concepts of mental health and mental illness • Prepare mental health guideline for religious leaders	Increased awareness about mental health issues Good practice guidelines for religious leaders on mental health	2011-2015	Minutes of meetings Evaluations of trainings		

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Liaison with universities	University health sector collaboration improved to benefit of training, service delivery and health outcomes	• Liaison of MOHP with universities at the national level • Service level agreements with universities re training and service delivery • Extend provision of guidance and counselling centres to Universities in each governorate	Service level and cooperation agreements	2011-2015	Service level agreements Activity data of university guidance clinics		
Liaison with employers	People with mental illness can return to work and remain economically productive People at work can access mental health care	• Liaise with employers on prevention, treatment and rehabilitation in workplace • Work with employers to find job placements for people with severe mental illness • Encourage employment of young people • Apply the Presidential regulations on employment of people with special needs • Liaison between health, social and employment services to provide on the job rehabilitation programmes for people with illness, disability and handicap.	Good practice guidelines for workplaces Increased posts for people with severe mental illness, special needs and youth.	2011-2015	Employment of people with severe mental illness, disability and of youth		Employer attitudes Companies prefer foreign workers Lack of statistics Weak economy Weak companies

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
9. PUBLIC HEALTH EDUCATION							
Public Health Education	Improve community awareness of mental health issues Reduce stigma Enhance mental health in all age groups Liaison with schools	• Develop and implement public health education national, governorate and district programmes in media, schools, campaigns, community groups, religious groups etc for children, adolescents, adults of working age and older people. • Find, stimulate and co-ordinate well known public figures to be product champions. • Establish mechanisms for briefing politicians at national and local levels. • Educate teachers to do mental health promotion in schools • Link to substance abuse and other risky behaviour education programmes • Hotline for mental health	Public health campaigns. Reduction of stigma and enhanced mental health at population level. Mental health included in health education curriculum Mental health education integrated with substance abuse/ HIV prevention Hotline established	2011-2015	Media reports of mental health. Public attitude surveys. School curriculum.	Budget to produce materials. Post for PHE officer. Budget for printing and developing campaigns. Budget for training.	Difficulties in cooperation with different authorities. Lack of public health education expertise. Lack of support for teachers.
10. NGOs							
MENTAL HEALTH NGOs **and** **GENERAL NGOs relevant to mental health** **(Local, National and International)**	Strengthen NGO support of promotion of mental health, prevention of illness and support to people with mental illness	• National, governorate and district committees to map NGOs • List NGOs in good practice guidelines • Visit of students/trainees to NGOs for orientation • Stimulating NGOs (through meetings and provision of technical advice) to contribute to mental health promotion, community awareness, rehabilitation services and in individual rehabilitation and work placements at governorate, district and PHC levels. • Improve cooperation between NGOs on mental health	Map of NGOs. Liaison of public sectors with NGOs at national, governorate, district and PHC levels. NGO roles enhanced. Client outcomes improved	2011-2015	List of NGOs available and in guidelines. NGOs contribute to intermediate services.	Budget for training	Differing perspectives Lack of interest from some NGOs

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
11. HUMAN RESOURCES Cooperation between different ministries responsible for HR, universities and training institutions							
Psychiatrists	Continue to train psychiatrists Ensure orientation to community working, delivering a service to defined population, to support PHC, link with other sectors, to research	• Increase numbers of psychiatrists from 43 to 100 • Review postgraduate training of psychiatrists • Establish continuing education programme for psychiatrists • Add exposure of trainees to PHC settings, to research and teaching skills, to population perspective and to community working, and to delivering a service to a defined population.	Revised curriculum Psychiatrists available in every governorate	2011-2015	Curriculum. Exams.	Budget for training and follow up	
Nurses	Strengthen psychosocial skills and rehab skills in basic nurses, primary care nurses and specialist nurses	• Review basic training of nurses to include mental health. • Give PHC nurses mental health skills • Establish two year course for mental health psychiatric nurse training –produce 40 each year • Develop at least two psychiatric nurses in each district and several in each governorate. • Develop mental health continuing education of nurses • Develop nursing guidelines and standards • Give some Occupational Therapy and rehabilitation skills to nurses • Curriculum to include communication skills, psychosocial skills, treatment, rehabilitation, relapse prevention etc	Revised training programmes. Guidelines disseminated to nurses. 200 psychiatric nurses produced by 2015	2011-2015	Curriculum. Exams.	Budget for training and follow up	

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Social workers	Give social workers therapeutic skills, skills to achieve social inclusion of their clients	• Review basic training of social workers to include mental health • Review continuing education of SWs at PHC and specialist levels	Revised training programmes and curricula	2011-2015	Curricula exams	Budget for training and follow up	
Occupational therapists	Develop sustainable OT programme *(In meantime ensure other professional have some basic OT skills)*	• Develop OT training programme • Establish course for OT training –produce 20 each year • Include some OT skills into nurse training	OT courses, curricula 100 OTs produced by 2015.	2011-2015	Curricula, exams	Budget for training/ follow up	
Psychologists	Strengthen their contribution to the mental health service.	• Audit where clinical psychologists are currently employed and what they are doing outside and inside the health service. • Review clinical training of psychologists in mental health and orientation to community work, liaison between schools and PHC (with inclusion of dyslexia and mental retardation), and liaison with prison sector . • Strengthen cooperation with other mental health professionals • Develop clinical psychologist posts at district level (and ideally eventually at PHC level).	Psychologist courses and curricula	2011-2015	Curricula, exams, job plans at district and PHC level.		Negative attitudes of psychiatrists

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Primary care staff	Basic training , post basic and continuing professional development for doctors, nurses, health educators and social workers	• Include mental health in undergraduate curriculum to assess, diagnose and treat mental disorders • Develop one year postbasic special course for some selected GPs (one for each district) , to deploy such medical expertise to the district level pending deployment of sufficient numbers of psychiatrists • Develop continuing education for primary care staff so that they can attend a one week course every 5 years. • (this will rely on training 3-4 trainers for each governorate so that each governorate can run 4 courses a year, for 20-25 participants each • Require CPD in mental health for all health staff once every five years	Newly trained doctors able to assess and treat mental disorders Specialist services available at district level 100 GPs receive mental health CPD in each governorate each year, enabling national coverage every 5 years	2011-2015	Training reports Evaluation questionnaires and exams Staffing records CPD records and certificates CPD regulations	Training funds	

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
12. RESEARCH							
Research capacity	strengthen research capacity especially Health Sector Research and epidemiology	• Compile a database and summarise all previous Yemeni research • National epidemiological surveys to estimate prevalence of main disorders, risk factors, and consequences including depression, psychosis, addictions including Qat, childhood disorders, including emphasis on disorders in women, students, prisoners, orphans, street children. • Research on suicidal ideas, suicide attempts and completed suicides to establish frequency, risk factors, and methods. • Survey of Yemeni attitudes to mental health, mental illness, people with special needs, understanding of causes and consequences, attitudes to treatment by public services and by THPs • Research on revenge culture and mental health • Research on conflict and mental health. • Research on impact of male absence from family through work driven migration to cities/other countries • Research on impact of older age parents on mental health of children through delayed marriage and child bearing for economic reasons • Evaluate PHC training • Audit needs and outcomes of inpatients • Epidemiological survey of prisons • Epidemiological survey of schools • Epidemiological survey of orphans • Evaluations of effectiveness of services and • treatments • Evaluation of clients and interventions in THPs • Effectiveness of methods of raising community awareness • Progress of national mental health strategy	Research on context, needs, risk factors, interventions and service improvements.	2011 -2015	Research publications	Budget for conducting research	

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
Research ethics	Strengthen ethical considerations in research on vulnerable populations	• Continue work of ethics committee, and draw on international ethics committee experience in handling people with mental illness	Ethical committee decisions	2011-2015			
13 Suicide Prevention Strategy							
	Prevent avoidable suicides	• Establish suicide prevention national committee • Establish national database on numbers of suicides, methods used, and sociodemographic factors • Work with media to influence reporting of suicides • Reduction of access to means of suicide e.g. guns , knives, medicines, poisons (pesticides) • Education of PHC and secondary care teams about assessment and management of suicidal risk and support to high risk groups • Ensure women can access psychiatric services • Training PHC to conduct through assessment and management of depression and suicidal risk • Support to people with previous suicide attempts. • Public education about importance of accessing treatment for depression. (DO NOT EDUCATE ABOUT SUICIDE ITSELF).	Suicide national action plan, and implementation Reduced suicide rates	2011-2015	Decreased suicide rates	Budget for meetings, research, Database Annual reports	Attitudes to suicide preventing collation of accurate data and action plan

Programme Component	Objectives	Activities	Output	Time frame	Monitorable Indicators	Resource required	Potential constraints
14 Strategy To Reduce Premature Physical Mortality Of People With Mental Illness							
	Prevent avoidable deaths	• Ensure high quality physical health care to people with severe mental illness		2011-2015	Decreased SMRs of people with mental illness		

Psychological Health in Yemen (Past, Present and Future)

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July 2008

Introduction

The Social Investment Authority appointed a group of specialist researchers in the field of psychological health for studying the real situation of the psychiatric health in Yemen. This task is considered an initial step to the establishment of a general strategy of the psychiatric health in this country. This kind of pioneer research is very essential for surveying the nature and characteristics of the psychiatry situation of the individual in Yemen and their relations with the local environment as a whole, the matter which was completely ignored for many years by almost all the different concerned sectors.

Focus on the individual psychiatry health in the present time is a first priority in developed countries because of the constant increase in the percentage of psychologically sick people. International efforts are going on for promoting care of psychiatric health so that it goes hand in hand with the care of general physical health.

WHO's reports show that about 870,000 persons commit suicide every year due to the pressure of psychological, neurological and mental problems. More and more numbers of people die as a result of accidents caused by psychological problems. Not a single country is protected against such health problems and their consequences that cause severe types of suffering for millions of people. Reports indicate that only one out of four people who need actual psychological treatment consult different health centres, while the rest of the patients keep suffering silently without any kind of diagnosing. Hence families, relatives and society as a whole pay the cost of their suffering because they spread the effect of their disturbance. Yemeni society is not exceptional of this picture. The radical changes that Yemen witnessed since the second half of the last century have spread tremendously the suffering of psychological problems. And in spite of the fact that there is no statistic given of the psychologically sick people in Yemen, undoubtedly the number may come to hundreds of thousands, especially when we take the socio-economic circumstances, the prevailing health conditions, the life style and the great increase numbers of population. Economical pressures faced by the society affect the life of the Yemenies very painfully. According to the official the average percent people who are below the poverty line is about 35%. (the family financial survey, 2005). However, the number is certainly very much bigger today. And because the unemployed people in Yemen lack any governmental pension or any social insurance and because of the low individual income rate in Yemen which is about $870 a year comparing to $2390 in the Middle East and North Africa, the economical pressures inevitably represent one of the most causes of psychological and social difficulties to both the individuals and the Yemeni family as well.

Furthermore, spending money on chewing qat contributes effectively in exalting those pressures and complexing the problem dramatically. Special studies emphasize that more than 10% of the family income is wasted in buying qat. This percent is far more than the amount spent for medicine or the actual needs. In addition, chewing qat is regarded one of the causes of many divorce cases and the collapse of family relations, (this will be discussed in more details later).

A number of other social, cultural and health problems are added to form a strong closed circle of pressures that drive very many families and individuals to falling under various kinds of severe psychological troubles.

Therefore, laying emphasise on psychiatric health is an essential part of focussing on the total investment process for the human being is the essence and the real state in the process of development and making social and economical changes. Everybody in the society should have the least necessary needs of the preliminary psychological services especially in the present age, the age of anxiety,

pressures and bais globalization in which the social and economic role of the government is withdrawing from a number of sects such as health services and free education. It is apparent that this role of the government is shrinking and the private school and hospitals, which only rich people can benefit from their services, are stepping up. The majority of the people are left without any cover.

The present research was carried out by a group of eight assistant researchers and three specialist professors; Prof. Mohammed Attashi, Prof. Ali Attareq and Dr. Belqees Jobari as a head of the team. The research had five chapters and it includes the appendixes of the tools and instruments used in it.

The research contents:

Dedication
Introduction
The Need for the Research
The Problem of the Research
The Objectives
The Concept of Psychiatric Health
The Objectives of Psychiatric Health
Standards of Psychological Health
Features of Psychiatric Health

The Causes of Psychiatric Diseases:

- Different Disabilities
- Accidents
- Spreading of Diseases
- Lack of Health Care
- Increasing Population
- Increase of Poverty Rate
- Chewing Qat

Psychiatric Health Centres and Institutions

1. General Psychiatric Hospitals
2. Psychiatric Clinics
a) General Clinics
b) Consultation clinics

3. Health Care and Rehabilitation Clinics
a) General
b) Special for Old People

4. Professional Qualification Centres
a) Children Health Care Centres
b) Children Hostels

5. Local and Original Unions and Conferences

History of Psychiatric Health in the Republic of Yemen

Introduction

Psychiatric Care in Yemen in the Past until 1962 Revolution and 1967 (Independence Year in the South)

Psychiatric Care between 1962 until 1980

Activities of Ministry of Health and Other Ministries in both Yemens:

- North Yemen (1962 – 1980)
- South Yemen (1967 – 1980)
- Psychological Health in North Yemen (1980 – 1990)
- Psychological Health in South Yemen (1990 – 1990)

Psychiatric Health Care in Unified Yemen (1990 – 2004)

- In The Capital
- In Aden
- In Taiz
- In Hodaidah
- In Ibb
- In Dhamar
- In Hadhramout
- In Shabwah
- In other Governorates
- General Hospitals and Psychiatric Health Centres and Private Clinics
- Quran Treatment Centres

Local Planning

- **Psychological Health Care in Britain and Some Other European Countries**
- Psychological Health Care Services
- **Protection of Psychological Diseases**

Methodology and Procedures of the Research

- **Its Society**
- **Its Sample**
- **Instruments:**
    1. People's Attitudes toward the Profession of Psychological treatment
    2. Measurement of People's attitude
    3. Questionnaire for Institutions
    4. Questionnaire for Clinics
    5. Questionnaire for Universities

Analysation and Discussion of the Findings

Law Draft No. ( ), 2004
Law Draft of Psychiatric Health, 2007

Suggestions and Recommendations Relating to:

- Cadre and Human Resources
- Constructions
- Communal Awareness and Attitude Changes
- Patient Care
- Private Clinics and Hospitals
- Psychic Diseases Protection Views

- **Solutions for Academic Development**
- **List of References**

The Significance of the Research

This research is considered to be the first academic research (as far as we know), to be conducted in the Republic of Yemen that tackles the current situation of the psychiatric health services provided in five governorates. It studies and analyzes the status of the psychiatracies clinics, hospitals and prisons in the Yemen Universities relating to psychiatry. It also includes attitudes assessment of individual towards psychiatrics. The study of all these issues will certainly help predicting the future of psychiatrics and hence finding solutions for potential problems. So this research represents a foundation stage for general strategic planning of the psychiatric health in Yemen at the beginning of the third millennium which can go hand in hand with various changes and development in the concerned field.

The Research Problem

It can be difficult to reach a true, comprehensive and precise identification of any psychiatric prevailing situation in any country in the present time. The reasons are many. People who suffer from psychological problems may or may not go to the institutions that take care of such disturbances. Some of them may even neglect their problem for some time whereas some others are not recognized by their families or, at least, their families are not aware neither of the seriousness of the problem on the individual him/herself nor of its effect on the whole family. Also there are psychologically sick people who have no chance whatsoever to go and seek help anywhere. Some other times, the degree of the problem may not be as severe as it is necessary to take the person to psychotherapy. Further, the reasons may be other than all of these, therefore, the when governmental institutions records remain insufficient for a comprehensive identification of the problem, the private clinics records are not usually available.

However, the situation in Arab countries in general and in Yemen in particular is far more difficult, in spite of the fact that there is an increasing concern in the subject at the present time. Of course, there are a number of factors that cannot be overlooked. Of them are the lack of specialists, the lack of clinics and the family attitude towards the problem (many families because of social, cultural or financial reasons, keep it secret). Besides, the few existed clinics are situated mainly in a number of big cities that cannot be reached by sick people who need help.

Nowadays, there is no doubt that psychological disturbances, life style and financial pressures play a vital role in the emergence of chronic physical diseases such as various cancers, heart, blood circulation, diabetes, lack of immunization and the spread of infectious diseases. These types of diseases, if diagnosed properly, can spare billions of dollars spent for the wrong treatments. However, there are many obstacles against taking such procedures. One is the non-acknowledgement of the seriousness of psychological disturbances. The other is the prevailing negative view in our societies to the problem. The third obstacle is the awareness either of the problem or of the different types of available services. In addition, the lack of awareness of health policy makers about the necessity of the contribution of all social organizations to preventive and protective medicine of these psychological problems.

The spreading of psychological disturbances affects negatively the economic sect because they reduce the ability of those who suffer from this type of problems. Reports show that about 40% of the sick employees frequently visit doctors, for psychological reasons, while 40-60% of the absentee employees are, again, suffer from the same reason, (Okashah, 1998:22)

In Yemen, it is regretful that psychiatric services are really lagging for behind. They are not only unable to provide the minimum level of help, but also they ate not yet included in the basic health services. It was found that only 11 institutions out of 164 hospitals in five provinces have psychiatric clinics, (Central Statistics Establishment, 2006). Statistics of the same year indicate that there are only 44 psychiatrists out of 8534 specialist doctors in the whole country which means only one psychiatrist for almost 500000, (statistics 1980). This serious situation calls for collective efforts to improve the level of psychiatric health services.

Societal and individual awareness of the psychological diseases is really very significant in encountering the spread of these diseases and in facing their consequences. Acknowledgement of the individual, and the society as well, of the sickness is the first condition for its treatment.

Thus it becomes very apparent that the adoption of a national policy and making relevant laws concerning psychological health care are considered very essential for psychological health care in the country. Creating a strategic plan in this regard requires a sort of a preliminary study to identify practically the prevailing situation on the Republic of Yemen, and this is the main goal of this research.

The Research Objectives

1. Evaluating the current situation of psychological health on the level of;
   - Relevant legislations, their aims, the ways of developing them, and revising them on the basis of the present moment's requirement.
   - Existed policy and strategy and the programmes and related studies to psychological health.

2. Analysing the individual consciousness of psychological health and sickness, and verifying the social, financial and cultural dimensions of this consciousness.

3. Analysing the Societal Consciousness.

4. Identifying with the present situation of the psychological health among males and females, children and adults for the purpose of knowing the most spreading cases and their direct and indirect causes.

5. Listing the centres that provide psychiatric treatment and knowing the kinds of services that they offer to public.

6. Knowing the number of psychiatrists and psychologists and their adaptability to the work in the field.

7. Checking the courses taught in the Faculty of Medicine and its suitability to the basic provided service.

8. Knowing the psychological specializations in both the Faculty of Medicine and the Faculty of Arts.

9. Knowing the problematic areas, the available chances and the risks of working in the field of psychological health.

10. Knowing all the partners and relevant people in the government and in the supporting organizations in private sects and civil society organizations.

The Notion of Psychological Health

Al Qousi, defines psychological health as, "a complete harmony of the different physical functions, ability to face everyday difficulties and positive sense of strength, energy and vitality".

Kafafi, defines psychological health as, "a state of balance and complementarily of the individual's psychological functions in a way which makes one accepts him/herself and be accepted by others and hence feels a certain degree of satisfaction".

The Goals of Psychological Health

1. Developmental goal which means employing our psychological knowledge in improving the people's everyday life and helping them to improve their talents and abilities and make use of them in work, productivity and creativity in an effective and fruitful way for themselves as well as for their society.

   Hamed Zahran states that developmental goal is increasing happiness and self-sufficient of the normal and right individuals during their growing period till they attain their maximum level of psychological health. This can be achieved through the study of the individuals' and groups' potentialities and abilities and directing them psychologically, educationally and professionally in a proper manner which focuses on the correct growth (social, mental, physical, emotional...) and provides chances for the individuals to mature naturally. Developmental services should be provided to both healthy and sick, normal and abnormal. Developmental goal is an essential factor of giving guidance and instruction, (a factor that should be taken into account especially in Yemen).

2. Preventive Goal; a goal in which we employ out psychological knowledge in finding the persons who suffer from pressures, frustration, conflict, crises, even though they still look physically healthy, and then helping them and guiding them until they overcome their difficulties. Preventive method in this sense is a way of avoiding all kinds of psychological disturbances. The aim here is to minimize perversity and losing direction.

3. Therapeutic Goal, it is meant to exploit out psychological knowledge in diagnosing, caring and curing the psychologically and mentally disturbed people so that we can limit the consequences (like unemployment, begging, going homeless, etc), and stop deterioration as possible as we can. It also aims at activating the individuals' potentialities and abilities so that they may not get sick again.

The Research Community

The research community is selected in a way that represents all social classes (literate, illiterate, primary school, preparatory, secondary, university, degrees holder MA. PhD.), in the five governorates, (Sana'a, Aden, Taiz, Hodaida and Hadhramout) and in their universities, medical institutions, treatment and guidance centres and some hospitals and clinics.

The Sample

The sample of the research is deliberately specified so that it can provide us with certain estimations about both the citizens' attitudes toward the profession of psychological treatment and guidance, and about the analysis of consciousness of people in regard to psychological services in the Republic of Yemen.

This deliberate method is selecting the sample, it is well known, does not differ from or contradict the random method selection, (Raouf, 2001:171).

The number in the first instrument is 238 and in the second 870. The number of institutions in the third instrument is 19 and 19 clinics in the fourth instrument. The number of the universities in the fifth instrument is 5.

Research Instruments

The First Instrument

Is a questionnaire to measure the citizens' attitudes towards the profession of psychological treatment. The researchers used this instrument in order to know about the people's attitudes, therefore it was distributed to 238 males and females.

The Second Instrument

Is to measure the people's attitudes towards the profession of psychological guidance and it was distributed to 870 people from both sexes.

The Third Instrument

Is the institutions questionnaire which is designed to evaluate, list and collect various information about

psychological services in the Republic of Yemen. The questionnaire includes questions about a number of variables like the kind of institutions, (governmental, private), its legality (governmental, charity, commercial), the level of services provided, the types of patients visiting the institution frequently, the method applied with training sides, financial resources, the supporting organizations, free societal services, acculturation programmes, the levels of psychiatrists performance in different sections, the facilities and equipments available, the cadres and their scientific and professional degrees.

The researchers, when designing this questionnaire, benefited greatly from a previous instrument prepared by both Dr. Abdullah Showkel and Dr. Saif Almeeri.

The instrument is administered in 19 institutions, (hospitals, departments in hospitals or psychiatries) and to the knowledge of the researchers, this number represents all the research community in the five studied governorates.

The listed institutions are as the following table:

No.	Governorate	Name of institution
1	Capital	The Republic Hospital
2	Capital	Department of Psychiatric diseases. Al-Thourah Hospital
3	Capital	Police Hospital
4	Capital	Yemeni-German Hospital
5	Capital	The First Clinic of Psychiatric Neural Diseases
6	Capital	Arrashad Hospital for Psychiatric Neurologistic Diseases
7	Capital	Al-Amal Hospital for Psychiatric Treatment
8	Capital	The Psychiatry of the Central Prison
9	Hodaidah	Dar Assalam Hospital
10	Taiz	Al-Thourah Hospital
11	Taiz	Psychiatric and Neurologistic Hospital
12	Taiz	Abdulqawi Mokred Psychiatry
13	Taiz	Psychiatry Treatment Centre
14	Taiz	The Psychiatry of the Central Prison
15	Taiz	Psychology and Research Centre, Taiz University
16	Taiz	Alamal Centre for People of Mental Problems
17	Hadhramout	Ibn Sina Hospital
18	Aden	Psychiatric Diseases Hospital
19	Aden	Al Dhia Hospital for Psycho-Neural Diseases

The Fourth Instrument (Clinics Questionnaire)

This questionnaire is specially designed for evaluating clinics and centres that provide psychological services in Yemen. It includes questions for collecting information about the cadres qualification and training, labs, charges and the types of sick people visiting the centres very often in 2007.

The questionnaire was administered in 19 psychiatric clinics, most of them are in the capital Sana'a. This number is considered a large number because the number of existed clinics is small. The number of specialists in the five governorates is only 31.

The clinics are as follows:

No.	Governorate	Name of Clinic
1	Capital	Dr. Abdullah Abdulwahab Al-Sharabi
2	Capital	Psychiatric Consultation Clinic, M. Hezam Almagrami
3	Capital	Psychiatric Clinic, Dr. Abdulgader Almotawkil
4	Capital	Dr. Fekri Atnnaieb
5	Capital	Al-Kholaidi Clinic
6	Capital	Psycho-Neural Clinic, Dr. Abdussalam Oshaish
7	Capital	Dr. Ahmed Makki
8	Hodaidah	Dr. Abdulmajeed Alazazi
9	Aden	Al-Dhai Clinic for Psycho-Neural Diseases
10	Aden	Psycho-Neural Clinic, Saber Hospital
11	Hadhramout	Dr. Faraj Abdullah Saleh
12	Hadhramout	Dr. Khaled Al-Abiadh's Centre
13	Taiz	Dr. Abdulhaq Nasher
14	Taiz	Dr. Taleb Ghashan Al-Mohammedi's Clinic
15	Taiz	Psycho-Neural Treatment Centre
16	Taiz	Dr. Mohammed Ahmed Al-Qobati Clinic
17	Taiz	Dr. Abdulqader Al-Mojahed's Clinic
18	Capital	Dr. Mohammed Ahmed Al-Tashi Clinic
19	Capital	Educational & Psychological counselling centre

The Fifth Instrument (Universities Questionnaire)

This questionnaire is for evaluating educational and training programmes in the Yemeni Universities. It includes 90 items which cover all the aspects of taught subjects related to psychological health in both the Faculty of Medicine and the Faculty of Arts. The items also ask about educational facilities, obstacles of education process, the number of specialist staff and teacher, their qualifications, their performance and the textbooks use in teaching. The questionnaire was administered in the five existed governmental universities in the five governorates.

The Research Findings

The researcher finding points are very many but the focus here will be on the most important ones. Those are summarized as follow.

1. Reading 2004 psychiatric legislation as well as the law draft of 2007 prepared by the Ministry of Health headed by Dr. Majed Yehya Aljonaid as assigned by the Minister Dr. Abdulkareem Radea, the research team found that 2007 law draft has avoided a number of the generalization existed in the applied law at the present time. The new law has amended the definitions, the general principles and the nature of rights and commitments to the working individuals in the field of psychiatric treatment. This law seems to be more specific and more comprehensive as well as regard with the requirements of psychiatric treatment. It has established more precise rules and regularities than the current law. Further, it widened the range of rights and at the same time it tightens the level of punishment against any negligence or carelessness in psychiatric treatment.

2. As for the individual attitudes towards psychiatric consultation, they were by and large positive. The figure below shows the individuals' attitudes.
3. No differences in the individuals' attitudes toward the matter attributed to sex are noticed.
4. However, differences attributed to age are noticed, i.e. people above 53 are the least to accept psychiatric counsel, while the group of 33-42 occupied the first rank in accepting treatment, after that comes the group of 23-32. Both groups are distinguished from other groups by a number of characteristics, of them are the education and employment.
5. No significant differences observed in the respondents' attitudes based on their level of education.
6. Again, there are no differences in the attitudes towards the psychiatric treatment on the bases of the social status.
7. As for their attitudes according their area of living, it is noticed that the most positive attitudes are in Hadhramout, Aden, Taiz, Hodaidah and Sana'a repectively.
8. The most important variables which played an influential role on the respondent's attitudes are first the medical experience and then the level of education.
9. The evaluation of the institutions shows that the number if the available bed in 9 institutions are 992 out of 1100 in the whole country which simply means one single bed for every 200000 people while there is a bed for every 2500 in the developed countries, i.e. the difference is about 80 times. At least 8800 beds are needed.
10. It is found that 55% of the institutions do not have general or special sections for women, even the psychiatries of the prisons, or for diagnosing and estimating the severe cases. 83% of them do not have special sections for addiction or chronic cases treatment and 91% do not have special sections for children, old or teenagers.
11. It is found that the number of patients who visit psychiatries or hospitals for psychiatric treatment in the five governorates is (127,630). The numerous patients who seek preliminary psychiatric help are not included.
12. As for the spreading of the diseases, the results show that most of the patients suffer from schizophrenia (36.13%), 21.72% suffer from neurological disturbances, 19.15% suffer from emotional problems. 6.67% from epilepsy and 4.4% from behavioural disturbances among adults.

The following table shows the number of patients suffering from one of the illness groups and who visit clinics frequently.

Type of Illness	Males			Females			Total		
	No.	%	Rank	No.	%	Rank	No.	%	Rank
Dotage or Senility	998	1.13	11	638	1.61	9	1636	1.28	10
Disturbance resulted from habituation to certain substances	1350	1.53	9	174	0.44	11	1524	1.19	11
Schizophrenia	33234	37.71	1	12877	32.60	1	46111	36.13	1
Emotional problems	16399	18.61	3	8038	20.35	3	24437	19.15	3
Neural Disturbances and Depression	18463	20.95	2	9261	23.44	2	27724	21.72	2
Behavioural disturbances associated with physical disturbance	1788	2.03	8	1158	2.93	7	2946	2.31	7
Adults behavioural disturbances	3979	4.52	5	1632	4.13	5	5611	4.4	5
Mental damage	2608	2.69	6	1451	3.67	6	4059	3.18	6
Psychological growth disturbance	1207	1.37	10	615	1.56	10	1822	1.43	9
Children's emotional and behavioural disturbance	1869	2.12	7	995	2.52	8	2864	2.24	8
Epilepsy	6229	7.07	4	2667	6.75	4	8896	6.97	4
The number of affected cases									

Type of institution	Governorate											
	Capital		Hodaida		Hadhramout		Taiz		Aden		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
A section in a governmental hospital	3	17.6	0	0	1	33.3	1	8.3	0	0	5	13.2
A section in a private hospital	2	11.8	0	0	0	0	0	0	0	0	2	5.3
Governmental psychiatric hospital	0	0	1	50	0	0	1	8.3	1	25	3	7.9
Private psychiatric hospital	3	17.6	0	0	0	0	0	0	1	25	4	10.5
A psychiatry	0	0	0	0	0	0	2	16.7	0	0	2	5.3
A psychiatry belonging to the Ministry of Interior	1	5.9	0	0	0	0	1	8.3	0	0	2	5.3
A Governmental centre for education and psychological consultaion (guidance)	1	5.9	0	0	0	0	2	16.7	0	0	3	7.9
A private centre for social and psychological consultation (guidance)	0	0	0	0	0	0	0	0	0	0	0	0
A Private clinic	7	41.2	1	50	2	66.7	5	41.7	2	50	17	44.7
Total	17	100	2	100	3	100	12	100	4	100	38	100

14. Most institutions provide very good services in the training field for faculties of medicine, faculties of arts, high nursery institutions BA clinical psychology and doctors and nurses. This by itself represents additional burden for the trainers who are at the same time physicians, counsellors and university teachers.

15. The result show that about 27% of institutions do not keep flues of the patients' history cases which means the absence of checking.

16. As for clinics it is found that most clinic charge YR 1000 and the more the charge increases the less the visiting patients becomes. However, it is interesting to notice that free treatment is associated with the minimum of patients' visits.

17. In respect to keeping files in clinics, it is found that 95% of them do not even keep a preliminary computerized record, while 79% keep simple record in a notebook kept with the doctor's assistant and

18. The number of the psychological specialists is shown in the following table:

Cadre	Governorate	Clinic	Institution	Total
PhD Psychiatrists	Capital	10	11	21
	Aden	2	1	3
	Hodaidah	0	0	0
	Taiz	1	3	4
	Hadhramout	2	1	3
	Total	15	16	31
MA. Psychiatrists	Capital	2	11	13
	Aden	0	3	3
	Hodaidah	1	2	3
	Taiz	2	5	7
	Hadhramout	0	2	2
	Total	5	23	28

General Doctors	Capital	2	21	23
	Aden	1	10	11
	Hodaidh	1	5	6
	Taiz	1	5	6
	Hadhramout	1	0	1
	Total	6	41	47
PhD Clinical Psychiatrist Consultant	Capital	6	2	8
	Aden	0	1	1
	Hodaidh	0	0	0
	Taiz	1	0	1
	Hadhramout	0	0	0
	Total	7	3	10
MA. Clinical Psychiatrist	Capital	0	0	0
	Aden	2	9	11
	Hodaidh	0	0	0
	Taiz	1	0	1
	Hadhramout	0	0	0
	Total	3	9	12
BA psychiatrist in training	Capital	3	13	16
	Aden	0	12	12
	Hodaidah	0	9	9
	Taiz	2	8	10
	Hadhramout	0	1	1
	Total	5	43	48
Total	Capital	23	58	81
	Aden	5	36	41
	Hodaidah	2	16	18
	Taiz	8	21	29
	Hadhramout	7	4	3
	Total	41	135	176

19. The evaluation of the universities in the five governorates shows that four universities have faculties of medicine where general medicine and paediatrics are taught, whereas three universities teach only pharmaceutics and laboratories, two universities teach dentistry and four universities teach psychology and behavioural science to the student of general medicine and paediatrics.

20. The numbers of specialist psychology teaching staff members in the universities are shown in the following table.

Subject	PhD	MA	BA
For Psychology in Faculty of Medicine	7	2	2
For Behavioural Science in Faculty of Medicine	8	5	2
For Clinical Psychology in Faculty of Medicine	3	0	0
For Psychology in Faculty of Arts	1	0	0
For Behavioural Science in Faculty of Arts	5	2	2
For Clinical Psychology in Faculty of Arts	2	0	0
Total	26	9	6

21. The evaluation of the psychology courses taught in the concerned faculties, it is found:

1. In the Faculties of Arts (Psychology Department)

- All psychological courses and programmes are a kind of borrowed copy from old Arab universities which, because of their established conventions and regularities, find difficulties in adjusting to modern changes.
- Curriculums are mostly theoretic with a very little practice. Graduated students very often lack the basic skills in psychological examinations or the preliminary ability to assist others.
- Courses lack the necessary integrity and comprehensiveness for psychology specialization as a field which integrates humanistic, natural sciences and technology.
- Courses also lack general and special goals.

2. In the Faculties of Medicine:

It is found that psychology as a subject is overlooked in a number of ways:

- The department of psychiatric in the Faculties of Medicine in both Aden and Hadhramout

are headed by non psychiatric graduated teachers from psychology department rather than by psychiatrists. Of course, this is due to either the non-willingness of specialists or to the lack of cadres before the unification. This indicates that less importance is given to psychiatric field.

- The subject of psychiatrics in the Faculty of Medicine is considered non-failing subject with only 15 marks out of 600 marks of the subject of internistry, i.e. 2.5% whereas psychiatrics is given 100% as any other subject in all world universities.
- The courses and textbooks are foreign and differ according to the teacher's background. Some are very short while some others are long. They mostly do not focus on the common diseases in Yemen.
- Research in psychiatrics is very rare because a) the administration in the faculties are not concerned, b) the teachers are very busy in teaching in different levels and in working with patients, c) financial resources for research are very limited, and d) the absence of team-work.
- During the last 18 years since the opening of psychology department, no more than three demonstrators were sent by the Ministry of Health for study abroad (to Sudan).

Finally, the researchers have listed at the end of the research a number of suggestions and recommendation which may be of great use for further strategic planning.