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Mental health in Sudan – the psychiatric & psychological infrastructure[1]

Introduction and summary

This briefing compiles the evidence presented in reports and articles, as well as from interviews with both practitioners and beneficiaries, of mental health provision in Sudan. It considers the availability of psychological and psychiatric help, the cultural realities of requiring treatment, and the situation facing failed asylum seekers returned to the country with extant mental health problems, especially where they were receiving or requesting help via services in the country in which they were seeking sanctuary. It concludes that returning someone with severe mental health difficulties to Sudan would constitute a breach of Article 3 of the European Convention on Human Rights on medical grounds.

Over the past two decades development of mental health legislation has not been a priority for the Sudanese government. The last version of mental health legislation passed by the government dates back to 1998 and requires updating.[2] Since then policy has undergone minor reformulation in 2006-2008, however it is far from sufficient.[3] A national mental health authority now exists under the umbrella of preventive medicine at the federal level, but mental health services are not available at the primary level or organised in primary health care service packages.[4]

Expenditure on health services remains one of the lowest in the world.[5] As little as 1% of the Government's total spending goes towards health, while reportedly as much as 70% is afforded to the security sector,[6] which rises to 76-78% if you include salaries and remittances.[7] Furthermore, the budget allowed for mental health, as a percentage from the total health budget, is determined to be far below the range to promote mental health services.[8] It is speculated that Sudan spends fewer than US$0.25 per person per year on mental health.[9] This underfunding is expressed within the system as unequal distribution of coverage for patients.

Rural populations and people of lower socioeconomic status are disproportionately disadvantaged by the existing mental healthcare structure. There is an uneven distribution of resources in favour of services in the capital Khartoum - in 2005 only 6 of the 25 states had psychiatric treatment facilities.[10]

Refugees and failed asylum seekers are at substantially higher risk than the general population for a variety of specific psychiatric disorders. These are related to their exposure to war, violence, torture, forced migration and exile, and to the uncertainty of their status in the countries to which they seek asylum.[11] With high prevalence rates of mental health disorders among Sudanese refugees and failed asylum seekers, and inadequate and unequal provision, it is clear that returning individuals with mental health problems to Sudan may lead to discontinuity of care and risk of serious harm.

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[1] Our thanks to Waging Peace interns Sam Godolphin, Dylan Prazak and Ayesha D'Costa for their help preparing this report.

[2] World Health Organization, *WHO-AIMS Report On Mental Health Systems In Sudan*, WHO-AIMS, Ministry of Health Sudan, Khartoum, Sudan 2009 <http://www.who.int/mental_health/who_aims_report_sudan.pdf> p.5 (Accessed June 2016)

[3] Ibid, p.5

[4] Ibid, p. 10

[5] Leon Nyerere, *Understanding disability in Sudan*, University of Manitoba, 2011, p. 32

[6] Nuba Reports, *Sudan's Economy: Annual Budget Designed for War, 12 February 2016* , <*http://nubareports.org/sudans-economy-annual-budget-designed-for-war/*> *(Accessed October 2016)*

[7] The Enough Project, *Khartoum's Economic Achilles' Heel: The intersection of war, profit, and greed*, August 2016 <http://enoughproject.org/reports/khartoum%E2%80%99s-economic-achilles%E2%80%99-heel-intersection-war-profit-and-greed>, p. 9 (Accessed October 2016)

[8] World Psychiatry (WPA), *Mental Health Services in the Arab World*, Ahmed Okasha, Elie Karam, Tarek Okasha, 2012, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3266748/ p.52-54. (Accessed June 2016)

[9] Elsadig Abdelgadir, *Exploring Barriers to the Utilization of Mental Health Services at the Policy and Facility Levels in Khartoum State, Sudan*, University of Washington, 2012, <https://digital.lib.washington.edu/researchworks/bitstream/handle/1773/20682/Abdelgadir_washington_0250O_10393.pdf?sequence=1&isAllowed=y> p.1 (Accessed June 2016)

[10] *WHO-AIMS Report On Mental Health Systems In Sudan*, p.19

[11] Kirmayer, L.J et al (2011) *Common Mental Health Problems in Immigrants and Refugees: General Approach in Primary Care*, Canadian Mental Health Association Journal, p.3

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Facilities available

Sudan already fails to secure the minimum appropriate staff and operating supplies for its medical facilities. Partly in recognition of this fact, many members of the medical profession have initiated strikes in recent months.[12]

In the context of this overall scarcity, it is important to note that three separate forms of mental healthcare institutions exist within Sudan: mental health hospitals, forensic inpatient facilities, and community-based psychiatric units. Each differs in its ability to provide treatment with specialised staff and equipment.

Mental/psychiatric hospitals: There are only two mental health hospitals in the entirety of Sudan, both of which cater to the centralised population of Khartoum. This forces a large proportion of patients to travel long distances to access mental health care. These hospitals provide inpatient care with a combined total of 0.86 beds per 100,000 population, or 327 (326.8) beds.[13] From 2007-2010 these hospitals averaged 24,322 patients per year.[14] Taha Bashar, one of the hospitals, has no phones or ambulances to help patients.[15]

Forensic inpatient facilities: All of Sudan's 200 forensic inpatient beds are located inside of prison mental health facilities.[16] Most recent data suggest approximately 28,880 patients are treated per year. The majority of patients are admitted involuntarily by police, often following violent outbursts.[17] The use of the word 'bed' should be understood loosely here; those who have visited these types of facilities suggest that 'cell' might be a more appropriate term, and have even seen individuals shackled alongside inmates on death row.[18] Some even fear that mental health treatment will be used as a punishment for engaging in anti-government activities.[19]

Community-based psychiatric unit: The most widely accessible form of psychiatric assistance, community-based psychiatric units offer at least 760 beds for inpatients.[20] Though they are the most conveniently located service for the majority of Sudan's population, community-based psychiatric units employ staff with the least medical experience and provide no relevant specialised equipment. These psychiatric units provide traditional healing alternatives shaped by religious, spiritual and cultural factors.[21] In parts of Sudan, patients seek help from spiritual and traditional healers in their initial instance rather than seeking conventional psychiatric help from mental health services.[22] Traditional and religious healers rarely have relevant formal education yet have a considerable impact on mental health patients' access to care.

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[12] Radio Dabanga, *Medical strike in Sudan expanding*, 10 October 2016, < https://www.dabangasudan.org/en/all-news/article/medical-strike-in-sudan-expanding> (Accessed October 2016)
[13] *WHO-AIMS Report On Mental Health Systems In Sudan*, p.11 [Data extrapolated from last Sudanese census, taken in 2008]
[14] Elsadig Abdelgadir, *Exploring Barriers to the Utilization of Mental Health Services at the Policy and Facility Levels in Khartoum State, Sudan*, University of Washington, 2012, <https://digital.lib.washington.edu/researchworks/bitstream/handle/1773/20682/Abdelgadir_washington_0250O_10393.pdf?sequence=1&isAllowed=y> p.18-19 (Accessed June 2016)
[15] Ibid, p.11
[16] *WHO-AIMS Report On Mental Health Systems In Sudan*, p.12
[17] Abdelgadir, *Exploring Barriers to the Utilization of Mental Health Services at the Policy and Facility Levels in Khartoum State, Sudan*, p.22
[18] Information supplied by contact who travels regularly to the region and researches disability provision in Sudan.
[19] View expressed by UK-based expert on Sudan following interviews with human rights defenders and activists from country.
[20] Abdelgadir, *Exploring Barriers to the Utilization of Mental Health Services at the Policy and Facility Levels in Khartoum State, Sudan*, p.12
[21] Ibid
[22] Ali, S.H & Agyapong, V.I.O (2016), *Barriers to Mental Health Service Utilisation in Sudan – Perspectives of Carers and Psychiatrists* in *BMC Health Services Research,* 16:31, p. 7 (Accessed September 2016)

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Barriers to access

In Sudan there are many barriers to mental health service utilisation. The most significant relate to stigma, lack of knowledge of illnesses and their treatability, as well as financial constraints.[23] Each of these barriers affects the availability, accessibility and efficiency of mental health identification, diagnosis and treatment.

Cultural barriers: Like many around the world, Sudanese society has stereotyped views about mental illness and how it can affect people. Culture perpetuates harmful stigmas surrounding mental health and wellbeing, often leading to discrimination and the social isolation of affected individuals. For men, chronic mental illness often leads to an inability to maintain work, stymieing the ability to marry, afford food, and live constructively.[24] For women, struggling with mental illness can lead to their family restricting their social presence and diminishing their opportunity to marry.[25] Children in particular often face widespread abuse and neglect.[26] The negative stigmas attached to mental illness likely prevent many individuals from seeking medical assistance.

Lack of trained professionals: Perhaps the most perpetuating circumstance in determining Sudan's insufficient mental healthcare is the vast shortage of trained professionals. Pursuing fields such as psychiatry and psychology is disincentivised by lower wages as compared with other health professions.[27]

Healthcare Occupation	Number of Professionals per 100,000 People[28]	Estimated Active Professionals*	Professionals Working inside Khartoum	Professionals Working outside Khartoum
Psychiatrists	0.09	34 (34.16)	27 (27.2)	7
Psychologists	0.2	76 (75.92)	61 (60.736)	16
Nurses	0.2	76 (75.92)	61 (60.737	16
Social Workers	0.1	37 (37.96)	30 (30.368)	7

*Data extrapolated from last Sudanese census, taken in 2008

In addition to the fact that the number of health personnel is much below that needed to provide adequate mental health care, the few psychiatrists working in Sudan lack appropriate motivation and incentives.[29] Absence of accurate knowledge about disability; its causes, prevention and treatment has a negative impact on mental health provision.

Financial constraints: Amount of funding, distribution and allocation of services are strong influences on the utilisation of mental health care in Sudan. Socioeconomic circumstances have a significant impact on the wellbeing of an individual, particularly where specialised medical attention is required.

The cheapest anti-psychotic medication in Sudan is 72% of the daily minimum wage.[30] Given that neither drugs nor inpatient care would routinely be provided for by the state, meeting these sort 'out of pocket' payments would push some individuals into 'catastrophic health expenditure', where the sum paid would disrupt household living standards.

[23] Ibid
[24] African Arguments, *Sudan's Great Depression: mental illness dangerously ignored by country's health services*, Dr Mohamed Shawgi, 2015 <http://africanarguments.org/2015/04/08/sudans-great-depression-mental-illness-dangerously-ignored-by-countrys-health-services-by-dr-mohamed-shawgi/> (Accessed June 2016)
[25] *WHO-AIMS Report On Mental Health Systems In Sudan*, p.11
[26] Leon Nyerere, *Understanding disability in Sudan*, University of Manitoba, 2011, p. 30
[27] *WHO-AIMS Report On Mental Health Systems In Sudan*, p.11
[28] World Psychiatry (WPA), *Mental Health Services in the Arab World*, p.52-54, table 2
[29] Ali, S.H & Agyapong, V.I.O (2016), *Barriers to Mental Health Service Utilisation in Sudan – Perspectives of Carers and Psychiatrists* in *BMC Health Services Research,* 16:31, p. 7
[30] Ibid, p. 8

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The population generally lacks social or private health insurance to mitigate this risk. A National Health Insurance Fund (NHIF) was introduced in 1996, originally managed at a state level and only mandatory for civil servants. This year, Sudan's parliament passed an amendment to the NHIF 1996 law extending it to the whole population, with the aim of achieving Universal Health Coverage (a Sustainable Development Goal) by 2020, and with funds now pooled at a federal level. But the issues evident from the handling of the NHIF from 1996 onwards show the difficulties with its roll-out to the entire population. It is likely that health insurance will continue to cover only part of the population, such as civil servants, salaried workers, and some vulnerable groups such as the families of 'martyrs' (soldiers who have died on active service). Other groups, such as farmers or pastoralists, will have almost zero coverage. The health services provided or covered by the NHIF in rural areas, peripheries, and suburbs are of low-quality, and in any case families working in traditional agriculture and pastoralism do not have the ability to make regular cash payments.

Furthermore, as NHIF's 2015 annual report shows, there is still a comparative unwillingness to treat mental health needs. In 2015 NHIF covered 390 mental health claims which accounted for 0.4% of total consultations costs, which in their turn comprised only 5.4% of total medical services costs in 2015.[31]

Impact of conflicts: The pressures of Sudan's economic crisis, regional wars, and persistent conflict in Darfur, South Kordofan and Blue Nile state, as well as the prevalence of organised violence in the east of the country, have led to a change in budget priorities and further neglect of mental health.[32] With mental illness highly prevalent among victims of war and conflict, the lack of mental health provision is particularly felt in the country's warzones.

A radiologist and nuclear medicine physician based in the UK, Dr Mohamed Shawgi explains: "Mental illness is also very common amongst war victims living in war zones like the Darfur region where there are elevated rates of post-traumatic stress disorder, anxiety, depression and social dysfunction. These problems are also common amongst internally displaced victims who are faced with unemployment, malnutrition, poor living conditions, lack of security in refugee camps and sexual violence (particularly against women). However, provision for mental health in war-torn areas remains limited or non-existent."[33]

Although not mentioned directly, the need presented by failed asylum seekers would be similarly dire, given that they have faced the same circumstances, potentially been re-traumatised by their journey to and across Europe, faced daily uncertainty about their living situation in the country where they sought sanctuary, and then been returned to the site of their original traumatic experiences. Studies examining the prevalence of specific psychological disorders of refugees living in a Western country found that the prevalence of depression, anxiety, and PTSD is often high. The mean prevalence of depression in refugees was found to be 36%, anxiety 28%, and post-traumatic stress disorder 43%.[34]

Waging Peace's own experience working with the Sudanese refugee and asylum-seeking populations in the United Kingdom strongly suggests that they suffer from higher levels of PTSD, especially where they have faced detention in Britain's immigration removal centres. We regularly make referrals for individuals to access the services offered by dedicated organisations like Freedom from Torture or the Helen Bamber Foundation, though these are over-subscribed, meaning many have to rely on often overstretched local services where available. Policies of dispersal and changes in the provision of National Asylum Support Service accommodation can then lead to care discontinuity.

[31] Report in Arabic, information relayed by trusted contact preparing an MSc research project on Catastrophic Health Expenditure in Sudan.
[32] Edward Thomas (2015), *The Future of Sudanese Health Care and the Wealth-Sharing Protocol of Sudan's 2005 Comprehensive Peace Agreement,* p. 6

[33] African Arguments, 2015
[34] Primary Care and Mental Health, *Mental illness in asylum seekers and refugees,* Caroline M Mann, Qulsoom Fazil, 2006, <http://www.mhfmjournal.com/mental-health/mental-illness-in-asylum-seekers-and-refugees.pdf p.58> (Accessed June 2016)

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Conclusion

The Sudanese government spends a tiny proportion of its budget on healthcare, and an even more miniscule proportion of that on mental health support. Mental health needs are consequently deprioritised, especially for poorer, rural, and marginalised groups without access to private provision. These groups are likely to try and hide their mental illness, or to treat it using traditional techniques that increase social isolation and stigma.

By UK standards or any metric, these types and levels of provision should be considered insufficient and even actively unhelpful. This puts failed asylum seekers at risk of harm, self-harm or even suicide were they to be returned to Sudan. In particular, the evidence suggests that returning someone with severe mental health difficulties to Sudan would constitute a breach of Article 3 of the European Convention on Human Rights on medical grounds, including in accordance with the interpretation of 'inhuman treatment' under N v SSHD (2005) where the mental illness exhibited is acute and has reached a critical state.