MENTAL HEALTH POLICY OF ETHIOPIA pdf

1: WHO | Mainstreaming mental health in Ethiopia

A critical milestone for Ethiopia's mental health care sector, the National Mental Health Strategy serves to provide accessible, affordable, and acceptable care for all Ethiopians. The Strategy was developed with extensive input from a wide range of stakeholders.

How Common are Mental Illnesses? Mental illnesses are among the most common health conditions in the United States and around the world. Around one in five American adults experience some form of mental illness. Even the most serious mental health conditions can be treated, however, allowing people to better contribute to their families and communities. In addition, the Mental Health Program is part of an international effort to reduce stigma and discrimination against people living with mental health and substance use conditions. The Center works with key partners at the government and community levels to help build sustainable mental health care infrastructure in post-conflict Liberia. Public Policy Health care policy is shifting from a focus solely on the management of illnesses towards one that proactively creates health and well-being in individuals, organizations, and communities, otherwise known as population health. Population health focuses on building "cultures of health," in order to reduce the burden of disease and maximize overall health and well-being. Evidence shows that behavioral health plays a major role in the successful completion of these efforts. Therefore, the Mental Health Program has undertaken a multi-year effort to help ensure that the consideration of behavioral health and well-being is at the center of efforts made to manage the health of populations. Department of Justice, and implementing a child and adolescent mental health initiative. Stigma Reduction As part of an international effort to reduce stigma and discrimination, the Rosalynn Carter Fellowships for Mental Health Journalism provide stipends and training to journalists to support reporting on topics related to mental health and substance use issues. The fellowships develop a cadre of better informed professional journalists to more accurately and sensitively report information and influence peers and important stakeholders to do the same. In efforts to expand national and international dialogue on the current prevalence and understandings of stigma against people with mental illnesses and substance use conditions, the Mental Health Program works with important organizations and leaders in the stigma reduction field providing expertise in media and mental health. Results from these collaborations have included significant conferences related to stigma reduction, a media guide for journalists, and a national report on the evidence base for ending discrimination against those with behavioral health conditions. Carter played a key role in the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of , which ensures that mental illnesses are covered by insurance at parity with other illnesses. Working with the Liberian government , the Center has helped to create a corps of over locally trained and credentialed mental health clinicians now serving all 15 counties in the country, 42 of whom have a specialty in children and adolescents. Since the Rosalynn Carter Fellowships for Mental Health Journalism were established in , fellows have produced more than 1, stories, documentaries, books, and other works during and after their fellowship year. Their projects have garnered an Emmy, nominations for the Pulitzer Prize, and other awards. From â€” , the annual Rosalynn Carter Symposium on Mental Health Policy has brought together national leaders in mental health to focus and coordinate their efforts on issues of common concern and recommend action steps to move an agenda forward.

MENTAL HEALTH POLICY OF ETHIOPIA pdf

2: Why Africa needs to start focusing on the neglected issue of mental health

The Government of Ethiopia has shown strong commitment for improving mental health care and getting services to the people who need them, as evidenced not only by the development of a mental health strategy, but also by the allocation of new funds for the roll-out of a mental health strategy across the country.

Preventive, promotive and curative components of health services in the country have shown a remarkable improvement, meeting equitable and quality health components of health care for all parts of the population [1] and encouraging private and nongovernmental organization participation in the health sector. The health sector follows a 5-year rolling plan as part of the national development plan. Since â€”, three consecutive phases have been completed and currently the country is implementing the fourth comprehensive Health Sector Development Programme HSDP. The health system has had a huge transformation over the past two decades, with a dramatically improved potential access to care through the accelerated expansion of health facilities. An innovative community-level health service, the Health Extension Programme was introduced by training and deploying female health extension workers and institutionalizing community health care at the health post level. Over the past decade, the Government of Ethiopia has given priority to the expansion of health facilities, especially those of primary health care. In order to expand comprehensive obstetric care services further to the community level, the Government is planning an accelerated expansion of primary hospitals in each woreda. Recently, the Ministry of Health has introduced a three-tier health care delivery system. Level one is a woreda health system comprised of a primary hospital for 60 â€” people , health centres for 15 â€”25 population and their satellite health posts for â€” population , connected to each other by a referral system. The primary hospital, health centres and health posts form a primary health care unit. Level two is a general hospital for 1â€”1. Over the past two decades, the private sector and private-for-profit sector has rapidly expanded. The major health system response focuses on the primary health care approach: In general, service coverage has increased over time, although the performance is not uniform across programmes. Owing to economic, sociocultural and geographical factors, health care utilization is still low, with a 0. Overall, there is a global deficit of 2. To monitor the performance of its health services, the Government has designed and adapted a new health management information system and implemented it country wide. However, this health management information system is inadequate for data generation and dissemination and for decision-making at different levels of the health system. The Government has initiated and is implementing community-based health insurance and social health insurance schemes to address financial barriers to accessing health services. To improve the quality of health services, the focus is on the provision of quality health services at standard health facilities at all levels, including speedy delivery and effectiveness of services, patient safety, ethical considerations and professionalism, with adequate numbers of health workers and sufficient finance and pharmaceuticals. Quality improvement has become an integral part of service delivery in the health system, thus the Federal Ministry of Health has established a quality management committee and designed a reference manual to guide its implementation. Although the majority of maternal deaths could be prevented through appropriate reproductive health services before, during and after pregnancy, only one fifth of all deliveries are currently attended by a skilled health professional. However, TB control is still far from reaching the international standards for Millennium Development Goal achievement. The TB case detection rate is still below the international target, while the treatment success rate has almost reached targets.

MENTAL HEALTH POLICY OF ETHIOPIA pdf

3: Health in Ethiopia - Wikipedia

Mental health is one of the most disadvantaged health programmes in Ethiopia, both in terms of basic amenities and skilled manpower. The average prevalence of mental disorders in Ethiopia is 18% for adults and 15% for children. 1 Nearly million people alive today suffer from mental disorders, according to estimates from World Mental Health Day 1 Twenty percent of people are affected.

Common medical issues and cultural concerns of Ethiopian patients Social structure Ethiopia is located in northeast Africa on the Horn of Africa. It is one of the most populous countries in sub-Saharan Africa with more than 85 percent of the population living in rural areas. Large numbers of Ethiopiansâ€"primarily young, urban malesâ€"came to the U. Ethiopia is a nation of many ethnic groups and religions with strong cultural similarities, but political and language differences. In Minnesota, the Oromo, Amhara, Anuak, and other ethnic groups from Ethiopia live and work together, although each group speaks its own language and relationships are often strained because of a long history of political differences. Most young Ethiopians in Minnesota speak English. Ethiopians tend to speak softy and politely. Bowing and offering a polite greeting using the formal title of Mr. Hugging, kissing cheeks, and touching are acceptable forms of greeting among family and friends. Unlike most Americans and Europeans, Ethiopians do not have family names. The Oromo Center in the Minneapolis Cedar-Riverside area is a meeting place where Oromo immigrants gather and discuss cultural and political topics. Injera is a major food staple, and provides approximately two-thirds of the diet in Ethiopia. Teff contains high levels of calcium, phosphorous, iron, copper, aluminum, barium, and thiamine. Ethiopians place high importance on eating and drinking moderately to stay healthy. Religion often dictates nutritional habits. Orthodox Christians do not eat meat, eggs, or dairy products on Wednesdays and Fridays, and fast on a number of occasions, including 55 days at Easter. Religion Nearly half of the population in Ethiopia is Muslim, and half Christian. Coptic Orthodox Christians account for most Christians. Christian churches in Minnesota that offer services for Ethiopian immigrants, include the Minnesota Ethiopian Evangelical Church in St. Medical care The health care system of Ethiopia is among the least developed in sub-Saharan Africa, with lack of access to basic health care facilities in rural areas. With widespread poverty, poor access to health services, poor nutrition, low education levels, and an increase in HIV infection rates, the life expectancy in Ethiopia of only The median age in Ethiopia is currently Malnutrition and vaccine-preventable diseases, including tuberculosis, diphtheria, whooping cough, tetanus, polio, measles, hepatitis B, and cervical cancer are widespread in Ethiopia. Changes in lifestyle and diet for Ethiopians in the U. A common belief among Ethiopians is that well being is based on a balance of spiritual, physical, social, and environmental forces. In addition, they place a high importance on cleanliness for staying healthy. Illness can be attributed to God, destiny, nature, demonic spirits, emotional stress, or a breach of social taboos or vows. Ethiopian medicine relies heavily on magical and supernatural beliefs, such as the belief that miscarriages are the result of demonic spirits. Ethiopians often use home-based therapies and herbal remedies, such as animal products, minerals, eucalyptus leaves, oil seeds, and spices to heal common ailments. Mental illness and some physical illnesses, such as epilepsy, are commonly attributed to evil spiritsâ€"with the view that these types of illnesses are a stigma. Many families do not disclose information to the community about family members with such illnesses for fear of being shunned. Men and women generally avoid marrying into families with members who are mentally ill or have other disabilities, and they often resist psychiatric treatment for themselves and other family members. When treating Ethiopian patients, providers are advised to be explicit about the importance of taking medications regularly and completing a full course of antibiotics. Explain the complications and outcomes associated with chronic diseases, such as diabetes and hypertension. Patients may question illnesses with no apparent symptoms. Patients should be reminded not to double or triple dose if they miss a medication. This is especially important because many Ethiopians frequently fast for religious reasons and may not take their medications during these times. Family members usually attend to the needs of the sick. In this culture, they can often overindulge the patientâ€"rather than encourageing self care and attempts at recovery. Providers are advised to encourage movement, rehabilitation, and self care to

stimulate recovery from an illness or surgery. Trust is important in the patient-provider relationship. Modesty is especially important to Ethiopian immigrantsâ€”matching the gender of a patient with that of the provider and interpreter can address this issue. Some Ethiopian patients may fear surgery or the process of blood donation, and require additional information and reassurance. A religious person may be called to administer a sacrament to the patient. When a person dies, Ethiopian men may cry out loud and grow a beard as a sign of respect. Women often cry uncontrollably, tear their clothes, and beat their chests. Some women may wear black for at least a year and shave their heads or cut their hair very short. Autopsy, organ donation, and cremation are generally unacceptable within this population. Ethiopians in Minnesota According to the U. However, representatives from the Ethiopian American community believe that number to be very low. Unofficial embassy estimates suggest numbers of Ethiopians to be , to ,, with an estimated , to , living in Washington, D. The Census shows 13, Ethiopians living in Minnesota, although local community leaders believe the population is much larger. Efforts to reduce health disparities must be holistic, addressing the physical, emotional, and spiritual health of individuals and families. Also important is making connections with community members and recognizing conditions in the community. Get to know your patients on an individual level. Not all patients from diverse populations conform to commonly known culture-specific behaviors, beliefs, and actions. Generalizations in this material may not apply to your patients. In order to provide equitable and effective health care, clinicians need to be able to function effectively within the context of the cultural beliefs, behaviors, and needs of consumers and their communities. According to the Institute of Medicine report Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, racial and ethnic minorities tend to receive lower quality health care than non-minorities even when access to insurance and income is accounted for. Failing to support and foster culturally competent health care for racial and ethnic minorities can increase costs for individuals and society through increased hospitalizations and complications. Additional Resource YouTube Video: Do I need an interpreter? Video vignette in Oromo created by the Minnesota Multilingual Resource Exchange The Exchange through the Building Healthier Communities award to inform limited English speaking patients on their right to an interpreter at no cost. Census, FactFinder 2, , viewed January 20, 2. The Emergence of an Ethiopian Diaspora, viewed January 20, 3. Every Culture , viewed November 23, 5. Index Mundi , viewed January 02, 6.

4: Community Perception towards Mental Illness among Residents of Gimbi Town, Western Ethiopia

Mental health expenditures by the government health department/ministry are not available. Mental hospital expenditures are more than 85% of the total mental health budget.

However, there has been encouraging improvements in the coverage and utilization of the health service over the periods of implementation of Health Sector Development Plan, the health chapter of the national poverty reduction strategy, which aims to increase immunization coverage and decrease under-five mortality at large. The HEP is designed to deliver health promotion, immunization and other disease prevention measures along with a limited number of high-impact curative interventions. Ethiopia had the lowest level of expected human capital among the 20 largest countries with less than 5 health, education, and learning-adjusted expected years lived between age 20 and 64 years. This put it in th place, an improvement over its position in when it was th. The effort to control tuberculosis began in the early 60s with the establishment of TB centers and sanatoria in three major urban areas in the country. From the very beginning the CO had serious problems in securing sufficient budget and skilled human resource. In , a well-organized TB program incorporating standardized directly observed short course treatment DOTS was implemented in a few pilot areas of the country. An organized leprosy control program was established within the Ministry of Health in , with a detailed policy in This vertical program was well funded and has scored notable achievements in reducing the prevalence of leprosy, especially after the introduction of Multiple Drug Therapy MDT in This has encouraged Ethiopia to consider integration of the vertical leprosy control program with in the general health services. This finding indicates that the actual TB prevalence and incidence rates in Ethiopia are lower than the WHO estimates. Additionally, the survey showed a higher prevalence rates for smear positive and bacteriologically confirmed TB in pastoralist communities. However, pertaining to its methodology, the survey did not produce further disaggregated sub-national estimates. Maternal and child health[edit] Maternal and child health program is a priority agenda of the government of Ethiopia and this has been clearly indicated on the currently being implemented strategic plan of the FDRE Ministry of health. Though Maternal and child health program is still one of the target area which needs much organized, systematic and focused effort, clear progress has been witnessed over years as per the Demographic health survey report of the country. The recent DHS [1] in the country shows these steady changes. Maternal health status could be assessed with many indicators of which Modern contraceptive use, skilled delivery and maternal mortality are some of the majors. Modern contraceptive use by currently married Ethiopian women has increased over 15years prior to the DHS. The total fertility is declining but the changes are not that significant. The pregnancy related mortality has also dropped over the last three surveys and this could be attributed to the improvement on skilled delivery and family planning. The fact that Ethiopia is on the verge of eradicating polio could be a good evidence for that. Childhood mortality has declined substantially since However, the change in neonatal mortality is not significant compared to post neonatal and child mortality. Reducing child mortality MDG 3 has been achieved previously and if the effort is maintained the target of decreasing the under-five mortality to 25 could be met by the end of the target. Traditional medicine[edit] The low availability of health care professionals with modern medical training, together with lack of funds for medical services, leads to the preponderancy of less reliable traditional healers that use home-based therapies to heal common ailments. High rates of unemployment leave many Ethiopian citizens unable to support their families. In Ethiopia an increasing number of "false healers" using home-based medicines have grown with the rising population. However, only about ten percent of practicing healers are true Ethiopian healers. Much of the false practice can be attributed to commercialization of medicine and the high demand for healing. Both men and women are known to practice medicine from their homes. It is most commonly the men that dispense herbal medicine similar to an out of home pharmacy. Before the onset of Christian missionaries and Medical Revolution sciences, traditional medicine was the only form of treatment available. Traditional healers extract healing ingredients from wild plants, animals and rare minerals. AIDS, malaria, tuberculosis and dysentery are the leading causes of disease-related death. Largely because of the costs, traditional medicine continues to be the most common

form of medicine practiced. Many Ethiopians are unemployed which makes it difficult to pay for most medicinal treatments. Many physical ailments are believed to be caused by the spiritual realm which is the reason healers are most likely to integrate spiritual and magical healing techniques. Traditional medicinal practice is strongly related to the rich cultural beliefs of Ethiopia, which explains the emphasis of its use. The first is attributed to God or other supernatural forces, while the other is attributed to external factors such as unclean drinking water and unsanitary food. Most genetic diseases or deaths are viewed as the will of God. Miscarriages are thought to be the result of demonic spirits. Nearly four out of five Ethiopian women are circumcised. There are three levels of circumcision that involve different degrees of cutting the clitoris and vaginal area. Many of these practices are done with an unsanitary blade with little or no anesthetics. It can result in heavy bleeding, high pain, and sometimes death. Today there are three medical schools in Ethiopia that began training students in two of which are linked to Addis Ababa University. Although there have been huge leaps and bounds in medical technology there is still a large problem in the distribution of medicine and doctors in Ethiopia.

MENTAL HEALTH POLICY OF ETHIOPIA pdf

5: Solving Health Issues in Ethiopia with Religion - Inquiries Journal

A National Mental Health Strategy is critical to the development of Ethiopia's health system. Mental health is an integral component of any efficient, well-functioning structure of health care.

Faced with many challenges, including intractable poverty, infectious diseases, maternal and child mortality, as well as conflict, African political leaders and international development agencies frequently overlook the importance of mental health. This trend is often compounded by three factors: Absence of treatment is the norm rather than the exception across the continent. Yet there are several reasons to give greater priority to mental health. These include the fact that doing so delivers other health benefits; that it helps tackle socioeconomic challenges; that there are economic benefits; and that human rights offences are reduced. Mental and physical health are inseparable Chronic non-communicable diseases such as hypertension and diabetes, as well as infectious diseases like HIV and tuberculosis, have high levels of co-morbidity with mental illness. A study in Ethiopia showed that people living with severe mental illness â€" conditions like schizophrenia, bipolar mood disorder and severe depression â€" died 30 years earlier than the general population, mainly from infectious causes. Maternal depression has also been shown to affect the development and growth of infants. In addition, research shows that people living with mental illness or substance use disorders are more likely to become infected with HIV. In a further twist, people with HIV have been shown to be twice as likely as the general population to be depressed. And treating them for depression improves adherence and boosts their immune systems. Mental health and poverty There are strong links between mental health and poverty. In a large review of studies from 36 low and middle-income countries we found that poverty was strongly associated with common mental disorders. These included depression, anxiety and somatoform disorders psychological disorders with inconsistent physical symptoms. The study included several African countries. In addition, the relationship between mental health and poverty is cyclical. Conditions of poverty increase the risk of mental illness. This happens through the stress of food and income insecurity, increased trauma, illness and injuries and the lack of resources to cushion the blow of these events. Conversely living with a mental illness leads those affected to drift into poverty through increased healthcare expenditure, disability and stigma. Human rights People living with mental illness particularly severe mental illness are frequently stigmatised , shunned, and excluded from mainstream society. This is as true in Africa as it is in societies around the world. Those with schizophrenia, bipolar mood disorder and epilepsy are frequently subjected to human rights abuses. They are often cast aside because of beliefs that psychosis or epileptic seizures are signs of demon possession or evil spirits. And they are denied access to life changing treatment. There is hope A range of mental health interventions across the continent are leading to clinical improvements. Since the early s, a series of randomised controlled trials in African countries have provided compelling evidence that mental health interventions are highly effective. These include pharmacological and psychological interventions. Many of these have used non-specialist health providers in local communities, reducing the cost of care. In northern Uganda for example, scientists have shown significant improvements in depression and daily functioning by using group inter-personal therapy. These were delivered by local non-specialist facilitators. Significant improvements in depression, anxiety, disability and health related quality of life have been noted. How a community-based approach to mental health is making strides in Zimbabwe Mental health interventions also improve the economic circumstances of people and households affected by mental illness. Most studies that evaluated the economic impact of these interventions showed how clinical and economic improvements went hand in hand. As this new evidence emerges, the tide is beginning to turn. The critical question is how evidence-based interventions can be taken to scale using existing health care systems, while maintaining quality. In a similar vein, studies are being conducted in low and middle-income countries by the Emerald consortium which is working in the five countries as well as Nigeria. The aim is to strengthen information systems, improve governance and calculate the costs of scaling up integrated packages of care. A good investment By neglecting mental health, it will be difficult to attain many of the Sustainable Development Goals related to poverty, HIV, malaria, gender empowerment and education.

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Improving mental health is a means of unlocking development potential â€” a neglected link in the development chain in Africa. Investing in mental health means promoting resilience on the African continent. Mental health is both a means to social and economic development, and a worthy goal in itself. This is an edited version of an article that appeared in the African Policy Review.

MENTAL HEALTH POLICY OF ETHIOPIA pdf

6: CDC Global Health - Ethiopia

Ethiopia among the least privileged nations in the world. The Health Policy of the Transitional Government is the result of a of health including mental health.

Advanced Search Abstract Background Integrating mental health with general medical care can increase access to mental health services, but requires helping generalists acquire a range of unfamiliar knowledge and master potentially complex diagnostic and treatment processes. Generalists and specialists collaboratively developed mental health treatments to fit the knowledge, skills and resources of the generalists. The model recognizes commonalities between mental health and general medical care, focusing on practical interventions acceptable to patients. It was developed through a process of literature review, interviews, observing clinical practice, pilot trainings and expert consultation. Preliminary evaluation results were obtained by debriefing generalist trainees after their return to their clinical sites. Results In planning interviews, generalists reported discomfort making mental health diagnoses but recognition of symptom groups including low mood, anxiety, thought problems, poor child behaviour, seizures and substance use. Diagnostic and treatment algorithms were developed for these groups and tailored to the setting by including possible medical causes and burdens of living with HIV. First-line treatment included modalities familiar to generalists: Training introduced basic skills, with evolving expertise supported by job aides and ongoing support from mental health nurses cross-trained in HIV testing. Conclusions An integration model based on collaboratively developing processes that fit the generalist setting shows promise as a method for incorporating complex, multi-faceted interventions into general medical settings. Formal evaluations will be needed to compare the quality of care provided with more traditional approaches and to determine the resources required to sustain quality over time. A central part of these plans includes increasing general medical sector capacity to identify and treat mental health problems and to be a more efficient gateway to specialty services where they exist. The concept of integrating new services into general or primary medical care is not new, but integration of mental health poses unique problems when compared with somatic care. Most generalist providers have had minimal graduate or post-graduate training in mental health when compared with infectious diseases or other specialties. Thus, the foundation on which to add additional skills is limited. In addition, mental health concerns are stigmatized among clinicians as well as the general public and often neither see medical services as a place where mental health is discussed Horwitz et al. Finally, mental health concerns, as they are conceived by specialists, do not lend themselves to rapid diagnosis or to brief interventions in the context of very short clinical visits. Nonetheless, some success has been achieved overcoming these barriers. Some programs have involved training for general medical providers themselves Roter et al. The majority of these programs have focused on single conditionsâ€”most often depression among adults and adolescents. Depression makes a particularly attractive target because it is among the most common mental health problems in these populations, it is detectable with simple screening instruments across many cultures and is often responsive to readily available medications or brief cognitive treatments. Mental health needs in HIV care, however, are more complicated. By various estimates, mental health problems are anywhere from two to five times more prevalent among people living with HIV than in the general population Rabkin ; Deribew et al. While dissemination of single-condition integration programs may be possible with traditional models in which specialist experts choose an evidence-based intervention and teach it to generalists Bauman et al. For complex interventions in heterogeneous patient populations, alternative models of integration development have evolved that seek to leverage existing front-line clinician expertise rather than replace it with new knowledge Hargreaves ; Daleiden et al. In these models, the integration evolves collaboratively, with specialists responding to what patients and front-line clinicians say they need. The goal of this article is to describe in detail a collaborative model of integration development applied to the integration of comprehensive mental health and general medical care. The model aims to produce programs that fit well into the worlds of both specialist and generalist providers Aarons et al. To illustrate the model, we use a case study of its application to the design of an integrated HIV-mental health program in Ethiopia. Addis Ababa is

culturally diverse and has, overall, a higher literacy rate than the rest of the country, which is mostly rural and in which the population tends to be poorer Macro International Inc. Some mental health nurses are better distributed around the country, but they often practice in isolation without access to consultation or medications Ministry of Health ART anti-retroviral therapy providers, who can be nurses, health officers or generalist physicians, vary in their workload across sites, but may be required to see as many as 50 patients a day in visits that can be as short as a few minutes. Development process The overall process was based on similar projects using collaboration with target patient and provider populations Afifi et al. We searched medical and psychological databases PubMed and PsychInfo , used general Internet search engines and reviewed publications of the WHO, following up on citations within publications and suggestions from colleagues. The second step involved individual meetings with Ethiopian health professionals and officials to determine both priority conditions and approaches that would be consistent with overall health policy. It was particularly important to understand the structure of the health care system so that we could try to talk with individuals at key clinical sites as well as important divisions regional and federal of the health care administration. Thus, we spoke to individuals in the federal Ministry of Health, regional health offices, hospitals with HIV clinics, universities and community-based organizations that served individuals living with HIV or mental illness. Table 1 contains the questions we sought to answer in these visits. We also held four group meetings: Table 1 Questions for ART clinicians during program development Questions about the scope of mental health services needed.

7: National Mental Health Strategy of Ethiopia | Mental Health Innovation Network

"The first study that looked at mental health in the Ethiopian community in North America was conducted in Toronto in ," Dr Welansa said. "The study looked at the frequency of depression and the risk factors involved in the occurrence of depression in the Ethiopian immigrant community.".

For Ethipoia, health issues represent a major challenge. In the battle to prevent and eradicate such maladies, religion has become an invaluable asset. In the case of official religions, such as Christianity and Islam , the prevention of health problems is aided via resource mobilization, community empowerment, the dissemination of health information through religious institutions, and assistance in the care of AIDS patients by establishing hospices and other community resources. Traditional religious beliefs and practices can be another major health resource, often overlooked by the mainstream medical system. They can not only provide relief in the case of some maladies, such as mental illnesses, but they are also a way to bring together the community in healing and caring for the patient, and even mediating between the traditional community and various Western, biomedical prevention projects. From the first bishop, Frumentius, until , Ethiopia did not have a native bishop. In , the Ethiopian Orthodox Church also became autocephalous. The EOC practices are similar to those of other Orthodox churches: Also, women enter through the right side of the church, separated from men. The other major religion in Ethiopia is Islam, which entered Ethiopia during the Axumite kingdom. In the 15th and 16th centuries, Muslims wanted to conquer and destroy the Christian power in Ethiopia but were defeated in , and subsequent attacks reappeared in and , but were always foreign. Most of the Muslims are Oromo,10 an ethic group of people originally from the southwest of Ethiopia, who converted after their association with another ethic group, the Galla. But it was only in the nineteenth century, with the rise of the war leaders, Muslim traders finally found a propitious ground to spread their religion, in a slow, strong process of syncretism. It is estimated that there is one doctor for every 40, Ethiopians, 87 hospitals with 12, beds for over 70 million people. In , an estimated , children under age 5 were HIV-positive, and an estimated 1. In general, the maternal and infant mortality rates in Ethiopia are amongst the highest in the world. In this, Ethiopia is no exception, and although such factors as the level of education and socio-economic status are important and play major roles in what prevention and healing routes people decide to take, cultural factors, and among these religion, are equally important. Because Ethiopia is one of the countries with the highest number of HIV-infected people and with the highest maternity and infant mortality rates, it is interesting to see how religion plays into the use of prevention and healthcare services in these cases. A study done in , showed that, in urban areas, more Orthodox This region is plagued by high infant mortality and low levels of contraceptive use. In addition, it is a highly diverse region in terms of its population 80 ethnic groups , and culture, especially religion. Through its vast network of church members the estimation was of , priests, deacons and monks and 35, churches and monasteries , the EOC could be a major player in developing and implementing programs of prevention against this epidemic. Two special focuses were put on the Amhara region, where the program included training for all religious denominations and targeted priests, preachers and Sunday school students as future communicators and counselors, and on the Tigray region, where the program was initiated and institutionalized in the EOC structure.

MENTAL HEALTH POLICY OF ETHIOPIA pdf

8: Ethiopians in Minnesota - health care issues | Culture Care Connection

In fact, the World Health Organization (WHO) described mental health in Ethiopia as "one of the most disadvantaged health programs in Ethiopia, both in terms of facilities and trained manpower with estimates of the average prevalence of mental disorders in Ethiopia at 15% for adults and 11% for children".

This is an open access article distributed under the Creative Commons Attribution License , which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. Despite the increased burden of mental health problem, little is known about knowledge and perception of the public towards mental health problems in Ethiopia. Community based cross-sectional study was conducted among selected Gimbi town residents from May 28 to June 28, Out of the total study participants, Significant proportions of the community in Gimbi town were found to have poor perception of mental illness. Poor perception is common among old aged, less educated, private workers, those unable to access mental health information, and those with no family history of mental illness. Mental health education on possible causes, treatment options, and possible outcome of treatment to the community is required. Background Mental and behavioral problem exist in all countries, in women and men at all stages of life, among the poor and rich and among rural and urban people. As many as million people worldwide are estimated to be suffering at any given time from some kind of mental or brain disorder, including behavioral and substance related disorders [1]. Worldwide it is estimated that life time prevalence ranges from The conceptualization and perceived cause of mental illness vary from community to community. Accordingly, people with mental health problem get different names in different societies [4 â€” 6]. People tend to have strong beliefs about the mental illness, and many of these concepts are based on prevailing local systems of belief. Stigma against people with mental illness remains a significant barrier to positive outcomes across cultures and nations, related to the threat value of mental symptoms, intolerance for diversity, and inaccurate conceptions of mental disorder [9 , 10]. Education and social media are the major factors which move the perception of the community to the scientific perspectives [11]. Globally, including developed and developing countries, people held different explanation regarding mental illness, especially its causal and treatment option. Mental health, neglected for far too long, is crucial to the overall well-being of individuals, societies, and countries and must be universally regarded in a new light. Unfortunately, in most parts of the world, mental health and mental disorders are not regarded with anything like the same importance as physical health [13]. Poor perception of mental illness in different community contributed to low treatment seeking and stigmatization of people with mental illness. They often go to hospitals after they have tried all options and after the symptom has got worse and this in turn negatively affects the prognoses of treatment [14]. Studies done in different areas have shown that poor perception towards the mentally ill is mainly deep rooted with various sociodemographic and other factors [7 , 8 , 10 , 13 â€” 18]. In Ethiopia there are few published studies [18] assessing community perception towards people with mental illness and no studies were done in Gimbi town concerning this topic. Therefore, this study has great value on assessing the perception of the community towards mental illness. Method and Materials 2. The town is located at a distance of Km from the capital city, Addis Ababa to the west. Gimbi town has got two hospitals and one health center. Following purposive selection of the administrative town Gimbi town , the two kebeles out of four the smallest administrative level were selected randomly. Households in the selected kebeles were approached by systematic sampling method with the first household selected randomly. From each selected household, one individual, 18 years of age and older based on information from household head , was included for the interview. A lottery method was used to select one individual in a house hold where more than one individual, 18 years of age and older, was found. Data Collection and Measurements Data were collected through face to face interview by trained data collectors. A case vignette based standardized questionnaire which explains cases like schizophrenia, major depressive disorder, epilepsy, and generalized anxiety disorder [18] as well as questionnaires adopted from previous studies to assess sociodemographic characteristics and other associated factors was used. Standard 9 items of five semantic deferential scales were also used to assess community perception about mental illness. A score

above mean score of five semantic differential scales for positive questions and below mean score for negative questions was considered as having good perception of mental illness. Four trained diploma nurses interviewed the community and were supervised in the field during data collection. Eligible participants not available at home during the first visit of data collection were revisited once on the next day and then registered as nonresponse if not found. Data Quality Control The tool was first developed in English language and translated to Amharic language with back translation to English for consistency. Amharic version questionnaire was used to collect data as Amharic is the national official language that majority of Ethiopians speak. To assure the quality of data the questionnaire was pretested 1 week before the actual data collection time among 40 people not included in the actual sample and appropriate modification was made. The reliability of the tool was found to be. Training on objectives of the study, over all data collection procedure and ethics of the study, was given to data collectors and supervised by principal investigators on the actual data collection site. To ensure confidentiality, interview was conducted in private setting. Throughout the course of the data collection, interviewers were supervised at each site; regular meetings were held between the data collectors and the principal investigator. Two more additional visits were made for eligible respondent not accessed in the first visit. The collected data was reviewed and checked for completeness before data entry. Data Processing and Analysis Data clean-up and cross checking were done before analysis. Descriptive statistics like frequencies, percentages, mean, and standard deviation were used to present data. Tables and figures were also used to present data. Binary logistic regression was used to see associated factors with the dependent variable. Those variable with value less than 0. Ethical Considerations Ethical clearance was obtained from the Institutional Review Board of University of Gondar and Amanuel mental specialized hospital. Permission letter was obtained from Oromia regional health bureau, West Wellega Zonal health department, and Gimbi town health office hierarchically. Written informed consent was obtained from each study participant. After reading the consent statement by the data collectors, finger prints were obtained from those participants who could not read and write. The respondents were informed that their inclusion in the study is voluntary and they are free to withdraw from the study if they are not willing to participate. Also all respondents are informed that they did not have direct payment for their participation in the study. Anonymity was maintained to ensure confidentiality of respondents. Results A total of selected peoples in Gimbi town were interviewed, out of which 29 responses were excluded for gross incompleteness and considered as nonresponse. Therefore, analysis was made based on questionnaires, yielding a response rate of Sociodemographic Characteristics of Respondents Among the total respondents, The majority, Six hundred and fifteen Mental Health Information Mental health information refers to information on the types of mental illness, causes, possibility of treatment, treatment options, and magnitude of mental illness. Accordingly, among all study participants, Among respondents having information regarding mental illness Mental illness are serious problem Among the total participants, Distribution of family history of mental illness among residents of Gimbi town, Table 3 shows the distribution of perceived cause of mental illness in the case vignettes Table 3. Seven hundred and seventy-four Majority of the respondents Distribution of respondents preferred place of treatment mental illness among residents of Gimbi town, West Wellega Zone, Ethiopia, Respondents Perceived Severity of Mental Illness Respondents were asked to rank the case vignette from the most serious to the least. Schizophrenia was seen as the most severe by majority of the respondents. Following schizophrenia, epilepsy, major depressive disorder, and generalized anxiety disorder were seen from the most severe to the least, respectively Figure 4. Respondent age, educational level, occupation, mental health information, and family history of mental illness were found to be independently associated after multivariate analysis. This shows that perception towards mental illness is higher among educated people. Mental health information is also associated with perception of mental illness. Discussion This community based cross-sectional study identified important information on community perception towards mental illness. Significant number of the respondents from Gimbi community had poor perception of mental illness. This study is in line with the study conducted in India where The variation might be due to socioeconomic and cultural difference among respondents. This study demonstrated that there was higher proportion of poor perception of mental illness among those above 39 years of age compared to the youth. The finding is not

consistent with a study done in North Western Ethiopia, Agaro town, where younger respondents were more likely to hold socioenvironmental deprivation responsible for mental and physical illnesses than older respondents [18]. This could be due to the difference in educational level between these two groups or may be due to the fact that the younger respondents may have access to information. This could be due to the tool used or sample characteristics as rural and urban community are involved in both studies [13 , 14]. Educational level was found to be one of the sociodemographic characteristics significantly affecting perception of mental illness in this study. This finding is in agreement with the study done in Agaro town [18]. Study done in Nigeria also found out that perception of mental illness correlates with educational level [20]. Less educated respondents were more likely to attribute mental illnesses to supernatural retribution. This could be due to poor understanding of scientific explanation regarding causation of mental illness. Occupational status was significantly associated with perception of mental illness. Government employees will have good perception of mental illness compared to private workers, which implies those in government organization may have more access to current policies, directions, and strategies relatively than those in private organizations. However this finding is not clearly observed in other studies. This may be due to the difference of tool used. In addition, respondents having information about mental illness from any source were of good perception of mental illness compared to those having no information. This finding is in line with the study done in Karfi region of Nigeria [15]. Theory of psychology also supports this fact. If perception is deductive, no probabilistic association needs to be added and no cognition is required.

9: Policy Issues | Mental Health America

The Centers for Disease Control and Prevention (CDC) office in Ethiopia was established in and works closely with the Ministry of Health and other partners to maintain strong programs in training, treatment, counseling and testing, and laboratory capacity building.

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