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## COUNTRY PROFILE

# Mental health in Mongolia

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Mongolia is a country with an approximate area of 1.5 million km<sup>2</sup>. Its population is 2.5 million, nearly 90% of whom are ethnically Mongolian. Khalkh Mongols form the largest subgroup (approximately 79% of the population); the next largest subgroup is the Kazakhs (5.3%), followed by smaller groups such as Tuvins, Uzbeks, Uighurs, Russian and Chinese. The population is young, with 35.9% under the age of 15 years. The official language is Mongolian. Just under half the population live in rural areas and around a fifth live a nomadic life. About 80% of the land area is suitable for agriculture, mostly for animal husbandry.

According to the statistical data, gross domestic product (GDP) per capita was 500 744 tugriks (approximately US\$420) in 2002. In 2000 some 36% of the population were living below the poverty line, and in 2002 the unemployment rate was 3.4%. Education is obligatory for all children aged between 8 and 15 years and the literacy rate is 98% for men and 95% for women.

Life expectancy at birth is 63.5 years (2002). The infant mortality rate is 23.5 per 1000 live births (2003), and the maternal mortality rate is 110 per 100 000 live births (2003). Socio-economic changes such as poverty, unemployment, the destabilisation of family structure, natural and man-made disasters, changes to traditional culture and lifestyle, and urbanisation are major factors affecting mental health. These current social changes result in suicide, street children, acts of violence and substance misuse, especially alcohol-related problems.

## Epidemiological research

According to the results of an epidemiological survey conducted between 1976 and 1984, the prevalence of

mental disorders per 1000 population varied widely across the country, from 9.8 in Altai (a mountainous region), to 13.1 in Khangai and Khentii (both also mountainous regions), 18.3 in Dornod (a steppe region), 23.5 in the Gobi (a desert region) and 24.0 in the capital, Ulaanbaatar (Byambasuren, 2000). These figures do not include those people with less severe psychological or psychosocial problems. Epidemiological studies on the prevalence of suicide (Byambasuren *et al*, 2003) and schizophrenia (Khishigsuren *et al*, 2004) have been conducted. According to this research, the number of suicides in Ulaanbaatar increased nearly threefold between 1992 and 2002, to reach 3.0 per 10 000 population. The prevalence of schizophrenia in Ulaanbaatar is 0.97 cases per 1000.

## Mental health legislation and the National Mental Health Programme

Mental health legislation passed in 2000 and the National Mental Health Programme of 2002 have been the key elements of a reform of mental health care in Mongolia.

The legislation covers all aspects of mental health, including:

- policy and principles
- the duties of state organisations, business entities and individuals
- mental health promotion
- the structure, management and financing of mental healthcare services
- the rights of people with mental illness
- involuntary admission
- the provision of security and social welfare assistance to people with mental illness.

The aim of the National Mental Health Programme is to reduce the prevalence of mental and behavioural

Contributions to the country profile section are welcome: please contact Shekhar Saxena (email saxenas@who.int).

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Thus, nationally, there are in total 594 psychiatric beds and 83 psychiatrists. This equates to 2.4 beds per 10 000 population (1.7 psychiatric beds in mental hospitals and 0.7 psychiatric beds in general hospitals) and 3.3 psychiatrists per 100 000 population.

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disorders, to create an environment which promotes mental health, and to improve the accessibility of mental healthcare.

## Mental health resources

### Budget

The health budget represents 4.6% of GDP (2003 figures). Of the overall healthcare budget, 5.0% is allocated to mental health. In turn, of the total state mental health budget (to cover treatment, rehabilitation and social care), 90% is spent on hospital care (i.e. the provision of in-patient and out-patient mental healthcare).

### Services

In 1974, the closure of four inter-provincial psychonarcotics hospitals with 50–75 beds each, located in Khovd, Arkhangai, Darkhan and Dornod provinces, was due to the transition from a centrally planned economy to a market economy.

At present, mental health services for the population are provided through general practice clinics, specialised out-patient clinics and the psychiatric units of general hospitals at the provincial level. There are 5–15 beds in psychiatric units at general hospitals in each of the 21 provinces, giving a total of 194 such beds; there are 23 psychiatrists attached to these units. At the state level, services are provided by the Mental Health and Narcotics Centre (an out-patient facility staffed by 26 psychiatrists), the State Mental Hospital and the Narcotics Hospital (which together have 400 beds and 34 psychiatrists). Thus, nationally there are in total 594 psychiatric beds and 83 psychiatrists. This equates to 2.4 beds per 10 000 population (1.7 psychiatric beds in mental hospitals and 0.7 psychiatric beds in general hospitals) and 3.3 psychiatrists per 100 000 population. There are 4.4 psychiatric nurses, 6.0 psychologists and 3.0 social workers per 100 000 population.

The Mental Health and Narcotics Centre regularly conducts training sessions, and holds meetings on mental health issues and the care of patients for family members, to help integrate patients into family and community life.

### Rehabilitation

Clinics providing psychosocial rehabilitation for people with mental illness have been established in Ulaanbaatar (the Mental Health and Narcotics Centre, the State Mental Hospital and the Narcotics Hospital), Dornogobi, Orkhon, Khovd, Khuvsgul and Bayan-ulgii provinces. These teach music, carpentry, welding, cooking, sewing, herding and farming in order to improve the life skills of patients. For the development of psychosocial rehabilitation, the World Health Organization has provided support by giving 10 *gers* (Mongolian traditional tents) and a mini-van, and the Geneva Initiative has provided a supply of materials such as sewing machines, musical instruments and games equipment. Also, Open Society and the Soros Foundation supplied four *gers*. In 2004, the State Mental Hospital built

houses for 30 people with mental illness, with support from World Vision.

### Pharmaceuticals

Essential psychotropic drugs are available at all levels of service provision, although supplies are limited by a lack of funds. There is a centrally compiled list of essential drugs, but it is in need of review and update. The antipsychotics on it are chlorpromazine, haloperidol and fluphenazine injections. The chief antidepressant is amitriptyline and the anxiolytic is diazepam. Thus there is a need for the newer drugs.

### Disability benefits for persons with mental disorders

Disability benefits are provided in accordance with the Law on Social Welfare as revised and adopted in 1998.

## Medical education

At present Mongolia has a shortage of mental health specialists. Ninety per cent of medical staff working in the field of mental health were trained during the 1970s and 1980s, and many lack the knowledge, attitude and skills required for community-based mental healthcare. The implementation of the national healthcare reform has led to a need for the reorientation of the medical and nursing curriculum, with a new focus on training in community health, health promotion and prevention.

The Health Law of 1998 includes provisions related to the licensing of medical practitioners and the accreditation of health institutions.

### Undergraduate education

In 2000, the National Medical University substantially revised the undergraduate medical curriculum. The new curriculum consists of 21 'blocks'. Block number 15 is mental healthcare, and is worth 5 credits. The mental healthcare course is run by the departments of anatomy, medical genetics, pharmacology, child psychiatry, psychiatry, medical psychology and general practice. The course time (a total of 200 hours) is divided into lectures, practice and independent practice, and the programme consists of psychiatry (80 hours in total), child psychiatry (36 hours), general practice (28 hours), medical genetics (8 hours), anatomy (12 hours), pharmacology (20 hours) and medical psychology (16 hours).

### Postgraduate education

Postgraduate psychiatric education includes a training course (2–5 months), clinical residency (1–2 years), a Masters degree course (2 years), a refresher training course (2–3 months), PhD (3 years) and a scientific degree (Dr Sc Med).

### International continuing medical education

As part of the Mental Health Project, the World Health Organization's Regional Office for the Western Pacific (WHO/WPRO) conducted a training programme for psychiatrists and family doctors on the integration of

mental health into general healthcare and psychosocial rehabilitation. In addition, the WHO has provided support for psychiatrists to receive training abroad on management, community-based mental health and narcotics. The Belgian agency Brothers of Charity sent at its own expense 17 Mongolian doctors and nurses from Ulaanbaatar on a 1-month study tour to visit Belgian mental health facilities for the psychosocial rehabilitation of people with mental illness.

### The mental health information system

A mental health database has been established in the Statistics Department of the Mental Health and Narcotics Centre within the framework of the National Mental Health Programme, which is being implemented jointly with the WHO, for data collection at the national level.

Basic mental health data collected by family doctors are integrated into the national health information system. In 2002–03, the Mental Health and Narcotics Centre conducted a study using existing mental health data in collaboration with other government and non-governmental organisations.

### Mental health promotion and advocacy

Comprehensive mental health promotion and advocacy have been carried out with a view to improving the knowledge and attitudes of the general population with regard to mental health. In 2001, the celebration of World Mental Health Day was later officially included in Government Resolution 224, with the aim of strengthening activities to enhance healthy lifestyles and behaviours.

The Ministry of Health in collaboration with the Ministry of Education, Culture and Science translated and printed the WHO documents *Life Skills Education in Schools* and *Mental Health Programmes in Schools*. The secondary school curriculum was revised to introduce elements of life skills, with the consequent preparation and distribution of guidelines and manuals in schools and teaching on this subject. In addition, training courses were held for teachers, school doctors and social workers on the development and implementation of a school mental health programme.

Mental health services for adolescents started with the support of the WHO's project Adolescent Friendly Service. Hope, a telephone counselling service, is present in the two provinces and three districts of Ulaanbaatar. In addition, two private counselling centres have been established in Ulaanbaatar.

Lessons and discussions have been organised for parents on the topic of the common mental and behavioural disorders in children and adolescents. This became an important measure to help parents understand the psychology of their children and to teach them how to assist their children to make the right decisions and overcome difficult issues in their daily life.

New 'relaxation clinics' have been opened in various health facilities across the country.

Training on psychological counselling for the population affected by *dzud* (wintertime natural disasters) was carried out in the 13 *dzud*-affected provinces with the assistance of the WHO; this involved around 170 doctors, social welfare workers, Red Cross staff, police and local administrators.

The United Nations Children's Fund (UNICEF), in collaboration with the Mental Health and Narcotics Centre and the National Children's Office, have implemented a project called 'Providing Social and Psychological Support to Children from Areas Affected by *Dzud*' in the provinces of Khuvsgul, Uvs, Zavkhan and Bayankhongor. Under this project, training was carried out for children from herding families, and promotional materials were disseminated to reduce stress in families and children caused by *dzud* and to teach the skills required to overcome stress.

### The Mongolian Mental Health Association

The Mongolian Mental Health Association was created in 1999 with the support of the WHO. Its role is to contribute to mental health education and mental health promotion, and to uphold the international norms of rights and social protection of people with mental disorders.

The Association has a membership of psychiatrists, volunteers and representatives of non-governmental organisations. It has carried out a series of public education activities through newsletters and pamphlets which explain the basics of mental health to the public.

### Conclusions

Mongolia is a country which is changing from socialism to a market economy following democratic political reform in 1990. This transition has affected all aspects of Mongolian life: political, economic and social. It has had an effect on the family. Many social problems have emerged as a result of economic decline and inflation, which affect the population generally but vulnerable groups especially.

The national healthcare reform shifted treatment from a specialist to a generalist healthcare delivery system. As a consequence, appropriate training in mental health and psychosocial skills is given to 40% of family doctors. These general practitioners have started to manage patients with mental health problems in their clinics and have included mental health topics in their health education activities in schools and in their home visits, as well as in campaigns promoting healthy lifestyles among the population.

The recent mental health legislation and the National Mental Health Programme have created an environment for the organisation and provision of community-based mental healthcare in Mongolia. Training was carried out not only among health sector personnel (health administrators, doctors at town hospitals, family doctors and mental health professionals) but also among administrators from other sectors, secondary school teachers

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Since 1998, a decrease in the admission and length of hospital stay at the State Mental Hospital has been noted. At the same time, increases in the numbers of patients treated by family doctors as well as those referred have been recorded.

Existing programmes are hampered by the shortage of commitment, personnel and funds. There is a tangible lack of commitment to mental health in Kenya, reflected in the fact that it receives less than 1% of the Ministry of Health's budget, which is itself less than 7% of the national budget.

and patients' relatives. This training facilitated the creation of a supportive environment for mental health problems.

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The collaboration and involvement of all key partners is crucial for mental health promotion and prevention. The WHO has played an important role in the introduction of a mental health component in primary healthcare and the development of psychosocial rehabilitation.

#### COUNTRY PROFILE

## Mental health policy and programmes in Kenya

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Following a 10-year war of liberation (fought by the Mau Mau against the British), Kenya attained full independence from colonial rule in 1963. For 10 years the country enjoyed rapid economic growth (6–7% per annum) but this slowed steadily to near stagnation in the 1990s. Poor governance, abuse of human rights, internal displacements of citizens, large numbers of refugees from neighbouring countries and the AIDS pandemic conspired to reduce Kenyans' life expectancy to 47 years (in the UK it is presently 77 years). Some 42% of the population now live below the poverty line, and 26% of Kenyans exist on less than US\$1 per day. The annual per capita income in Kenya is US\$360 (in the UK it is \$24 000) (World Bank, 2002). AIDS currently has an estimated prevalence rate of 12%. In large parts of rural Kenya many sexually active adults are unable to work, and elderly grandparents are left to look after orphaned children (some already infected with HIV), as they struggle to deal with their own grief for the loss of many of their own children. In December 2002 a new government was elected, which gives some grounds for optimism in an otherwise bleak situation.

### Mental health policy and resources

Given the circumstances, it is unsurprising perhaps that mental healthcare was relegated to near oblivion; at present there is no mental health policy. Little or no

### References and further reading

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thought was given to mental health as the country struggled with more life-threatening conditions, including diarrhoeal diseases, measles, malaria and tuberculosis. Commendable efforts are, however, in place to develop a policy with the assistance of the UK's Department for International Development and the Institute of Psychiatry in London, which are now working on a collaborative project with Kenya, Tanzania and Zanzibar.

Existing programmes are hampered by the shortage of commitment, personnel and funds. There is a tangible lack of commitment to mental health in Kenya, reflected in the fact that it receives less than 1% of the Ministry of Health's budget, which is itself less than 7% of the national budget.

Kenya has only 47 psychiatrists for a population of 30 million, although there is the prospect of this number increasing, albeit slowly. More than half of them work in the major urban centres, while the majority of Kenyans live in the rural areas, which makes the relative shortage much worse.

Mathare Hospital started off in 1911 as an isolation unit for people with smallpox and is now a large, poorly resourced traditional mental hospital that houses approximately 750 mainly long-stay patients with psychosis, but it also serves as the forensic referral centre as well as an acute treatment centre. The buildings are in a state of disrepair and require major renovation. This is in marked contrast to the high morale of poorly paid staff, who work tirelessly without complaining and delivering, in their quiet way, a very high-quality service. A newly established drug rehabilitation unit is complemented by a well established occupational therapy department.