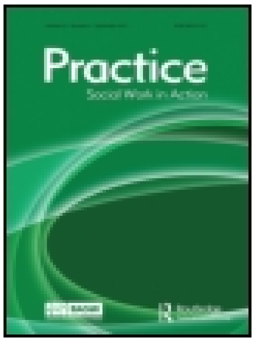

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Caregivers of Mentally Ill Patients: A Cross-sectional Need-Based Assessment of Social Workers in Post-conflict Somalia

Vincent Ekow Arkorful, Adam A. Mohamed, Osman Jama, Sarah Pokuaah, Ibrahim Basiru, Anastasia Hammond, Eric Kwadwo Agyei and Amadu Latif,

This study seeks to investigate the needs of family caregivers of people living with Mental illness in Somalia. Using an exploratory research design technique, a qualitative approach was employed for a one-on-one interview module to collect data from a total of 51 respondents identified as family caregivers of mentally ill persons undergoing rehabilitation in five (5) selected mental health facilities sampled for the study. In analyzing and interpreting qualitative data, a thematic content analysis was done which revealed that, in addition to medical care, family caregivers need not only social support in a form of affection to assist them in their various engagements, but also, adequate relaxation and leisure to regain lost energies and save them from stress and its harmful ramifications on their health. They also need decent accommodation to maintain their mentally ill relatives. The results further revealed that, caregivers needed financial support as well as emotional support from friends and society in order to psyche them up for their task. To understand the needs of patients' treatment history and condition, caregivers need information. It is, therefore of necessity to social workers and other stakeholders that the needs of caregivers are adequately and sufficiently addressed.

Keywords: caregivers; mentally ill patients; needs-based assessment; social workers; post-conflict Somalia

Introduction

WHO-AIMS (2009) estimates that, between 35% and 50% of people with severe mental health problems in developed countries, and another, within the range of 76% to 85% in developing countries receive no treatment. Vos et al. (2015), in a seminal research into 301 diseases, amongst other things identified

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mental health problems to be a major cause of disease burden worldwide accounting for 21.2% of years lived with disability worldwide. According to the World Health Organization (2013), approximately 450 million people are battling with mental health challenges globally. From the foregoing, it becomes more apparent that, the situation reported to be prevailing in developing countries is a disturbing one.

The mental health situation in developing countries brings into sharp focus the state of wellness of the state of Somalia, a developing African country situated on the horn of Africa, that has in the face of conflicts experienced massive destabilization which has profoundly had a debilitating effect on its health care system. The impact of the dire dearth of governance that gripped the post-Siad Barre period has created a stateless generation without adequate access to public institutions and services like health and welfare. This has also precipitated an attendant sharp deterioration in human conditions. The ensuing unhealthy state of statelessness in the wake of the collapse of the central government has sharply taken a toll on health care and service delivery in Somalia. The ramifications of the virtual non-existence of governance has resulted into a groundswell of widespread global concerns for the people of Somalia. Chief amongst them has been the concern about limited access to social service facilities and the deterioration of public health and welfare service dispensing institutions.

The UN Development Programme Human Development Report (2000) according to WHO (2010) ranked Somalia lowest in all health indicators, except life expectancy. Moreover, according to General Assistance and Volunteer Organization (GAVO) (2004) as cited in UNHCR (2016), the prevalence of mental illness in Somalia is thought to be the highest in the world. Further, it states that, whiles most Somalis spend most of their time trying to stay alive and keep their families alive, one person in every two households have some form of mental illness.

WHO (2010) also highlighted that, 21% of surveyed households care for at least one family member with a severe mental health problem. The statistics obtained from a group of 50 persons indicated that 26.5% have at least one person in a household in Hargeisa with a mental or behavioral disorder. Gruppo per le Relazioni Transculturali (GRT) data in Puntland confirms these worrying statistics, stating that one person out of three households suffer or has suffered in the past from certain forms of mental distress. These estimated prevalence levels in mental health situation in households is apparently very high and unnerving.

WHO (2010) notes that, 10% of the world population is affected by some kind of mental distress, and mental disorder increases up to 20% in war-torn and conflict-prone countries such as Somalia, where the extent of violence has permeated different social layers. In the face of this harrowing experience, financial, as well as human resources are utterly inadequate. This has brought about an unhealthy situation whereby almost all Somali zones entirely depend on external aids for health financing.

Globally, psychiatric literatures assert that, conflict situations increase the prevalence of mental health disorders, with violent acts such as targeted killings, amputations and other forms of violence expected to have long-term psychological effects on those who have experienced or witnessed them (WHO, 2010). The prevalence of mental disorders in Somalia is high due to the fact that the local populations have experienced persistent civil conflicts during the last two decades, eventually burdening the entire society (Cavallera et al., 2016). However, in the post-conflict period, it is reasonable to conclude that there is a high prevalence of mental disorders that can have a long-term impact on the development of the people and their communities (Cavallera et al., 2016).

It is widely perceived that no governmental or institutional infrastructure capable of supporting the development or expansion of mental health care exists in the country (WHO, 2010). The state of Somalia, face to face the attendant institutional breakdown, particularly of the healthcare system has invariably affected the care for mentally ill patients to such an extent that, mental healthcare has not received much priority (WHO, 2010). The sector has been abandoned in favour of outpatient community care which has increased the demands for families to act as caregivers (Tan et al. 2012).

The state of care of mentally ill patients in Somalia is appalling (Omar, 1986; Sheriff, 2010), with deficient treatment options (WHO, 2009). Though statistics on mental health infrastructure in Somalia prior to and after the civil implosion is quite difficult to come by, it is however obvious how institutional breakdown has created a shift in care for mentally ill patients which before the destabilization was the core responsibility of the central government. Omar (1986), Sheriff (2010), and Landinfo (2014), in providing varying insight into mental health situation in Somalia, bemoan the weak state of mental health infrastructure. This state of affairs has engendered a situation whereby care for mentally ill patients now largely lies in the hands of family caregivers (Cooper 2014). A deeper reflection on the prevailing situation, particularly of mental health, an almost neglected and forgotten sector, invokes global worries.

Given the mental health situation in Somalia, the institutional breakdown and the large shift in care to from the state to family relations, one cannot discount family care givers due to the key roles they play in the delivery of services with respect to mental health (Shankar and Muthuswamy 2006). Globally, family caregivers play an important and ever-expanding role as developments in medical care find new ways to help control illness, more particularly at a time when health and social service systems are resource-challenged (World Federation of Mental Health 2014). In India for instance, about two-thirds (69%) of family caregivers have provided care for their ill relatives (National Alliance on Mental Illness 2008). In the United States of America, the policy of deinstitutionalization in the early 1960s that moved patients out of the institutions into the community resulted in families becoming caregivers

(Parker 1993). This has also been the case in South Africa as well as in Uganda where majority of psychiatric patients are supported emotionally, physically and financially by the family (Sreeja et al. 2009). Mentally ill patients in Nigeria also spend a larger portion of their life with family caregivers (Baronet 2003**).**

Recognizing the state of mental health, vis-à-vis the state of urgency precipitated by the dearth of attention to the sector, it becomes important that stakeholders endervour to assign much attention to the sector, more especially to the roles of caregivers and their challenges. Family caregivers have dispensed support services in diverse ways ranging from emotional, physical and financial support to persons with mental illness. Against the backdrop of the indispensable roles caregivers offer to the mentally ill patients, it becomes important to undertake a cross-sectional need-based investigative research relative to the physical, social and psychological needs of caregivers. This study, as matter of interest to social workers, therefore attempts to investigate the physio –psychological challenges and needs of family caregivers of people living with mental illness in Somalia.

Research Methodology

The study was done in selected mental health facilities established to facilitate the rehabilitation and reintegration of psychiatric patients back into their communities. Respondents within the age range of 18 to 55 years were interviewed for the study. The study was preceded by an exploratory study undertaken to identify and investigate the physical, social and psychological needs of family caregivers of mentally ill persons in the selected facilities including; The Habeb Mental Health Hospital, Hargeisa Mental Health Hospital, Mental Health Department – Bosaso General Hospital, Mental Health Department – Galkayo General Hospital and Berbera Mental Hospital. Exploratory studies, in the views of Sandhusen (2000), aids in cataloguing cause-alternative options for remedying social malaise. This was employed because the study is meant to provide information to enhance a better appreciation of the subject matter under investigation. In selecting respondents who had supported a mentally ill person for the study, a purposive sampling technique was used to choose participants. In all, a total of fifty-one respondents interviewed were all family caregivers of mentally ill persons. Forty-five of the respondents were females and six were males. Eight participants were younger than fifty years and they were all females, with the oldest caregiver respondent being sixty-nine years. Participants for the study were selected based on these inclusion criteria:

a. Participants must be family caregivers of mentally ill people in the selected facilities
b. The Caregiver must be proficient in Somali or English language or both.
c. Participants must have been involved in caregiving for at least 10 months.

d. Family Caregiver must be 18 years or more.
e. Respondent must be an emergency contact.
f. Caregiver must be living with the patient or spend most time with the patient.
g. Caregiver must either be a decision maker or financial provider.

On the other hand, respondents' exclusion was based on the following criteria:

a. Family caregivers who were reluctant to participate in the study.
b. Family caregivers less than 18 years.

Prior to the interview, participants were given an information sheet on the study, with detailed explanation of the nature and purpose of the interview. Those who could not read had the details read to them. A 30–35-minutes interview was held after receiving consent. Three (3) research assistants were present for the entire session of data collection to clarify and answer enquiries. All researchers were briefed on the use of the instruments to ensure consistency in the data collection process. A semi-structured interview guide was used.

Data collection instruments included an audio recorder, pens and a jotter. Data were collected within two weeks to ensure meeting the varying schedules of participants. A qualitative based descriptive approach was chosen to investigate family caregivers of mentally ill patients. This qualitative descriptive approach was done using individual in-depth interview questionnaires. To ensure quality research work, higher research standards were adhered to. As such, an interview guide with bearing on mental health by family caregivers was designed, submitted to experienced mental researchers for vetting, approved and subsequently piloted. After two rounds of piloting, the questionnaire was refined. Before commencing the actual data collection, the interview guide was presented to research experts for final approval and pretested. This was however not included in the data. Before the commencement of the face-to-face interview, respondents were asked to provide information related to their demographic characteristics (Table 1) like Gender, Age, Residence, Employment Status, Income level, Educational level, Marital Status and Years served as caregivers.

Data Analysis

Miles and Huberman's framework of thematic content analysis was employed. Miles and Huberman (1994) described the major phases of data analysis to comprise data reduction, data display, conclusion drawing and verification. Each audio-taped interview was transcribed verbatim and was used as a primary data source. The recordings of participants' description of experiences as family caregivers of individuals with psychiatric conditions were then

Table 1. Sociodemographic Characteristics of Respondents.

Variable	Category	Respondents number	Percentage (%)
Gender	Male	6	11.8
	Female	45	88.2
Age	38-43	3	5.9
	44-49	6	11.7
	50-55	36	70.6
	56-61	5	9.8
	62+	1	2.0
Residence	Rural	6	11.8
	Urban	45	88.2
Employment status	Employed	13	25.5
	Unemployed	38	74.5
Income level	US$ 0–30	38	74.5
	US$ 31-60	5	9.8
	US$ 61-90	4	7.8
	US$ 91-120	3	5.9
	US$ 121-150	1	2.0
Education level	Formally educated	6	11.8
	Not formally educated	43	88.2
Marital status	Single	4	7.8
	Married	25	49.0
	Widowed	9	17.7
	Divorced	13	25.5
Year(s) served as caregiver	1-5	41	80.4
	6-10	8	15.7
	11-15	2	3.9

Source: Field Data *2018.*

transcribed verbatim. Once the interviews were transcribed, an overall summary was written based on responses to the research questions from each interview. Transcription of recorded in-depth interviews were later done by the research team with the guide of investigators' field notes.

Afterwards, the information was subjected to crosschecks to validate the accuracy and completeness of the translations before coding of data. Assigning much attention to details, transcripts were patiently read line by line in order to become conversant with them. Initially, codes were identified after which codes with similar themes were integrated to help in undertaking detailed content analyses. The themes derived from the in-depth interviews of family caregivers of mental health patients were then subsequently summarized.

Ethical Consideration

The ethics committee of the faculty of health sciences of the Global Science University approved the study. Respondents were informed about the aim of the study after which consent was sought to carry out the study. The identity of study respondents was kept confidential throughout the study. To ensure confidentiality of data gathered, transcriptions were safely kept in a password protected folder on a computer. The administrators of the hospital approved the use of the facility for the study. Study participants were alerted of their liberty to withdraw their approval at any time.

Results and Findings

From the analysis, emerging highlights revealed the needs of caregivers of mentally ill patients in Somalia. The findings of the study as identified by participants comprised largely of physiological needs, social needs and psychological needs.

Physiological Needs

Physiological needs of family caregivers in relations to this study has got to do with the basic needs of caregivers without which the performance of their activities and survival is likely to be impaired. The essence and contingency of human physiological needs as espoused in a treatise '*A Theory of Human Motivation*', by Maslow (1943) conceptualizes physiological needs as things very core and critical to human survival. They include: food, water, air, warmth, sex and sleep. In the exercise of social responsibilities, family caregiving service providers are exposed to risks. This in one way or the other endangers the gratification of their physiological needs. In gathering data on the physiological needs of family caregivers, an interaction with respondents was carried out with the guide of a semi structured questionnaire. In the course of the interaction, almost in a consensus, caregivers identified some engagements they undertake and associated challenges with the performance of such duties. To help improve and ensure the efficient and effective performance of their duties, caregivers were also asked to identify some support forms needed.

In our interaction with caregivers, as revealed by this study, there was almost a general consensus amongst caregivers that their duties differed and varied from one person to the other. Whereas some participants indicated the deadweight financial responsibilities imposed on them by caregiving obligations, others pointed out that, managing hyperactive or mild patients demands and comes diverse approaches, skills and needs. Also, the study revealed that, managing mental patients with mild mental conditions was difficult. It was also revealed that; the aggressive nature of male mental patients made their management more difficult as compared to their female counterparts who according to some respondents are somehow docile, calm and prefer living antisocial, solitary and distant life. Our interaction with respondents revealed a great wealth of information. A respondent had this to say:

> He is my only Son. His management is very difficult but I have no option than caring for him. I have had to frequently be with him to see his situation … Caring for him is very hectic. It involves a lot like cooking, washing … a lot. I have been taking care of him for the past 2-3 years. I am ageing. And you can see I am getting weak as well". (Female family Carer A)
>
> Another noted that;
>
> His aggressive nature makes his management very difficult for me. I am a resident in another city. I have had to combine my work with his management. In between days, I have to commute to check up on him. This is very difficult for me. Transportation and other expenditures are all my burden. (Female family Carer B)

Psycho-Physiological Challenges of Family Caregivers

Caregivers in the discharge of their duties are saddled with a lot of psychological problems. As gathered through our interviews with respondents, because of the strong relationship between caregivers and patients, caregivers equally go through emotional and psychological stress akin to patients. In the views of participants, ordeals like headache and sleeplessness experienced, adversely affects effective caregiving. Guerin et al (2004) ascribes the psychological stress and trauma of family caregivers of mentally ill patients to society's communal and social orientation, coupled with the spirit of togetherness that such an orientation imbues and imbibes the individual with. Some other forms of psycho-physiological challenges identified included: weariness, weight loss, rising blood pressure, sex life deprivation and mental instability. In cataloguing some of the related challenges, a respondent recounted that:

> Her mental state has been my greatest source of worry. I have been an unhappy woman since. I can't believe my daughter is mentally unstable. Looking at how she was brilliant at school then, the bright future I envisage for her and seeing her situation now, saddens me greatly. (Female family Carer C)
>
> Another remarked that:
>
> As I speak with you now, I am soulless and I have no companion. I have no one to show me love. I have no one to share my thoughts with. The person supposed to do that is now indisposed. Have been without sex. That's not my worry though. I am only looking forward to seeing my better half regain his stability. (Female family Carer D)

In the face of the daunting challenges caregivers face, our interaction revealed a sense of resoluteness exerted in carrying out services. Though a few demonstrated despondency. A respondent stressed that:

> He is my son. I have no option. I gave birth to him and I owe it a responsibility to care for him. Whatever he does, I have laid down my life to seeing to his recovery. (Male family Carer D)
>
> Another emphasized that;
>
> Walahi, there are times I get filled with trepidation and fear for my life with his life-threatening acts of aggression. (Female family Carer E)

Family Caregivers Physiological and Physical Assistance Needs

In fulfilling the purpose of the study, we attempted to probe participants on the support required for their physiological and physical wellbeing. Participants enumerated several well-being needs. In as much as the responses were varying, there were common grounds in responses, most of which revolved around a much-sought-after external support by family caregivers of mentally ill patients. Whereas some respondents emphasized on a decent accommodation for rest and sleeping, others reiterated the need for feeding and supply of medical needs of patients. Other respondents were however not comfortable stating the kind of help needed. In their reticence, they indicated their readiness to welcome any form of assistance that would be extended to them.

Captured below are some concerns raised by some participants:

> The burden of his care has been shoved unto me. Nobody comes in to help me. Everybody is much concerned about himself. I can't complain because he is my husband. I love him. I have vowed to live with him in thick and thin till death. I wish I had support but none is forth coming. So, I am carrying everything alone. (Female family Carer B)

> He has been the bread winner of the family. After the onset of the problem, the family have not had any sustainable source of income. Our sons are too young to work to support us. So, it's difficult for us. As we speak now, our rent has expired. The landlord is on the verge of ejecting us. That is a problem for us. We are challenged now. Where do we pack our belongings to now? Where do we accommodate our kids and the family?. (Female family Carer E)

Family Caregivers Expectations and Needs

In the views of Maslow (1943) as espoused in '*A Theory of Human Motivation*', social expectations and needs are hinged on love and stems from one's sense of social belongingness. According to him, these needs are met by virtue of social connections with family relations, peers, classmates, teachers and other social contacts. In probing needs of caregivers, the study investigated needs, social engagements and commitments of caregivers, challenges encountered and general knowledge of patients' situation.

Our interaction with respondents revealed that, caregivers were tied up in so far as their social life and commitments were concerned. Because of the burden of care responsibility on them, they are either unable or constrained in meeting social obligations such as attending group meetings. Whereas others ascribed their inability to patronize such events to the stigma associated with mental illness, others indicated unavailability and limited time at their disposal to allow them meet such social demands. A few however conceded meeting those obligations despite the caregiving responsibilities.

A participant intimated:

> Since the onset of my daughter's mental illness, I have not been involving myself in social activities. Socially, let me say I am disconnected. People have some weird and erroneous impressions about having such a patient. I don't get into people just to save myself from gossips. (Female family Carer F)
>
> Another emphasized that:
>
> Though I have little time for social engagements, I have not totally isolated myself from the society. I socialize! Not as I used to do earlier. Getting into people to me helps alleviate and relieve me of heavy thoughts. I meet people in the public space who empathize with me, share encouraging stories of themselves and others who ever experienced such situation. This offers me hope. (Female family Carer A)

Some respondents however expressed sentiments that were in sharp contrast with earlier ones. They indicated how they happily move about with their patients. This according to them was a form of psychological therapy for both caregivers themselves and patients as they believe it could contribute to expediting recovery. Others also stressed that, taking a walk with their patients helped bridge the social gap brought about by the ailment. In this regard, they see that, before, during and after recovery of their patients, rehabilitation and social reintegration will be easier.

Caregivers' Social and Environmental Difficulties

In investigating the social and environmental difficulties of caregivers, the study sought to probe and gain a deeper insight into the difficulties encountered in the exercise of their duties. Most participants admitted having experienced one form of stigmatization or another because of their relation with a mentally ill patient. Others complained of their how association with patients had affected their businesses. This confirms that, stigmatization brought about by mental illness does not only affect patients and close relations, but also, the economic activities of caregivers as well.

Participants expressed the following:

> People were buying from my small home-based shop. But now, they are not buying because they say I have a mentally ill daughter. So now it has affected my small trade too. (Female family Carer G)

> Other people are of the belief that, mental illness is caused by Jins (evil spirit). And because this has been the belief, people are of the view that, patients (Walli) ought to be ostracized and isolated from the larger community. So now, we are almost living as such. (Female family Carer H)

> The misconception about the cause of mental illness is somehow steeped in the language used to describe patients which is Walli, loosely translated to mean crazy or insane. About the misplaced impressions about mental illness, culture and religion has come to complicate the situation. Through this, people believe that, since mental illness is caused by evil spirits, they resort to the recitations of suras (Koranic verses) on patients to set them free. (Female family Carer C)

Some respondents who have borne the brunt of social rejection and ridicule had this to say:

> People intentionally cast aspersions at us. And anytime my daughter goes out to do something, they wouldn't understand her situation, but would rather come and insult us for our inability to control her. (Female family Carer F)

> You know, our people have strange thoughts about mental illness. Apart from stigmatizing patients, they think no matter how well one is treated, he or she can never be the same as previously. There is even a proverb in our local language which confirms it. They say that: **(nin waashay wuu ladnaaday mooyee wuu bogsaday maleh)**. So, to most people, mental illness treatment (daawayn) is totally impossible. (Female family Carer G)

There is ample evidence in literature about the social, cultural and religious factors surrounding mental health issues in Somalia. This is confirmed by Guerin et al. (2004), Bentley and Ahmad (2008) who discourse on the interplay of socio-cultural, spiritual and religious implications of this conception on mental health, service and illness.

Johnsdotter et al. (2010) in a research finding also confirms the traditional Somali belief that holds that '*people can be possessed by evil spirits known as "Jinn," which may cause the individual to hear voices, speak strangely, or otherwise behave in an unusual manner'*. Jinns are beings that all Muslims are obligated to believe in. Among Muslim scholars a majority maintain that such spirits can enter into people's bodies and possess them" (Johnsdotter et al. 2010). Delbar et al. (2010) also made some profound general observations about mental healthcare issues in Africa and notes that '*People in some societies in Africa … often integrate the natural and supernatural causes of health and illness in their system of beliefs*'.

Relative to the perceived misconception about mental illness, (Johnsdotter et al. 2010; Wallin and Ahlstrom 2010) again found that. 'Some Somalis believe that a person can be affected by "*sexir,*" which involves negative feelings originating from another person who may wish to inflict harm upon the person due to feelings of jealousy, or other negative feelings towards that person'.

On how participants cushioned themselves against anti-social gestures, few confessed having being beneficiaries of warmth and good reception from within and amongst their social relations. That notwithstanding, there was a general consensus among other respondents that, they manage their situation by withdrawing from public spaces where they think they were likely to be ridiculed, mocked at or discriminated against.

Generally, it was revealed that, the needs of caregivers of mentally ill patients and their patients are interlocked and have certain commonalities. On the needs of caregivers of mentally ill patients, respondents called for medical assistance from experts. This they believe would help provide some form of education and training on how to manage mental health patients. They also called for a demonstration of leniency and warmth towards the mentally ill. Others suggested for the institution of financial, family and social support centers and schemes.

A participant expressed the following:

> Care for the mentally ill is a capital-intensive venture. Without enough funds and sustainable source of income, it is kind of difficult. So, it wouldn't be out of place if social organisations initiate schemes meant to cater for such unforeseen contingencies. (Female family Carer F)

Psychological Needs of Family Caregivers

Ae-Ngibise et al. (2015) stresses on the psychological stress that family caregivers undergo in dispensing services. In his views, psychological needs which are triggered by complexities and tensions surrounding caregiving necessities incentivizes people and spurs them on to perform and achieve goals (Ae-Ngibise et al., 2015). In finding out more about challenges of family caregivers, ways of managing them, and what is needed to improve their conditions, participants admitted having experienced folds of psychological challenges such as stress, anxiety, shock and sadness. On management of the challenges, responses widely varied. Some participants admitted having control over it, by engaging relations in conversations. Others however appeared clueless.

Some participants had this to say:

> I sometimes find people to talk to. Either on one-on-one basis or I call them on phone and we talk just to relieve stress (Female family Carer C)

> In times of breakdown, I try my best to either read consoling quranic verses or listen to 'Digri' (a Somali song). This helps me to feel better and relieved. (Female family Carer F)

Family Caregivers Psychological Needs

Respondents offered a wide range of opinions on the psychological support needed as caregivers. The needs ranged from medical assistance, love and affection, to counselling. This according to respondents are critical for a balanced mental state for caregiving role. Some participants indicated the following:

> I feel the whole world has caved in on me. I feel pressured with the ailment of my relative. We have no money. So, the little we get is what we spend on the ailment. (Female family Carer C)

> The only thing that would make me happy is her recovery. That will be the happiest day in my life. This ailment has been a burden to us. (Female family Carer G)

Discussion

The results from the data gathered for this research were elicited from a diverse community of family caregivers of mentally ill health patients in sampled mental health facilities in Somalia. Analysis of the data gathered revealed that, family caregivers with mental illness were predominantly older females not less than age fifty (50) – specifically within the age range of 50–55 ($n = 36$) making up 70.6% of the respondents. This finding is consistent with a study in Hong Kong that indicated that females have the natural tendency to provide caregiving services (Chien, Chan, and Morrissey 2007). On the same breadth, the research outcome of (Hamada, Ohta, and Nakane 2003; Shankar and Muthuswamy 2006; Grandón, Jenaro, and Lemos 2008; Ae-Ngibise et al. 2015) also confirms that, women family caregivers of mentally ill patients outnumber that of the men.

Rudnick (2004) offers an explanation by asserting that in addition to the fact that female caregivers attach greater essence to situations more positively than their male counterparts, they naturally and culturally assume care responsibility. The issue of old women engaged in caregiving, however raises grave concerns to the effect that, patients with aged family caregivers would not receive effective and efficient care and as such are more likely to be under cared for a long period of time. And this may impact on recovery and possibly rehabilitation – hence the need for a more coordinated and institutionalized care. This is also a corroboration of the research findings by Seppala (2013) who indicated that, women naturally demonstrate more nurturing, caring and compassion compared to men. This also implies that, women, whether married, divorced, widowed, employed and unemployed, play and take up extra roles in addition to the already burdensome engagements of household management duties such as child care, cooking, washing and other duties. The above revelations represent a true reflection of the dominance of females in caregiving roles as confirmed by (Shankar and Muthuswamy 2006).

It was also revealed that, the financial situation of most of these predominantly unemployed caregivers was apparently poor and posed a substantial challenge in caregiving. The unemployed respondents ($n = 38$) in this study constituted 74.5%. The study confirmed that, this has been the case because of the tight caregiving duties for which reason they are unable to work. And even for those who managed small businesses, the stigma of association with the mentally ill has affected their economic activities as customers no longer patronize their wares. As such, they are deprived of a sustainable source of livelihood to anchor their survival. So, in effect, the financial responsibilities occasioned by care for the mentally ill adds extra financial task that strains family budgets.

As revealed by this research, in the face of the physical, physiological and psychosocial stress brought forth by financial difficulties, burdensome thoughts and other related difficulties amply suggests that, caregivers require some form of help to mitigate the effects of caregiving duties. This finding is in concord with the World Federation of Mental Health (2014) who assert that, caregivers are deprived of necessities of life like food and water; leisure and pleasures of life like sex and sleep. The stress-related effects of caregiving services on caregivers is something well established in literature. In the views of Kiecolt-Glaser et al. (1991), King, Oka, and Young (1994), Schulz and Beach (1999), it could impair the normal functioning of the immune system. Lee et al. (2003) posit that it could also lead to the development of cardiovascular ailments. The stress could also result into increased insulin levels (Vitaliano et al. 1996), and affect healing time for wounds (Kiecolt-Glaser et al. 1995). This makes it imperative that caregivers are offered medical attention and some form of education and training.

The research further revealed a dearth of social life for family caregivers of mentally ill patients. In as much as social life was admitted by many respondents to have been a great source of comfort, others reported of a restraint in enjoying their social life such as attending social gatherings. These restraints were ascribed to their association with care for the mentally ill. Family caregivers have been noted to have an increased risk of developing depressive disorders, with approximately 30% suffering from significant depression (Schulz et al. 1995; Haley and Bailey 1999).

Among the findings, the research revealed that, caregivers suffer stigmatization, mockery and other forms of ridicule from members of the society. The combined effects of these on caregivers equally place them at risk of mental illness burden just as patients (Rudnick 2004). The various forms of difficulties caregivers go through is again corroborated by the seminal research works of (Shankar and Muthuswamy 2006; Ae-Ngibise et al. 2015). The results further revealed that, some caregivers are socially disconnected because of stigmatization. Most respondents confirmed that, quite unfortunately for them, the solitary life occasioned by their disconnection has not been therapeutic, as the more they dissociated themselves, the more sorrow-entrapped, depressed and hopeless they become.

Haley and Bailey (1999) and Robinson-Whelen et al. (2001) attest that, whenever this happens, caregivers withdraw from the social space. This takes a toll on caregiving services as people are discouraged from providing such services in times of need (Pinquart and Sörensen 2003). Under such a circumstance, it becomes pertinent that, in addition to calling for attitudinal change geared towards extending love and affection to caregivers and patients, financial support as well as the extension of counselling services is extended to them, in order to have a good condition for caregivers' roles.

Conclusion, and Recommendations, Implications for Future Policy and Practice

Somalia's mental health system needs to be fully integrated into all aspects of its national health system to enhance the delivery of primary and secondary health care. Mental health is everyone's business. And a good mental health planning could be a bedrock for a better future not only for Somalia, but also for the whole world. The pertinence of health in general, and of mental health in particular, as underscored by the sustainable development goals (SDGs) becomes more crucial especially given the interconnectedness of the global goals which largely owes its overall achievement predicated on good health as captured under goal 3. In a country with a centralized government structure such as Somalia, mental health development needs strong and continuous support from government and non-government actors. Somalia also needs to strengthen awareness of the importance of non-state organizations and their potential role in integrating various social resources to help provide valuable supplementary services for mentally ill patients.

Given the weak state of care for mentally ill patients in Somalia (WHO 2010), community and home-based care for most patients need to be encouraged and promoted. Family members should be supported to provide community-based care for their ill relatives. Government support and investment in clinical studies and health policy researches are necessary to establish evidence-based treatment backed by relevant strategies and policies. Moreover, economic evaluations from the perspective of a functional recovery and long-term outcomes and benefits for mentally ill patients are needed to inform the design of sustainably efficient policies and reimbursement.

With continued political commitment, timely assessment of needs and resource matching, development of appropriate public health policies, delivery of effective interventions, strengthening of human capacity, efficient mobilization of financial resources, rigorous monitoring and evaluation, Somalia could be in a better position to build and strengthen a national sustainable mental health system. A mental health policy and plan is essential in this regard to facilitate the coordination of all services and activities related to mental health. Without adequate policies and plans, efforts are likely to be inefficient and unproductive and counterproductive.

This study found that caregivers might experience high burden. Factors that led to high burden were the low income of caregivers having to cope with care giving over long periods, and resource constraints. Similarly, factors that lowered the burden were also examined, including personal coping skills of the caregivers, family involvement by way of providing spiritual and social support. However, in providing these forms of support, family caregivers encounter physical, social and psychological challenges which impede their work. They are therefore left in need of assistance to help them deliver effectively. Concerning physical well-being, caregivers need, medical attention to assess and improve their physical health which is mostly deteriorated by the rigours of providing care to ill relatives. Also, concerning social lives, family caregivers need social affection and social acceptance other than being discriminated against in the society. They also need insights into patient’s treatment and conditions which will enable them to offer proper care. Financial support could also go a long way to help in caregiving.

There is therefore the need for advocacy programmes and sensitization to drive behavioral change. It is in this respect that social workers have a lot to do. More specifically, social workers, in concert with other state and non-state entities can form self-help community-based groups to provide physical, social and psychological support to family caregivers and patients. Also, family caregivers should be included as beneficiaries of both state and non-state led social protection interventions. Another important way to improve the lives of mentally ill patients and caregivers could be through policies, plans and programmes that would lead to better services. To implement such policies and plans, a country needs good legislation to improve access to mental health care, treatment and support.

Civil society can also resolve to lay a strong foundation for mental health care issues by learning from the other model countries like Ghana and a host of other countries who have taken initiatives in implementing mental health legislations. The important role of mental health legislation should be taken into high consideration for any future mental health interventions and strategies for Somalia to improve:

- Access to mental health care for every individual who is in need
- Rights of mental health service consumers, family members, and other care givers
- Competency, capacity of service and wellbeing of people with mental illness
- Inception of quality mental health facilities and services
- Integration of persons with mental disorders into the community and
- General promotion of mental health throughout society.

Given the strands of evidence from the cross-sectional need-based assessment of caregivers of mentally ill patients in Somalia, it is apparent that there are challenges and systemic policy deficits which is a matter of relevance to stakeholders like policy makers and social workers. In this article, we have argued for the considerable need for psychosocial services to be provided by social workers and psychologists to caregivers. There are also specific interventions that may be applied by such professionals to ameliorate the problems associated with caregiving.

Limitations of the Study

The study encountered some challenges which needs to be highlighted to serve as a guide for future academic inquisitions. Restricting the study to five facilities contributed to exempting respondents outside the facilities in the study area. Per the qualitative nature of the research work, and given the general subjectivity of answers that characterize such studies, it limits the extent to which generalizations could be made. However, this does not compromise or invalidate the results of the findings. Future studies should concentrate on other facilities in other areas and perhaps focus on the capacity of the overall mental health system to help investigate the impacts of socio-cultural and religious beliefs and practices such as indigenous healing practices and local knowledge on mental health. Further studies could also be conducted into the need to make mental healthcare an integral part of primary healthcare in Somalia.

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