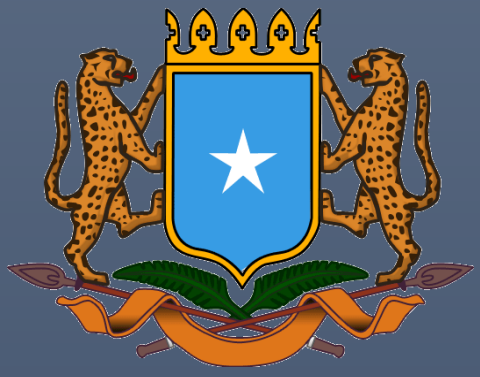
2019-2022



Somali Mental Health Strategy

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FOREWORD BY THE MINISTER

Somalia is one of the countries with the highest prevalence mental health illnesses in the world. Even though the exact prevalence of the problem has never been scientifically estimated, it believed that there is at least one member in every three households who has some form of mental illness. The effects of longstanding war, routine exposure to traumatic conditions such as suicides and mass casualties, unemployment, drugs and substance abusers have been identified as some of the causes of mental illness among the Somali people. Despite the problem being common, health services are unavailable for the majority of population in Somalia. Because mental health illnesses present itself in different forms whose clinical signs often overlap, diagnosis is mostly difficult.

Denial of illness on the side victims also delays timely interventions while lack of awareness or suspicion among healthcare workers about mental health illnesses aggravates the situation. Health facilities providing services for mental illnesses are few and far between, often lack the essential medicines or instruments for treatment patients and dearth of human resources cadres with specialties in psychiatry, psychology or related professionals are common.

It is against this background that led to the development of a Mental Health Strategy for Somalia. The process of developing the mental health was led by Ministries of Health with WHO offices both at the country and regional level providing technical support. The overall goal of the mental health strategy is to strengthen the integrated response of the health sector and other related sectors through the implementation of evidence-based and achievable plans for the promotion of mental health and for the prevention, treatment and rehabilitation of mental and neurological disorders. The strategy is strongly anchored on principles of respect for human rights and social protection as expressed in the Somali prioritized health policy directions, the Somali Compact Strategy – a document that is mainly guided by the Regional Mental Health strategy and Global Mental Health action plan 2019-2022.

Stigmatization was identified as an impediment to both the creation of awareness and in delivery of mental health services. The strategy was commended for the inclusion anti-stigmatization initiatives and advocating for societal openness and support for people suffering from mental illnesses.

Sincerely,

The Minister Dr. Fawziya Abikar Nur
Ministry of Health and Human Services
Federal Government of Somalia

Executive Summary

Mental Health is a public health priority in Somalia. The long years of conflict with high exposure to trauma and violence, the large proportion of displaced population, high stigma and discrimination in the community towards persons with mental disorders, limited opportunities for education and employment have all have contributed to the high mental health needs of the population. During the recent years, there have been some mental health initiatives like the 'chain free' initiative, improvement of the mental health care facilities, and training of the human resources along with development of private sector care facilities. There are still limited mental health resources available to address the needs of the population of Somalia. The overall goal of the mental health strategy is to strengthen the integrated response of the health sector and other related sectors through the implementation of evidence-based and achievable plans for the promotion of mental health and the prevention, treatment and rehabilitation of mental and neurological disorders, with respect for human rights and social protection in line with the Somali prioritized health policy directions, the Somali Compact strategy, stipulated within the New Deal framework, planned over three years (2014-2016), guided by the regional mental health strategy and Global mental health action plan 2013-2020.

The strategic directions suggested are:

1: Leadership and Governance

2: Integrated community-based provision of mental health care

3: Development/strengthening the human resources

4: Strengthening information, evaluation and monitoring

There are short-term, medium term and long-term activities to meet the goals of the mental health strategy.

Chapter 1

Introduction and overview

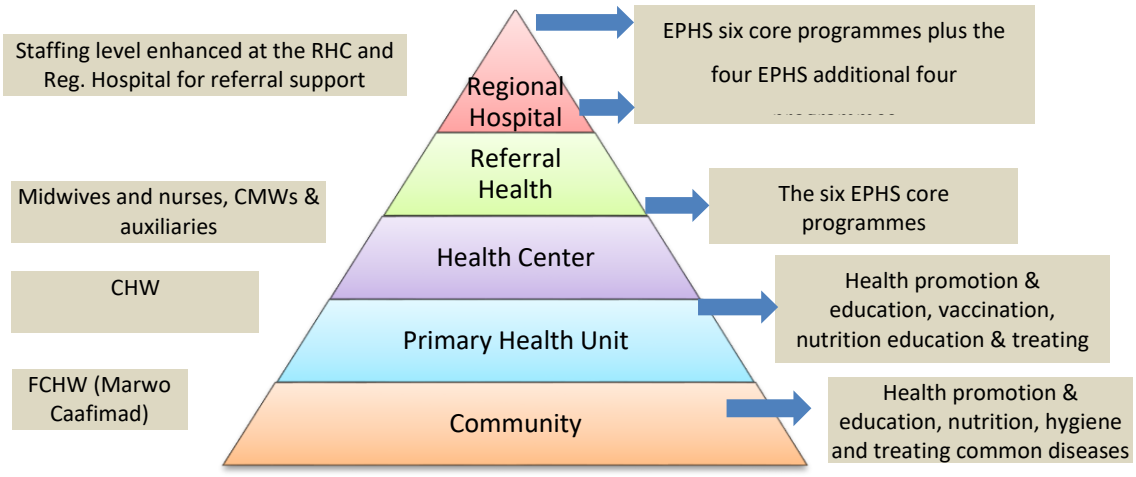
After the fall of the central government of Somalia in 1991, protracted civil unrest ensued with the absence of a unified national government. Somalia is considered the world's most fragile state with more than 40% of the population living on less than US$ one dollar a day and 73% on less than US$ two dollars per day. Somalia's current population is roughly 13 million people, although estimates range from 8 to 15 million. Currently around 1.5 million people are internally displaced across the country and some 2.4 million Somalis are in food crises representing 32% of the entire population. More than 80% is estimated to be illiterate. The country has adopted federalism as a political system. Federal States are currently 5 in number and include Puntland, Galgaduud, Hirshabelle, South-West and Jubbaland State. Mogadishu is the seat of the Federal Government of Somalia. In the northwest of the country, Somaliland has claimed secession from Somalia in early nineties and managed to restore a degree of political stability and public administration.

Health status

The legacy of the past two decades has escalated the burden of communicable diseases prevalent in all the geographical areas, collectively posing challenges to the health system. Moreover, there is a growing burden of Non-Communicable diseases (NCDs) especially those related mental health which reportedly affect as much as 33% of the population.
The Somali health system comprises of five tiers (figure1). These include the community based trained Female health workers (FCHWs). FCHWs operate from their homes and conduct home visits to provide their assigned services at the household doorstep. The FCHWs are supported and supervised by specially trained FCHW supervisors. The next level is the primary health care units (PHUs) providing basic promotive, preventive and simple curative services staffed by at least one community health worker (CHW), supported by the local leaders in the organization of health services delivery.

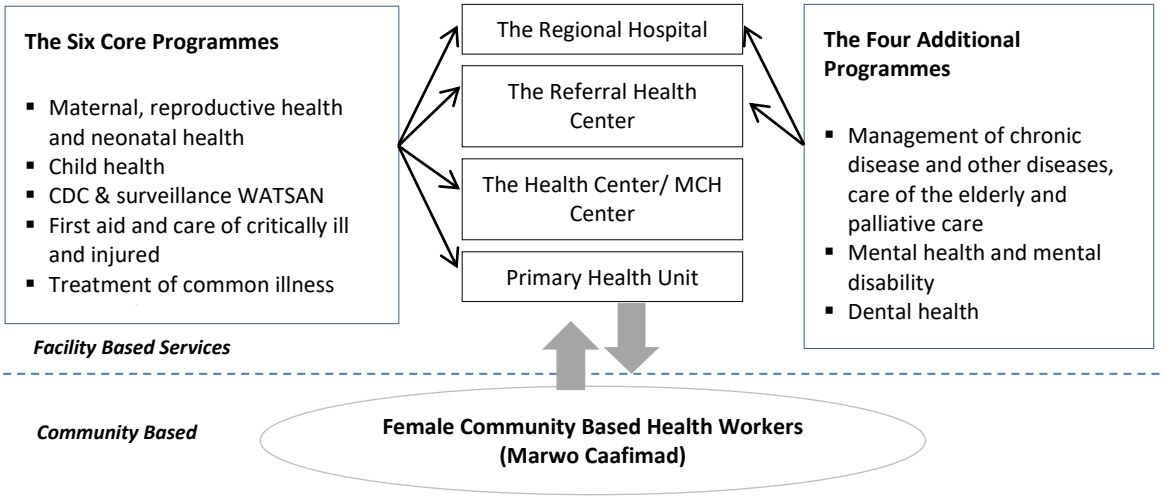
The next higher level is the Health Center (HC), operated by qualified nurses and midwives, and nurses providing EPI, nutrition and basic emergency obstetric care (BEmOC) services supported by a number of delivery beds provided for this purpose. Maternal and child health (MCH) care facilities are operate where technical capacities for establishing HCs are not available. The fourth tier is the referral health center (RHC) or the district hospital. These facilities are expected to provide important referral support functions that include the comprehensive emergency obstetric care (CEmOC) services. The principal referral level is the regional hospital expected to provide major health care speciality services performed by a number of qualified medical and midlevel health professionals and support staff. The PHUs and HCs report to their district health officers, who along with the hospital director report to the regional health officer (RHO). The EPHS constitutes a standardized package, comprising of six core and four additional programmes that need to be delivered through the health services (figure 2).

Figure 1. The Regional Health System Organization, Staffing and Performance functions



The Private Sector During the past two decades, a major expansion of the private health sector was witnessed in all the federal States, frequently used in the urban areas that account to about 30-35% of the population, which is poorly regulated with a flourishing traditional, spiritual and herbal medicine system

Figure 2. The ten EPHS Programmes



Considering the global thresholds set by WHO for the collective density of doctors, qualified nurses and qualified midwives of 23 per 10,000 population, representing the minimum coverage level, necessary to support the realization of UHC alongside the attainment of the health related MDGs. The cumulative Somali score ranges between 3 and 4 per 10,000 population (three doctors; eleven nurses and three midwives for every 100,000 people). The situation is further compounded by lack of coherent policy development; standardised job descriptions; uniform pre-service and in-service training and monitoring programmes and certification and accreditation systems (Table 1).

Table 1: Human Resources for Health in Somalia – table not clear – what is suppose to populate the human resource column

Human Resources	**CSS**	**Somaliland**			**Puntland**			**TOTAL**
	Total	Public	Private	Total	Public	Private	Total	
Doctors	94	43	42	85	32	42	74	300
Pharmacists	4	-	-	-	14	3	17	21

Nurses	189	240	96	336	128	208	336	995
Midwives	10	44	15	59	29	18	47	282
Technicians	333	462	242	704	160	215	375	1,512
TOTAL	630	1241	243	1184	363	486	849	3,110

Source: Zonal Ministries of Health, 2007

Table 2: Somali Maternal Health Indicators

Indicator	**Level**	**Source**
Maternal Mortality Ratio (MMR)	732 per 100,000 live births in 2015	Health profile – WHO Somalia 2015
Total fertility rate	6.7	UNFPA 2015
Unmet need for family planning	26 per cent [Somaliland: 20.2 per cent - MICS 2011] [Puntland: 11.4 per cent - MICS 2011]	UNFPA
Percentage women at least 1 ANC visit	26 per cent [Somaliland: 31.7 per cent (By skilled person) - MICS 2011] [Puntland: 24.2 per cent (By skilled person) - MICS 2011]	UNFPA
Percentage births attended by skilled personnel	15 per cent [Somaliland: 44.1 per cent - MICS 2011] [Puntland: 38.4 per cent - MICS 2011]	WHO 2018 UNFPA
Reported prevalence of FGM/C	98 per cent [Somaliland: 99.1 per cent among women and 20 per cent among girls - MICS 2011] [Puntland: 98 per cent among women and 25.9 per cent among girls - MICS 2011]	UNFPA

Table 3: Somali Infant and Child Health Indicators

Indicators	**Level**	**Source**
Under 5 Mortality rate (U5MR)	137 per 1000 live births in 2015 [Somaliland: 90 per1000 lb – MICS 2011]	Levels and Trends in Child Mortality, - WHO 2015
Infant Mortality Rate (IMR)	108 per 1000 live births in 2010 [Somaliland: 72 per1000 lb – MICS 2011]	
Neonatal Mortality Rate(NMR)	52 per 1000 live births in 2010 [Somaliland: 42 per1000 lb – MICS 2011]	
Acutely malnourished children (under five) weight-for-age	36 per cent	MICS 2006
Immunization coverage for DPT-3 vaccine	Somaliland: 10.8 per cent Puntland: 7.2 per cent CSZ: NA	MICS 2011

Health service delivery is constrained due to the limited number of health facilities across Somaliland, Puntland and CSZ that are not equipped to provide the necessary range and of services. The numbers of

health facilities vary across the three zones, according to population and geographic size. Infrastructure, such as adequate water and sanitation facilities need rehabilitation. See **Table 4** below.

Table 4: Number and types of health facilities in Somalia

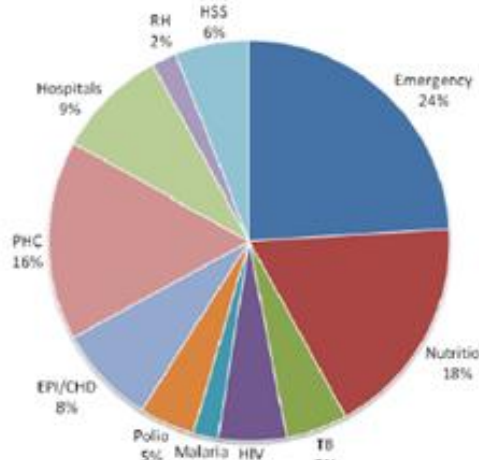
Zones	Health Posts	MCH	District Hospital	Referral Hospital
Somaliland	160	83	8	**1**
Puntland	120	47	4	**1**
CSZ	264	130	15	**5**
Total	544	260	27	7

Source: Somali HMIS, 2010

In recent years, while funding for the health sector is increasing it is still largely dependent on external resources. Between 2007 and 2009, donor finances averaged US$ 100 million annually, bulk of which has traditionally been going to vertical programmes outside the Public Sector, which has resulted in an uneven distribution of resources. While Somaliland's average budget contribution to health over the same period was US$ 1 million a year, with Puntland's contribution estimated at US$ 300,000 annually.

There are currently no FGSR contributions to the health sector in CSZ. Procurement, supply chain and logistics management for essential medicines is challenged by the security environment, poor infrastructure, human resource shortages, poor capacity for supervision and monitoring, and weaknesses in reporting and communication.

Figure 3: Financial Aid to Somalia Health Sector,2009



The Health Management Information System (HMIS) collects data from health facilities with an over-reliance on a small quantity of data sources which are not updated regularly. The effective use of health information is thus very limited at all levels and does not yet play a central role in evidence-based decision-making, guiding programming or policy development.

Chapter 2

Mental Health overview

Global and Regional situation

Mental disorders are common and disabling. At any given time about one person in every ten is suffering from a mental disorder, and about one in four families has a member with a mental disorder. Rates of mental disorder are even higher where there are complex emergencies, such as are being faced by many countries in the Eastern Mediterranean Region. Nine out of the 20 leading causes of years lived with disability worldwide are mental, neurological and substance-use disorders, which account for more than a quarter of all measured disability, and 10% of the global burden of disease (which includes deaths as well as disability). Rates of suicide have increased by 60% over the past 45 years. Globally, 800,000 people commit suicide each year, making it the tenth leading cause of death and one of the three leading causes of death among people aged 15-44 years. Suicide is expected to account for more than 2% to the global burden of disease by the year 2020.

The costs of mental disorders are already huge, and year-by-year are expected to grow exponentially. In 2010, the global cost of mental disorders was estimated at US$ 2.5 trillion. Over the next 20 years the cumulative global impact of mental disorders in terms of lost economic output will amount to US$ 16 trillion. It is estimated that the cost of mental disorders in HICs, in terms of expenditures incurred and loss of productivity, equates to about 4% of GNP. It is predicted that the costs of mental disorders will more than double by 2030, affecting LAMICs as well as HICs.

Evidence-based action can ensure that the limited resources available to mental health care are used most cost-effectively. Effective pharmacological and psycho-social treatments are available for depression, schizophrenia, epilepsy, alcohol and substance abuse and that these treatments can be successfully applied in low-income countries. However, the vast majority of people with a mental disorder do not receive treatment. The treatment gap, between people who require care but do not receive treatment, has been estimated to be more than 90% in the Eastern Mediterranean Region.

The reason for this unacceptable gap is that mental disorders and services for those affected have been neglected in many countries worldwide. Until recently, mental health has not featured on the political agenda, and policies and legislation have been either absent or outdated, paying scant regard to the human rights of people with mental disorders.

Inadequate resources have been devoted to mental health; countries in the Eastern Mediterranean Region typically spend 2% of their health budget on mental health, which compares with 5-10% required to match contemporary comprehensive health care systems. The median spend of US$ 0.15 on mental health per person is well short of the US$ 3-4 needed for a selective package of cost-effective mental health interventions in low-income countries and up to US$ 7-9 in middle income countries. Furthermore, centralized and institutionalized care consumes a disproportionate amount of mental health expenditure, and more cost-effective intervention can be achieved through community-based mental health care.

The high prevalence, disability and growing costs of mental disorders, taken together with the huge treatment gap despite cost-effective treatments, forms a compelling case to reassess the provision for mental health care. In order to bridge the gap WHO launched mental health gap action programme in 2008 (mhGAP) and in 2011 the regional strategy on mental health and substance abuse (WHO Regional Office for the Eastern Mediterranean, 2012) was adopted. The strategy aimed to reinvigorate efforts to improve mental health provision (components 2 and 3), but recognises that this can only be achieved by strengthening leadership (component 1), working in partnership (component 5), and promoting operational research to provide evidence to advocate for placing mental health higher on the social and developmental agendas (component 6).

Building on these initiatives the Global Mental Health Action Plan 2013-2020, was adopted at the 66th World Health Assembly. The Mental Health Action Plan sets out a new vision (see Box 1) and goal for mental health to be articulated through four objectives and six measurable global targets to be achieved by 2020.

The four Objectives of the Mental Health Action Plan 2013-2020 are:

- To strengthen effective leadership and governance for mental health.
- To provide comprehensive, integrated and responsive mental health and social care services in community-based settings.
- To implement strategies for promotion and prevention in mental health.
- To strengthen information systems, evidence and research for mental health.

Box 1. Vision of the Mental Health Action Plan 2013-2020

A world in which mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally-appropriate health and social care in a timely way to promote recovery, all in order to attain the highest possible level of health and participate fully in society and at work free from stigmatization and discrimination.

Country situation

Assessment of need

There are no national studies on the prevalence of mental disorders which could be identified however there a number of small-scale studies that used variable methodologies to estimate burden. Most of these studies have been done in Somaliland. According to GAVO Report (December 2004), It is estimated that at least one person has some form of mental illness in every two households in Somaliland ,52% of whom were unemployed when first diagnosed with mental or psychological disorder. Another survey conducted by VIVO in Hargeisa in 2002, indicated that 21% of surveyed households care for at least one family member with severe mental health problem. It also estimated that 23.1% of the people with mental disorders are ex combatants and at least one sixth of persons who have actively been in a war developed a very severe form of mental disorder later in their lives. Research also showed that a large number of ex-combatants suffer from drug abuse and severe mental disorders, that compromises their ability to reintegrate into civil society, eventually constituting a burden for the society as a whole. The GRT data in Puntland indicated that that 1 person out of 3 households suffers or has suffered in the past from certain forms of mental distress. No clear-cut research has been done in Central-South Somalia on the issue; however, in the presence of continuing violence, it is reasonable to conclude that the prevalence of mental disorders will be at least be comparable to the other two zones.

In Somalia and in neighboring countries an important factor is consumption of Khat; a traditional practice that is believed to go back to ancient times; which is associated with onset/worsening of severe mental disorders. During the recent decades, khat, has had a remarkable boom and the khat sessions have become a source of social support.

In a cross-sectional study in Hargeisa carried by VIVO in 2003, 16% of former combatants were severely impaired in their everyday functioning suffering mostly of psychotic disorders and associated excessive khat use. The greatest amount of khat use was among respondents with PTSD who indicated that they found drugs help them to forget war experiences. Moreover, another survey conducted by VIVO in 2002 revealed that 80% of patients that suffer from psychosis were excessively using khat before they became ill. The statistics collected from the 2011 survey by WHO indicated that at least 76% of the patients consumed khat before becoming mentally ill, whereas 70% of the patients were still consuming it.

In recent years other substances notably Hashish (marijuana) and Alcohol are also being used by youth.

According to GRT assessment in Puntland zone as well as in Central South Somalia (2004), the stigmatization of mental disorders is evident and severe. Once the person develops mental health problems the stigma of "mad" will accompany him/her even after a possible recovery. The containment with chains or imprisonment of the mentally ill persons is very widespread.

Indeed, GRT data shows that 90% of the treated patients were subjected to chaining at least once in their lifetime (Table---).

Table: People in Chains in Mental Health Facilities (WHO 2011)

Name of the facility	People in chain		Bed Capacity of the facility	% patients chained/facility
	men	Women		
Mental health unit, Berbera	14	0	100	14%
Mental health unit Hargeisa,	30	1	100	31%
Mental health unit Bossaso	0	0	4	0%
Nasrulah, Garowe	16	0	33	48.5%
Habeb Hospitals. Mogadishu	0	0	232	0%

Traditional healing systems are often a first point of contact on the pathway to care. Amongst the rites used in dealing with mental related problems are (i) Koranic treatment; (ii) Mingis (originally from the north, pagan origin but blended with some Islamic believes similar to Ethiopian rite of Saar);(iii) Dawo Somali (traditional medicine with herbal and natural infusions);(iv) Sharax (officiated on the coastal region, Arabic origin);(v) Borane (similar to Mingis in the area of Juba, Lower Shabelle…); and (vi) Xayaad.
While lack of medical facilities may be one factor resulting in communities consulting traditional healers but it is also important to understand that these practises have strong cultural resonance with the communities.

Mental Health System Response Capacities and Resources

Based on the WHO 2011 assessment it is evident that mental health facilities are grossly deficient. In the South and central zone, much is still left on the initiative individuals able to catalyze attention and mobilize resources, while in the northern areas some public structures are available to the populations (Table--) The catchments area of the facilities is not well defined. Besides the small number of facilities, they seem to offer a range of services (table--), however it is important to note that while women are more likely to be in need of mental health services and support, they have less access to those services, for example in Somaliland, GAVO estimated that 25% of users are women while in Puntland GRT registered 34% of the admitted inpatients as female. No data from South Central Region is available. Similarly, in all the three regions no services and facilities exist exclusively for children and adolescents.
This table (see next page) clearly shows that all facilities have an inpatients unit that should be taken into account in order to evaluate for the quality of services offered and the observance of human rights. Outreach activities outside the hospitals such as patients monitoring and follow up and preventive campaign such as awareness initiatives in the schools and through mass media are generally carried out in those facilities supported by INGOs or with a strong leadership regardless of the general management of the structure. Most of the surveyed facilities keep record on number of outpatient visits, outpatient diagnosis and outreach activities and all the facilities keep record on inpatient admissions.

However, they have different ways of collecting data. Only 3 facilities (in Hargeisa, Berbera and Bossaso) use the HMIS system but none of them has received any training on HMIS or the use of information.
The availability of drugs on a regular basis is an issue raised by all facilities. Only 5 facilities receive drugs and only those in Somaliland receive them on a regular basis from WHO, iNGOs or private donations.

Table: Mental health facilities in Somalia

Type of facility	Somaliland	Puntland	Galmudug	Hirshabelle	Banadir	South-West	Jubaland	Number of facility	%
Mental Hospital	Berbera Mental Health Hospital				Forlanini Hospital Savannah Hospital				
Ward within a general Hospital	Mental health unit in Hargeisa Group Hospital	Mental health unit, Bossaso General Hospital		Belet Weyne Regional hospital					
Community owned psychiatric inpatients units	Sahan Clinic		Shifo Mental Health Hospital			Baidoa mental health hospital	Habeb Mental Health Manbile Mental Health		
Community residential facility		Nasrulah Community Centre. Garowe							
Mental Health Day Treatment facility	-	-	-						
Total	**3**	**2**	**1**	**1**	**2**	**1**	**2**		

Table: Mental Health services provided

Services	**No**	**%**
Outpatient care	7	87,5%
Inpatient care	8	100%
Outreach activities (by hospital staff)	4	50%
Preventive / Promotive services	3	37,5%
Organization and management support:		
In- service training	3	37,5%
Supervision	5	62,5%
Health information system	4	50%
Drug supply system	8	10

A major problem related to Human Resources in Somalia is the lack of properly qualified professionals: only three psychiatrists are working in public facilities in the country. In Puntland and CSZ only general practitioners acting as psychiatrists are available (table--)

Table: Human resources per location

Category	**Somaliland**	**Puntland**	**CS zone**	**TOTAL**
Psychiatrists	2	-	1	3
Other medical doctors, not specialized in psychiatry	-	1	-	1
Nurses	3	7	12	22
Psychologists	-	-	6	-
Mental health Social workers	8	1	10	19
Others(including auxiliary staff, non-doctor primary health care workers, health assistants, medical assistants)	9		24	33
Support staff	21	10	10	41
Total	43	19	57	**119**

To ameliorate this situation a number of initiatives have been undertaken by INGOs (THET, GRT,VIVO and GAVO) and WHO over the last decade to improve the quality of services as well as enhance the human resources available for delivery of services. One such initiative is the **Chain-Free Initiative** which was launched initially in Mogadishu in 2006, the initiative focused on improving the quality of life of people with mental disorders through combating stigma and facilitating humane treatment in hospitals, at home, and in their communities. The first phase of the initiative involved creating chain-free hospitals through removing chains and more generally, through reforming hospitals into humane facilities with minimum restraints. The

second phase has focused on private residences by providing education and training to families of people with mental disorders. The final phase has consisted of removing the "invisible chains" of societal stigma and human rights restrictions on people with mental disorders

Habeb Mental Hospital in Mogadishu has implemented all three phases of the Chain-Free Initiative. Chains were removed from more than 1700 patients between 2007 and 2010. Currently, no patients are chained in this facility. Meanwhile, the number of people accessing services at the hospital has increased significantly, as the community started to realize the importance of seeking treatment for their relatives with mental disorders. The Chain Free Initiative has now expanded to other parts of the country: Hargeisa Group Hospital, Berbera Mental Hospital, in Garowe and Galkayo in Somaliland and Puntland.

To enhance the human resources available for mental health WHO organized two three-month courses of training in Bossaso in 2005 and Hargeisa in 2009. These courses built the capacity of 55 health workers from the three zones of Somalia.

Two participants from these courses are now mental health coordinators/focal points in Puntland and Somaliland. Three newly-established mental health facilities are also being managed by participants from these courses and in most (7 out of 8) facilities at least one person had received training on mental health through these courses.

Following the launch of mhGAP in 2008 aimed at scaling up services for mental disorders WHO organized the planning and contextualization workshop in order to scale up mental health services in Somalia and to reduce treatment gap for mental health disorders in 2012.

Professionals from the three zones developed specific implementation plans for each zone (including selecting districts, role of each professional cadre, plan of training and supervision, community awareness, monitoring and evaluation and other issues). The priority conditions identified in mhGAP were ranked by the participants as below.

	SUM	**MEAN**
Psychosis	39	1.8
Depression	58	2.6
Drug Use	93	4.2
Behavioural disorders in children	106	4.8
Epilepsy	125	5.7
Medically unexplained complaints	128	5.8
Bipolar	134	6.1
Dementia	162	7.4
Suicide	169	7.7
Developmental disorders in children	177	8.0
Alcohol	186	8.5

Following a workshop to adapt the mhGAP intervention guide materials WHO in collaboration with the Ministries of Health in Somalia organised a training of trainers' workshop on the mental health GAP action programme (mhGAP) intervention guide in Addis Ababa, Ethiopia. A total of 18 mental health professionals attended the training. The pre and post-training assessment, as well as structured feedback on individual sessions indicated significant improvement in knowledge and skills of participants to conduct training of non-specialists in their respective regions. Since then roll out trainings have been conducted for PHC staff in Gardo, Mogadishu, Bari, Bossaso, Garowe and Galkayo. Nevertheless, lack of coherent, consolidated human resource development plan for mental health raise some concerns about the quality of human resources available for mental health services in Somalia.

Parallel to these efforts, work has been underway specifically in Somaliland by iNGOs. The Kings-THET-Somaliland Partnership has supported the development of the health workforce through training, as well as via

salary support, mentoring, and support of leadership and governance in training institutions and professional organizations. As part of overall health workforce development, mental health issues have been incorporated into the training of a wide variety of health workers. Selected junior doctors (interns) have received additional training to be mental health representatives in order to actively integrate mental health care into existing health systems. In addition, the international organization VIVO has collaborated with the German University of Konstanz to train social workers in Somaliland.
Since 2003, the Italian nongovernmental organization Grupo per le Relazioni Transculturali (GRT) has focused on building capacity of health workers in Puntland, and later also in Somaliland.

Training has emphasized diagnosing and treating common mental disorders, prescribing psychotropic medications, establishing rehabilitation plans for patients and their families, and engaging communities through awareness raising and advocacy.

Over the last few years there has been a mushroom growth in institutions for training of medical and allied disciplines (see Table--) however the quality of facilities, availability of qualified faculty, teaching training methodologies and standard curriculum are extremely variable. It is also not clear whether mental health is integrated in the curricula being taught and how many credit hours are devoted to its teaching /training.

Somali Health Training Institutions:

Puntland Health Training Institutions

Name of School	Program/s
College of Health Science, Bossaso	**Qualified Nurse, Lab-technician, Nurse midwife**
Hagi Abdi Health Training Institute, Garowe	**General nursing, Midwife**
East Africa University, Faculty of medicine, Bossaso	**Medicine, Public health**
College of Health Science, Gardo	**General Nurse**
Higher Institute of Health Science, Galkayo	**Qualified nurse, Lab technician**
Puntland University of Science and technology	**Medicine, Nurse, Midwife, CHWs, Auxiliary midwives**

Name of School	Program/s
Amoud Medical School	**Medicine, Dentistry, Community midwife, Qualified Nursing, Pharmacy, Lab technician, Nurse midwife**
Faculty of Medicine, Hargeisa	**Medicine**

Hargeisa Institute of Health Science	**Qualified Nurse, Nurse Midwife**
Burao Institute of Health Science	**Qualified Nurse. Nurse-Midwife, Community Midwife**
Edna Adan Maternity Hospital	**Qualified nurse, Nurse midwife, Assistant Lab-technician, Health Officer, Community Midwife, Lab-technician**

South and Central Somalia - Health Training Institutions

Name of School	Program/s
SOS Nursing School, Mogadishu	**Registered Community Nurse**
Faculty of medicine, Benadir University	**Medicine**
Faculty of medicine, Jazeera university, Mogadishu	**Medicine, Nursing, Lab technician**
Faculty of Health Science, Galkayo University, Galkayo South	**Medicine, Lab technician, Auxiliary Nurse, Community Midwife**
Mogadishu Nursing School	**General Nurse**
Mudug University, Galkayo South	**Medicine, General Nurse**
Faculty of Nursing and Health Science, Mogadishu University, Mogadishu	**Qualified nurse, Lab technician**
Faculty of medicine, Somali University, Mogadishu	**Medicine, General Nurse, Lab technician**
Mogadishu Midwifery school, Mogadishu	**Post-basic midwifery, Established in July 2012**
Simad University - Mogadishu	**Medicine, Nursing, Microbiology/lab science, Public Health**
University of Somalia (UNISO) - Mogadishu	**Medicine, Nursing, Dentistry, Lab Sciences, Public Health**
Jaziira University - Mogadishu	**Clinical Medicine, Nursing, Lab Sciences, Midwifery**
Jamhuriya University of Science and Technology - Mogadishu	**Medicine, Nursing, Public Health, Lab Sciences, Pharmacology, Midwifery**
Somali International University - Mogadishu	**Medicine, Nursing, Midwifery, Public Health**
Somali National University - Mogadishu	**Medicine**
Al-Imra International University - Mogadishu	**Medicine and Health Sciences**
Daarusalaam University - Mogadishu	**Medicine, Nursing, Public Health, Lab Sciences,**
Daaha University	

Capital University – Mogadishu	**Medicine, Nursing, Public Health, Lab Sciences, Nutrition and Dietetics**
Darul Hikma University - Mogadishu	**Public Health, Nutrition, Lab Sciences**
Green Hope – University - Mogadishu	**Medicine, Nursing, Midwifery, Public Health, Lab Sciences, Nutrition and Food Sciences, Pharmacology,**
Hope University - Mogadishu	**Medicine, Public Health**
Horseed International University - Mogadishu	**Clinical Medicine, Nursing, Public Health, Medical Laboratory Sciences**
Indian Ocean University - Mogadishu	**Nursing, Public Health**
Sombridge University - Mogadishu	**Nursing, Midwifery, Public Health, Medical Laboratory Sciences**
Merka University - Mogadishu	**Medicine, Nursing, Public Health**
Plasma University - Mogadishu	**Medicine, Nursing, Midwifery, Public Health, Lab Sciences,**
Shifa University - Mogadishu	**Medicine, Nursing, Midwifery, Pharmacology, Lab Sciences,**
Golis University – Erigavo	**Medicine, Nursing, Public Health, Nutrition, Lab Sciences,**
Jubba University of Science and Technology - Mogadishu	**Medicine, Nursing, Midwifery, Public Health, Lab Sciences,**
Kismayu University	**Medicine, Nursing, Public Health,**
Imam Shafi University	**Nursing/Midwifery, Public Health, Nutrition, Lab Sciences,**

South central Somalia Health Training Institutes

Challenges

Reviewing the current mental health situation in Somalia, a few key challenges can be identified:

1. **Mental health has a low political and public health profile:**
    - Lack of information and/or misinformation about mental health issues results in development of stereotypes which translates into stigmatizing attitudes and discriminatory practices which contribute to mental health being accorded low priority in national developmental agendas and public health policies. This also contributes to human rights violations of individuals suffering from mental ill health with little or no legislative provisions.
2. **Lack of a coordinated strategic and legislative framework**
    - This is contributing to chronic under resourcing, widespread human right violations, mushrooming of isolated disjointed initiatives for provision of services which are not consistent with best practices, observant of human rights, inaccessible to the most vulnerable sections of the society, like women and children
3. **Chronic under-resourcing:**
    - Financial, logistic, organizational, infrastructural and human is another major challenge. Inadequate funding, shortage of specialist trained staff, limited skills of general health care staff, paucity of opportunities for acquiring knowledge and skills about mental health at undergraduate, post graduate levels or in service, lack of integration of mental health services with in general health care and social care services, tend to hamper the development of integrated community-based services underpinned by evidence.

These challenges are occurring in a milieu of mental health illiteracy permeating all levels of the society, chronic insecurity, violence and displacement, resource constraints, competing emergency priorities compounded by a chaotic policy and regulatory environment.

Opportunities:

1. Despite the multiplicity of challenges, adoption of the global action plan 2013-2020 , accumulating evidence for cost effective mental health interventions which can be implemented in in an integrated manner in priority platforms like PHC, mother and child health care programmes and NCDs in low resource settings which provide opportunities for adopting more efficient models of mental health care by reorienting mental health services to reach more people by more cost-effective use of the limited resources available.
2. At the country level, there is movement towards developing a common health policy directions and priorities harmonized with the Somali Compact strategy, stipulated within the New Deal framework (2014-2016)
3. There is growing recognition of the importance of mental health to society, productivity, security and social cohesion as evidenced by inclusion of mental health among the package of EPHS albeit as an additional programme.
4. Setting up of community-based care services through development of a cadre of FCHWs which is to be expanded in a phased manner across all the regions
5. Availability of local as well as iNGOs and involvement of the Diaspora and local communities also provide opportunities to develop partnerships and strengthen the mental health services which are community based, accountable and accessible

6. New technologies also provide opportunities for reaching hitherto inaccessible and underserved sections of the population for community-based care, mental health promotional and public education programmes.

Process and rationale for the development of the mental health strategy:

The development of the mental health strategy for Somalia has been a collaborative effort with active consultation of the different stakeholders. As part of this process, building on the Situation Analysis of 2010, (WHO, 2010) workshops were organised in Puntland, Somaliland and South-Central Region in May 2012 followed by a consensus building workshop in Nairobi, with representatives from the ministries from three zones and voluntary organisations, both national and international.
In each of these workshops, the following topics were discussed: importance of Mental Health; global mental health developments; regional mental health developments; and country mental health situation analysis. Following this the mental Health Strategy in terms of the goals, values and principles and strategies were discussed. The objectives for each strategy and activities for each objective were outlined as relevant to the region. Finally, the activities along a time frame, namely short term, medium term and long term were identified.
In the workshops, the special importance of the private sector, contribution of expatriate mental health professionals and the diaspora along with the role of religion was emphasised as relevant to mental health of the population of Somalia. These inputs have been reflected in the Strategy document besides building on the developments in mental health sector over the last decade.

Chapter 3

National Mental Health strategy

Vision

The mental health strategy envisions that people of Somalia have access to a community based, comprehensive and integrated care across the domains of promotion, prevention and treatment consistent with the human rights respecting local norms embodying recovery approaches promoting inclusiveness and reintegration with community.

Goal

The goal of this strategy to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorder.

Values and Principles:

Mental well-being is fundamental to participation in civil, social and economic life, and for the exercise of human rights. People with MNS disorders have the right to equal access to health services, employment, and education. Mental health care should be delivered and legislated to international standards of human rights.

The values underpinning this strategy are those espoused in the World health report on mental health 2001 and Global mental health action plan 2013-2020:

- ***Integration:*** integrate mental health with general health care, and develop a community care approach to mental health to enhance psychological well-being of the population;
- ***Empowerment, Participation and acceptability:*** Empower the service-users, family associations to engage and participate in policy and service development, being sensitive to cultural relativism, while protecting vulnerable sections of the population;
- ***Availability, accessibility and equitability:*** Provide financial protection to people with MNS disorders against the cost of ill-health by developing mental health care that is accessible to all people, and that has equity with general health services; and
- ***Evidence-based:*** Make use of the best available scientific evidence to develop services and provide interventions across the life course.

Strategic Directions:

1. Leadership and Governance
2. Integrated community-based provision of mental health care
3. Development/strengthening the human resources
4. Strengthening information, evaluation and monitoring

1. Strengthen leadership and Governance for mental health

Strong, well-informed and sustained government led commitment is crucial to addressing the development and maintenance of an integrated mental health system as part of the general health system. Leadership is required to develop, regularly review and update policies, plans and legislation. There is need for a mental health unit/directorate responsible for development, coordination, monitoring and evaluation of mental health strategies, policies, plans, legislation and service provision, which are adequately staffed and resourced. This should be both at the Central level and at each of the Regions. Mental health legislations need to be promulgated to ensure that the provisions of the UN Convention on the Rights of Disabled (UNCRPD) are reflected to safeguard the rights of persons with mental disorders and disabilities. Furthermore, robust implementation mechanisms also need to be in place.

Objectives:

- To establish and strengthen a common governance mechanism to ensure endorsement/adoption facilitating and monitoring implementation of the provisions of the mental health strategy.
- To develop and/or review mental health legislation that meets the provisions of international standards and conventions.
- To review existing mechanisms of health financing and suggest methods to ensure mental health services are equitable.

Activities:

- Establish /strengthen units/directorates within respective ministries of health with resources and authority to facilitate and monitor implementation of mental health strategy.
- Review existing health and social sector policies/ strategies to ensure mental health component is reflected in governmental and developmental partner (s)policies/strategies
- Develop mental health and related laws so that they are in line with international human rights standards including the CRPD.
- Carry out a resource needs assessment based on locally agreed service coverage targets and intervention priorities
- Increase and prioritize budgetary allocations for addressing the agreed upon service targets and priority interventions
- Include defined priority mental disorders in the national/social insurance and reimbursement schemes to protect the most vulnerable sections of the population

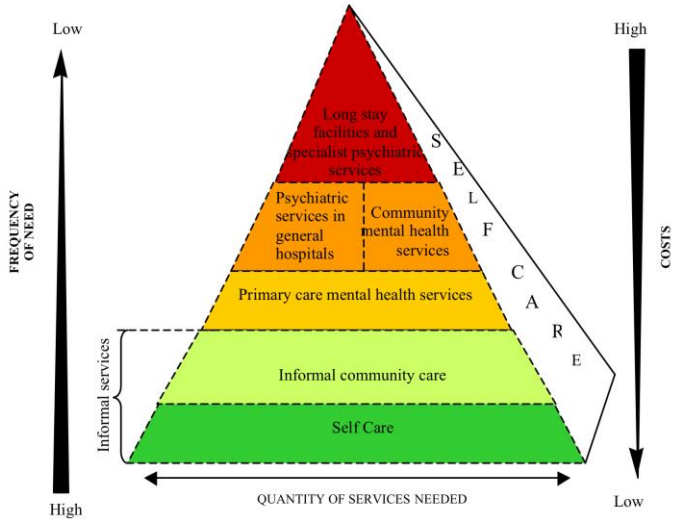
2. Development of Integrated community-based provision of mental health care:

The main thrust of this strategy is provision of mental health care, that is accessible to all, makes efficient use of the resources available to provide effective mental health care, in a way that is equitable and fully respects the human rights of people with mental disorders and their careers. At the heart of mental health care lies the health care service, alongside the promotion of mental health and well-being and prevention of mental disorders. Together these form the interface of mental health care with individuals, families and communities. These complementary approaches are the means to achieve the **goal** of the strategy "to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorder".

People who are suffering with a mental disorder need to be able to seek care near to their home in a way that does not carry stigma. Ideally this can be provided by the primary health care (PHC), in just the same way as for other health problems. Integration of a mental health component in PHC not only opens up access to mental health care, but it also improves identification and treatment rates for priority mental disorders, and provides holistic care for particularly disabling comorbid physical and mental health problems. This is achievable, even in countries where PHC is weak, so long as PHC workers have appropriate training and continuing support and supervision by the secondary mental health services. Training packages for the priority mental disorders have been developed, such as the WHO mhGAP program, which provide all the resources needed to support the provision of front-line services to be delivered through PHC and other priority programmes.

WHO has proposed the *WHO Service Organisation Pyramid for an Optimal Mix of Services for Mental Health* (see Figure). This model incorporates the recovery paradigm that people with mental disorders are central to their own recovery and they can manage their mental health problems themselves, supported by family, friends and community institutions. At successively higher level of the pyramid the mental health needs of the individual require more intensive professional assistance with commensurate higher costs of care.

Figure: WHO Service Organisation Pyramid for an Optimal Mix of Services for Mental Health



There is a strong consensus, supported by evidence that a balanced approach to secondary mental health services, incorporating both community and hospital services offers the best model for a modern mental health service.

Objectives:

- To develop, strengthen and scale up integrated, community-oriented mental health services through integration of mental health among the priority programmes in the EPHS, Somalia.
- Promote inter and multi sectoral collaboration for promotion of mental health and prevention of mental disorders
- Provide for populations vulnerable to humanitarian crises

Activities:

- Integration of mental health into primary care and other priority healthcare programmes using the evidence-based intervention packages available to deliver pharmacological and psychosocial interventions in non-specialized health-care settings.
- Integrate detection and management of postnatal depression for women, parenting skills training as part of routine antenatal and postnatal care and home visitation programmes by FCHWs and MCH staff using the available intervention packages.
- Develop multidisciplinary community outreach teams for defined catchment population, based in district hospitals to provide mental health care and to support FCHWs, PHC MCH professionals.

- Establish/strengthen mental health services in regional referral hospitals for outpatient and acute inpatient care.
- Ensure availability of essential psychotropic drugs in general health care settings at all facility level services
- Monitor and improve the quality of care and dignity of persons admitted to mental hospital using Q&R toolkit
- Reduce number of admissions from areas served by community mental health services and/or referral hospital psychiatric units
- Implement mass promotion public awareness campaigns to improve mental health literacy and reduce stigma harnessing the emerging technologies which can drive down costs.
- Set up Toll free hotlines manned by trained staff for crisis interventions
- Implement interventions for children, especially joint nutrition and parenting skills enhancement and class room-based interventions in complex emergencies
- Promote life skills education (LSE) employing a whole school approach
- Review the legal status of suicide and self-harm and promote the decriminalization of suicide
- Embed mental health and psychosocial support in the national /zonal emergency preparedness plans
- Strengthen the capacity of Health professionals for recognition and management of priority mental disorders during emergencies using mhGAP-IG (humanitarian version).
- Empower the emergency responders to provide psychological first aid.

3. Development/strengthening the human resources

In order to deliver on the goal of the mental health strategy to enhance the coverage for mental health, One of the key innovations required is to develop an appropriately skilled workforce that can deliver in the community setting adopting a multidisciplinary team work ethos, integrated into PHC, linked with expertise for referral and inpatient care, networked with local resources in a collaborative way for efficient and cost effective mental health care.
Commonalities shared by all zones of Somalia, regardless of situation, include: a shortage of health workforce (doctors, nurses) particularly the specialized mental health workforce (psychiatrists, social workers, psychologists and psychiatric nurses); and variable access to psychotropic medications with differential prescribing rights for health care personnel.

Delivering integrated community-based care will not only needs an increase in the number of workers at all levels of care, it also needs the existing workforce to work collaboratively adopting new roles, changing the skill-mix and developing new skills.

This requires transformation of roles and responsibilities of general health workers and specialist mental health service providers, such as through various types of task-shifting, and developing new cadre for mental health professionals like mental health clinical officers and case managers

A need is to have a mental health track within the national/zonal human resource plan to build the capacity of non-specialist health workforce and specialist mental health workforce to provide Community-based integrated care for priority mental disorders including the components of; workforce mapping; gap analysis; realistic intervention targets, appropriate skill mix; task shifting, training and supervision; stepped, collaborative care and referral pathways

Objectives

- To develop/strengthen the capacities of non-specialist health workforce provide Community-based integrated care for priority mental disorders including
- Develop new cadres for delivery of mental health care like case managers, mental health clinical officers and clinical psychiatric nurses
- Enhance the numbers specialist mental health workforce

Activities

- workforce mapping, gap analysis and defining realistic intervention targets for each level of care
- Identifying appropriate skill mix; task shifting, training and supervision requirements for each level of care and referral pathways
- Conducting TOTs for supervisors of FCHWs to train and supervise on detection and management of postnatal depression for women, parenting skills training as part of routine antenatal and postnatal care and home visitation programmes by FCHWs
- Conducting TOTs for supervisors of MCH centers to train and supervise on detection and management of postnatal depression for women, parenting skills training as part of routine antenatal and postnatal care and home visitation programmes by MCH staff
- Develop multidisciplinary community outreach teams at district level to provide services and support for MCH and FCHWs
- Train a group of social workers as case managers at district and regional referral level to carry out case management tasks
- Train identified doctors and nurses as mental health clinical officers and nurses to provide outpatient and acute inpatient care with case managers at regional level
- Review the curricula of medicine and nursing institutions for integration of mental health component based on mhGAP-IG as done in Hargeisa and Amoud universities in collaboration with THET/king's fund/partnership.
- Long term Fellowships for training of psychiatrists and clinical psychologists.
- Support enrollment of mental health focal points of ministries in Masters and diploma programmes on mental health policies and services and mental health legislation

4. Strengthening information, evaluation and monitoring

Information about need, resources, capacities and interventions implemented is crucial to monitor and plan improvements in service provision. Routine information systems for mental health in all zones of Somalia are rudimentary or absent, making it difficult to understand the needs of local populations and resources available and to plan accordingly. Data relating to internationally agreed as well as locally determined mental health indicators can be collected in two main ways: routinely or periodically. Ideally, most of the data requirements should be generated on a routine basis via local information systems; for example, deaths attributable to suicide and self-harm should be recorded in vital registration systems, while cases of mental disorder receiving care and treatment should be identifiable through facility-based recording systems.

In situations where routine health information systems may not yet be in place or functioning well, or where more periodic assessment may be sufficient (e.g. the compliance of local mental health legislation with international or regional human rights instruments), periodic but regular surveys can be used to monitor developments. For example, in order to measure current and increased service coverage for severe mental disorders – a core mental health indicator of the global Action Plan – many countries may consider carrying out a baseline and repeat survey in one or more defined geographical areas of the country.

Objectives

- To collect, analyze and report on available mental health system resources and capacities
- Integrate a small number of agreed mental health indicators in the zonal/national health and related national information system.

Activities

- Periodically assess and report the mental health resources and capacities available using standardized methodologies.
  - Establish a national focus of expertise and leadership to implement the development, reporting and use of mental health surveillance and information.
  - Develop procedures, regulations and training to ensure that the processes of collecting, analyzing, reporting and using data meet standards of quality and confidentiality.
- Develop or strengthen national Health Information Systems incorporating the mental health indicators in the Appendices.
- Collaborate with the Regional Strategy for NHIS Strengthening to develop information systems that utilise web-based technologies and data warehousing to facilitate integration of information.

Chapter 4

Plan of action: Short-term, medium term and long-term activities

Strategic Directions	Activities to be undertaken over the coming 1 year	Activities to be undertaken over the next 02-03 years	Activities to be undertaken over the longer term
Leadership and Governance	Establish /strengthen units/directorates within respective ministries of health with resources and authority to facilitate and monitor implementation of mental health strategy. Review existing health and social sector policies/ strategies to ensure mental health component is reflected in governmental and developmental partner Strategies / plans Carry out a resource needs assessment based on locally agreed service coverage targets and intervention priorities Increase and prioritize budgetary allocations for addressing the agreed upon service targets and priority interventions	Increase and prioritize budgetary allocations for addressing the agreed upon service targets and priority interventions Develop mental health and related laws so that they are in line with international human rights standards including the CRPD.	Increase and prioritize budgetary allocations for addressing the agreed upon service targets and priority interventions Include defined priority mental disorders in the national/social insurance and reimbursement schemes to protect the most vulnerable sections of the population

Strategic Directions	Activities to be undertaken over the coming 1 year	Activities to be undertaken over the next 02-03 years	Activities to be undertaken over the longer term
Integrated community-based provision of mental health care	Strengthen the capacity of Health professionals for recognition and management of priority mental disorders, mhGAP-IG (humanitarian version). Integrate detection and management of postnatal depression for women, parenting skills training as part programmes by FCHWs and MCH staff Set up Toll free hotlines for crisis interventions Develop multidisciplinary community outreach teams, based in district hospitals Implement mass promotion public awareness campaigns harnessing the emerging technologies Establish/strengthen mental health services in regional referral hospitals for outpatient and acute inpatient care. Empower the emergency responders to provide psychological first aid Ensure availability of essential psychotropic drugs in general health care settings	Monitor and improve the quality of care and dignity of persons admitted to mental hospital using Q&R toolkit Integrate mental health into primary care Promote life skills education (LSE) employing a whole school approach Review the legal status of suicide and self-harm and promote the decriminalization of suicide Embed mental health and psychosocial support in the national /zonal emergency preparedness plans	

Strategic Directions	Activities to be undertaken over the coming 1 year	Activities to be undertaken over the next 02-03 years	Activities to be undertaken over the longer term
Development and /or strengthening the human resources	workforce mapping, gap analysis and defining realistic intervention targets, identifying appropriate skill mix; task shifting, training and supervision requirements for each level of care Conducting TOTs for supervisors of FCHWs and MCH staff Train Multidisciplinary outreach teams Train a group of social workers as case managers at district and regional referral level to carry out case management tasks Train identified doctors and nurses as mental health clinical officers and nurses to provide outpatient and acute inpatient care with case managers at regional level Support enrolment of mental health focal points of ministries in Masters and diploma programmes on mental health policies and services and mental health legislation	Support enrolment of mental health focal points of ministries in Masters and diploma programmes on mental health policies and services and mental health legislation	Review the curricula of medicine and nursing institutions for integration of mental health component based on mhGAP-IG Long term Fellowships for training of psychiatrists and clinical psychologists

Strategic Directions	Activities to be undertaken over the coming 1 year	Activities to be undertaken over the next 02-03 years	Activities to be undertaken over the longer term
Information evaluation and Monitoring	Strengthen national Health Information Systems incorporating select mental health indicators Periodically assess and report the mental health resources and capacities available using standardized methodologies		

Appendix

Proposed Indicators for inclusion in HMIS

Routine National HMIS	Routine National Information System other than HMIS
1. Number and Proportion of persons seen with MNS disorders in different service settings (disaggregated by age, sex and diagnosis of priority disorder) 2. Proportion of PHC facilities having regular supply of essential psychotropic medicines for priority mental disorders 3. Proportion of the mental health beds in general hospitals 4. Number and proportion of admissions for severe mental disorders to inpatient mental health facilities that a) exceed one year and b) are involuntary 5. Proportion of general hospitals which have outpatient departments for mental health 6. Number and proportion of primary care staff trained in mental health 7. Number and proportion of mental health facilities regularly monitored to ensure protection of human rights of persons with mental disorders using Quality and Right Standards 8. Number of mental health workers by category 9. Number and proportion of MCH professionals trained in early recognition and management of post natal depression and to provide early childhood care and development and parenting skills to mothers and families	1. Proportion of schools implementing the LSE packages 2. Number of suicide deaths per year 3. Recording Suicide as the cause of death using relevant ICD-codes (X codes) is mandated by law

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