Federal Ministry of Health and Human Service

Section of Mental Health

First Draft

SOMALIA MENTAL HEALTH POLICY

2022 – 2026

CONTENTS

FOREWORD

ACKNOWLEDGEMENTS

ABBREVIATIONS

COVID-19	Coronavirus Disease
CSO	Civil Society organization
DALYs	Disability- Adjusted Life Years
EML	Essential Medicines List
EMRO	Eastern Mediterranean Region
GAVO	General Assistance and Volunteers Organization
GRT	Gruppo per le Relazioni Transculturali
HIS	Health Information System
IDP	Internally Displaced People
IMC	International Medical Corps
IOM	International Organization for Migration
IRC	International Rescue Committee
mMhGAP	Mental Health Gap Action Program
MHIS	Mental Health Information System
MHPSS.	Mental Health Psychosocial Support
MIDA	Migration for Development in Africa
MNS	Mental, Neurological and Substance use
MoH & HS	Ministry of Health and Human services
NGO	Non-Governmental Organization
SCI	Save the Children International

SNU	Somali National University
UN-CRPD	UN Convention of Rights for Persons with Disabilities
WARDI	WARDI Relief & Development Initiatives
WHO	World Health Organization
WHO-AIMS	The WHO Assessment Instrument for Mental Health Systems

PART 1: BACKGROUND

1.7 Introduction

Mental Health, Neurological and Substance use are worldwide health problems, affecting social groups of all ages. Although, reliable prevalence studies on mental illnesses are missing, Somalia is believed to have one of the highest in the world, according to a WHO mental health situational analysis, one in every three persons in the country suffers from one form or another mental health illness (WHO, 2010). Major contributing factors include protracted civil conflict, trauma, poverty, high unemployment, domestic violence, and substance use.. The dire situation of the mental health in the country is further exacerbated by the use of khat, an amphetamine like psychostimulant which is widely chewed largely by men with serious negative impact on the mental wellbeing of the chronic chewers, which impacts on their families and the nation as a whole.

In Somalia, mental illness is highly stigmatizing for both the individual and the whole family. People with mental disorders are highly discriminated against and marginalized, putting them at a disadvantage in every aspect of their life including financial situation, housing, marriage and basic human rights. Worse still, there is no mental health legislation to protect people with mental disorders. Prevailing mental health services in the country are old fashioned, hospital based, expensive and lack equity.

Notwithstanding this alarming scenario, there is an almost total absence of sector financing. Mental health is underfunded and highly neglected sector. Somalia Ministry of Health and Human Services recognizes that mental health illness is one of the most pressing public health issues which need substantial intervention through integration into the general health care system in the country, which prompted the initiation of development of this MH Policy.

Thus, developing a clear and complete 'Mental Health Policy' is the first step towards addressing, developing and sustaining quality mental health service nationwide, as WHO stated, "Plan without Policy is an aimless and disorganized list of activities".

This Mental Health policy is based on WHO Somalia Country Office, GRT and other stakeholders past experience and information related to current situation while following WHO guidelines on developing mental health policy (WHO, 2003), the global comprehensive Mental Health Action Plan 2013-2030 (WHO, 2021) as well as the regional framework to scale up actions on mental health in the Eastern Mediterranean Region (WHO, 2016) and the Ministry of Health and Human Services (MoH & HS)'s vision

of Universal Health Coverage. This policy is intended to fundamentally reform the mental health system in the country ensuring the attainment of the highest standards of mental health service delivery which is based on the respect and protection of the individual rights of people with mental disorders.

In light of major developments in global mental health research during the past ten years, Somalia Ministry of Health and Human Service (MOHHS) came to the conclusion that development of MH Policy is priority. This new policy not only puts emphasis on a primary health care based mental health service, but the creation of outreach services community based services. Moreover, this new policy will give major consideration to gender challenges particularly pregnancy related mental health issues, its management and prevention. An important part to this MH policy is about mental health in emergency since Somalia is prone to both natural and made disasters (drought, floods and displacement) and recurrent epidemic outbreaks.

The current document includes chapters on prevention, promotion, mental health information system, essential drug procurement and distribution channels, advocacy and mental health in emergency. It is nevertheless acknowledged that it will undergo periodic revision as to flexibly adapt to the changing scenarios and hopefully the improvement of the sector.

1.8 Understanding Mental Health

The World Health Organization (WHO) in its constitution of 1948 defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" [1]

Mental health is defined as "a state of well-being whereby individuals recognize and realize their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities"3 (WHO: 2003). Positive mental health includes emotion, cognition, and social functioning and coherence. (WHO: 2009).[2]

Mental health is a key determinant of overall health and socio-economic development. It influences a variety of outcomes for individuals and communities such as healthier lifestyles; better physical health; improved recovery from illness; fewer limitations in daily living; higher education attainment; greater productivity, employment and earnings; better relationships with adults and with children; more social

1. http://www.who.int/about/definition/en/print.html (Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.)
2. http://www.who.int/mental_health/media/investing_mnh.pdf (World Health Organization, Investing in mental health.)

cohesion and engagement and improved quality of life (WHO: 2009).

1.3 Mental Health and Mental Disorders: Determinants and Consequences

Determinants of mental health and mental disorders include not only individual attributes such as the ability to manage one's thoughts, emotions, behaviours and interactions with others, but also social, cultural, economic, political and environmental factors such as national policies, social protection, living standards, working conditions, and community social supports. Exposure to adversity at a young age is an established preventable risk factor for mental disorders.

If untreated, mental disorders can create an enormous amount of suffering, disability and economic loss (WHO: 2003). Mental disorders have an impact on individuals, families, communities and nations. People with mental disorders experience disproportionately higher rates of disability and mortality. Mental disorders frequently lead individuals and families into poverty. Homelessness and inappropriate incarceration are far more common among people with mental disorders than for the general population, and having mental disorders exacerbates their marginalization and vulnerability.

Persons with mental disorders often have their human rights violated, as a result of stigmatization and discrimination. Many are denied economic, social and cultural rights, with restrictions on the rights to work and education, as well as reproductive rights and the right to the highest attainable standard of health. They may also be subjected to unhygienic and inhumane living conditions, physical and sexual abuse, neglect, as well as harmful and degrading treatment practices in health facilities, spiritual and traditional healing centers and in the community.

They are often denied civil and personal liberty, and the right to exercise their legal capacity on other issues affecting them, including their treatment and care. As such, persons with mental disorders often live-in vulnerable situations and may be excluded and marginalized from society, constituting a significant impediment in the achievement of individual, family and societal goals.

In Somalia there are few mental health facilities, and these facilities are scattered across the country with limited capacity and low levels of coverage. In addition, the population continues to face main stressors with on-going conflict in various parts of the country. The limited infrastructure in Somalia currently allows the Ministry of Health and Human Services to only provide hospital-based tertiary mental health services, but not primary and secondary levels of care for mental illness. Although tertiary mental health services are essential part of the continuum of care, the bulk of mental health services need to be at primary and secondary level. The traditional approach to utilizing tertiary mental health services have been found to be

less effective and removing persons with mental illness from their normal family and community life disrupt their normal daily and family lives, delay their recovery process and in most instances impose extra burden on families and health care providers.

There is a natural confluence between Mental illness and mental disability issues. In Somalia people with mental illness are treated inhumanely and also discriminated against in society and require their rights protected. Persons with mental illness may not be able to claim their rights whenever there is a violation of their rights; Such as when they are being treated against their will, confined against their will, or whenever their lives are under threat due to a belief that they may be harboring evil spirits. People with mental illness are human beings with human rights; they are entitled to the full range of human rights accorded by international and local laws.[3]

1.4 Policy Rationale

The development of the Mental Health Policy was informed by the need to reform the mental health systems in Somalia. This policy seeks to address the following:

a. To align the mental health services with the Constitution of Somalia, and with the national and global health agenda

b. To address the mental health systemic challenges, emerging trends and mitigate the burden of mental disorders

c. To allign the efforts of mental health actors, raise adequate resources for mental health and integrating mental health services within mainstraim health services.To increase awareness about mental health and improve mental health services resulting in respect for the rights of persons with mental disorders in accordance with national and international laws.

1.5 Policy Development Methodology

The Somalia Mental Health Policy 2022-2026 is a commitment pursuing policy measures and strategies for achieving optimal health status and capacity of each individual. The goal of this policy is the attainment of the highest standard of mental health and wellbeing. This policy recognizes that it is the responsibility of all stakeholders in the public and private sectors to ensure that this goal is attained.

3. Somalia Mental Disability Policy

Mental health policy interventions are broad and cut across other sectors and therefore it is imperative that a multi-disciplinary and inter-sectoral approach is employed in the implementation of this policy. This policy has been developed through a consultative process involving public, private, non-state actors, UN agencies, local and international NGOs under the stewardship of the Ministry of Health and Human Services.

1.6 Situational Analysis

1.6.1 Burden and prevalence of mental disorders: The GlobalContext

Globally, mental, neurological and substance use disorders affect about 10% of the general population, but in countries affected by humanitarian crises, one in every five people is estimated to suffer from some form of mental disorder. While importantly more than 75% of people with mental, neurological and substance use conditions in low- and middle-income countries, especially in conflict and post-conflict settings, do not have access to effective mental health services. The lack of treatment increases the burden of illness in terms of mortality, morbidity, stigma and discrimination and evidence shows that mental illnessis a leading cause of disability globally.

Economically, mental disorders lead to reduced productivity, unemployment, loss of wages and resultant poverty, which affects the financial well-being at the individual level and eventually at the national andglobal levels. Depression and anxiety alone cost the global economy about a trillion United States dollars a year, while the total financial cost of mental illness is expected to exceed US$ 6 trillion by 2030*(4)*. Low- and middle-income countries bear more than 50% of these costs. Despite the enormous financial consequences of mental health, tackling mental illness is still less of a priority in low- and middle-income countries, with most such countries allocating less than 2% of their health budget to mental health services[4].

Further, WHO estimates that 60% of people attending primary care clinics have diagnosable mental disorder [5] **(**WHO: 2008) Mental disorders are important risk factors for other diseases, as well as unintentional and intentional injury. By their very etiology, mental disorders increase the risk of getting ill from other diseases such as HIV, cardiovascular disease, diabetes, and vice-versa.

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4. Vigo D, Thornicroft G, Atun R. Estimating the true global burden of mental illness. Lancet Psychiatry. 2016;3(2):171–8.https://doi.org/10.1016/S2215-0366(15)00505-2

5. WHO 2008

Stigma and discrimination against patients and families prevent people from seeking mental health care. Human rights violations of people with mental and psychosocial disability are routinely reported in most countries, even though anecdotal evidence suggests that the reported cases are far below the actual numbers.

Globally, there is huge inequity in the distribution of skilled human resources for mental health. Shortages of psychiatrists, psychiatric nurses, psychologists and social workers are among the main barriers to providing treatment and care in low- and middle-income countries. Low-income countries have ranges from 0.05 psychiatrists and 0.42 nurses per 100 000 people[6]. Even in the low- income countries, there are internal inequities in the distribution of these already low numbers of mental health workers, whereby the available professionals are concentrated in cities and teaching hospitals (which are often in the capital cities), while rural areas are left with far fewer professionals.

It is estimated that four out of five people with serious mental disorders living in low- and middle-income countries do not receive mental health services that they need. Neuropsychiatric disorders are estimated to contribute to 13% of the global burden of disease. (The Global Burden of Disease – 2004)[7].

1.6.2 Burden and prevalence of mental disorders: The Somali Context

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 varying or different methodologies to estimate burden. Most of these studies have been done in the northern regions of Puntland and Somaliland. According to General Assistance And Volunteers Organization 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 (VIVO, date). Research also showed that a large number of ex-combatants suffer from drug use and severe mental disorders, that compromises their ability to reintegrate into 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;

6. WHO Global Health Observatory data repository. Beds. Data by country. Geneva: World Health Organization; 2019 (https://apps.who.int/gho/data/node.main.MHBEDS?lang=en, accessed 12 July 2021).

7. Lopez, Alan D. "Disease Control Priorities Project: Global burden of disease and risk factors." Disease control priorities project: Global burden of disease and risk factors (2006).

however, in the presence of continuing violence, it is reasonable to conclude that the prevalence of mental disorders will be at least comparable to the other two zones if not worse.

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 Although in the past chewing khat was a highly regulated social norm commonly consumed by adult men, the consumption and patterns of use has shifted and now increased addiction is being seen in women and youth 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. [8]

There are six key barriers to increased access to effective mental health services:

- The absence of mental health from the public health agenda and the implications for funding
- The current organization of mental health services
- Lack of integration within primary care
- Inadequate human resources for mental health
- Lack of public mental health leadership and government.
- Lack of mental health financing and budgetary allotment

8. Somali Mental Health Strategy (2019 – 2022)

PART 2: MENTAL HEALTH POLICY FRAMEWORK

2.1 Guiding Principles

The following principles guided the development of the National Mental Health Policy and should guide its implementation:

1. **Mental health is an integral part of health**

   Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity - WHO 19489. 'There is no health without mental health'.

2. **Mental health and socio-economic development**

   Mental health contributes significantly to socio-economic development of individuals, households, families, communities, nations and societies at large.

3. **Mental health is a human right**

   Mental health is a human right which should be respected regardless of religion, disability, gender, culture and socioeconomic status

4. **Equity**

   The principle of equity is meant to ensure Universal Health Coverage for all. Services should be provided equally to all individuals in a community irrespective of their gender, age, caste, color geographical location, culture, and social class. Focus should be on inclusiveness, non-discrimination, social accountability, and gender equality.

5. **People-centered approach to mental health interventions**

   A people-centered approach should ensure health, and mental health interventions are organized around people's legitimate needs and expectations. This calls for community involvement and participation in deciding, implementing and monitoring of provided interventions.

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9. WHO 1948

6. Participatory approach to delivery of interventions

Participation should be encouraged in the design and delivery of interventions in order to maximize the contributions of different actors, in attaining the best possible outcomes. Collaborative models of dialogue should continually be emphasized to achieve desired outcomes.

7. Multi-Sectoral approach to maximizing achievement of mental health goals

A multi-sectoral approach is based on the recognition that mental health cannot be improved by interventions relating to mental health services alone, but that other related sectors are equally important in attaining the overall health goals. A focus of 'Mental Health in all Sectors' should be applied in attaining the objectives of this policy. Such related sectors include: Education, labour, security, correctional services, children services, planning, finance, legal justice system, industrialization, agriculture

8. Efficiency in application of health technologies

Health technologies including e-health and specialized mental health equipment are integral in the delivery of mental health services. Health technologies should maximize the use of existing resources and build capacity. This is in the selection of technologies that are appropriate, accessible, affordable, feasible and culturally acceptable to the community for addressing the mental health challenges, and in the application of such technologies.

9. Social accountability

The constitution of Somalia obligates all institutions to be accountable to the public directly and through their representatives. Realization of the highest standards of mental health can only be achieved by bridging public perceptions and their needs through assessments, performance reporting, public awareness, transparency and public participation in decision making on mental health related matters.

10. Life Course Approach

Policies, plans and services for mental health need to take account of health and social needs at all stages of the life course, including prenatal, infancy, childhood, adolescence, adulthood and older age.

2.2 Vision, Mission, Values, Principles, Goals and Objectives

Vision:

The mental health policy 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.

Mission:

The mission of this policy 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

The following principles guided the development of the Mental Health Policy and should guide its implementation:

Values	Principles
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;
Evidence-based	Make use of the best available scientific evidence to develop services and provide interventions across the life course.

Goals and Objectives

Based on vision/mission and drawing from values and principles outlined in previous sections, the goal and objectives of the mental health policy are as following,

A. Goals:

- Strength the leadership in the mental health sector at the national, state and district levels.
- To reduce distress, disability, exclusion, morbidity, and premature mortality associated with Mental Health problems across life span of the person,
- Enhance understanding of the mental health in Somalia

B. Objectives

- Enhance the capability of the Ministry to integrate mental health into the Somalia's General Health Policy, the General Health Sector Strategic Action Plan (at all levels of the health system), and annual operational plans, and hence drive the implementation of the mental health program across Somalia, as a core component of general health system strengthening.
- Ensure the basic supply of essential psychotropic drugs to primary health care units, general hospitals and outpatient departments. Provide quality mental health services that are accessible, affordable to the community and integrated into the General Healthcare System using a Multi-disciplinary and Biopsychosocial and spiritual approach.
- Provide comprehensive and interactive Mental Health Programs for the rehabilitation and effective integration of clients through Community empowerment.
- Promote and protect the Human and Civil Rights of Persons suffering from Mental Health Disability.
- Provide equitable access to Mental Healthcare to all people, especially those most vulnerable population such as children, women, the elderly, prisoners, and people living with HIV.
- Increase the knowledge, understanding and awareness of the population about Mental Health Disabilities and health education in schools.
- Promote and establish mechanisms for intersectoral liaison between health, education, social development, police and prisons and NGO sectors etc at national and regional and local levels to promote good mental health, prevent mental illness, and ensure effective interventions for people with mental illness.

2.3 Policy Directions

2.3.1 Legislative Framework

In Somalia there is no single legislation to ensure adequate regulatory framework for mental health government, management and regulation of mental health services, training, professional licensing as well community integration of persons with mental disorders, integration of mental health at primary health care and establishing access to health care at community level.

Mental health legislation is necessary for protecting the rights of people with mental disorders, who are a vulnerable section of society. They face stigma, discrimination, and marginalization in all societies, and this increases the likelihood that their human rights will be violated. Hence Somalia Mental Health Legislation will be developed on the basis of a Human Rights approach consistent with the UN Convention of Rights for Persons with Disabilities (UN-CRPD) which reinforces International Standards and Laws, thus allowing for full implementation of the UN Convention.

- Enacting an ACT of Parliament (Senate and House of People) to establish or consolidate laws) relating to mental health care, management and administration of mental health services, training, regulation and practice of mental health professionals and other related purposes.
- Critically review the existing legislation (if any) and identify legislation gaps, including International human rights laws, conventions and international standards
- Establishing monitoring standards of Service Delivery and Care, Privacy, Dignity and Confidentiality as part of protecting the users' Human Rights.
- In partnership with the Attorney General's office, justice ministry and prison services, establishing of forensic mental c services within the mental health system and developing Standard Operating Protocols (SOPs) and procedure manuals developed.
- Legislation for establishing and mandating Inter-Coordinating Agency, Ethics Committee and other relevant Bodies, to provide a mandate.
- Establishing Minimum Standards in Service Delivery, ensuring Educational Qualifications is present and ensuring staffing is maintained for the specialized Service Delivery as well as maintaining those facilities are mandatory by Law.
- Ensuring all health staff are trained in human rights and the key components of the mental health legislation.
- Licensure and regulation of mental health service providers across public, for-profit, non-profit and alternative services such as traditional and spiritual healing services

This Legislation will safeguard the Human Rights of all persons with Mental Health Disorders and Disabilities

Significant background framework is represented by International Convention on the Rights of People with Disability which the Federal Republic of Somalia ratified in 2018, the Disability Law developed by the MoWHRD, and the Somalia Social Protection Policy developed by the MoLSA where a social protection issue is acknowledged in relation to mental health.

2.3.2 Mental Health Financing

Mental Health Financing is a critical factor in the realization of a viable mental health system. It is the mechanism by which plans and policies are translated into action through the allocation of resources. Without adequate financing, plans remain in the realm of rhetoric and good intentions. With financing, a resource base is created for operations and the delivery of services, for the development and deployment of a trained workforce, and for the required infrastructure and technology.

In Somalia there is no funds allocated for mental health care both in the federal level and the Federal Members states level. Mental health sector is largely dependent on donations from External Donors and private individuals, mainly from the Somali diaspora. In some areas, e.g. Somaliland and Puntland only the salaries to some of the staff working at the regional mental health facilities or at Mental Health Units are paid by the relevant Ministry of Health/local authority.

To ensure equity and sustainable financing, this policy will affirm the following:

- Legislated minimum allocation of sustainable government fund to mental health sector
- Mandatory taxation of recreational substances such as tobacco products (cigarettes) Khat, alcohol among others to fund treatment and rehabilitation of addiction and mental health services. Increasing taxes on recreational substances is a win-win proposition: for example, increasing cigarette taxes results in fewer kids starting to smoke, and in more adults quitting while at the same time providing substantial revenue to fund important health, as well as tobacco prevention programs.
- Legislated mandate for integration of mental health services across primary and secondary health services across all government (federal, state, regional and municipal), non-profit organizations, academic affiliated health facilities and private health sector.
- Strengthen public private partnership to finance the mental health sector
- Strengthen the national and local organizations to sustain mental health implementation

- Awareness and mobilization of Somali chamber of commerce and industry to support mental health financing.

2.3.3 Mental Health Advocacy

Stigma and discrimination against people with mental disorders is common in the Somali context with detrimental negative impact on the people's health seeking behavior, adherence to treatment and quick recovery. Stigma is also an important factor why mental health is given a low priority. Reduction of stigma through increased advocacy will ensure parity for mental health at all levels in both public and private sectors and will lead to equitable resource allocation and funding for mental health projects, programs and service provision.

The target groups for advocacy are the planners, policy makers, general public, service users and families, professional bodies, non-state actors, health workers, traditional and spiritual healers, and other service providers.

In Somalia, major issues in mental health advocacy are:

- Insufficient implementation of mental health policy, plans, programs, and legislation.
- lack of mental health services in PHC level
- Absence of accessible and affordable health care
- lack of parity between mental health and physical health.
- Poor quality of care in mental hospitals and other psychiatric facilities.
- Violations of human rights of persons with mental disorders.
- Lack of housing and employment for persons with mental disorders.
- Stigma associated with mental disorders, resulting in exclusion.
- Absence of promotion and prevention in schools, workplaces, and communities.
- Poor and inadequate mental health data in country

Thus, this policy calls for:

- MoH & HS leads efforts of developing Mental Health Advocacy Paper
- The Ministry of Health and Human Service (MoH & HS) to take more active role in sensitizing the nation on the plight of people with mental disorders in Somalia;
- The (MoH & HS) Update the national strategies to include educating the public with the goal of reducing stigma.

- The (MoH & HS) to promote the establishment and operation of users and family associations involved in mental health care and issues;
- That mental health policy issues are integrated and mainstreamed in all national policies and legislations;
- The (MoH & HS) through the Mental Health Inter-Coordinating Agency shall coordinate efforts by different line ministries, the community, Civil Society Organizations (CSOs) and other Stakeholders who are willing to contribute to the reduction of stigma in Somalia Mental Health Community.
- Political/multi-stakeholder commitment to mental health advocacy and its implementation

2.3.4 Mental Health and substance use Services

In Somalia public mental health services are centralized and exists only in few secondary and tertiary-level public hospitals, there is limited primary health care based mental health services in the country. Some public hospitals do provide limited secondary mental health services, both inpatient and outpatient services, while limited primary mental health services are provided in few private health facilities.

In addition to the few mental health departement/outpatient units at secondary level public hospitals services are provided in private health centers are unregulated. (providing mix of treatments and physical restraints and conaintment), while also some traditional healing sites (Cilaj Centers in local Somali language) exist and provide traditional and spiritual healing services.

Most of the above facilities provide mental health services without proper trainings, licensing and regulation. Moreover, majority of the patients served in those facilities are men. In some hospitals, admissions are for men only due to lack of female wards at the limited mental health facilities. Medicine supplies are inadequate and none of the facilities have a sustainable means of medical supplies. There is neither government monitoring system to overse the quality of services provided in those facilities nor the protection rights of the patients being admitted into those facilities.

Although accurate statistics are lacking, it is well known that the majority of people with mental disorders seek help from traditional and religious healers (above 85% according to GRT data in Puntland) before any other treatment is sought. There are a plethora of residential mental health centres (also known as cilaaj) run by traditional and religious healers throughout the country particularly in major towns. The majority of these facilities are not licensed through the ministry of health. There is no system to oversee or monitor the

quality of services provided in these centers nor the human rights aspect of the patients kept in those premises. Only few of those facilities which provide psychotropic medications employ qualified medical staff that come under the jurisdiction of the Ministry of health.

A. Recommend: To put in subsections of

- Primary (linkage EPHS)
- Secondary and tertiary
- To integrate in maternal mental health into services delivery

Separate MH services from substance use services

- Any services delivery in substance use to be rearranged within (primary, secondary and tertiary)
- Provide clear directions on traditional healer, spiritual in the policy

Substance Use

Substance use is commonly known to be a leading factor that contributes to mental illness in many people. In Somalia, a lot of substance use disorder such as known as Khat and other drugs which is legally imported from Ethiopia and Kenya. Khat is ~~consumed~~ are miss using daily and effecting the lively hood many people in the country through chewing the fresh leaves. Khat leaves contain a substance with stimulating effects which is categorized in the family of amphetamines. Although more recent research on prevalence is lacking in Somalia it is believed that large proportion of the population chew khat on regular basis.

In addition to the mental and psychological consequences of Khat ~~consumption~~, of substance. it has also other detrimental social, economic, and medical effects on the individual as well as the entire community.

More recently more alarming reports have been coming up in the local media indicating a rising increase of substance misuse among the Somali youth the use of alcohol and cannabis among the Somali Youth. This is something which need the attention of the government to investigate and set up preventive measures.

In compliance with the regional framework for scaling up public health action to substance use (WHO, EMRO, 2019), this policy calls for:

- A nationwide Action Plan on substance use prevention, treatment, care and rehabilitation with special focus on Khat consumption. And Narcissistic
- Strengthening capacity to deliver services that are effective, adequate and respect the human rights of affected individuals.
- Evidence-based technical guidance on mental health and substance use disorder for all public and private health care centres.
- Develop a nationwide social welfare program for affected families
- Capacity building in individual level after intervention.

Table (1): Mental Health Facilities

TYPE OF FACILITY	PUNTLAND	SOMALILAND	JUBALAND	HIRSHABLE	GALMUDUG	BANADIR	S/WEST
MH Hospital		Berbera Mental Health Hospital		Baladweyn hospital		Forlanini Hospital Savannah Hospital	
MHD in Hospital	Mental health unit, Bossaso General Hospital	Mental health unit in Hargeisa Group Hospital	Habeb Mental Health Manbile Mental Health		Shifo Mental Health Hospital		Baidoa mental health hospital
Community MH center	Nasrulah Community Centre. Garowe						
Private Stabilization Center	Gelhor and Abdulqadir khaliif centres					Rajo mental health centre	
Total	**3**	**2**	**2**	**1**	**1**	**3**	**1**

2.3.5 Organization of Mental Health

In Somalia the Ministry of Health and Human services has Mental Health section which coordinates activities with other Mental Health sections in the member states and Benadir Regional Administration (most of them represented by one focal person), However, the section is underfunded and understaffed, as there is only one Mental Health focal person in the whole section who coordinates all mental activities.

The federal **government** works in partnership with the states to address **mental health issues and coordination**. Assumably, the federal role in **mental health** includes regulating systems and providers, protecting the rights of people with Mental Health disorders, advocating funding for services, and supporting development national strategy, policy, action plan and supporting their implemention.

Mental health has now been incorporated into the Essential Package of Health Services (EPHS) at the level of basic health center, referral health center and district hospital but yet to be implemented at all levels. In terms of community involvement, there is intermittent community support from the Somali Diaspora and youth support.

More needs to be included in terms of this new policy's direction on mental health services. we can discuss this during the next phase of the meeting

- Strengthening mental health section (well-structured section with clear Organogram and job description) at federal and federal member states & Benadir Region.
- Establish strong multisectoral coordination mechanism to ensure quality mental health services are provided.
- Empowerment of professional associations such as mental health associations

2.3.6 Human Resources and Development

Human resource is the backbone of any well-functioning health care system including mental health care in any country. The performance of the health services provided depends ultimately on the knowledge, skills and motivation of the mental health work force. In Somalia mental health professionals are severely scarce at all levels and there is dire need to reverse this trend.

Thus, the policy seeks to ensure:

- Leaders and champions of mental health are empowered at central, regional and district levels.
- Staff capacity is increased in the Mental Health Section and Regional Mental Health Units in planning, service monitoring and the translation of research findings into policy and practice.
- Multidisciplinary teams of psychiatrists, general physicians, mental health nurses, social workers, psychologists, physiotherapists, traditional healers are working at all mental health specialist facilities.
- The Ministry of Health and Human Services takes the responsibility to set up mechanisms to increase the mental health work force and retain professionals.
- Medical staff working at all primary health care facilities including health centers receive trainings on mental health based on the appropriate mental health and psychosocial trainings.. The Ministry of Health and Human services (MoH & HS) is responsible to ensure that other teams such as psychosocial workers, community health workers and occupational therapists are also part of the teams at PHC facilities.
- Primary health care staff receive regular support and supervision on mental health.
- Ministry of Health and Human services in collaboration with relevant ministries and institutions to develop a comprehensive mental health training plan with particular attention to undergraduate and post graduate Physicians, Nurses, Ancillary Disciplines and Traditional Healers. In addition, in-service training and continuing professional development on Mental Health will be provided for all mental health care staff. Regional mental health units will be responsible for such trainings under the support and guidance of the Mental Health Section, MOHHS Mental Health Unit.
- Institutionalizing of Mental Health knowledge through academic and learning institutions, (Curriculum to be developed for mental health professionals).
- Development of specific HR policy and terms of reference (TOR) for mental health professionals at different levels
- Engaging private sector providers to support mental health patients and reporting
- Integration of mental health services in the primary health care (clinical psychologist)
- Industrial organizational psychology (Every company that has HR service should have someone who has a background of industrial psychology in order to be aware of the employee's mental wellbeing)
- Additional HR for mental health, Clinical psychology, Counselling psychology and Child psychology

Table (2): Mental Health Human Resources

HR types	Puntland	Somaliland	Jubaland	Hirshabelle	Galmudug	Banadir	S/west
Psychiatric							
Other medical doctors, not specialized in psychiatry							
Psychiatric Nurses							
Psychologist							
Mental health Social workers							
Support Staff							
Total							

2.3.7 Prevention of Mental Illness and Promotion of Mental Well Being

Promotion of mental health and prevention of mental disorders are some of the main priorities of this policy. Well invested and executed mental health promotion and prevention can improve the mental health of the population. The risk and vulnerabilities to mental illnesses and disorders are strongly associated with all social issues like poverty, unemployment, housing and displacement issues, and social exclusion. To properly address those issues will contribute to enhanced mental health in any community.

Mental health promotion and prevention activities are essential in reducing mental illnesses and disorders and enhancing protective factors for good health, as well as taking part in realizing supportive effects on a scope of social and economic outcomes.

Targeted and selected promotion programs should be developed for the national health integration and strategies developed for reducing the increasing burden of mental disorders and improving overall health and well-being of the population.

Prevention of mental illness and promotion of mental health shall take place in collaboration with all stakeholders within and outside health sector. In all relevant national and international events, messages of mental health should be observed and seen by the general public, through partnerships and collaboration.

Those messages should also be mainstreamed in the programs that closely relate to mental health such across the lifespan from early childhood, youth, and reproductive health including mental health to old age

Thus, this policy calls for:

- Capacity strengthening of health care providers (all levels including PHC) in promotion and prevention interventions. (Training on evidence-based MH interventions)
- Implementation of mass promotion of public awareness campaigns to improve mental health literacy and reduce stigma and discrimination.
- Implementation of school-based prevention interventions targeting both children and parents, such as joint nutrition and parenting skills and specifically designed interventions in complex situations like droughts/floods, and civil conflict (covered by the first policy point above)
- Implementation of community empowerment interventions to promote mental health, social well-being and reduce the risk of mental disorders for young people, women, elders and families living in poverty.
- Increased accessibility and affordability of MH services through integration of mental health services in the primary health care (bringing the services close to the community)
- Implement robust supervision, monitoring and evaluation to ensure the quality of MH services and training programs
- Develop prevention programs for the common addiction problems such as drug and substance abuse (with special focus on the vulnerable groups such as youth.
- Develop MH prevention interventions that address the social determinants of health including those related to improving the quality of live for the vulnerable populations.
- Rehabilitation and integration of ex combatants, prisoners into society.
- Capacity strengthening of traditional and religious community elders in health promotion, change advocates and referral focal points.
-

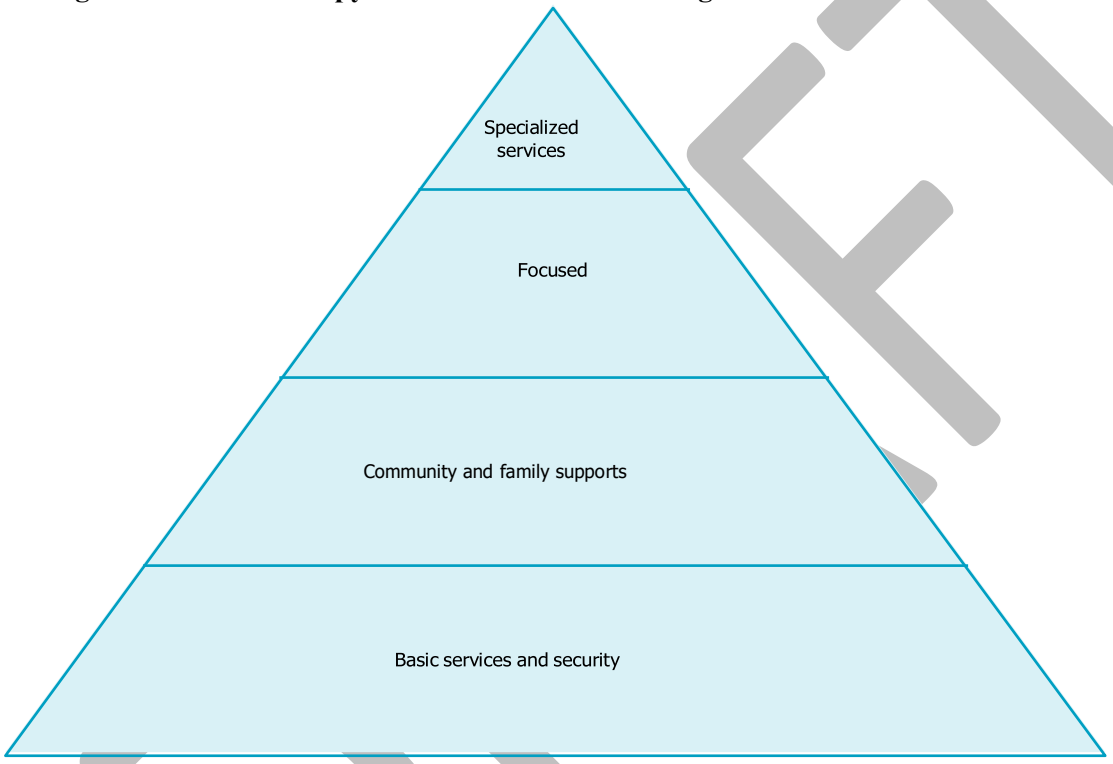
2.3.8 Mental Health in Emergencies

Given the mental health and psychosocial trauma associated with humanitarian crisis, international humanitarian organizations under the auspices of the Inter-Agency Standing Committee (here in referred to IASC) provided framework and guidance on how best to support the mental health and psychosocial needs of those in such humanitarian situations in setting minimum multi-sectoral guidance. The IASC brings together leading UN agencies such as the World Health Organization (WHO), United Nations

Children's Fund (UNICEF), and the International Organization for Migration (IOM) in addition to the International Red Cross, Medicines Sans Frontiers, Save the Children, International Medical Corps and host of other major global organizations[10].

In 2007, the IASC developed the guidelines on mental health and psychosocial support in emergency settings that emphasizes and ensures psychosocial interventions are integrated in every stage of humanitarian service as illustrated in the pyramid below [figure 1).

Figure 1: Intervention pyramid for MHPSS in emergencies



Somalia is prone to emergencies, the current COVID-19 pandemic being the latest. Other examples include recurrent droughts, floods and periodic cholera outbreaks. Moreover, since the civil war broke out in 1991 armed conflict is a major cause of displacement of substantial number of people, in addition, regional

10. Inter-Agency Standing Committee. (2008). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Setting: Checklist for field use. In *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Setting: Checklist for field use* (pp. 39-39).

conflicts such as civil war breakout in Yemen and Ethiopia resulted in refugee influx into Somalia which deteriorated the vulnerability situation in the country despite gradual increase of stability in most of the country there are still large number of internally displaced people (IDPs), returnees and refugees living in the outskirts of the most major towns in Somalia. Pre-existing distress among the public due to unemployment, poverty, insecurity and political uncertainty further contributed new negative impact of emergencies. With all these vulnerabilities to emergencies in general, there is no mental health and psychosocial preparedness mechanisms to mitigate the plight of affected populations which often lead to long-term consequences within communities, families and vulnerable groups.

Thus, in line with the Inter-Agency Standing Committee (IASC) guidelines, this policy calls for:

- Establishing of a single, inter-sectoral MHPSS coordination group chaired by the federal Government of Somalia and federal member states and co-chaired by organization/agency with defined Terms of References.
- Inclusion of MHPSS to be a core component in any national emergency preparedness and recovery/resilience plans.
- Caring and protection of people with serious mental illnesses (SMI) who are often forgotten during emergencies.
- Involvement of the media to provide accurate mental health information produced by the ministry of health that reduces stress and enable people to access humanitarian services.
- Establishing and training of emergency respond teams in all levels (federal and state) to provide Psychological First Aid (PFA) and basic psychosocial interventions.
- Ensuring all health staff, particularly those working in the primary health care facilities, receive relevant mental health training to provide proper response in the event of disaster.

2.3.9 Essential Drug Procurement and Distribution

Regular supply of psychotropic medicines to all health facilities providing mental health services is an integral part of the mental health policy. Making psychotropic available and accessible to those who need them enhances the credibility of the health care system and encourages people to seek health services.

Thus, this policy calls for:

- Availability of essential psychotropic medicines, as provided on the Somalia Standard Treatment Guidelines and Essential Medicines Lists (EML) at all facilities which offer mental health services, particularly PHC facilities.
- The quantification, procurement, storage, distribution, and disposal of psychotropic drugs should ensure the availability of essential psychotropic drugs at all levels of health system in adequate quantities and varieties and guided by relevant national documents such as the Somalia National Medicine policy.
- An elaborate and organized system for collecting, processing, and recording psychotropic products should be availed. The available national LMIS should be updated to include psychotropic products.
- MOH to develop required strategies and plans to counteract the widespread presence of counterfeit psychotropic drugs in the market. At the same time MOH will ensure close coordination is established with relevant authorities mandated to enforce regulations on counterfeit psychotropic products.
- Regulation/restriction of the availability of controlled prescriptive psychotropic drugs in black market.
- Regular supervision of prescribing habits and other methods of audit to the public and private sector as regards to rational use of psychotropic drugs,
- Introduction of a Legislation supporting the availability and accessibility of essential psychotropic medicines.
- Finding of sustainable means of financing of psychotropic medicines.
- Regular training of prescribers on the rational use of psychotropic medicines.
- Regular monitoring and evaluation of adverse reactions due to psychotropic medications.

2.3.10 Mental Health Information System

A mental health information system is a system for collecting, processing, analyzing, disseminating and using information about a mental health service. It is a tool for measuring coverage and needs to enable managers and policy makers see existing gaps. Accurate information gathered from services delivered will provide some measures of how well available resources are being used and the quality of services being delivered. It is also a means to ensure accountability.

Without having regular access to reliable (MHIS), we will not be able to develop a mental health action plan which suits the needs of the community. Moreover, to regularly update the national mental health policy we need an up-to-date and reliable information about the community. Well-developed mental health information systems are also necessary for research to assess the burden of mental disorders in the community, risks and protective factors as well as cost-effectiveness of interventions. Accurate information about the needs can also be used to secure appropriate levels of funding for mental health services.

Thus, this policy calls for:

- Integrating national mental health indicators with the MOHHS Health Information System (HIS).
- Developing Mental Health Information System (MHIS) capacity in all mental health facilities in Somalia.
- Developing a core set of mental health indicators for inclusion in national HMIS and developing mechanisms for data collection, analysis and interpretation for Evidence-based programming.
- Mapping of existing capacities and services using WHO-AIMS.

- Routine use of the information gathered for guiding of policy and for planning and management of mental health services at all levels.
- Evaluating policy implementation using the data from the mental health information systems.
- Monitoring of the mental health system against agreed norms and standards using the mental health information systems.
- Promoting a culture of information use for mental health service development through capacity building addressing the various stages of data collection, processing, dissemination and use of mental health information.
- Identifying priority research areas for Somalia in collaboration with academia for developing implementation research proposals to focus on these priorities.
- Data to be stored in both electronic and hard copies.
- Data bank to be installed and shared by Ministry of Health, International Stakeholders mandated for Health support,
- Preparation of an annual national mental health report to be laid before Parliament.

2.3.11 Research and Ethics

There is a need for the establishment of a Research and Ethics Unit that incorporates measures for systematic investigation in order to discover and/or establish emerging Mental Health Facts, attitudes and principles. The data information shall be used for measuring indicators or parameter for quality Mental Health Service. The Research and Ethics Unit shall come under the Ministry of Health.

Therefore, this policy calls for the:

- Ministry of Planning to incorporate with National Data /Information Bank and Academic and Research Institutions.
- Incorporate data information with the annual Health Plan
- Link the Research Unit with International Stakeholders in order to support the Research Unit

PART 3: IMPLEMENTATION FRAMEWORK

The mental health policy will be interpreted and implemented in line with the Second Phase of the Health Sector Strategic Plan (HSSP-II) 2017-2021 through a multi-sectoral approach including all health actors. The Mental Health Policy shall be implemented through 5-year strategic plans.

3.3 Management and coordination of the policy framework

The Mental Health Policy will be managed in accordance with the overall Health Sector Management and Coordination Framework and other related Laws of the Federal Republic of Somalia.

3.4 Roles and responsibilities

a. Roles and Responsibilities of the National Government

- Develop policy, legislation, standard setting, regulation, capacity development, coordination, monitoring and evaluation and offering technical assistance to the states.
- The Ministry of Health will facilitate policy implementation and ensure there is adequate capacity in terms of finances, human resources, commodity supply, health information and infrastructure.
- The Mental Health and Substance use Unit will provide strategic leadership in the implementation of the policy through, an integrated strategic plan, programmes and guidelines.
- The Ministry of Health and Human Services shall provide critical oversight on the implementation of this policy.
- The Government will provide an enabling environment for the enhancement of private/public sector partnerships.

b. Roles and Responsibilities of Federal Member States

- Include mental health in the State Integrated Development Plans, Strategic Plans and Annual Implementation Plans.
- Resource mobilization, monitoring and evaluation.

- Capacity building and technical assistance for effective implementation of the policy.

c. Roles and Responsibilities of Health Regulatory Bodies through the National Health Professional Council (NHPC)

- They shall regulate health professionals under their area of jurisdiction
- They shall register, license and retain members of the mental health profession.
- Receive and facilitate resolution of conflicts from patients, aggrieved parties and discipline members who commit professional misconduct.

d. Roles and Responsibilities of the non-state actors

- The non-state actors shall expand coverage and improve access to mental health care as well as participate in formulation, financing, implementation, monitoring and evaluation of mental health programmes
- The non-state actors shall actively participate in advocacy for promotion of mental health and mental health care.

e. Roles and responsibilities of media

- The mass media will play a key role in positive advocacy and creation of awareness on matters related to mental health.

f. Roles and responsibilities of individuals, families, and communities

- The individual, family and community will play a key role in the promotion of mental Health, prevention, treatment and rehabilitation of persons affected by mental, neurological and substance use disorders.
- They will also advocate for and participate in Community-based mental health programmes.

g. Role and Responsibilities of Development and Implementation partners

- They will support Mental Health Policy implementation through the Health Sector Partnerships and Coordination Framework with emphasis on mental health priorities and plans.

- They will be involved in resource mobilization and technical assistance.

h. Roles and Responsibilities of Training and Research Institutions

- The universities and colleges training in health shall include mental health in their training curricula that conforms to the national and international standards.
- The institutions shall provide evidence-based approaches and practices in mental health training and curricula
- They shall conduct scientific mental health research and share information to inform the policy implementation.

i. Roles and Responsibilities of Professional Bodies

- They offer technical advice and professional expertise.
- They ensure and facilitate professional growth and look into the welfare of the members.
- They maintain professional and ethical standards.

PART 4: MONITORING AND EVALUATION POLICY

This policy will be implemented through five-year Mental Health Strategic Plans. These plans will be supported by programme investment plans with objectives around specific health systems.

A core set on indicators for Mental Health shall be defined to monitor and evaluate the implementation of the policy. The mental health policy shall be evaluated every 5 years. The results of the policy evaluation shall be used to inform the best practices in terms of mental health policy interventions.

This policy will be implemented through medium-term strategic plans that will elaborate on the comprehensive medium-term strategic and investment approaches through two key elements:

1. Medium-term mental health and related service outcome indicators and targets for each of the policy objectives, defined by the national and state governments.
2. Priority investments across the policy orientations shall be required to attain the above-mentioned medium-term health and related services objectives. Priority investments shall be defined by the respective planning units, to enable attainment of the defined objectives for the sector.