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PERSPECTIVES

A National Program to scale up investment and reducing the gap in mental health in Somaliland: first year achievements

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ABSTRACT

In Somaliland, mental health has been neglected for years. Only two years ago, there was no office, no staff, and no funding for mental health within the ministry. Public mental health services were often of poor quality and available at few inpatient facilities in major cities such as Hargeisa, Berbera, Borama, Buroa and Gabiley with total number of beds of 216 for a population of 4 million people. This encouraged the opening of a plethora of unregulated private mental health facilities with poor records of quality of services and human rights. One of the major impediments to improvement of mental health services in the country was a lack of financial resources. Due to public pressure, in late 2020, the government decided to change the situation by funding mental health services through a sin tax on khat imported into the country. Tax collection started in January 2021, and the first funds were released for use in July 2021. Soon, a five-year national program on mental health services was launched. We present early program achievements and their possible relevance to public health for other resource strained countries looking for ways to improve their mental health services through mobilization of local resources.

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Introduction

In Somaliland, mental health has been neglected for years [1]. Only two years ago, there was no office, no staff, and no funding for mental health services within the ministry. For many years, mental health services were confined to few in-patient psychiatric units in the major towns such as Hargeisa, Berbera, Buroa, Borama, and Gabiley. The total capacity of beds was 216 beds for a population of about 4 million people. The two eastern regions of Sool and Sanaag have never had any public mental health services. Moreover, none of the regions have primary or community based mental health services. The few existing mental health facilities were in poor conditions, had a scarcity of trained mental health professionals, and were providing services of poor quality where the rights of patients were regularly violated [2, 3]. This situation has encouraged the opening of a plethora of private mental health inpatient facilities, called "*Cilaajs*" throughout the country. They are managed by religious leaders and businesspeople with no knowledge about mental health.

With this background and due to increasing prevalence of mental illness in the country [4,5] and public outcry for improved public mental health services, the ministry has recently made mental health a priority area that was included in its Health Sector Strategic Plan (HSSP II) for 2017-2021 [6]. In line with this paradigm shift a consultant (the first author of this paper, YAA), was recruited through the International Organization for Migration (IOM) to assist the Ministry of Health Development (MOHD) early 2019. He was to explore ways to strengthen mental health services in the country. By that time YAA had just completed a successful 8-year community based mental health program which was funded by the Swedish ForumCiv/Sida in the Awdal region with a staff of 26

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persons [7]. YAA joined the ministry, bringing with him this vast experience in managing, leading, and conducting community-based mental health projects in poor settings. This arrangement also facilitated the incorporation of the ForumCiv/Sida-financed project regarding the services and the staff into a national mental health program under MOHD securing its sustainability.

The immediate task of the consultant was to reactivate the mental health unit within the ministry. It included to lobby for mental health within and outside the ministry, reset the leadership role of the ministry among the partners and other stakeholders in mental health through the creation of a Mental Health and Psychosocial Coordination Group (MHPSS-CG), revise the existing mental health policy, and develop a mental health strategy (MHS) while exploring ways to fund the implementation of the strategy. Most of these activities were carried out during the first two years without any office and with no financial resources. Without funds, the work came to a dead end, and it was not possible to put the MHS into action. Insufficient financial resources have been identified as a key barrier to improving mental health in low-income countries [8]. Despite the daunting challenges, we had no option but to continue fighting for resources for mental health.

The miracle happened in late 2020 with a little bit of luck, persistent lobbying both in- and outside the ministry, and by unrestricted backing from the leaders of the MOHD. Thanks to an idea from the current minister of finance, Dr. Sa'ad Ali Shire, and his resounding support for the issue, it was suggested to fund mental health through a sin tax on khat being imported into country. The khat traders also reacted favourably and approved the idea after several educational discussions with them. At first, it was decided to impose a tax of 200 Somaliland shillings (Slsh), or approximately 0.023 US dollars (1 US dollar = 8600 Slsh), on each kilogram of khat imported into the country. The collection of the tax started in January 2021, and the first funds were released for use in July 2021.

Soon, a five-year National Mental Health Program (NMHP) (2021-2025) was officially launched on August 1, 2021, at a ceremony held at Maansoor Hotel in Hargeisa. High dignitaries in attendance included ministers of health, finance, religious affairs, and endowments, Director General (DG) of the MOHD, university deans, legislators, and representatives of local, state, and international stakeholders. The program soon started and yielded immediate and tangible results. After seeing the quick impact of the allocated financial resources on transforming mental health services across the nation, the khat sellers have since voluntarily increased the tariff to Slsh 500 (around 0.058 US $) per kg of imported khat. Around 40 million kg of khat are imported into Somaliland each year [9], which is expected to generate tax revenue of around US $2 million per year but still falls short of the minimum funding recommended by the WHO for mental health [10].

In this report, we present the most significant accomplishments made during the first year (July 2021 to July 2022) of this unique mental health program reflecting on its applicability and implications for public health in countries with comparable settings in terms of mobilizing local resources to finance the commonly neglected sector of mental health care.

The program

Establishment of a new Department of Mental Health (DMH)

A high-performance mental health system needs strong leadership and sound governance. An entirely new Department of Mental Health (DMH) was established within the ministry shortly after the Mental Health Fund was created, which is in itself a remarkable step. There are currently 9 employees working for this new department, including the director (the first author of this article), two psychiatrists, one of whom serves as the deputy director (co-author), a financial officer, a secretary, a pharmacist, and three public health officers. The department is divided into three distinct sections: (1) mental health services; (2) behaviourial change; and (3) mental health information, monitoring, and research. In each of the major 5 regions, we set up mental health units (offices) run by mental health coordinators to decentralize the office's operations and encourage geographic equity. Also, we hired psychiatrists to lead four of the five currently operating mental health facilities in the regions.

Finance, administration, and control

A separate account has been established for the Mental Health Fund at the Somaliland National Bank, to ensure that the money collected goes toward the designated goals. In addition, a National Board on Mental Health (NBMH) has been established with a total of 7 members, including 2 representatives from the national khat trader's committee, 1 from civil society, and 4 ministers (health, finance, religious affairs and endowments, and social affairs) to oversee the proper use of the funds. The DMH is responsible for managing the fund according to the MHS which is based on four main goals: 1) establishment of mental health leadership and governance; 2) improvement of mental health services and its integration into the primary health care; 3) development of human resources in mental health; and 4) establishment of mental health information system. A budget request is first prepared in accordance with planned activities. After the department's finance officer confirms that the requested budget matches the activities that are scheduled, the head of the department signs the document.

The ministry's finance department receives the signed documents for additional review and double-checking. The DG and the Minister of Health then review and approve it before it is ultimately submitted to the General Accountant within the Ministry of Finance Development. At predetermined intervals and following receipt of complete financial reports, the Office of the Accountant

General transfers the funds to the designated special account at the National Bank. Finally, the department meets the NBMH on quarterly basis and reports to them the program's accomplishments and how the budget has been used.

Mental health Infrastructure and services

Since most of the existing hospital based mental health facilities in the country were in bad physical conditions, we started to renovate the old mental health hospitals. Another reason why we started with the renovations of the existing facilities so early in the program was to show the public, the users, and the khat traders that the program is delivering immediate and tangible results observable to the public eye.

Another important move in this context has been the expansion of mental health services to the regions of Sool and Sanaag. Shortly after the program started, we opened outpatient mental health clinics in the general hospitals of Laasanood and Erigabo, the capital towns of the Sool and Sanaag regions. We also brought five persons (1 coordinator, 1 doctor, 1 nurse, and 2 social workers) from each of the two regions to Hargeisa and trained them on the WHO Mental Health Action Gap program (mhGAP) intervention guide version 2.0 [11]. These trained individuals are now running the two outpatient clinics with online support from our senior mental health specialists in the other regions.

The mhGAP is WHO's action plan to scale up services for mental, neurological, and substance use disorders in countries especially low and lower middle-income countries. The WHO mhGAP manual [11] is an evidence-based training manual for non-specialized health staff that is regularly updated by the WHO staff. The Intervention Guide presents the integrated management of priority mental health conditions using algorithms for clinical decision-making. The priority conditions addressed by the mhGAP are depression, psychoses, suicidal risks, epilepsy, dementia, disorders due to use of alcohol and psychoactive substances, mental and behavioural disorders in children, and other conditions including medically unexplained somatic complaints and emotional, physical, or behavioural problems after exposure to an extreme stressor.

Moreover, we started to build two new mental health hospitals in Laasaanood and Erigabo, the capital towns of the Sool and Sanaag regions. The two hospitals will have a capacity of 40 beds each (25 males and 15 females). The construction of the two hospitals is close to completion and will be opened soon for service. This will markedly improve the accessibility of quality mental health services in those two regions, and patients will not have to travel to distant regions to get mental health services.

Staff motivation and development

We started also to retrain all non-speciality staff working in the existing mental health facilities on the WHO mhGAP Intervention Guide [11] to update their knowledge on mental health. The trainings, which are ongoing, also include capacity building on the human rights of people with mental disabilities using the UN Convention on the Rights of Persons with Mental Disabilities (CRPD) [12].

One of the most important lessons learned from the ForumCiv sponsored project is that the key to success in any project is keeping the staff motivated by keeping their skills up to date, including them in the decision-making process, and giving them enough incentives. So, in this program, we put a lot of focus on making the staff more motivated through incentives, trainings, regular supervision, and consultation with them to hear their ideas and get their input.

Provision of free food and psychotropic drugs

Drugs are invaluable tools in any health care delivery system. One of the first actions we took was to make drugs available to all mental health facilities throughout the country, including primary health care (PHC) centres, that received training on the MhGAP. This was followed by the creation of a harmonized and unified evidence based essential psychotropic drug list based on the most recent WHO Essential Drugs List [13] to facilitate drug procurement and ensure rational prescribing. We purchase drugs through a competitive tendering from the local drug wholesalers.

Besides drugs, all inpatients admitted to public mental health facilities get free food and hygiene items.

Integration of mental health into the primary health care

To decentralize services and bring them closer to the community, we started to integrate mental health services into the PHC. As part of this endeavour, we started to train nurses and doctors working at the PHC on the WHO mhGAP intervention guide-version 2.0 [11]. Hitherto, we provided training on the mhGAP to 450 nurses and doctors working at different PHC centres throughout the country. The work will continue until all PHC staff are reached and are well acquainted with how to manage the most common mental disorders. PHC staff who have been trained in the mhGAP have begun to screen and manage patients with common mental health disorders or refer more severe cases.

The MhGAP is a friendly guide that consists of modules organized by individual priority conditions and a tool for clinical decision-making and management. The guide begins with "**Essential Care and Practice**", a set of good clinical practices and general guidelines for interaction between care providers and clients, followed by an overview describing key assessment and management steps.

The assessment section is presented in a framework of flowcharts with multiple clinical assessment points. Each module starts with common presentations of the suspected condition, from which there are a series of clinical assessment questions one should move down, answering yes or no, which directs the user to move on for further instructions to reach a final clinical assessment.

The management section consists of intervention

details, which provide information on how to manage the specific conditions that have been assessed. This includes more technical psychosocial and pharmacological interventions when appropriate.

The follow-up section provides detailed information on how to continue the clinical relationship and detailed instructions for follow-up management.

Outreach services

In all regions, we created multidisciplinary outreach teams consisting of doctors, nurses, social workers/female community health workers, and/or psychologists where such human resources exist. These teams have access to minibuses, which were purchased solely for this purpose. All maintenance and fuel costs for the minibuses are paid from the Mental Health Fund. These teams have scheduled home visits in their respective regions three times per week. They provide follow-up of patients who are discharged from the mental health hospitals and are unable to return for controls - patients mostly from poor families. The teams provide also regular support and supervision to the PHC which has started to provide mental health services. In this way, the PHC staff can sustain their knowledge and gain the confidence to receive patients in their health centres. Outreach teams also make visits to prisons to treat mentally unstable inmates and train prison guards on mental illness and human rights.

Advocacy and public education

The DMH has a quarterly based contract with the national TV and Radio Hargeisa to release mental health advocacy programs on a weekly basis. These programs include radio messages, which are broadcasted several times each day, TV programs in the form of interviews and short plays, and messages on the stigma on mental illness. These programs have been going on throughout the year (2022) and have received a wide audience throughout the country. We also received positive feedback from the public, who expressed satisfaction with the programs that it helped them understand more about mental health and even changed their attitudes towards people with mental disorders. Moreover, to reach the youth, we use social media outlets like YouTube, and the ministry's website.

Every year on October 10th, we commemorate World Mental Health Day by organizing events and celebrations, sometimes lasting a week in major towns, refugee camps and in poor communities jointly with local and international partners. We use this day as an advocacy day in which hundreds of people, including mental health care users, health professionals, religious leaders, politicians, civil society organizations, and the media, participate. We arrange marches through the streets of towns with banners, T-shirts, and caps eliciting slogans on mental health, arrange football matches, and TV panel discussions. We also erect billboards with messages on mental health and stigma in all major cities and arrange large gatherings in all the regions, which are well attended by well-known politicians and public figures.

Private sector

Costly and loosely regulated private and faith-based mental health facilities known as "*Cilaajs*," which means treatment in Arabic, are common in Somaliland. Many people with mental illnesses are treated in those facilities. Our team recently conducted a survey (yet to be published) and found 24 such facilities across the nation: 16 in Hargeisa, 2 in Borama, 5 in Buroa, and 1 in Lasanood. Around 1600 persons were receiving treatment in those centres at the time of our review, with 167 (10%) of them being women. According to our analysis, there were significant violations of the patients' rights in those facilities, including admission without consent and chaining and cramming them into confined spaces. Only a small portion of the staff had training in mental health, and the services offered were of poor quality.

Cilaajs function as rehabilitation facilities, where most patients stay for extended periods of time - in some cases, years. People typically place their loved ones in the facilities to keep them away from drug abuse, especially khat chewing. Many of those people also suffer from mental illnesses. Some of the facilities do employ nurses, doctors, and occasionally psychiatrists on a part-time basis. Staffing is insufficient given the sheer number of patients they are caring for. Patients are typically given medications, but very few, if any, receive psychotherapy. Several facilities offer occupational therapy for the patients, including instruction in reading and writing, language training and exercise and practice in mathematics, sewing, and painting, among other things. Quite a few of the facilities additionally have access to playgrounds.

After reaching an agreement with the facility owners, we provided trainings on the Convention of the Rights of Persons with Disabilities (CRPD) and the WHO Quality Rights Toolkit (QRT). CRPD is an international human rights treaty of the United Nations intended to protect the rights and dignity of persons with disabilities, while QRT is a manual that provides countries with practical information and tools for assessing and improving quality and human rights standards in mental health and social care facilities. Since the beginning of October 2022, we conducted four trainings for 48 employees and Cilaaj heads. In the pre- and post-test evaluations, the participants´ knowledge grew on average from 33% to 70%. Participants received certificates of attendance. To improve the quality of services in the centres, we are collaborating with the Cilaaj heads to develop Standard Operating Procedures and Standard Treatment Guidelines. Now, all these institutions must also obtain licenses from the Ministry based on their performance according to the WHO mental health best practices [14].

Discussion

Many programs in developing countries that receive external funding fail at the end due to lack of sustainability. The uniqueness of this program is that it is government funded through a sin tax on khat imported into the country.

A body of literature exists linking poor mental health in Somaliland or Somalia to khat chewing [15, 16]. Since the colonial period, successive authorities both in Somalia and Somaliland have tried to prohibit khat chewing and its importation into the country mainly from Ethiopia and Kenya. All attempts have been to no avail. It has proven extremely difficult, if not impossible, to stop khat coming into Somaliland. According to official figures above 40 million kg khat is imported annually. It makes sense to put a small tax to support mental health when khat chewing is a major contributor to mental ill-health. This program started less than two years ago, and the results from the first year are highly encouraging.

Financing has been one of the major challenges in scaling up mental health services in many countries in the developing world [17]. The World Health Organization (WHO) asserts that "*without adequate financing, mental health policies and plans remain in the realm of rhetoric and good intentions*" [18]. Research has shown that the cost of implementing a core package of mental health services at a high level of coverage in low-income countries is about US$2 per capital [10]. Nevertheless, most low-and middle-income countries spend less than 1% of their total public sector health care budget on mental health services [19]. In Somaliland, health care services are tax-funded, which is insufficient and often supplemented by external funds from the United Nations and international non-governmental organizations. Despite this, resources are still not sufficient, and many people rely on out-of-pocket payments to access their health care needs. The situation is even worse in the case of mental health, where there is no earmarked funding for mental health within the national health budget. Out-of-pocket payments is the dominant means of paying for one's mental health care. Considering the chronicity of severe mental illness as well as the strong correlation between mental health disorders and unemployment and low socioeconomic status [19], those in greatest need of services are often the least able to pay, leading to inequality in access to mental health care services.

Different countries have tried different methods to finance mental health services, such as government taxation, social health insurance, or private health insurance [19]. In Somaliland, the latter two systems of health financing do not exist. Thus, the Somaliland government chose to finance mental health care through taxation, specifically through khat taxation.

Regardless of this new financial arrangement to fund mental health, which promises universal mental health coverage, utilization rates may remain below socially desirable levels for quite some time. This is because of the huge stigma associated with mental health problems and the personal preferences of a large sector of the population to seek traditional and faith-based treatments as compared to conventional psychiatric care. Moreover, current mental health services in Somaliland are highly centralized and confined to major urban areas, leaving a majority of the population, including those in the rural areas without access to mental health services. Building new mental health infrastructure such as hospitals, outpatient clinics, and rehabilitation centres in all the regions and districts, integrating mental health into primary health care, and increasing the human resources in mental health to an acceptable level will all take time. In a politically volatile region, any political squabble with neighbouring Ethiopia could disrupt khat importation into the country, negatively impacting services. Thus, other complementary and more secure sources of financing mental health in Somaliland could be explored, like levying a small tax on cigarettes, beverages, etc.

Despite the shortcomings noted above, this program could have major public relevance for other countries with similar settings in different ways. Firstly, creating a mindset of self-reliance is important. Before starting this program, the author (YAA) was responsible for another highly successful community based mental health program which has been provided in the Awdal region of Somaliland for eight years [7]. The project was generously financed by the Swedish ForumCiv/Sida, but eventually must be phased out due to a lack of financial resources.

The successful key concepts in the ForumCiv project were that it was about knowledge transfer through the Somali diaspora, focusing on an illness that is very common in Somaliland that is largely neglected, and using female community health workers trained and supported by mental health professionals to bring much-needed mental health services to the doorsteps of families while empowering communities and individual patients to improve their health-seeking behaviour. Now, this government program has ensured that the services that the ForumCiv/Sida-sponsored project has been delivering as well as its staff can be integrated into the Ministry of Health's new mental health program. This ensures its long-term sustainability.

Many such programs are currently being implemented in parts of developing countries, with the looming risk and worry that they could end at any time with the loss of services and trained staff. Thus, mobilization of local resources such as putting small taxes on non-essential items imported into the country such as khat, cigarettes, tobacco, etc could generate quick financial resources to finance highly underfunded health services such as mental health. Locally raised financial resources in the form of government taxation have a higher level of assurance in sustaining programs as compared to donor driven projects, which eventually fail to endure.

Conclusion

This is a preliminary report from an ambitious five-year national mental health program to deliver human rights based universal mental health coverage to all citizens of Somaliland. It is unique in the sense that it is a government financed scheme, making its sustainability strong as compared to donor financed projects, although unforeseen challenges, which can derail the whole program can arise. This early phase of the program was intended to provide quick results to justify the project by embarking on a

nationwide advocacy program, improving the quality of existing services, both public and private, renovating of old mental health facilities, expanding the services to new regions, bringing the services closer to the community by integrating into PHC and lifting staff motivation and enthusiasm through incentives and upgrading their knowledge. The long-term objective of this program is beyond delivering services and is intended to invest in research to identify major determinants of mental illness in our society and to carry out preventive measures, particularly on stigma, substance abuse, and mother, child, and adolescent health and wellbeing, as well as social determinants of mental disorders.

Summary in Somali

SOO KOOBID

Somaliland caafimaadka maanku wuu dayacnaa muddo soddon sano ah. Ma jirin xafiis, shaqaale iyo dhaqaale lagu bixiyo caafimaadka maanka dalka mudadaas. Caafimaadka maanka ee bulshada oo tayadiisu liidatay kaliya waxa uu ku xadidnaa ama ka jiray cusbitaalaada la dhigo bukaanada ee ku yaala magaalooyinka Hargeisa, Berbera, Borama, Buroa, iyo Gabiley oo awood ahaan qaadaayay 216 sariirood iyadoo tirade dadka ku nool dalku ku dhawyahey 4 malyuun oo qof. Tani waxa ay dhiirigalisay in ay furmaan xarumo adeega caafimaadka maanka loogu adeego oo gaar loo leeyahay kuwaas oo adeeg bixintooda iyo dhawrista xuquuqda bukaanaduba aad u liidato. Caqabada ugu wayn ee caafimaadka maanka Somaliland waxay ahayd mid dhaqaale. Dadaalo badan kadib, dhamaadkii sanadkii 2020, dawalada Somaliland waxay go'aansatay in ay wax ka bedesho xaalada, iyadoo go'aansatay in ay dhaqaale u samayso adeega maanka, waxayna cashuur yar saartay Qaadka soo gala dalka. Cashuur ururintii u horaysay waxay bilaabatay bishii kowaad ee sandadkii 2021, iyadoo kharashkii u horeeyay ee adeega caafimaadka maanka la siidaayay bishii todobaad ee sanadkii 2021. Isla markiiba waxa la daahfuray qorshaha adeega caafimaadka Maanka Somaliland oo shan sanadood ah (2021-2025). Halkan waxa aanu ku soo bandhigaynaa guulihii u horeeyay ee mashruuca Somaliland ee caafimaadka maanku durbadiiba gaadhay. Waa barnaamij ay ka faaidaysan karaan wadamada kale ee aanu isku duruufaha nahay ee doonaya in ay adeega caafimaadka maanka ee bulshadooda kor u qaadaaan iyagoo isticmaalaya dhaqaalahooda gudaha ay ka abuureyn.

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We are also grateful to the current Minister of Health, Hon. Hassan Mohamed Ali (Gafadhi), who tirelessly supports the program in its entirety, his regular advice and support and by following closely the implementation of the program. Dr. Sa'ad Ali Shire, the current Minister of Finance has been a major enthusiast of this program and was the one who proposed and supports the sin tax on khat imported into the country. We are also grateful to the khat dealer's selfless support of the program.

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Author contributions

YAA drafted this article in its entirety, sharing the drafts with the co-author (LAH) for comments and feedback. The co-author also contributed the translation of Somali summary. YAA is the director of the DMH, which is responsible for the overall implementation of the program. The co-author is a full participant of the implementation of the program and a close partner of the Director for the day-to -day activities.

Disclosure ctatement

No potential conflict of interest in any kind by any of the authors.

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The program is financed through government funding by levying small tax on khat imported into Somaliland.

Paper context

In Somaliland, mental health has long been neglected. The Ministry of Health and Development embarked on an ambitious program to scale up mental health services throughout the country in 2021. The program is funded by a sin tax levied on khat imported into the country, a unique way of raising financial resources. The uniqueness and success of this program will have significant public health implications for countries with similar settings."

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