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Access to mental health services in Eritrea, Sudan, Ethiopia, Somalia and the Greater Horn of Africa region

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Abstract

Over the past ten years, Eritrea, Sudan, Ethiopia, and Somalia have consistently featured among the top twenty nationalities applying for asylum in the United Kingdom. People across the Greater Horn of Africa region face significant challenges in accessing mental health services, compounded by widespread stigma and cultural barriers that deter individuals from seeking help. Mental health services in the region suffer from limited resources and lack of funding, a shortage of trained professionals, and a lack of supportive national policies and legislation. There is a pressing need for basic psychosocial support, counselling, substance abuse services, and greater integration and prioritisation of mental health within broader health and social care systems. Recognising mental health as an essential part of the right to health for both citizens and refugees is crucial. Governments and international actors must invest in developing healthcare systems that can meet these needs, mobilising political will and funding to alleviate the substantial yet often invisible burden of psychological suffering among displaced populations. Achieving the goal of "no health without mental health" remains a distant but necessary aspiration.

Keywords *asylum, mental health care, Horn of Africa, Ethiopia, Eritrea, Somalia, Sudan.*

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1. Introduction

Over the past decade, four countries in the Greater Horn of Africa region[1] – Eritrea, Sudan, Ethiopia, and Somalia – have consistently featured among the top twenty nationalities applying for asylum in the United Kingdom[2]. Drivers of migration from the region include poverty and lack of economic opportunity, human rights violations, conflict and insecurity, and environmental pressures such as drought. In some cases, family reunification is a driver for migration to the UK, as asylum seekers from the region may have family members living in the UK.

Reports from those working with asylum seekers suggest that mental health issues, such as the unavailability of adequate care and treatment in countries of origin, is a factor in many of these applications. Many of these people have experienced highly distressing circumstances, such as conflict, violence, loss and grief, as well as disruption and loss of social, cultural and community structures, values and customs. As such, it is not surprising that data indicates high rates of distress and mental illness among displaced people, including Post Traumatic Stress Disorder (PTSD) (31%), depression (31%), anxiety disorders (11%), and psychosis (1.5%)[3] and in some cases other factors such as intellectual disability, or attempting to cope via alcohol or substance abuse, may also be present. Poor physical health is sometimes present in refugees and migrants too, due to conditions in their country of origin and during their journeys, which are often arduous. Refugees and migrants are at risk of exposure to communicable diseases and injury during their journey, as well as sometimes having poorly managed non-communicable diseases and health conditions, due to lack of proper treatment. Among women, maternity care is often required[4].

Addressing mental health for refugees is particularly complex, for several reasons. First, the mental health requirements of refugees and displaced people can be high, characterised by an elevated incidence of specific disorders such as depression, trauma and anxiety. Conflict, poverty and displacement have enormous impacts on the psychological wellbeing of affected people, with many of the same factors that lead to migration also being key determinants of mental health.[5] Most displaced people show normal distress reactions and display remarkable resilience in the face of adversity. Yet, there is evidence of an increased prevalence of mental disorders and people with pre-existing mental health conditions are likely to be particularly adversely affected by conflict and displacement. Studies suggest that rates of both Post-Traumatic Stress Disorder (PTSD) and depression are high amongst conflict-affected people, with estimates ranging between 15 and 30%. For children in conflict, the figures become truly alarming, with rates of PTSD at 47%, depression at 43% and anxiety at 27%.[6] Considering the large number of displaced people in the Horn of Africa, these statistics suggest a very high level of mental health problems in the region. Responding to these needs is no small task.

From a human rights perspective, the right to health – including for Internally Displaced Persons (IDPs) and refugees – is well established in international human rights law. It is recognised in Article 25 of the Universal Declaration of Human Rights (1948)[7], and in various international treaties, notably Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966[8]; the preamble of Constitution of the World Health Organisation (WHO), 1948[9]; and Article 16 of the African Charter on Hu-

1 Defined in this article as including the eight member states of the Intergovernmental Authority on Development (IGAD): Djibouti, Eritrea, Ethiopia, Kenya, Somalia, South Sudan, Sudan and Uganda. Founded in 1996, the Intergovernmental Authority on Development (IGAD) is a regional intergovernmental organization headquartered in Djibouti

2 UK Government Immigration Statistics, Nov 2022, https://www.gov.uk/government/statistics/immigration-statistics-year-ending-september-2022/list-of-tables#asylum-and-resettlement

3 Asylum Seeker and Refugee Mental Health, Royal College of Psychiatrists, https://www.rcpsych.ac.uk/international/humanitarian-resources/asylum-seeker-and-refugee-mental-health

4 Refugee and Migrant Health, 2 May 2022, WHO, online at: https://www.who.int/news-room/fact-sheets/detail/refugee-and-migrant-health

5 Ibid, p.148.

6 Tol, W. A.; Bastin, P.; Jordans, M. J. D.; Minas, H.; Souza, R.; Weissbacker, I.; Van Ommeren, M.; "Mental Health and Psychosocial Support in Humanitarian Settings, "In Patel, V., Minas, H., Cohen, A., Prince, M., (eds). *Global Mental Health - Principles and Practice*. Oxford University Press: Oxford, 2014, p. 384

7 Universal Declaration of Human Rights, 1948, online at: https://www.un.org/en/about-us/universal-declaration-of-human-rights

8 International Covenant on Economic, Social and Cultural Rights (ICESCR), online at: https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights

9 Constitution of the World health Organization 1948, online at: https://www.who.int/about/governance/constitution

man and Peoples' Rights (the Banjul Charter, 1986)[10]. This means that most of the countries of the world, including all 54 States in Africa, have formally recognised the right to health in some form. The right to health is interpreted broadly as the right of all people "*to the enjoyment of the highest attainable standard of physical and mental health*" (ICESCR, 1966), and is understood to contain several components. For example, the right to health is normally understood to include access to the "*underlying determinants of health*" which can be interpreted to cover, for instance, clean water and sanitation, safe food, nutrition, housing, and gender equality. The right is generally also interpreted as including "*the right to a system of health protection providing equality of opportunity for everyone.*" The right to health must also be applied so that all people – including refugees – can access health services *without discrimination*. As UNHCR asserts, under the 1951 Refugee Convention, "refugees should enjoy access to health services equivalent to that of the host population."[11]

While the right to health expressly includes both *physical* and *mental* health, the latter is often neglected. Mental, neurological and substance-use disorders represent around 14% of all health needs worldwide, and despite increasing attention to this area over the past twenty years, mental health is still given low priority by many governments, donors and policy-makers. Many countries lack appropriate and effective mental health policies, systems and institutions, and it is often the poorest countries which allocate the smallest proportion of their stretched health budgets to mental health.[12] As the Commission on Global Mental Health and Sustainable Development concluded in their report in 2017, "*the quality of mental health services is routinely worse than the quality of those for physical health. Government investment and development assistance for mental health remain pitifully small.*"[13] In Africa, mental health has often been neglected in debates about development and healthcare, and there is a gap in African mental health research, and in treatment of mental health conditions[14].

Table 1: numbers of applications for asylum in the UK from countries in the Greater Horn of Africa region, during the ten-year period 2012-2021

Country of Origin	**Number of applications**	**Rank among top countries of origin**
Eritrea	22,565	4th
Sudan	16,250	6th
Ethiopia	3,962	15th
Somalia	3,947	16th

This paper examines the mental health context in these four countries, as well as the Greater Horn of Africa region in general, discussing major mental health needs, access to mental health services and treatments, and wider social, cultural and policy factors.

10 African Charter of Human and Peoples' Rights, 1986, online at: https://au.int/en/treaties/african-charter-human-and-peoples-rights

11 UNHCR Access to Healthcare, online at: https://www.unhcr.org/what-we-do/protect-human-rights/public-health/access-healthcare. However, UNHCR's view is expressly rejected by some states, who impose limits on equal access to healthcare for refugees.

12 Minas, H, "Human Security, Complexity, and Mental Health System Development," in Patel, V., Minas, H., Cohen, A., Prince, M., (eds)., *Global Mental Health - Principles and Practice*. Oxford University Press: Oxford, 2014, p.157.

13 The Lancet Commission on global mental health and sustainable development. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31612-X/abstract

14 Amahazion F. Mental health in Eritrea: A brief overview and possible steps forward. J Glob Health. 2021 Jan 16;11:03018. doi: 10.7189/jogh.11.03018. PMID: 33643628; PMCID: PMC7898658.

2. Regional Overview – the right to (mental) health in the Horn of Africa and Sudan

Home to almost 305 million people, the eight countries which comprise the Greater Horn of Africa region include some of the poorest in the world. Six of the eight countries in the region are classified by the World Bank as low-income economies, with a Gross National Income (GNI) per capita of USD $1,085 or less; while the other two, Djibouti and Kenya, are in the lower-middle income bracket, with a GNI between USD $1,086 and $4,255[15]. The region has also endured significant insecurity, with four countries in the region – Ethiopia, Somalia, Sudan, and South Sudan – having experienced violent civil conflict in recent years. The region is also highly vulnerable to the unfolding global climate emergency, with Somalia, Sudan and Eritrea sitting near the bottom of world rankings for exposure, sensitivity, and ability to adapt to the negative impact of climate change[16]. The region has also experienced significant displacement, and the eight countries together host around 4.3 million refugees and 6.4 million internally displaced people (see Table 2 below).

Table 2: population and numbers of refugees and IDPs per country

Country	Population, 2022[17]	Refugees hosted, 2021[18]	Internally Displaced Persons, 2022[19]
Djibouti	1,120,849	23,232	6,100
Eritrea	3,684,032	121	No data
Ethiopia	123,379,924	821,283	2,905,000
Kenya	54,027,487	481,048	333,000
Somalia	17,597,511	13,804	1,773,000
South Sudan	10,913,164	333,673	933,000
Sudan	46,874,204	1,103,918	419,000
Uganda	47,249,585	1,529,903	36,000
Totals	304,846,756	4,306,982	6,405,100

In this context, it is perhaps not surprising that the burden of disease is high, due to the challenging living standards faced by many people in the region. Factors such as poverty, conflict, displacement, lack of access to essential infrastructure such as clean water and sanitation, lack of adequate nutritious food, and poor housing conditions, can all contribute to disease. Poor water and sanitation conditions contribute to high mortality and morbidity from infectious diseases, particularly diarrhoea, acute respiratory infections, soil-transmitted helminth infections and undernutrition[20] [21]. In a region where agricultural and pastoralist livelihoods are widespread, zoonotic diseases such as Rift Valley Fever, are also of concern[22]. Rates of tuberculosis are high, notably in Ethiopia, Kenya and Uganda[23] In 2022, the region saw outbreaks of anthrax, measles, cholera, yellow fever, chikungunya, meningitis, and other infectious diseases. Vaccination rates

15 World Bank Country and Lending Groups, online at: https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups

16 ND-GAIN Country Index, 2022, online at: https://gain-new.crc.nd.edu/ranking/vulnerability

17 World Bank Databank, Population estimates and projections, online at: https://databank.worldbank.org/source/population-estimates-and-projections

18 World Bank Databank, Refugee population by country or territory of asylum, online at: https://data.worldbank.org/indicator/SM.POP.REFG

19 Internal Displacement Monitoring Centre, Global Internal Displacement Database, online at: https://www.internal-displacement.org/database/displacement-data

20 World Health Organization, 2023. Burden of disease associated with unsafe water, sanitation and hygiene practices. Online at: https://www.who.int/teams/environment-climate-change-and-health/water-sanitation-and-health/burden-of-disease

21 The Global Health Observatory, SDG Target 3.9 Mortality from environmental pollution, online at: https://www.who.int/data/gho/data/themes/topics/sdg-target-3_9-mortality-from-environmental-pollution

22 Cavalerie L, Wardeh M, Lebrasseur O, et al. One hundred years of zoonoses research in the Horn of Africa: A scoping review. *PLoS Negl Trop Dis*. 2021;15(7):e0009607. Published 2021 Jul 16. doi:10.1371/journal.pntd.0009607

23 Global Tuberculosis Report, 2022. Online at: https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2022/tb-disease-burden/2-1-tb-incidence

are low[24]. Climate change is exacerbating the situation, with drought and flooding contributing to food insecurity, hunger, malnutrition and weakened immunity – a situation which especially affects children. There is also a significant mental health burden, with post-traumatic stress disorder (PTSD), depression, anxiety, substance abuse and psychosis being present in the region.

Health systems in the region are not well placed to respond to these needs. While the situation varies greatly between countries in the region, some of the key challenges relate to lack of resources and facilities, and shortages of trained medical personnel. These issues are exacerbated by conflict. For instance, in northern Ethiopia, Sudan, South Sudan, and Somalia, armed conflict has caused damage to health facilities, resulting in closures and reductions in services offered. Healthcare staff have been injured and killed in attacks on health centres.[25] Within countries there is often great disparity in access to healthcare between different groups. For example, additional barriers may be present for those living in remote rural areas or areas directly affected by conflict, while women, the elderly, and those with disabilities may experience additional vulnerabilities and barriers when seeking healthcare. Funding for strengthening healthcare services, disease surveillance, and public health measures is a key issue – across the region, current health expenditure (CHE) per capita is well below the global average, and some way below the average for the African continent (see Table 3 below).

Table 3: current health expenditure per capita, per country

Country	Current health expenditure (CHE) per capita in US$[26]
Sudan	23.39
Eritrea	23.98
Ethiopia	28.70
South Sudan	33.23
Uganda	33.90
Djibouti	62.81
Kenya	83.40
Somalia	No data
Africa, average	116.94
World, average	1205.61

With high numbers of refugees across the region, several countries, including Djibouti, Ethiopia, Kenya and Uganda, have made commitments to strengthen the legal rights of refugees to access healthcare systems and other social services. Part of the impetus for this is the Comprehensive Refugee Response Framework (CRRF). Five countries in the Greater Horn of Africa region have taken steps to implement the CRRF - Djibouti, Ethiopia, Kenya, Somalia and Uganda - and the region has developed a regional approach via the Intergovernmental Authority on Development (IGAD). The CRRF promotes the integration of refugees into the health and public services of host countries, supported by international actors, to benefit both displaced people and their hosts.

In light of the challenges facing the healthcare sector in general, it is perhaps not surprising that the availability of dedicated mental healthcare is very low in the Horn of Africa. For example, none of the countries in the region has more than three mental health workers per 100,000 people.[27] On average, every one mental health worker serves more than 70,000 people, and they may do so with limited access to training and resources. Mental health workers may also be concentrated in urban centres, further reducing provision of mental health support in rural and peripheral regions. National healthcare systems in the region are therefore unlikely to be able to meet the mental health needs of their populations without sig-

24 WHO, 03 November 2022, The greater Horn of Africa's climate-related health crisis worsens as disease outbreaks surge, online at: https://www.afro.who.int/news/greater-horn-africas-climate-related-health-crisis-worsens-disease-outbreaks-surge

25 WHO, Public Health Situation Analysis, Greater Horn Of Africa, June – December 2022. Online at: https://cdn.who.int/media/docs/default-source/documents/emergencies/greater-horn-of-africa--public-health-situation-analysis-january-2023.pdf

26 Global health expenditure database, WHO, online at: https://apps.who.int/nha/database/

27 Total mental health workers per 100,000 population as reported in WHO Mental Health ATLAS Member State Profiles, 2017: Eritrea 2.48; Ethiopia 1.74; Kenya 0.19; South Sudan 0.52; Sudan 0.64; Uganda 2.96. Data for Djibouti and Somalia not available. Figures include all psychiatrists, psychologists, mental health nurses, social workers, etc.

nificant investment and institutional strengthening. This means that the mental healthcare needs of some vulnerable groups – notably refugees and internally displaced persons – in the region will likely continue to be served by humanitarian agencies, such as the International Organisation for Migration (IOM) and Médecins Sans Frontières (MSF). Yet despite these efforts, it is quite common to hear humanitarian agencies state that their psychosocial services are stretched in the face of mounting needs.

Even where mental health services are available, there can be barriers which prevent vulnerable groups from accessing them. People with specific vulnerabilities and needs that can affect their ability to access mental healthcare include women, children, the elderly, ethnic and linguistic minorities, the rural poor, refugees and displaced people and those with pre-existing mental or physical disabilities. For instance, healthcare facilities may be located far from rural communities, so that distance, cost, and sometimes insecurity, make it difficult to travel there. In some cases, there may be a lack of awareness among specific groups that services are available at all. For refugees, these issues can be exacerbated by cultural and linguistic differences with the host communities, such as not speaking the same language as the healthcare provider. Ensuring services, whether delivered by governments or humanitarian actors, are accessible to these groups is vital to ensuring they are delivered equitably and without discrimination.

One major issue is the strong stigma and lack of awareness regarding mental health issues in the Horn of Africa, with cultural expectations discouraging or preventing people from seeking and accessing support. Such stigma is prevalent across many cultures and societies, and can be characterised by discrimination and marginalisation of people with mental health issues. Stereotypes, negative attitudes, and exclusionary or marginalising beliefs are often pervasive in society. For example, people with mental health issues may be perceived as unpredictable, dangerous, and frightening. Sometimes their disease may be interpreted as a moral flaw, a religious or spiritual defect, or viewed through the lens of folk beliefs and superstitions, such as a belief in witchcraft or possession. Such stigma can prevent individuals from seeking help or accessing healthcare, compound social exclusion and isolation, and create unnecessary barriers to accessing public services and livelihoods[28]. It can also cause long-lasting shame for the sufferer and their wider family and community, as well as contributing to worse health outcomes, making suicide more likely and treatments less effective. Addressing stigma is a challenge, and requires concerted efforts to raise awareness and demystify mental health issues, tackle negative and erroneous beliefs, and promote understanding and empathy towards those who are suffering.

28 Can we end stigma and discrimination in mental health?, The Lancet, 9th October 2022, online at: https://doi.org/10.1016/S0140-6736(22)01937-7

3. Methodology

The methodology for this briefing paper combined desk-based research and literature review with qualitative interviews with key informants. This approach aimed to ensure a comprehensive understanding of the subject matter, grounded both in scholarly research and practical, on-the-ground insights. The literature reviewed for this research included a broad range of studies and reports that provide valuable insights into the availability of mental health services, barriers to access, and the overall health system governance in the countries of the Horn of Africa. This included peer-reviewed journal articles, academic monographs, and reports and policy documents from international organisations and humanitarian agencies. This was complemented by qualitative interviews, conducted with five key informants who have substantial experience and expertise in mental health and psychosocial support in the region. These interviews were designed to elicit in-depth information on the current state of mental health care, the challenges faced, and effective strategies employed in different contexts. The key informants were purposively selected based on their professional backgrounds, relevant geographic experience, and their roles in the field. The research is also significantly informed by the firsthand experience of the lead author working in the Horn and East of Africa, including Djibouti, Ethiopia, Kenya and Uganda. This practical knowledge has provided firsthand insights to complement the findings from the literature review and interviews, to help ensure the briefing paper is reflective of real-world conditions.

4. Eritrea

Eritrea is a low-income country with high and persistent poverty levels[29]. In 1952, after around fifty years of Italian colonial control and ten years of British administration, Eritrea was incorporated as an autonomous region of Ethiopia. A thirty-year war with Ethiopia followed, which ended in victory for Eritrean separatist forces in 1991 and a referendum two years later in which the population overwhelmingly voted for independence. Following independence, a temporary government was established, led by Isaias Afwerki and his party the People's Front for Democracy and Justice, with the intention of transitioning to a permanent government through the promulgation of a constitution within four years. However, despite the drafting and ratification of a constitution in 1997, it has never been implemented, and both parliamentary and presidential elections have never taken place. Afwerki has remained Eritrea's only president ever since, and constitutional protections for human rights have been routinely ignored. During that time, the country's governance has been characterised by oppressive autocracy, extreme militarisation of society including indefinite mandatory conscription, and reports of serious human rights violations, including extrajudicial killings, torture, arbitrary detention, and forced labour.

From 1998 to 2000, Eritrea fought a border war with Ethiopia, which ended with the UN Eritrea-Ethiopia Boundary Commission (EEBC) ruling in favour of Eritrea in 2002. Ethiopia refused to accept the judgement of the commission for more than two decades and the contested areas of the border remained heavily militarised. During this time, national security was used as a pretext for Eritrea to orient much of the economy towards supporting the military, rather than investing in economic development or addressing the needs of the poorest citizens, and for ignoring human rights obligations. The UN Security Council imposed sanctions on Eritrea from 2009. In July 2018, Ethiopia, under newly elected Prime Minister Abiy Ahmed, finally accepted the ruling of the EEBC and signed a peace treaty with Eritrea[30]. The UN voted to lift sanctions later that year, and Eritrea began to restore ties with neighbouring countries. Since 2020, Eritrean troops have been engaged in the Tigray region of Ethiopia, supporting the Ethiopian government in the conflict against insurgents, and have been accused of egregious human rights violations in the country[31].

Due to a history of severe human rights violations in Eritrea, the country has been subject to scrutiny by UN special procedures since 2012, with the appointment of a dedicated Special Rapporteur. Despite some progress on human rights since the 2018 peace treaty with Ethiopia, many still regard Eritrea as one of the world's most repressive regimes, and the government has been criticised for not implementing more profound reforms. Key human rights concerns include severe restrictions on civil society, the absence of a free press and expulsion of foreign journalists, limitations on the movement of foreign diplomats and organizations, restrictions on freedom of expression, information, and assembly, frequent arbitrary arrests and detentions, and a lack of cooperation with the Special Rapporteur's mandate[32]. Additionally, Eritrean citizens are subjected to mandatory and indefinite national service in the military, contributing to the large number of Eritreans seeking refuge in other countries. These refugees and migrants often face heightened vulnerability to further abuse and punishment if caught attempting to leave Eritrea, while they are abroad or upon their return. From June 2014 to June 2016, Eritrea was also investigated by a UN Commission of Inquiry on Human Rights, which determined that the systematic violations over the past 25 years amounted to crimes against humanity. The inquiry identified various crimes, such as enslavement, imprisonment, enforced disappearances, torture, persecution, rape, murder, and other inhumane acts. These acts were committed systematically to instil fear, deter opposition, and control the civilian population in Eritrea. Certain minority ethnic groups and women in Eritrea are particularly vulnerable. They experience high rates of female genital mutilation, domestic violence, early marriage, and childbirth, and are at risk of rape and sexual harassment during compulsory military service[33]. Discrimination based

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29 World Bank, Eritrea Overview, online at: https://www.worldbank.org/en/country/eritrea/overview

30 World Bank, Eritrea Overview, online at: https://www.worldbank.org/en/country/eritrea/overview

31 United Nations, May 2022, A/HRC/50/20, Situation of human rights in Eritrea, Report of the Special Rapporteur on the situation of human rights in Eritrea, online at: https://undocs.org/Home/Mobile?FinalSymbol=A%2FHRC%2F50%2F20&Language=E&DeviceType=Desktop&LangRequested=False

32 Ibid.

33 Global Survey on the situation of human rights defenders 2018, Michel Forst, Special Rapporteur on the situation of human rights defenders.

on sexual orientation and gender identity is also prevalent, with same-sex activity being illegal in Eritrea.

Such factors have driven many Eritreans to seek safety and better opportunities in other countries. In 2022, UNHCR estimated the number of forcibly displaced and stateless Eritreans outside of the country to be 577,700[34]. Many of those are displaced within the region, with large numbers in Ethiopia, Sudan, Egypt, and Uganda[35]. Many of these people may be attempting to reach Europe, by crossing the Mediterranean Sea. In the first quarter of 2023, 653 Eritreans arrived by boat in Italy, and 137 in Greece[36]. Key destination countries for Eritreans in Europe include Germany, Sweden, the Netherlands, Switzerland and France, as well as the UK.

Eritrea has made some progress on health since 2000, with life expectancy increasing, infant and child mortality rates falling, and immunisation increasing[37] [38]. Addressing communicable diseases such as tuberculosis – a leading cause of death – remains a high priority. There are three tiers to the healthcare system, with primary-health centres at local level, secondary-level hospital and referral centres, and tertiary-level national referral hospitals[39]. The healthcare system continues to face several challenges, including limited resources, financing, and facilities, as well as shortages of trained medical personnel caused by outward migration. There is a low doctor to patient ratio, with only 0.5 doctors per 100,000 people[40]. However, the government has prioritised healthcare as a key area for development, and in April 2022 launched four new strategic plans for the sector: The National Health Sector Strategic Development Plan 2022-26 (HSSDP III) and its Monitoring and Evaluation Plan, the Essential Health Care Package (2021), and the National Action Plan for Health Security 2022-26 (NAPHS) on 28 April 2022. These documents were produced by the Ministry of Health with inputs from WHO, and are intended to help Eritrea make progress towards meeting Sustainable Development Goal (SDG) 3 (Ensure healthy lives and promote well-being for all at all ages)[41].

When it comes to mental health, Eritrea faces similar challenges as many other low-income countries in Africa. Recent data is hard to come by, but a survey conducted in 2014 suggested a 14.5% incidence of mental health disorders[42]. In 2015, it was estimated that there were 219,549 cases of depression (4.3% of the population) and 156,599 cases of anxiety disorders[43]. The lack of mental health professionals and facilities in the country means these may be underestimates. The network of mental health facilities in Eritrea is very limited, especially in rural areas. There are 1.63 mental health professionals per 100,000 population (of which the majority are mental health nurses), and 4.13 mental hospital beds per 100,000 population, which are well below global averages[44]. Twelve general hospitals have psychiatric units attached to them offering outpatient treatment and in some cases inpatient care. However, there is only one dedicated psychiatric hospital in the country, St Mary's Neuropsychiatric Hospital, built in 1971 in Asmara. It provides inpatient and outpatient care, and long-term residential care and receives most of Eritrea's dedicated mental healthcare financing[45]. There is another community care facility in Asmara, providing care for those with stable, chronic conditions requiring less intensive support. It was reported by the WHO in 2020 that there were only two qualified psychiatrists in the whole country[46]. Basic medications are typically

34 Eritrea - Data on forcibly displaced populations and stateless persons, UNHCR HumData, online at: https://data.humdata.org/dataset/unhcr-population-data-for-eri

35 ibid

36 Mixed Migration Centre, Quarterly Mixed Migration Update, Eastern and Southern Africa, Egypt and Yemen, Quarter 1 2023, online at: https://mixedmigration.org/wp-content/uploads/2023/04/QMMU_Q1_2023_ESA.pdf

37 Samuels, F; ODI, 2011. Progress in health in Eritrea: cost-effective inter-sectoral interventions and a long-term perspective

38 WHO Health Data Overview for Eritrea, online at: https://data.who.int/countries/232

39 Amahazion F. Mental health in Eritrea: A brief overview and possible steps forward. J Glob Health. 2021 Jan 16;11:03018. doi: 10.7189/jogh.11.03018. PMID: 33643628; PMCID: PMC7898658.

40 Ibid

41 WHO, April 2022, Launching of the Eritrea Health Sector Strategic Development Plan 2022-26 (HSSDP III), Essential Health Care Package, National Action Plan for Health Security 2022-26 (NAPHS), online at: https://www.afro.who.int/countries/eritrea/news/launching-eritrea-health-sector-strategic-development-plan-2022-26-hssdp-iii-essential-health-care

42 WHO-AIMS Report on the Mental Health System in Eritrea, 2014, online at: https://www.afro.who.int/publications/who-aims-report-mental-health-system-eritrea

43 Amahazion F. Mental health in Eritrea: A brief overview and possible steps forward. J Glob Health. 2021 Jan 16;11:03018. doi: 10.7189/jogh.11.03018. PMID: 33643628; PMCID: PMC7898658.

44 WHO Mental Health Atlas 2020, Member State Profile Eritrea, online at: https://cdn.who.int/media/docs/default-source/mental-health/mental-health-atlas-2020-country-profiles/eri.pdf?sfvrsn=7fad3b2c_6&download=true

45 Amahazion F. 2021, ibid.

46 Mental Health Atlas 2020 Country Profile: Eritrea, 15 April 2022, available online at:

available, although often not in rural areas. Family, and traditional and religious healers, often play an important role in responding to mental health needs. Mental health issues are often stigmatised and viewed as a divine punishment, a consequence of witchcraft, or caused by possession by evil spirits. There is often great shame surrounding mental health disorders, and community members may be concerned they are contagious, or the individual is dangerous. This can prevent sufferers and their families from seeking help[47].

https://www.who.int/publications/m/item/mental-health-atlas-eri-2020-country-profile

47 Amahazion F. 2021, ibid.

5. Sudan

Sudan became independent in 1956, having been a *de facto* British colony since 1899 under the terms of the Anglo-Egyptian Condominium. Under colonial rule, the territory had been governed in two parts, due to the cultural and geographical differences between the North and South. The North was largely desert, with a predominantly Arabic-speaking Islamic population, while the South was largely made up of forest, swamp and grassland, with a wide diversity of languages spoken and a population predominantly following Christian or traditional faiths. Under British rule, the South was intentionally isolated from the development that was occurring in the North, due to a belief that the indigenous peoples there were not ready for exposure to modernity. This policy exacerbated economic inequalities between the wealthier North and the poorer South, fuelling grievances which spilled over into armed conflict around the time of independence. A first Civil War from 1955 to 1972 led to increased autonomy for South Sudan under the Addis Ababa Agreement. A second Civil War from 1983 ended with a peace agreement in 2005, leading eventually to an independent South Sudan in 2011.

Since independence, Sudan's history has been punctuated by several *coups' d'état* and periods of political instability, as well as two longer periods of authoritarian rule. After a brief period of parliamentary democracy, in 1958, Sudan experienced the first of these *coups,* entering a period marked by ongoing civil unrest, conflict, political instability, and economic stagnation, with power changing hands several times. In 1969, a further *coup* installed Colonel Gaafar Mohamed el-Nimeiri as president, where he stayed for 16 years, maintaining close ties to Nasser's Egypt and Gaddafi's Libya during this time. His rule was characterised by an authoritarian one-party state and mixed socialism, pan-Arab nationalism and Islamist ideologies.

In 1983, after the government tried to implement Sharia Law, insurrections were led in the south by the Sudan People's Liberation Army (SPLA), as a response from a non-Islamic region discontented with the loss of autonomy to the central government in previous years. This was the start of a Civil War that would persist until 2005. In the latter part of el-Nimeiri time in office, discontent bubbled over his regime's policies, and domestic economic pressures were a key catalyst for his ouster in 1985. In 1985 a coup was led by General Abdel Rahman Swar al-Dahab rescinding the declaration to become an Islamic state. A transitional military council was established but another military coup was led in 1989 by Col. Omar Hassan al-Bashir, initiating a period of authoritarian rule characterised by the suppression of civil liberties and the imposition of Sharia law. Peace negotiations intensified in the early 2000s, resulting in the signing of a peace agreement in 2005, granting autonomy to the southern region and setting the stage for a referendum on the independence of the South Sudan in 2011. Al-Bashir would stay in power until 2019. The years immediately following his ouster were turbulent, with rival political factions vying for control. Tensions between two factions of the military government boiled over into a civil war in April 2023, with fighting between the Sudanese Armed Forces (SAF) and the paramilitary group the Rapid Support Forces (RSF). Peace talks have yet to yield a ceasefire and the conflict continues, causing a major humanitarian crisis marked many casualties, high levels of displacement and a high risk of catastrophic food insecurity and hunger[48].

In this context of longstanding instability, conflict, and authoritarian rule, it is unsurprising that the human rights situation in Sudan has been a matter of grave concern for decades. Historically, there have been extensive reports of human rights abuses and violations, including restrictions on freedoms of expression, assembly and association, as well as violence against women and ethnic minorities (notably in the Darfur region and the South), and severe restrictions on the ability of humanitarian actors to reach populations in need. Both main actors in the current conflict have been accused of serious breaches of humanitarian and human rights law in Sudan, including in the Darfur region, and in their heavy-handed responses to protests[49].

Sudan is a significant source country of migration. Historically, many Sudanese fled their country every year due to various factors, including conflict, economic hardship, and political instability. Since April

48 UNOCHA Situation Report Highlights, Sudan, 4th April 2024, online at: https://reliefweb.int/country/sdn

49 Human Rights Watch, Sudan, accessed 10th April 2024, online at: https://www.hrw.org/africa/sudan

2023 when the current civil war broke out, around 8.2 million people have been displaced[50] of which more than 1.76 million have crossed the border into neighbouring countries, making it one of the world's major displacement crises[51]. There are significant numbers of Sudanese refugees in Chad, South Sudan, Egypt and Ethiopia, contributing to humanitarian pressures in those countries. In particular, the reception centres at border crossings in Chad and South Sudan have been highly overcrowded[52]. Numbers of Sudanese refugees reaching the United Kingdom have increased somewhat in recent years (see table below) and there is a significant Sudanese population in the UK.[53]

2019	2020	2021	2022	2023
1,524	2,056	2,324	3,025	3,014

Healthcare services in Sudan are provided by a mix of public and private providers, but the country's healthcare system faces many challenges, with decades of civil war rendering most of the health infrastructure non-functional. Sudan has a high burden of infectious diseases, such as malaria and tuberculosis, with HIV/AIDS, Leishmaniasis and sleeping sickness also being a concern for the Health Ministry. Over the past decades, the training of healthcare professionals has increased. There are over 100,000 healthcare workers, male and female, mostly young, across more than 20 different professions. The practice of dual employment is very common[54]. Challenges include the emigration of trained professionals and the inadequate management and uneven distribution of existing physicians and paramedics, with more than one-third of all medical forces located in the capital. Consequently, there are still shortages of medical personnel, particularly in rural areas. Since 1992, when a Structural Adjustment Program (SAP) supported by the International Monetary Fund (IMF) introduced user fees for health services even in the public sector, the costs of health care have been difficult to meet for many poorer Sudanese. While public health insurance schemes have helped to some extent, for many people Out-of-Pocket expenditures (OOP) – such as fees charged by service providers or contributions required towards the cost of prescribed medicines – remain unaffordable. Private medical provision is also out of reach for many people, with users required to make insurance co-payments for most services and medicines. A review conducted in 2023 concluded that for many people in Sudan, such healthcare costs had negatively impacted household income and many citizens had struggled to meet costs, including reports of households needing to borrow money or sell their belongings[55].Parte superior do formulário

When it comes to mental health, Sudan faces significant challenges. Sudan's civil wars have been associated with a rise in mental illnesses such as depression and post-traumatic stress disorder (PTSD). The country's economic crises and civil instability have hindered health services, especially mental health treatment. There are very few trained mental health professionals in the country, and those who do provide mental health services are often concentrated near the capital. As well as limited access to treatments, stigma and limited awareness of mental health issues among the public, remain a major barrier to seeking treatment.

Prior to the start of the current crisis in 2023, there were some mental health services available in Sudan. Previous governments had recognised the importance of mental health and established a National Mental Health Program, last revised in 2009 in partnership with the WHO. A 4-year postgraduate course leading to an MD in psychological medicine was initiated in 1989. In 1990, a mental health unit in the Ministry of Health was established. In June 2018 the Mental Health Act, drafted in 1998, was approved by the Parliament. The National Mental Health Program's guiding principles were the integration of crucial mental healthcare into the broader healthcare system, especially within primary care facilities; the establishment of training programs for healthcare workers; the development of a suitable referral system, accompanied by comprehensive record-keeping practices; the provision of essential medications; and active communi-

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50 UNOCHA Situation Report Highlights, Sudan, 4th April 2024, online at: https://reliefweb.int/country/sdn

51 Ibid.

52 Mixed Migration Centre, MMC Eastern and Southern Africa. Egypt and Yemen, Quarter 4 2023, online at: https://mixedmigration.org/resource/quarterly-mixed-migration-update-esa-q4-2023/

53 Immigration system statistics data tables 29 February 2024, online at: https://www.gov.uk/government/statistical-data-sets/immigration-system-statistics-data-tables#asylum-and-resettlement

54 OSMAN AHM, BAKHIET A, ELMUSHARAF S, OMER A, ABDELRAHMAN A. Scaling up mental health services in Sudan: Sudanese psychiatrists' opinions. BJPsych International. 2020;1–4. doi: 10.1192/bji.2020.17. Available from: https://sci-hub.st/10.1192/bji.2020.17

55 M El Rayah AR, Elhussein DM, Habbani K, Kheir SGM, Awad MM. The Impact of Out-of-Pocket Expenditures on Utilization of Health-Care Services in Sudan from 2010 to 2020: A Critical Review. American J Epidemiol Public Health. 2023 Apr 29;7(1): 008-014. doi: 10.37871/ajeph.id64

ty engagement, along with close collaboration with other social sectors and organizations.

However, mental health services in Sudan are limited in scope and capacity, with access to mental health and psychosocial support varying greatly between the states, and 90% of services located in Khartoum state. Only 12 of Sudan's 18 states have fully equipped psychiatric hospitals run by qualified consultant psychiatrists, with the others being either managed by non-specialist medical doctors or by clinical psychologists and medical assistants[56]. Essential medicines are available in psychiatric facilities, but free access is restricted to emergency settings[57].

In Khartoum State, the occurrence of depression and anxiety among high-school students is estimated to be 12% and the prevalence of perinatal psychiatric disorders in primary care settings and communities is estimated at 23%. Internally displaced persons exhibit higher rates of psychiatric disorders, including major depressive disorder (24.3%), generalised anxiety disorder (23.6%), social phobia (14.2%), and post-traumatic stress disorder (12.3%). The prevalence rate for major psychotic disorders among IDPs is 1.5% but data regarding suicide attempts and completed suicides among this population are not available[58].

Sudanese refugees often escape imminent danger but carry deep traumas from the horrors experienced. Displacement fractures relationships, disrupts daily life, dismantles existing support networks, and has a devastating effect on mental health, overall well-being, and recovery. They are frequently in special need of psychological counselling and psychiatric care which, unfortunately, are virtually non-existent in refugee camps.

There are few resources available for research or training in the field of mental health in Sudan, with treatment for severe mental disorders not accessible at the primary care level. Instead, traditional healers are commonly relied upon for mental health services. A cooperative relationship has been cultivated with faith healers in recent decades as part of community-based mental health initiatives. Initially, there was considerable resistance from faith healers who viewed mental health professionals as competitors. But with time and a non-confrontational approach, the message that collaboration between the two was a possibility, particularly in cases of emotional disorders, was understood. This collaboration has gradually become formalised to establish referral pathways for individuals with mental and neurological illnesses, particularly psychoses and epilepsy, since community care facilities for patients with mental disorders are non-existent. This absence is attributed to challenges such as lack of transportation, shortage of social workers, and inadequate health education. As a result, numerous traditional healing centres have adopted comprehensive models integrating modern psychiatry. They receive regular support from medical assistants who have undergone specialised training in modern psychiatry to offer diagnoses and interventions. There is also a reluctance in seeking professional help because of pervasive stigma surrounding mental illness. Many are concerned about criticism from others, potential repercussions at work, impacts on social relationships and fear of attaching mental illness label to their family. These individuals turn to traditional healers, which are more socially acceptable. Most of these patients are male, unemployed, and often illiterate or have completed only primary education. They are directed to mental health facilities only if there is no progress in their condition after several months.[59] When treated at home, the lack of knowledge among family members leads many to only bring their patients to hospitals when the patient has already significantly deteriorated or become violent. From the patient's perspective, other reasons for not seeking psychiatric help include the distance to the treatment, the waiting time, and financial issues – from the cost of medication to the cost of the medical care itself.

Prior to the 2023 crisis, there were some non-governmental organizations (NGOs) and international organizations working to improve mental health provision in Sudan. These organizations provided a range of mental health services, including counselling, psychotherapy, and medication management. They also provided training for local health workers and community members on how to identify and address mental health issues. However, since the latest crisis began, many organisations ceased to operate or have faced new restrictions on their ability to operate, making it difficult to know what services remain opera-

56 Supra note 54

57 Abdalhai, K.A., Mokitimi, S. & de Vries, P.J. Child and adolescent mental health services in Khartoum State, Sudan: a desktop situational analysis. Child Adolesc Psychiatry Ment Health 18, 21 (2024). https://doi.org/10.1186/s13034-024-00707-1

58 Supra note 54

59 ABDELGADIR E. Exploring barriers to utilization of mental health services at the policy and facility level in Khartoum Sudan. thesis (master's)- University of Washington 2012. 2012.

tional. In the context of the current ongoing conflict, mental health services remain virtually non-existent.

In recent years, there have been some efforts to increase access to mental health services in Sudan. Sudanese health care providers believe mental health services are improving, although not adequate to the actual need[60]. However, much more work is needed to address the significant gaps in mental health services in the country, particularly in rural areas. The ongoing conflict and insecurity in some parts of Sudan also make it challenging to provide consistent and sustained mental health services. The WHO recommended that Sudan needs at least six mental healthcare workers per 100 000 population, having to greatly increase its mental health workforce from the current figure (pre-2023) of just 1.6 per 100 000 population. To achieve this, new models of service delivery should be developed to ensure the provision of sustainable services. This may involve training lay counsellors, psychologists, nurses, and primary care physicians to offer early interventions, particularly in rural populations.

There are very few psychiatric facilities in the districts, with services being centralised in Khartoum. The distance poses barriers for many outside the capital to access psychiatric services. For instance, a patient from Kordofan state, in western Sudan, would require approximately 2 days of travel to access these services, which makes it impossible for him to come for monthly appointments.[61] Rawan Hamid, a key informant interviewed for this briefing note, highlighted that beyond the government, other groups are active in Sudanese mental health, such as universities and NGOs, like Ahfad University that runs a trauma centre in the capital. She also noted that mental health services are very concentrated in the capital, forcing many patients to migrate to the region. Migrants from other countries may face barriers accessing mental health treatment due to lack of documentation or irregular immigration status, while internal migrants may face linguistic, cultural or financial barriers.

The cost of psychiatric treatment is also a significant barrier in Sudan, specifically the cost of medications. Medication treatments are often required for an extended period but the most affordable antipsychotic medication in Sudan costed 72% of the daily minimum wage in 2016.[62] Most families cannot afford the costs, as psychiatric medications expenses are not covered by health insurance. A 2020 study with over a hundred Sudanese psychiatrists endorsed the expansion of mental health services in Sudan through a lay counsellor model, considered suitable for a large, under-resourced country[63]. Still, many challenges may arise with this model, with a requirement for extensive training to ensure accurate recognition and identification of mental health issues, particularly in cases that are psychotic or complex. However, once lay counsellors have received adequate training, they could be strategically deployed to locations with high incidences of mental health disorders, such as camps for internally displaced persons.

Sudan's mental health policy, last updated in 2008, highlighted a significant gap in the mental health workforce, with only 0.06 psychiatrists per 100,000 people. This equates to fewer than 30 qualified psychiatrists across the entire country[64]. Since 1990, 178 psychiatrists have graduated but 75% have left Sudan to work abroad (primarily to work in the Gulf States).[65] To encourage psychiatrists of Sudanese origin to stay in the country, it was suggested that the government could mobilise efforts to establish a collaborative, integrated mental healthcare system. This would enhance national coverage and address the current deficiencies. Fighting stigma also plays an important role in improving assistance reach, as some healthcare workers reported experiencing stigma simply to their employment in mental healthcare facilities. [66]

Another initiative that has proven effective was the establishment of exchanges with mental health professionals from other countries and primary healthcare personnel from Sudan, following the WHO recommendation that mental healthcare should be integrated into primary care and community care. Initiatives in this regard were able to expand the knowledge of family healthcare professionals in depression, post-traumatic stress disorder, anxiety, psychosis, and schizophrenia. Sudan would also benefit from the develop of psychometric instruments to accurately measure and understand mental health conditions among the population and the formulation of a long-term strategy for growth, ensuring sustained prog-

60 Ibid

61 ALI, S.H., AGYAPONG, V.I.O. Barriers to mental health service utilisation in Sudan - perspectives of carers and psychiatrists. BMC Health Serv Res 16, 31 (2015). https://doi.org/10.1186/s12913-016-1280-2

62 Ibid

63 Supra note 54

64 Ibid.

65 Supra note 57

66 Supra note 59

ress and improvement in mental health services over time. This approach should help ensuring a mental healthcare framework specifically designed to meet the multiple mental healthcare needs of its people.

6. Ethiopia

Ethiopia is Africa's oldest country and, apart from a five-year period of occupation by Mussolini's Italian forces during World War 2, the territory has never been colonised. After the Italian forces were defeated, Emperor Haile Selassie returned to Ethiopia, initiating a modernization agenda, implementing reforms aimed at upgrading Ethiopia's economy, education system, and infrastructure. He was nearly deposed in a coup in 1960 but stayed in power until 1974, when general growing discontent with the government over corruption and famine led to a coup by a military faction called the Derg. The Marxist-Leninist Derg Regime was implemented, nationalizing industries, and undertaking land reforms. Farmers were unable to achieve the anticipated high yields following the land reform which led to food shortage. Meanwhile, drought worsened annually starting from 1980, reaching a peak in 1984 when the minor rains were minimal, and the major rains failed completely. This led to famine as government restrictions limited the ability of farmers to cope with previous shortages. Famine, economic hardship and political repression fuelled opposition against the Derg regime and Ethiopia started to transition to democracy, adopting a new constitution in 1995. Ethiopia continues to be affected by conflict, unrest and political tensions, both within its own borders (notably in the Tigray, Amhara and Oromia regions in recent years) and in neighbouring states. In November 2022, a peace deal was signed between the Federal government of Ethiopia and separatists in the Tigray region in the north of the country, ending a brutal two-year war there[67].

While Ethiopia has been progressive in lifting legal restrictions on refugees' right to access healthcare, major challenges lie ahead. Partly, this is because healthcare systems in Ethiopia and across the wider region operate with extremely limited funding – itself a reflection of general resource constraints. For instance, the average annual Current Health Expenditure (CHE) per capita for countries in the region is around 64 USD, with Sudan spending the most at 152 USD and Ethiopia the least at 28 USD per capita[68]. Ongoing conflict can make it more difficult to develop and invest in healthcare systems in particular areas, and public services such as healthcare provision can themselves be a factor in creating or sustaining divisions. For instance, a perception that particular areas or groups are benefitting more than others from services can contribute to friction between displaced people and the host community. In the Gambella region, which hosts more than half of all refugees in Ethiopia, host communities have felt marginalised and the strain on local services has contributed to tensions with the refugees, leading some humanitarian agencies to deliberately link healthcare programming with peacebuilding activities[69].

Ethiopia hosts around 900,000 refugees and in February 2019 issued a National Refugee Proclamation[70], joining several of its neighbours in the Greater Horn of Africa region in expanding the rights granted to refugees living in the country[71]. Amongst other provisions, the new law allows refugees access to national health services on the same basis as Ethiopian nationals and contains provisions that improve access to education, justice, employment, and other services.

The human rights situation in Ethiopia has been a matter of concern in recent years, with reports of human rights abuses and violations by state security forces, including extrajudicial killings, arbitrary arrests, and detentions, restrictions on freedom of expression and the press, and violence against ethnic minorities. The government has taken steps to address some of these issues, such as releasing political prisoners and lifting restrictions on media and opposition groups. However, there are still concerns about the human rights situation in the country, particularly in the context of recently concluded conflict in the Tigray region.

Ethiopia is a significant source of migration, with many Ethiopians fleeing their country every year due to various factors, including conflict, economic hardship, and political instability. In addition, Ethiopia is vulnerable to climate change and environmental degradation, leading to food insecurity and displacement, and there is a lack of access to basic services, including health care, education, and water and sanitation,

67 https://news.un.org/en/story/2022/11/1130137

68 WHO, https://apps.who.int/gho/data/node.wrapper.imr?x-id=4951

69 https://ec.europa.eu/trustfundforafrica/region/horn-africa/ethiopia/promoting-stability-and-strengthening-basic-service-delivery-host_en

70 https://data2.unhcr.org/en/documents/download/68964

71 https://data2.unhcr.org/en/documents/download/68014

which are also significant factors driving migration from Ethiopia. According to the United Nations, in 2021, approximately 30,600 Ethiopians arrived in Europe via the Mediterranean Sea, representing about 6.8% of all arrivals by sea.

Ethiopia has made various attempts to achieve universal primary health care, starting with the Alma-Ata Declaration of Primary Health Care in 1978, that failed due to the absence of coherent policies and insufficient dissemination of policy information. During the Derg Era, many doctors emigrated, exacerbating the situation. A new initiative was incorporated into the Health Sector Development Program III in 2005, aiming to expand and enhance primary healthcare services overall. Although the country has made significant progress in improving access to basic healthcare services in recent years, the healthcare system still faces many challenges, including limited resources, infrastructure, and trained medical personnel.

Healthcare services in Ethiopia are provided by a mix of public and private providers. The private sector in Ethiopia also provides a broad array of health facilities and services, across all levels of care[72]. This includes primary level facilities such as private pharmacies, health facilities, and primary healthcare clinics; secondary level facilities like private specialty clinics; and tertiary level facilities including private hospitals and specialty centres. The private for-profit sector primarily caters to wealthier income groups, suggesting cost is a barrier for many and private care is largely unaffordable for the poorest members of society. Overall, private sector healthcare in Ethiopia remains a relatively small part of the health sector as a whole and is not well integrated. According to Ethiopia's Ministry of Health, maternal and child health are two of the nation's most critical concerns, with women being socially pressured to become mothers without the proper infrastructure for pregnancy, childbirth, and infant care. Additionally, the government has implemented important public health initiatives such as distributing mosquito nets, HIV education programs and nutrition initiatives.

When it comes to mental health, Ethiopia has made significant strides in recent years. The government has recognised the importance of mental health and has established a National Mental Health Strategy. The country has also trained many community-based mental health workers who provide basic services in rural areas. Unfortunately, access to care is still a problem. An estimated 90% of people with severe mental illnesses, such as schizophrenia and bipolar disorder, never received evidence-based care and less than 1% of those affected can access continuous care.[73] In Ethiopia, mental health services are largely provided by the government and non-governmental organizations (NGOs). The government provides mental health services at the primary care level, as well as more specialised services at regional and national hospitals. There are also several NGOs and international organisations working to improve mental health provision in the country, such as the Ethiopian Psychiatric Association and the World Health Organization. WHO has commended Ethiopia's efforts in implementing WHO Mental Health Gap Action Programme as well as WHO's Comprehensive Mental Health Action Plan, citing it as a model for the region.

Two key informants, Rediet Kidist and Yonas Tadesse, with extensive experience in mental health in Ethiopia were interviewed for this paper. They highlighted that basic psychosocial support, counselling and substance abuse are Ethiopia's major mental health needs. They described a major gap in services, with a lack of awareness among the public and not enough referral hospitals and professionals to meet needs. In Ethiopia, mental health is understood as a luxury, with only the physiological aspects of health being given importance. People do not generally go to a therapist or any mental health professional and many mental health problems remain undiagnosed and under-reported. Despite national policies protecting the rights of people living with mental health conditions, the country's customs and cultural norms can lead to people with mental health conditions suffering emotional abuse. The key informants also described how stigma, discrimination, lack of government policies and funding, conflict and disaster, gender-based violence, and a shortage of resources are the key challenges in accessing mental health support in the region. Common mental disorders like depression, anxiety, and post-traumatic stress disorder are prevalent in conflict-affected areas, with vulnerable groups being women, children, adolescents, and people with disabilities. The state provides counselling services and mental health services in a few hospitals, but these services have very limited resources and manpower. NGOs, international agencies, private-sector, religious groups, and government contribute to improve access to mental health services, but very few specialised services are provided, and the quality of services is inadequate. Major gaps

72 Ethiopian Ministry of Health, World Bank Group, Global Financing Facility; Ethiopia Health Private Sector Assessment; October 2019, Available online at: https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Ethiopia-health-private-sector-assessment.pdf

73 FEKADU A, THORNICROFT G. Global mental health: perspectives from Ethiopia. Glob Health Action. 2014 Sep 30;7:25447. doi: 10.3402/gha.v7.25447. PMID: 25280740; PMCID: PMC4185092.

include the lack of government policies and funding, shortage of resources and human resources, lack of awareness and social support, and limited counselling services.

Some of the major mental health services provided in Ethiopia include counselling, psychotherapy, and medication management. The country also has several inpatient psychiatric facilities, as well as a national suicide prevention strategy. Notably, 11% of Ethiopia's total disease burden is attributed to mental health disorders, affecting marginalised individuals often subject to stigma and discrimination[74]. Aware of the importance of treatment for this group, the government has a plan to upscale integrated mental health care as crucial for enhancing health and development in the country.

Despite these advances, mental health provision in Ethiopia still faces many challenges. Stigma surrounding mental health remains a significant barrier to seeking treatment, particularly in rural areas. There are only 60 psychiatrists practicing in the public sector, with most located in the capital.[75] Common beliefs about mental health conditions include that they are the result of the influence of malevolent spirits, perceived attacks by demonic forces, grief resulting from the loss of loved ones, economic hardship, excessive worrying, and substance abuse. Individuals with mental illness are often perceived as exhibiting aggressive and physically violent behaviour, thereby reinforcing fear and societal stigma.

Individuals encounter discrimination and social avoidance due to their mental health status. Structural impediments, such as limited awareness, inadequate resources, and insufficient community mobilization, impeded the expansion of mental health services. Stigma led caregivers of mentally ill individuals to isolate themselves, driven by apprehensions of discrimination, ignominy, or embarrassment. Self-stigmatization profoundly affects their self-esteem and delays help-seeking. Various interventions aimed at mitigating stigma, including community-based rehabilitation programs, awareness-raising initiatives, and empowerment interventions for both service users and caregivers, demonstrated efficacy in ameliorating mental health stigma and fostering improved outcomes for individuals contending with severe mental illness. Stigma associated with sexuality is also a challenge as mental health issues are a major concern for LGBTQI+ people in Ethiopia, who report living under heavy anxiety and fear of being exposed, which is perceived as bringing shame to themselves and their families. A study conducted with LGBTQI+ people from Addis Ababa showed the majority only feel comfortable openly discussing their sexuality in online spaces, such as social media, and only around 20% are comfortable talking about it with their family[76]. In the same way, they are not motivated to seek care when they are sick from fear of discrimination.

There are also shortages of trained mental health professionals, and many of those who do provide mental health services are concentrated in urban areas, which has led the government to build partnerships, working closely with WHO, the European Union and NGOs. In addition, the work of traditional healers has been important for many, especially out of major cities, an agenda advocated by the WHO to improve access to mental health care. Despite these efforts, Ethiopia has faced significant challenges in providing mental health services to refugees and internally displaced persons (IDPs), who may be at increased risk for mental health issues due to displacement and trauma. The recurring internal displacements within Ethiopia, triggered by political tensions and conflicts, notably in regions like Oromia, Somali, Amhara, and the South Nations, Nationalities, and Peoples (SNNP) regions, have imposed a heavy toll, resulting in substantial loss of life, property, and displacement of populations, necessitating the establishment of temporary camps for IDPs. These camps, marked by adverse living conditions and harrowing experiences, have emerged as focal points for mental health issues, encompassing conditions such as post-traumatic stress disorder (PTSD), depression, anxiety, and psychotic manifestations.

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74 World Health Organisation in Africa, Ethiopia Country Information – Mental Health, available online at: https://www.afro.who.int/countries/ethiopia

75 HANLON C, ESHETU T, ALEMAYEHU D, FEKADU A, SEMRAU M, THORNICROFT G, KIGOZI F, MARAIS DL, PETERSEN I, ALEM A. Health system governance to support scale up of mental health care in Ethiopia: a qualitative study. Int J Ment Health Syst. 2017 Jun 8;11:38. doi: 10.1186/s13033-017-0144-4. PMID: 28603550; PMCID: PMC5465569.

76 TADELE, G., AMDE, W.K. Health needs, health care seeking behaviour, and utilization of health services among lesbians, gays and bisexuals in Addis Ababa, Ethiopia. *Int J Equity Health* 18, 86 (2019). https://doi.org/10.1186/s12939-019-0991-5

7. Somalia

The Republic of Somalia became independent in 1960. In 1969 president Shermarke was assassinated and Major General Mohammed Siad Barre rose to power, moving to dissolve parliament, suspend the constitution and abolish political parties. As well as grave political repression and human rights violations, Barre's regime was characterised by a divide-and-rule approach, in which differences and grudges between clans were exploited in order to contain possible political resistance. Over the subsequent years, the regime faced mounting resistance which, in 1988, spilled over into outright war in the northeast of the country and the collapse of the government in 1991. Barre fled the following year and a vicious civil war between armed clan factions ensued. The war was marked by killings, lootings and destruction of private property, and sexual violence, and drove a major humanitarian crisis and widespread displacement. Many Somalis fled to the Kenyan coast, gathering in the towns of Malindi and Mombasa, until they were relocated by the Kenyan government to refugee camps in Dadaab and Kakuma. The clan-based communal violence severely damaged social cohesion and trust between Somalis, with neighbours, friends and acquaintances turning on each other, enabled and encouraged by agitators pursuing specific political goals[77]. A short-lived UN-backed military intervention in 1995, which aimed to restore a degree of security, was terminated when troops were attacked in Mogadishu.

With support from the international community, a Transitional Federal Government (TFG) was established in 2004, with the goal of restoring Somalia's national political institutions. However, this was a contested process, and in 2006, the armed faction known as the United Islamic Courts (UIC) seized Mogadishu, and drove the TFG out. While UIC had considerable support among Somalis early on, but scepticism increased with the increasing influence of more radical groups in their ranks[78]. There was also international opposition to the movement, and an Ethiopian-led military operation was launched against UIC with international support. While UIC was defeated, from their ranks emerged an armed jihadist group, Al Shabab, which has caused widespread insecurity in Somalia and launched terror attacks both inside the country and in neighbouring states. International military operations, supported by the African Union and the United Nations, have aimed to bring greater stability and degrade the capacities of Al Shabab in Somalia. Violence continues, particularly in the south of the country, while the autonomous regions of Somaliland and Puntland enjoy relative stability. Insecurity is exacerbated by poverty, drought, outbreaks of disease and displacement. However, there have been some successes in lessening the threat posed by Al Shabab as well as reducing the incidence of piracy operations launched from Somalian shores.. In this context, in 2012, Somalia adopted a new Provisional Constitution and established the Federal Government of Somalia (FGS) with a bicameral democratic legislature, a presidency, an independent judiciary, and an executive branch led by a Prime Minister. However, after more than two decades of armed conflict, federal government institutions have limited capacity and continue to receive substantial international support.

The human rights situation in Somalia remains complex and challenging due to the ongoing conflict, violence, and political instability in the country. Human rights abuses and violations are widespread, including extrajudicial killings, arbitrary arrests and detentions, torture, and restrictions on freedom of expression, assembly, and association. The security situation in the country also affects access to basic services, such as health care and education. Somalia hosts more than 1.1 million internally displaced persons, who are mainly concentrated in the Banadir region in southern Somalia[79]. Factors contributing to internal displacement include armed conflict, prolonged droughts and flash floods, locust infestation, and inadequate resource distribution. The country has been a significant source of migration, with thousands fleeing their country every year due to various factors, including armed conflict, political instability, economic hardship, and environmental degradation. Many Somalis risk their lives to cross the Gulf of Aden or the Mediterranean Sea in search of better opportunities and a safer life. The number of Somalian migrants varies depending on the source, but it is estimated that there are about 2.6 million Somali refugees and displaced persons worldwide. According to the United Nations, in 2021, approximately 8,200 Somalis

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77 Kapteijns L. Clan cleansing in Somalia: The ruinous legacy of 1991 [Internet]. Philadelphia, Pennsylvania: University of Pennsylvania Press; 2012

78 UNHCR, 2016, Culture, context and mental health of Somali refugees: a primer for staff working in mental health and psychosocial support programmes. Available online at: https://www.unhcr.org/media/culture-context-and-mental-health-somali-refugees-primer-staff-working-mental-health-and

79 Ibid.

arrived in Europe via the Mediterranean Sea, representing about 1.8% of all arrivals by sea[80].

The main drivers of migration from Somalia include cycles of conflict, with Somalia having been marred by violence for decades. This is connected to a lack of stable governance, absent or weak institutions, and a lack of law and order, creating an unstable environment that pushes people to migrate. The economy of Somalia has been severely impacted by the conflict, leading to high levels of poverty, unemployment, and economic insecurity. Somalia has also been affected by environmental issues such as drought and desertification, which have contributed to migration as people seek more habitable environments. It is worth noting that the Somali diaspora has been developing new forms of social relations and identity. Many female-headed households have emerged, and women are pursuing education. On the other hand, Somali men in the diaspora often claim that their male authority has been lost or transferred to the welfare state, and their role as a man is affected by working restrictions while they wait for visas during asylum procedures.

Healthcare services in Somalia are extremely limited due to ongoing conflict, insecurity, and underfunding. The country's healthcare system has been severely disrupted by decades of conflict, which has led to the displacement of millions of people, the destruction of infrastructure, and the loss of many skilled medical professionals. Somalia's healthcare system is among the most fragile worldwide. Health outcomes in Somalia fall behind those of neighbouring countries, with women and children bearing deficiencies in maternal and child health services – only 11% of children receive basic vaccinations and just one third are born with the services of a skilled midwife. This all contributes to very high death rates for preventable diseases[81]. Presently, the country's health expenditure is just 1.3 percent of total government spending, falling significantly short of the 15 percent target established by the Abuja Declaration for African Union countries[82]. Somalia also faces a chronic shortage of health workers which is a significant barrier in achieving universal health care, while having a number of unregulated and unlicensed health professions whose competencies cannot be ascertained. In Somalia the first 20 medical students since 1991 graduated in 2008[83].

When it comes to mental health, Somalia faces significant challenges. There is limited awareness of mental health issues among the public, and stigma remains a major barrier to seeking treatment. There are also few trained mental health professionals in the country, and those who do provide mental health services are often concentrated in urban areas. Reliable data on mental health problems in Somalia are difficult due to limited research capacity and poor collection of routine data in health centres but the level of mental distress among people in Somalia is thought to be high, and risk factors for developing mental disorders are abundant within the Somali context: loss of people, property and status, disrupted interpersonal relations and social networks, severe and recurring traumatic experiences, displacement, insecurity, uncertainty for the future, and substance abuse. A situation analysis published by WHO in 2011 estimated that one out of every three Somalis has been affected by a mental health issue – higher than most low income and conflict-affected countries[84]. Most Somalis have been confronted with at least one violent event in their lives, including experiences such as witnessing severely injured individuals, being in combat zones, and being close to shelling or lethal attacks. Despite these numbers, in 2015 Somalia had only five WHO-recognised mental health centres.[85]

Somalia first developed a mental health policy in 1986, with support from WHO[86]. However, the political unrest in the late 1980sthat led to the collapse of the national government in 1991, meant these mental health initiatives were never implemented. Presently, Somalia lacks robust mental health legislation to protect the rights and guarantee treatment for individuals with mental illness. Somaliland introduced

80 UNHCR Global Focus, Somalia, online at: https://reporting.unhcr.org/operational/operations/somalia

81 MORRISON J, MALIK SMMR. Population health trends and disease profile in Somalia 1990-2019, and projection to 2030: will the country achieve sustainable development goals 2 and 3? BMC Public Health. 2023 Jan 10

82 Human Rights Watch, April 26, 2024, African Governments Falling Short on Healthcare Funding, online at: https://www.hrw.org/news/2024/04/26/african-governments-falling-short-healthcare-funding

83 Syed Sheriff, R. J., Reggi, M., Mohamed, A., Haibe, F., Whitwell, S., & Jenkins, R. (2011). Mental health in Somalia. *International psychiatry: bulletin of the Board of International Affairs of the Royal College of Psychiatrists*, *8*(4), 89–91. Available online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6735037/

84 A Situation Analysis of Mental Health in Somalia, World Health Organization, 2011, available online at: https://reliefweb.int/report/somalia/situation-analysis-mental-health-somalia

85 Supra note 83

86 Ibrahim, M., Rizwan, H., Afzal, M. et al. Mental health crisis in Somalia: a review and a way forward. Int J Ment Health Syst 16, 12 (2022). https://doi.org/10.1186/s13033-022-00525-y

a mental health policy in 2012, outlining plans for the development and organization of mental health services but implementation has been hampered by lack of funding and political commitment[87]. More recently, the Federal Government of Somalia has taken steps to revitalise key policies and strategies, including those related to mental health[88].

Currently, most of the population access mental healthcare through traditional and religious healers, especially herbalists and faith healers. This is related to the pervasive levels of stigma, discrimination, and human rights violations suffered by patients with mental illness. Research conducted by Human Rights Watch in 2015 highlighted ongoing and significant abuses including physical violence against people with psychosocial disabilities, involuntary confinement in psychiatric facilities, spiritual healers' centres, or family compounds, with patients sometimes chained or otherwise restrained against their will[89]. An estimated 170,000 people with mental health issues in Somalia are subjected to such conditions. In addition, neglect, insufficient nutrition, and poor hygiene are widespread, exacerbating the situation. A mental health patient has often severely deteriorated by the time he is brought to hospital, with 85% having previously visited a traditional or religious healer and 30% brought to their first clinic visit in chains[90]. There are no psychiatric staff available in general primary or secondary healthcare services, and access to psychotropic medication is very limited. The average duration between the emergence of mental health problems and the initial visit to a Mental Health Department in the Puntland region is approximately 3.5 years.[91] In many cases, this lack of early intervention and access to proper treatment allows mental illnesses to progress to the point of becoming incapacitating. Stigma has also been an issue when it comes to sexuality. Homosexual Somalis often hide their sexuality for fear of discrimination, social exclusion and potential violence, including death. The Queer Somalia organization reported in 2004 that gay men frequently fear death through suicide or through death sentences applied under uncontrolled and loosely applied Islamic law[92].

Pressure on women is also high. Early marriage is relatively common in Somalia, with families in refugee camps marrying their daughters to wealthy older men escape their impoverished economic situation. Somalia has some of the world's highest rates of Female Genital Mutilation, with around 98% of girls aged 5 to 11 years having undergone the most extreme type, infibulation, which is believed to be important for maintaining women's chastity before marriage[93]. After they get married, fertility problems are often blamed on the women and might lead to divorce. Furthermore, women who have lost their husbands or brothers are more vulnerable to sexual violence. In cases of rape, a woman may be blamed for bringing shame to her clan and may be forced to marry the perpetrator.

Religious beliefs may also interfere with the search for mental treatment. As many Somalis believe everything is preordained by God, they interpret mental illness as a test, not looking for cures but trying to experience and endure the illness to achieve a better afterlife[94].

Rawan Hamid, a key informant interviewed for this paper discussed the importance of not only providing medical care but also making sure it is consistently funded and supported in the longer term. She explained: *"mental health is not considered a priority... it's an after-thought usually. I have conducted an assessment countrywide assessment of Gender-Based Violence GBV and Mental Health and Psychosocial Support MHPSS services in Somalia. And one of the things we found that if an area or region has a provider of such services, today, in three months, they may not exist. So, the key word here is consistency of services. There are people who've been trained, on the positive side. Or we've been training people to do psychological first aid, basic counselling, responders, first responders of trauma, all these things. However, it is important that we have*

87 Ibid.

88 Ibid

89 Human Rights Watch, October 2015, "Chained Like Prisoners" – Abuses Against People with Psychosocial Disabilities in Somaliland, available online at: https://www.hrw.org/report/2015/10/25/chained-prisoners/abuses-against-people-psychosocial-disabilities-somaliland

90 Supra note 83

91 Ibid

92 Death Hangs Over Somali Queers, Behind the Mask, May 3, 2004, Available online at: https://www.glapn.org/sodomylaws/world/somalia/sonews007.htm

93 CARE international, Female Genital Mutilation: A daily grim reality for girls in Somalia, 6 Feb 2023, available online at: https://reliefweb.int/report/somalia/female-genital-mutilation-daily-grim-reality-girls-somalia

94 HCR, 2016, Culture, context and mental health of Somali refugees: a primer for staff working in mental health and psychosocial support programmes. Available online at: https://www.unhcr.org/media/culture-context-and-mental-health-somali-refugees-primer-staff-working-mental-health-and

those trained, employed and included in the response system or in Ministry of Health or permanently located in their communities. And this, again, will require funding."

The key informant also pointed out that, because of Somalia's clan-based society, some groups are considered inferior and as a result are marginalised. Statistics show they are often the last to get access to the health services. In her years of work, she has seen improvements in awareness, but believes that this needs to be accompanied by terms of service.

Despite these challenges, there are some mental health services available in Somalia. These services are largely provided by non-governmental organizations (NGOs) and international organizations. Some of the major NGOs providing mental health services in Somalia include the International Medical Corps, the Danish Refugee Council, and the International Organization for Migration. These organizations provide a range of mental health services, including counselling, psychotherapy, and medication management. They also provide training for local health workers and community members on how to identify and address mental health issues. Aiming to improve the quality of mental health treatment, the WHO has been producing training material for mental health facilities in Somalia. It shows principles that should be respected when treating people suffering from mental illness, such as respect for their dignity, acceptance of persons with disabilities, accessibility and equality between men and women.

However, mental health provision in Somalia remains extremely limited, and much more work is needed to address the significant gaps in mental health services in the country. The ongoing conflict and insecurity in Somalia make it challenging to provide consistent and sustained mental health services, and there is a need for more resources and support from the international community to address these issues.

8. Conclusions

The Horn of Africa region struggles with a lack of access to mental health services, as well as the presence of vulnerable groups such as women, children, and refugees, and widespread stigma and cultural barriers that prevent people from seeking help. Mental health services face limited resources and funding shortages, a lack of trained mental health professionals, and in many cases, the absence of national policies and legislation supportive of mental health services. There are significant needs ranging from basic psychosocial support, counselling, and substance abuse services, and a need for greater integration and prioritization of mental health services within wider health and social care provision. It is important that mental health is recognised as a vital part of the right to health, both for citizens and for refugees in the region, and that governments and international actors invest in the development of healthcare systems able to meet these needs. This will mean mobilising political will and funding to help alleviate the enormous, yet invisible burden of psychological suffering among displaced people in the region. There remains a long way to go before the slogan "no health without mental health" becomes a reality[95].

95 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61238-0/abstract

9. Annex 1 – List of Key Informants

- *Rawan Hamid* is a Sudanese-Canadian with a bachelor's degree in psychology and a master's degree in mental health and psychological therapies. She is pursuing a PhD in clinical psychology and has a Harvard postgraduate certificate in child protection and law. Hamid has worked in South Sudan, Somalia, and Uganda, as well as having good familiarity with Sudan.

- *Rediet Kidist* is an Ethiopian national, and graduated in psychology in 2016. For the past six years, he has provided mental health and psychosocial support in Ethiopia, working mainly with refugees, specifically South Sudanese and Eritrean refugees, as well as Internally Displaced Persons.

- *Samuel Kimbowa* is a Ugandan mental health worker, with training in occupational therapy and psychology. He works in mental health and psychosocial support in Uganda and conducts research on community-based mental health interventions. He also provides MHPSS trainings to organisations, has worked with refugees from across the East Africa and Great Lakes region, including Democratic Republic of Congo, Rwanda, South Sudan, and Ethiopia (especially the Tigray region).

- *Marilena Kollia* is a psychologist by training, with a masters in Environmental Psychology. She has worked in the humanitarian field for six years, previously in middle-east and more recently in South Sudan, based in Juba. She is a Protection Technical Coordinator for a major international NGO.

- *Yonas Tadesse* has an Ethiopian with 14 years of experience in mental health and psychosocial support in Ethiopia and the East Africa region. He has worked with refugees, asylum seekers and IDPs, with several international humanitarian organizations and government agencies.

10. Annex 2 – Authors

Lead Author *Matt Kinsella* is a researcher and consultant who has lived and worked in East Africa and the Horn of Africa, including Kenya, Ethiopia and Djibouti. He works as an external consultant providing research, analysis and evaluation services to the World Bank, UN agencies and NGOs in Africa and the Middle East. Matt has a Master in Public Administration from the University of York and is pursuing a PhD at the University of London. He is also a Research Associate with the Refugee Law Initiative.

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- *Paula Ulysses de Moraes Torracca* graduated in International Relations from Pontifical Catholic University of Rio de Janeiro. She is a researcher and founder of GHC (Global Health Collaborators).

- *Luis Felipe Herdy* has a bachelor's degree in International Relations from the Pontifical Catholic University of Rio de Janeiro. He is Special Projects Assistant at CEBRI (Brazilian Centre for International Relations) and Associate Researcher at Gepom (Study and Research Group on the Middle East).