A TRAINING CURRICULUM ON MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SERVICES FOR MIGRANTS IN THE GAMBIA

United Nations Peacebuilding

IOM UN MIGRATION

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Acknowledgement

The Ministry of Health wishes to express its gratitude to the United Nations Peace Building Fund and by extension, the International Organization for Migration (IOM) and the World Health Organization (WHO), for supporting the development of this training curriculum on mental health and psychosocial support (MHPSS) for migrant returnees, in The Gambia, as a contribution to the holistic reintegration of Gambian migrant returnees. This has become very necessary in dealing with the experiences posed by return migration and the sustainable reintegration of returnees in The Gambia.

Whilst mental health modules are taught in some of our health training institutions, they fall short of critical areas including migration and its impact on health.

This document is therefore timely as it will strengthen what is already in place and expand knowledge and skills in **Mental Health and Psychosocial Support Services (MHPSS)** to other training institutions across the country.

Having skimmed through the document, the contents address some of the critical gaps in our current mental health training curricular as well as providing new areas of knowledge and skills enhancement for our mental health and social care professionals to better deliver mental health services in the country.

Clearly, this document will enhance the health system's capacity to deliver MHPSS at the community level, which is the overriding goal and aspiration of our national mental health policy – ensuring equitable access to quality mental health services by populations across the country.

Recognizing the complex nature of MHPSS issues and the challenges surrounding it, the Ministry of Health applauds the consultative processes and stakeholder scrutiny that went into developing this important document.

Finally, the Ministry once again appreciates all the stakeholders and partners that have contributed directly or indirectly to the development of this document. Together, we can make a difference in realizing our goals and aspirations in ensuing a mental wellbeing for all.

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Dr Ahmadou Lamin Samateh

Hon Minister of Health

MINISTRY OF HEALTH ★ PERMANENT SECRETARY ★

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LIST OF ACRONYMS

AVR	Assisted Voluntary Return
AVRR	Assisted Voluntary Return and Reintegration
CGPA	Cumulative Grade Point Average
EMN	European Migration Network
EU	European Union
GBV	Gender-Based Violence
GNDP	The Gambia National Development Plan 2018-2021
GPA	Grade Point Average
IASC	Inter Agency Standing Committee
IDPs	Internally Displaced Persons
IOM	International Organisation for Migration
IPA	Individual Personal Assistants to SBGV survivors
LGBT	Lesbian Gay Bisexual and Transgender
M&E	Monitoring and Evaluation
MHPSS	Mental Health and Psychosocial Support
NGO	Non-Governmental Organisation
PFA	Psychological First Aid
PSS	Psychosocial Support
PTSD	Post Traumatic Stress Disorder
RA	Reintegration Assistance
REBT	Rational Emotive Behaviour Therapy
SGBV	Sexual and Gender-Based Violence

1.0 Introduction

1.1 Background information

1.1.1 Migration

According to the International Organization for Migration (IOM, 2019)[1], migration is the movement of persons away from their place of usual residence, either across an international border or within a state. Migration can be either regular or irregular and the regular migration status can become irregular. The reasons for irregular migrations are many, complex and multifaceted arising from problems associated with and ranging from economic, psychosocial, political, environmental and religious to mention a few.

According to the Gambia National Development Plan 2018-2021[2], The Gambia has a youthful population with 38.5 percent between the ages of 15 and 35, the official age bracket for youth. This reveals a high dependency factor in society and has serious implications for development programming including social protection. Furthermore, the plan stated that "poor and inadequate education continues to limit the youth's productivity and acquisition of skills, while insufficient access to knowledge and information (including business development services for the entrepreneurial youth) is hindering their gainful engagement". Furthermore, it identified "poverty has also been a push factor that triggers young Gambians to leave the country by irregular means to Europe and other destinations. Additionally, poverty levels remain unchanged with the percentage of households living below the poverty line of $1.25/day increasing from 48.4 percent in 2010 and 48.65 percent in 2015. There is a rising rural poverty (The rural areas account for 42.2 percent of the country's population, but they hold 60 percent of its poor) and a growing gap between rural and urban Gambia with regards to access to health, education, and basic services. While the proportion of households living below the poverty line is 31.6 percent in urban areas, the proportion rises to 69.5 percent for rural Gambia.

The European Migration Network (EMN, 2015) reported that between 2009 and 2013, 124,940 asylum seekers were Western African nationals, representing 8 percent of the total

[1] International Migration Law (2019). Glossary on Migration. International Organization for Migration.

[2] Gambia National Development Plan, 2018 – 2021.

of all asylum seekers to the EU during that period, whilst 176,840 third country nationals (TCNs) originating from Western Africa were found to be irregularly staying on EU territory[3]. Usually, the expectation of the migrant is that life will be better at the place one intends to migrate to. In 2017, it was globally estimated that 258 million people were counted as living in countries other than their country of origin, representing 3.45 percent of the world's population. Out of this figure, those who were displaced as a result of persecution, generalized violence, conflict, violation of human rights or other reasons stood at 68.5 million (26.6 percent). Women accounted for 124.8 million (48.4 percent) with 36.1 million (14 percent) as children. Migrant workers, international students and registered refugees stood at 150.3 million (58.3 percent), 4.8 million (1.9 percent) and 25.4 million (9.8 percent) respectively (Global Migration Indicator, 2018)[4].

Kebbeh (2017, cited in GNDP, 2018, p. 295) estimates that there are about 140,000 Gambian migrants' resident in Italy, United States, Spain, Germany, United Kingdom, Sweden, Senegal, Sierra Leone, Mali and Guinea Conakry. The IOM cited by the GNDP (2018, p. 292) reported that Gambians recorded 34. percent (991) and topped the list of five West African countries that arrived by sea in Italy between January and February 2016. The Gambia had the 15th highest rate of emigration of highly educated individuals. The Gambian Diaspora profile has two extreme characteristics representing the very high number of skilled professionals and irregular (backway) migrants mostly not so very educated. These different migrant groups have different experiences, exposures, and challenges when it comes to reintegration either in host countries or upon return to countries of origin.

According to the GNDP 2018-2021 (p. 296), "in 2016, the total of Diaspora remittances to The Gambia was $200 Million, being 21.5 per cent of GDP. It is estimated that if remittances sent through informal means were included in the annual sum, it would represent over one third of GDP. The Gambia was the 10th remittance receiving country in the world, and the 3rd in Africa … the contribution and impact of the Diaspora in Gambian socioeconomic and political development is substantial". The remittances are utilised by the receiving families primarily to meet their survival needs and the remainder for investment in small and medium scale

[3] EMN (2015). European Migration Network (2015).
[4] Global Migration Indicator (2018)

enterprises (SMEs). As for the latter, some returnees come home only to realise that their remittances were mismanaged further hampering their chances to reintegrate In their communities of origin/return.

1.1.2 Reintegration

The mere fact that someone returns to a country or place where s/he has previously been living does not mean that reintegration is seamless[5]. Reintegration in general is understood as the **re-inclusion or re-incorporation** of a person into a group or a process, e.g. of a migrant into the society of his or her country of origin or habitual residence[6].

IOM (2017) defines reintegration as a multidimensional process that requires the re-establishment of economic, social and psychosocial ties. As such, successful reintegration depends on various factors such as the migrant's time spent abroad as well as his/her personal abilities and resources; the acceptance by his/her family, peers, and community; but also on environmental and structural capacities as well as development and economic opportunities available in the country of origin[7].

Recent years have seen the rise of larger-scale irregular migratory flows as a result of continually limited regular migration channels and unaddressed drivers of migration[8]. The numbers of migrants returning to their countries of origin under the Assisted Voluntary Return and Reintegration (AVRR) programmes have grown too,[9] not only in the volume of migrants in need of assistance but for the diversity of actors involved and the intricacy of challenges. García-Pereiro and Biscione (2016) within the context of migration and return have categorized returns into three distinct groups: (1) Assisted Voluntary Return (AVR) these are migrants assisted by IOM to return to their country of origin, (2) migrants who had been deported from the country of destination, and (3) migrants that returned home on their own initiative and volition and need to be reintegrated[10].

Returnees will require assistance packages to resettle in their communities of return. Considering the investment in terms of time, efforts, emotions and resources that migrant

[5] Towards an integrated approach to reintegration.
[6] International Organization for Migration, Glossary on Migration.
[7] A definition of reintegration. Towards and integrated approach to reintegration
[8] Drivers of Migration.
[9] IOM (2017) AVRR Key highlights 2016
[10] Garcia and Biscione (2016). Return Migration in Albania: the profiles of returnees

returnees make when embarking on their migratory journey, reintegration assistance is a key factor in minimizing migrant vulnerability upon return, protecting their rights, and supporting them to restart their lives within communities of return[11]. EMN (2015) identified that good practices in return and reintegration include: (a) Involving the Diaspora community and/or organisations to reach, inform and convince; (b) Tailoring support to individuals' needs; (c) Offering third country nationals (TCNs) from West African countries an employment or business perspective upon return; (d) Mobilising the knowledge of local organisations in return countries; and (e) Analysing migration dynamics and the phenomenon of interstate migration[12]. Under the EU-IOM Joint Initiative for Migrant Protection and Reintegration, migrant returnees receive various forms of Reintegration Assistance (RA) in the form of Vocational Training; Education; Housing; Job placement; Micro-business; Medical support; Psychosocial support; and a host of others, including referrals to other government and private sectors.

The International Organization for Migration (IOM, 2019) reported that from the start of 2017, an average of about 143 Gambian men and women voluntarily returned to their homes every four weeks. And through the EU-IOM Joint Initiative for Migrant Protection and Reintegration, 3,273 returnees have benefitted from different forms of reintegration assistance, in The Gambia[13].

IOM asserts that reintegration can be considered sustainable when returnees have reached levels of economic self-sufficiency, social stability within their communities, and psychosocial well-being that allow them to cope with (re)migration drivers. Having achieved sustainable reintegration, returnees are able to make further migration decisions a matter of choice, rather than necessity[14].

[11] Towards an integrated approach to reintegration.

[12] EMN Inform: Challenges and good practices in the return and reintegration of irregular migrants to Western Africa

[13] IOM The Gambia EUTF Monthly Report: 30 September 2020

[14] This definition implies the absence of a direct correlation between successful reintegration and further migration after return. The latter can take place and can still be a choice regardless of whether reintegration is successful, partially successful or unsuccessful. On the other hand, returnees are unlikely to reintegrate if they find themselves in situations whereby moving again or relying on a family member abroad is considered necessary for their physical or socioeconomic survival.

Despite IOM's support, the returnees still face challenges in their communities further impeding their sustainable reintegration. Aside from having limited economic resources, they also face stigma and discrimination from family members and communities, further deteriorating their health and psychosocial wellbeing. Sonko's (2020) report on the mental health and psychosocial needs or effects of irregular migration on some of the returnees in The Gambia is summarized as follows[15]:

> … irregular migration erodes the protective support mechanisms that are normally available, increases the risks of diverse problems and tends to amplify pre-existing problems. While social and psychological problems occur in most groups, it is important to note that every individual will experience the same event differently and will have different resources and capacities to cope with the event.
>
> The incidence of psychosocial problems significantly increases during the migration continuum. Exposure to violence, the disruption of social networks, the loss of and/or separation from relatives and friends, deteriorating living conditions, poverty and limited access to support can have both a short and a long-term impact on the well-being of returnees, families, communities and helpers.
>
> Irregular migrants suffer serious physical, social and emotional consequences in host and transit countries. These symptoms on the returnees may not be visible and the trauma can extend to their close relations and the unfavourable experience, violation and abuse meted on these returnees can lead to anxiety, depression, fear, sadness, post-traumatic stress disorder, aggression, withdrawal, substance/drug abuse, anti-social behaviours, self-harm and an extreme feeling of hopelessness, nihilism and even suicide.
>
> Society oftentimes responds to such returnees with damaging stigma and discrimination thereby worsening their condition and further causing problems in the effective reintegration of these individuals in the community to lead a meaningful life and their families as well.

The psychosocial impact of being a returnee increases the chances of engaging in delinquent behaviour, and twice more likely to experience mental health problems later in life. Lack of

[15] Bakary Sonko: National Mental Health Programme Manager, The Gambia.

access to psychosocial support, health care can have dangerous psychological and health implication leading to acute or chronic problems. The traumatic effect of being a returnee on families is huge and needs to be equally managed to develop social support networks at the level of the household.

Most recently, the COVID 19 pandemic has affected the lives of people globally. A large part of the world's population is affected by the virus in different ways, including uncertainties about the future, lost of livelihoods opportunities, financial hardship, loss of loved ones, stigma and the perduring effects of isolation as well as heightened anxieties[16]. These concerns are causing unusual psychological reactions that can worsen or exacerbate pre-existing mental health conditions or vulnerabilities[17] among different groups including migrants. The COVID-19 pandemic is a threat to both the physical and mental health of migrants and their psychosocial well-being.

In a recent survey by WHO (2020) among 130 countries on how the provision of mental, neurological and substance use services have changed due to COVID-19, the types of services that have been disrupted, and how countries are adapting to overcome these challenges, countries reported widespread disruption of many kinds of critical mental health services: over 60 percent reported disruptions to mental health services for vulnerable people, including children and adolescents (72 percent), older adults (70 percent), and women requiring antenatal or postnatal services (61 percent); more than a third (35 percent) reported disruptions to emergency interventions, including those for people experiencing prolonged seizures, severe substance use withdrawal syndromes and delirium, often a sign of a serious underlying medical condition; 30 percent reported disruptions to access for medications for mental, neurological and substance use disorders; around three-quarters reported at least partial disruptions to school and workplace mental health services (78 percent and 75 percent respectively)[18]. Community-based services and mental health prevention and promotion programmes, already limited in availability, are reported to be disrupted at a time when society needs them the most due to the adverse mental health impacts of COVID-19[19].

[17] https://eea.iom.int/publications/covid-19-guidance-and-toolkit-mental-health-and-psychosocial-support-mhpss-teams

[18] The impact of COVID-19 on mental, neurological and substance use services: resultsof a rapid assessment. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO

[19] WHO (2020)

While COVID 19 continues to linger, the situation has not been any different in The Gambia. With activities halted, programmes redesigned to fit into COVID 19 prevention and control measures, migrant returnees and their communities continue to face limited access to social services, due to the COVID 19 disruptions.

A quick review of the training curricula for all levels of nursing and medicine in The Gambia shows the presence of Mental Health and Psychiatry courses or modules being offered, however, they do not directly address issues relating to the mental health and psychosocial support (MHPSS) for migrant returnees but enhance skills necessary for improved MHPSS care delivery to migrant returnees and other vulnerable persons. Similarly, MHPSS is not covered in the training of other non-health personnel working with migrant returnees. Due to the limited availability of mental health training in institutions and care facilities, the MHPSS needs of migrant returnees are not addressed holistically, leaving a huge gap in terms of training and service delivery.

Given the foregoing, it is important that staff working with migrant returnees receive training on Mental Health and Psychosocial support to prepare them to (1) better understand the care needs of migrant returnees; (2) provide such care without feeling burnout; and (3) enable the migrant returnees to benefit from programmes/activities designed to allow the government to achieve one of its visions of “reaping the demographic dividend through an empowered youth”.

1.2 Aim

To equip participants with knowledge and skills training necessary to provide Mental Health and Psychosocial Support Services to migrant returnees, in The Gambia.

1.3 Objectives

By the end of the training, participants will be able to:

- Define psychosocial wellbeing in relation to mental health
- Appreciate the psycho-emotional and social consequences of migration
- Conduct rapid MHPSS assessment among people exposed to traumatic events
- Recognize different consequences of trauma in the individuals, families and communities
- Identify the psychosocial problems of returnees and their families

- Identify the psychosocial needs of returnees and their families
- Provide basic psychosocial support for returnees and their families
- Demonstrate the basic principles required to work with vulnerable individuals including migrants
- Identify and collaborate with international, national, NGO, community and family support structures in the provision of skills for returnee (re)integration
- Develop coping strategies for both returnees and self during the process of psychosocial support (PSS) delivery
- Understand and use basic communication skills for contact with vulnerable individuals including migrant returnees
- Learn how to deliver basic counselling for migrant returnees
- Apply Problem-solving skills when dealing with problems related to migrants and returnees
- To understand the link between COVID 19 disease and mental health
- Deliver psychological first aid to people exposed to traumatic events
- Conduct mental health promotion
- Refer migrant returnees and their significant others affected by mental health issues to relevant services

1.4 Programme description

Programme schedule

LEVEL/PART	INPUT	COURSE CODE	COURSE	DURATION			CREDIT HOURS
				Theory	Practice	Hours	
				Week(s)	Weeks		
1 (Basic)	Theory	PSS 101	• Introduction to MHPSS course • Overview of Health and safety at work • Introduction to the MHPSS strategic Framework • Introduction to mental health promotion • Introduction to problem solving • Introduction to psychological first aid • **COVID 19 and mental health** • Migration, immigration and emigration and its impact on Gambian society • Introduction to Medico-legal issues in Mental Health delivery services • Concept of peace building and social cohesion • Overview of MHPSS Services • Self-Care Skills I • Introduction to developmental psychology • Introduction to Basic Counselling • Personality and coping skills • Introduction to sociology • Introduction to community/social work • Communication Skills & Basic Helping Skills for Professionals I • Introduction to Mental Health Trauma • Stress Management and Trauma Stewardship Skills	2			3

	Field practice I	PSS 102	Community/Instructional attachment		2		1.5
	Theory	PSS 103	• Introduction to Human Rights • Trauma Informed Care • Survival skills training • Gender studies • Self-Care Skills II • Values & Ethics • Psychosocial Impact of Conflict and Violence • Psychosocial impact of diseases and pandemics eg the COVID -19 • Crisis Intervention/management • Psychological First Aid • Loss, Grief and Bereavement • Entrepreneurship skills training I • Communication Skills & Basic Helping Skills for Professionals II • Integration services • Psychological counselling I	2			3
	Theory	PSS 104	• Suicide Prevention, Assessment & Intervention • Entrepreneurship skills training II • Sexual and Gender-Based Violence • Psychological counselling II	1			1.5
	Field practice II	PSS 105	• Community/Instructional attachment		3		1.5
(Advanced)			• Revision and, • Mid Term/Semester Examination	1			2
	Field practice III	PSS 106	Community/Instructional attachment		5		3
	Theory	PSS 107	• Maslow's Hierarchy of needs • Case management • Identifying and working with support groups	1			2

2			• Multidisciplinary and multi-sectoral approaches to MHPSS services • Documentation and research for MHPSS services • Monitoring and Evaluation for MHPSS				
	Field practice IV	PSS 108	Community/Instructional attachment		5		3
	Project write up	PSS 109	Case study/project	3			1.5
		PSS 110	Comprehensive exam	1			
			Total (weeks - Theory)	**10**			
			Total (weeks - Practice)		**15**		
			Total credit hours				**22**

Theory - 1 credit hour = 15 hours of instruction ***Practice – 1 credit hour = 45 hours of field practice***

1.5 Hours of engagement

<u>Both Theory and Practice</u>

- Mondays to Thursdays – 09.00 – 15. 00 hrs = 6hrs x 4 days = 24 hrs
- Fridays – 09.00 – 13.00 hrs = 4 hrs x 1 day = 4 hrs

1.6 Duration of training

- Six months

1.7 Teaching/learning methods

In order to maximise learning opportunities in the programme, a variety of teaching and learning methods are used. The following strategies will be utilised, to maximise interactive learning experience**:**

- Lecture/Discussion
- Field Attachment
- Demonstrations
- Case Study/Project Presentation
- Seminars/Workshops
- Study Group/Brainstorming.
- Interview/Tutorials
- Guidance & Counselling
- Mentorship/Preceptorship
- Role Play
- Reflective Practice
- Computed Assisted Learning
- Simulations

1.8 Teaching/learning materials and Aids

- Models & other simulation devices
- Case Studies
- Books & handouts
- Graphics, Flow Charts, Diagrams, Schematic Drawings
- Posters & Print Outs
- Photographs
- Videos
- Slide Projectors, Over Head Projectors, Film Strips
- Blackboard, Whiteboard, Flipcharts, Transparencies
- Open & close circuit television
- Other Audio-Visual Aids e.g. Computers/internet
- Observed Field Experience

1.9 Supervision

The ability of participants to have hands on experience working directly with returnees under supervision is a central part of this training. As a result of this, about sixty-one (61) percent of the duration of training will be spent on field practice where participants will be supervised by already trained staff who will appraise the participant's progress and report at the end of each of the four field attachments. Trainers will also visit and observe participants' performance.

Suggested field practice sites include but not limited to health facilities where psychiatric nurses and social workers are based, youth centres, refugee camps, National Drug Law Enforcement Agency, Department of Social Welfare (DSW), prisons, child welfare support agencies, clinical psychologists and NGOs engaged with youth empowerment and the prevention of gender-based violence.

1.10 Self-Care

The participants may experience stress or trauma during the course of their field attachment, therefore, they need to be trained on coping skills and on measures that will enable them to build their resilience and sustain their well-being.

1.11 Training venue(s)

The training can be offered by any of the health training institutions offering Diploma programmes.

1.12 Assessment

Marks from the following will constitute 60 percent of the final mark for the course:

- written assessments (portfolio, tests and assignments)
- project work/case studies
- supervision sessions including field attachment and supervision report.

The comprehensive exams will account for 40 percent of the final mark for the course.

1.13 GPA Scoring

The scoring would be based on what prevails in the institution hosting the training. The table below is an example.

Letter grade	Numerical marks	Interpretation	Grade Point
A	**85-100**	**Excellent**	**5**
B	**75-84**	**Very Good**	**4**
C	**60-74**	**Good**	**3**
D	**50-59**	**Credit**	**2**
E	**40-49**	**Pass**	**1**
F	**Below 40**	**Fail**	**0**

1.14 Certification

Participants must have a Cumulative Grade Point Average (CGPA) score of at least 2.50 to graduate (based on the institution's requirements). They will receive a certificate upon completion of level 1 and a diploma upon completion of the second level mentioned in the programme schedule above. In addition, they must fulfil the following requirements:

- 90 percent attendance of the level for which they are being certificated

- Satisfactory grade of at least 50% in the supervision sessions including a satisfactory field attachment and supervision report
- Minimum of 40 percent in the written assessments (portfolio, tests and assignments)
- Minimum of 50 percent in his/her project work

1.15 Trainee selection criteria

The course is designed for health and non-health professionals working in/desiring to work in the field of MHPSS services. This includes but not limited to nurses, midwives, doctors, social workers, psychologists, psychosocial support workers, counsellors, protection officers, lawyers, law enforcement officers working in both governmental and non-governmental organizations. Participants must have a minimum of three credits passes in English language science and any other subject (GCE "O" Levels or WASSCE) to be considered for enrolment. Mature students with five years work experience in the fields of social work, migration and mental health and a minimum of a pass in English.

1.16 Language of instruction

- English language

1.17 Programme accreditation

The programme will be hosted by a training institution(s) that have received the National Accreditation and Quality Assurance Authority.

2.00 MHPSS Training programme content

2.1 LEVEL: 1 (Basic) Course: PSS 101 - Theory Credit units: 3 Duration: 2 weeks

Courses	Course content
Introduction to the MHPSS Training Program	• Introduction of participants and trainers • Getting-to-know-you and team-building exercises • Training Ground Rules • Overview of objectives of the program • Training Structure • Overview of training topics • Review of supervision requirements • Learning Agreement • Participants' expectations and goals • Review of expectations for completing the course • Adult learning approach and methodology • Supervision and practice - Value of supervision for MHPSS service providers - Supervision plan - Supervision evaluation - Identify individual practice goals/objectives
Self-care skills	• Definition of Self-Care Skills • Definition of self-care

	• Impact of stress: physical, emotional, cognitive, social and spiritual • Recognizing stress in yourself and colleagues and seeking help • Relaxation, mind-body techniques and anxiety management I • Development of a self-care plan I
Overview of MHPSS Services	• Defining MHPSS, psychosocial well-being, psychosocial distress and other core concepts • Different methods of PSS delivery • Types of PSS providers
Migration, immigration and emigration and its impact on Gambian society	• Migration • Burden of irregular migration • Impact of migration, immigration and emigration and its impact on Gambian society • Drivers of irregular migration • Migration management crisis and its psychosocial implications
Introduction to the MHPSS strategic Framework	• Organization of Health Services • Financing of Health Services • The National Policy for Mental Health Services Delivery • Burden of Mental Disorders in The Gambia • Purpose and Justification • Vision Statement • Mission Statement • Values and Guiding Principles • Governance and Leadership • Service Delivery • Human Resources • Essential Medicines • Information, Evidence and Research • Humanitarian Response • Monitoring, Evaluation and Learning
Introduction to Medico-legal issues in Mental Health delivery services	• Competent care • Collaborative care • Patient assessment and diagnosis • Appropriate prescribing • Patient handovers • Consent, privacy, and other considerations • Confidentiality and disclosure • Telepsychiatry • Risk management tips • Adequacy of information regarding forensic patients with mental health issues • Outcome of Insanity pleas • Absconding behaviour in patients with mental health illnesses • In/Out patient care decision-making • Medico-legal issues in Mental Health
Overview of Health and safety at work	• Overview of health and safety at work • Safety orientation checklist • Safety orientation supporting documentation

	• Safety training for MHPSS
Introduction to developmental psychology	• Developmental psychology • Foundations of modern developmental psychology • Theories ✓ Psychosexual development/psychodynamic ✓ Cognitive development ✓ Stages of moral development
Introduction to sociology	• General Sociological theory ✓ Sociology four theoretical perspectives ➢ Structural functional ➢ Social conflict ➢ Feminism ➢ Symbolic interactionism • Social Groups and organisations ✓ Group dynamics ✓ Peer groups ✓ Support groups ✓ Best practices for groups in PSS • Socialisation ✓ Social institutions ✓ Social change over time • Society ✓ Diversity in society ✓ Race and ethnicity ✓ Sex and gender ✓ Aging ✓ Comte's 3 stages of society and theory of positivism • Economy and politics ✓ Capitalism ✓ Socialism
Introduction to community/social work	• Traditional Gambian Community setup • Traditional Gambian Community leadership hierarchy • Family setup in traditional settings • Kith, kinship and class/caste system • Roles and expectation of different family members • Ways of disseminating information in rural and urban areas • Community mobilisation • Community participation
Communication Skills & Basic Helping Skills for Professionals I	• Characteristics of the effective helping professional therapeutic alliance: trust, empathy, caring, nonjudgmental communication • Verbal and nonverbal communication and attending behaviour • Communication styles
Introduction to Mental Health Trauma and trauma care	• Definitions, theories, and types of trauma • Trauma versus stressful life events • Trauma in adults: symptoms and short-term and long-term reactions • Trauma in children: vulnerability, symptoms, reactions at each developmental stage

	• Impacts of trauma: On development, on the brain, body, real or perceived threats • Interaction of trauma and chronic stress as a particular challenge in conflict/displacement contexts • Risk and protective factors: individual, family, community • Potential mental health and psychosocial problems from trauma: PTSD, and Acute Stress Reaction - Diagnosis, symptoms, triggers, Assessment and referral • Co-Morbidity - Recognizing dissociation - Depression, anxiety, dissociative disorders, psychotic disorders, substance abuse, etc. - Symptoms, case identification, assessment and referral • Introduction to trauma informed care, including principles, trauma informed psycho-education, and comparison to trauma specific services
Stress Management and Trauma Stewardship Skills	• Define Stress • Stress curve • Types of stress • Signs of stress • Stress and coping • Stress management • Recognizing stress • Maladaptive responses to stress • Building/encouraging resilience in helpers, individuals, families and communities • Definition of terms- primary trauma, secondary trauma and vicarious trauma • Symptoms of Compassion Fatigue, Vicarious Traumatisation and Burnout • Compassion satisfaction and vicarious resilience • Post-traumatic growth

2.2 LEVEL: 1 (Basic) Course: PSS 102 – Practice I Credit units: 1.5 Duration: 2 weeks

Course	Assessment
Community/Instructional attachment	Assessment of attachment report, logbook and portfolio

2.3 LEVEL: 1 (Basic) Course: PSS 103 - Theory Credit units: 3 Duration: 2 weeks

Courses	Course content
Introduction to Human Rights	• Introduction to human rights • Introduction to human rights-based approach • Basic Concepts and Principles of Human Rights • Universal Declaration of Human Rights

	• Examples of human rights in the work context • Human Rights violations and prevention
Child Rights	• Convention on the Rights of the Child • Child Abuse Maltreatment • Causes and patterns of discrimination and inequality-facing children • Identify changes you can implement to better incorporate a child-rights perspective in the interest of advancing child rights in your work
Values & Ethics	• Ethical values, principles and standards that guide practice • Review of Codes of Ethics (NASW) and IASC MHPSS core principles • Working with vulnerable groups LGBT, survivors of trafficking, children in or formerly in armed forces/groups - challenging stereotypes, attitudes • Ethical decision-making model • Applied ethics (case scenarios) ✓ Across culture ✓ Focus exercises on ethical dilemmas around: ➢ informed consent, boundaries, confidentiality, limits of competency, tolerance/diversity, mandatory reporting
Gender studies	• Gender: sex and gender, gender norms, gender continuum • Inheritance • Land ownership • Power and control • Marriage, divorcees and widowers • Mono and polygamy
Self-Care Skills II	• Relaxation, mind-body techniques and anxiety management II • Development of a self-care plan II
Survival skills training	• Understanding the survivor centered approach • A survivor-centered approach to violence against women • Prioritizing the rights, needs, and wishes of the survivor. • The survivor-centred approach in practice ✓ Attitude ✓ Effective listening • Empowerment
Psychosocial Impact of Conflict and Violence	• Impact of conflict and violence: ecological levels, factors, • Distress and disorders, ongoing stress, pre-existing conditions • Consequences of war, genocide, displacement, SGBV, torture and detention on vulnerable populations, communities, and societies • Vulnerable populations: vulnerability definitions, children, people with disabilities, the elderly, refugees and IDPs • Types of violence and loss from conflict: SGBV, torture, recruitment into armed groups, genocide, war and conflict, ambiguous loss, displacement and resettlement • Implications for interventions: Principles, needs and interventions, self-care ✓ Specific considerations given to developmental stage and considerations for ethnic, gender, ability, and sexual orientation of individuals

	• Best practices on basic PSS for conflict-affected populations (e.g. PFA, Trauma-Informed Care) • Introduction to Peace building and social cohesion
Crisis Intervention/ management	• Definition of crisis • Origins of crisis intervention • Reactions and responses to crisis ✓ Definition of crisis intervention, how it compares to MHPSS services. How it aims to avoid prevent danger and open up ✓ Opportunities, explore alternatives ✓ Crisis intervention principles and strategies ✓ Considerations for trauma-informed intervention • Why crisis intervention is important • Brief assessment • Steps in crisis intervention • Collaboration with multidisciplinary actors and Communication network for emergency cases • Practical application – connect to PFA • Add best practices for crisis intervention - Using a trauma informed approach
COVID 19 and mental health	• Definition of COVID 19 • Prevalence of COVID 19 • How COVID 19 can be contracted. • COVID 19 disease and social stigma • Infection, prevention and control measures. • Coping during the COVID 19 pandemic.
Psychological First Aid (PFA)	• Defining PFA • Role of PFA in response to crises and emergencies • PFA principles, conflict scenarios, and link to crisis intervention • Steps of PFA • PFA with young children (accompanied and unaccompanied), school-age children, adolescents, adults, elderly, people with disabilities. • People who likely need special attention • Caring for yourself and for your team members in emergencies • Adapting PFA to the local context
Loss, Grief and Bereavement	• Types of loss • Sudden loss • Grief and loss in conflict/violent/traumatic circumstances • Multiple losses (loss of: loved ones, property, livelihood, security, trust, control, dignity, roles, imagined future, social infrastructure), injury and loss of body function • Grief, bereavement process ✓ Complicated grief, grieving process, disruptions to grieving process due to conflict and displacement ✓ Supporting individuals with missing loved ones, children and developmental impacts, approaches for ambiguous loss • Healing rituals • Best practices

Entrepreneurship skills training I	• General concept of entrepreneurship • Characteristics of an entrepreneur • Factors affecting entrepreneurship • Employment • Small business enterprise • Processes involved in setting up Small Business enterprises • Major environmental factors affecting businesses • Taxation and tax exemption • Sources of finances
Communication Skills & Basic Helping Skills for Professionals II	• Emotional intelligence and communication • Interviewing Skills: active listening, open questions, reflecting, clarifying, paraphrasing, reframing, summarizing, affirming, empowering, normalizing, interviewing for goals and strengths • Communicating with children
Integration services	• Migration and return • Repatriation and (re)integration ✓ Definitions, Consequences, differences, models and programmes • Reintegration services and packages • Reintegration with home community • Family engagement strategies • Opportunities and challenges of reintegration of returnees • Evaluation for resilience and returnee reintegration • Identifying and working with support groups
Psychological counselling I	• Introduction to Psychological Counseling • Counseling Process • Introduction to Counselling theories • Self-Awareness as a Counsellor
Suicide Prevention, Assessment & Intervention	• Defining suicide extent of the problem, self-harm behaviour • Suicide myths • Being suicidal – suicidal tendencies • Risk and protective factors for suicide in adults and youth • Warning signs • Risk assessment – risk and protective factors; warning signs; ideation, intent, plan, behaviours, ✓ How to ask questions ✓ How and when to refer • Interventions ✓ Best practices • Safety planning (for suicidal tendencies and any safety risk situations) • Practical application

2.4 LEVEL: 1 (Basic) Course: PSS 104 – Practice II Credit units: 1.5 Duration: 3 weeks

Courses	**Assessment**

Community/Instructional attachment	Assessment of attachment report, logbook and Portfolio

2.5 LEVEL: 2 (Advanced) Course: PSS 105 - Theory Credit units: 2 Duration: 1 week

Courses	Course content
Entrepreneurship skills training II	• Production and distribution • Marketing • Pricing • Record keeping • Business evaluation
Sexual and Gender Based Violence (SGBV)	• SGBV Terms and Definitions: rape (including marital rape), sexual abuse, sexual exploitation, GBV, SGBV, domestic violence, intimate partner violence, Child marriage; forced marriage, etc. • Consent, informed consent • Types of GBV • GBV when and where • Structural Risk factors for GBV • Vulnerable groups • Consequences of GBV ✓ SGBV in the family and community; effects on children and others ✓ Physical, psychological, social, societal, and spiritual impact • SGBV in conflict and displacement settings, impact of stress/trauma on Individual Personal Assistants (IPA) • Psychosocial support for survivors ✓ Best practices ✓ Helping and protecting SGBV survivors, asking questions, strengthening coping ✓ Safety planning • Gender norms and practices that promote/discourage SGBV, and related help seeking, Challenging community norms and values that permit SGBV • Prevention of GBV
Psychological counselling II	• Theories and Therapies in Counselling ✓ Psychoanalytical Theory ✓ Psycho-Social Theory ✓ Person-Centred Theory ✓ Behaviour Therapy ✓ Cognitive Behaviour Therapy ✓ Rational Emotive Behaviour Therapy (REBT) ✓ Solution Focused Brief Therapy ✓ Play Therapy

2.6 LEVEL: 2 (Advanced) Course: PSS 106 – Practice III Credit units: 3 Duration: 5 weeks

Course	Assessment
Community/Instructional attachment	Assessment of attachment report, Portfolio and case study

2.7 LEVEL: 2 (Advanced) Course: PSS 107 - Theory Credit units: 2 Duration: 1 week

Courses	Course content
Maslow's Hierarchy of needs	• Understanding human needs • Understanding the theory of human motivation • Maslow's hierarchy of human needs • Human needs and conflict situations
Case management	• Case management process, principles, respect for clients and client rights, • Professional judgment • Initial engagement • Assessment • Direct and indirect disclosure • Creating a plan: Setting goals, objectives and care planning • Implementation of plan ✓ Actual referral networks in PSS care, Tailored service mapping ✓ How and which cases to refer ✓ Referral guidelines, processes, and checklists • Monitoring and revision of plan • Case closure • Evaluation of care • Terminating services • Best practices for basic PSS in case management
Multidisciplinary and multi-sectoral approaches to MHPSS services	• Teamwork • Multidisciplinary and multi-sectoral team members in MHPSS care • Benefits of multidisciplinary and multi-sectoral approaches in MHPSS
Documentation and research for MHPSS services	• Data management: case management records, forms, and standard checklists • Record keeping • Reporting • Research
Monitoring and Evaluation for MHPSS	• Defining Monitoring & Evaluation • Value of monitoring and evaluation for MHPSS service providers (M&E as an ethical obligation; as a skill that can improve practice) • Strategies for monitoring • Strategies for evaluation (collecting client feedback; assessing client change)

2.8 LEVEL: 2 (Advanced) Course: PSS 108 – Practice Credit units: 3 Duration: 5 weeks

Course	Assessment
Community/Instructional attachment	Assessment of attachment report, Portfolio and case study

2.9 LEVEL: 2 (Advanced) Course: PSS 109 - Theory Credit units: 1.5 Duration: 3 weeks

Course	Assessment
Project write up	Assessment of attachment report, logbook, Portfolio and Project work

2.10 LEVEL: 2 (Advanced) Course: PSS 110 -Theory Credit units: 1 Duration: 1 day

Course	Assessment
Comprehensive Examination	Comprehensive Theory exams- 3 Essay questions (answer any two) and 100 Multiple Choice Questions

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THE GOVERNMENT OF THE GAMBIA

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT STRATEGIC FRAMEWORK FOR MIGRANT RETURNEES (2020 -2025)

United Nations Peacebuilding

IOM UN MIGRATION

World Health Organization

MINISTRY OF HEALTH

2020

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STRATEGIC FRAMEWORK

Acknowledgement

The Ministry of Health wishes to express its gratitude to the United Nations Peace Building Fund and by extension, the International Organization for Migration (IOM) and the World Health Organization (WHO), for supporting the development of this strategic framework. Indeed, this Mental Health and Psychosocial Strategic Framework, as a contribution to the sustainable and holistic reintegration of Gambian migrant returnees, is a laudable and timely initiative.

Whilst the focus of this report is on migrants and returnees, it is no doubt that mental health problems and challenges are complex and multidimensional, exacerbated by different factors and contexts.

The Gambia is no exception to these challenges as the country continues to witness an upsurge of mental disorders. That said, mental health problems require complementary upstream-downstream and multi-sectoral approaches to addressing them.

As well articulated in this document, MHPSS is not only a strategic pillar for the reintegration of migrant returnees but a critical enabler for the overall health and wellbeing of Gambians. As the saying goes - there can be no health without mental health.

Recognizing the complex nature of MHPSS issues and the challenges surrounding it, the Ministry of Health applauds the consultative processes and stakeholder scrutiny that went into development this important document.

Finally, the Ministry once again appreciates all the stakeholders and partners that have contributed directly or indirectly to the development of this document.

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Dr Ahmadou Lamin Samateh

Hon Minister of Health

ACRONYMS

- **AI** Amnesty International
- **CBO** Community Based Organization
- **CEO** Chief Executive Officers
- **COOPI** Cooperation International
- **CHN** Community Health Nurse
- **CMD** Chief Medical Directors
- **CMHT** Community Mental Health Team
- **DHS** Directorate of Health Services
- **DHIS2** District Health Information Software 2
- **DPI** Directorate of Planning and Information
- **DSW** Directorate of Social Welfare
- **ECOWAS** Economic Community of West African States
- **EFSTH** Edward Francis Small Teaching Hospital
- **EU** European Union
- **FSQHE** Directorate of Food Standards, Quality and Hygiene Enforcement
- **HMIS** Health Management and Information System
- **HPE** Directorate of Health Promotion and Education
- **IEC** Information, Education and Communication
- **IOM** International Organization of Migration
- **LGA** Local Government Area
- **MOH** Ministry of Health
- **NGO** Non-Governmental Organization
- **NMHPM** National Mental Health Programme Manager
- **RHD** Regional Health Director
- **RN** State Registered Nurse
- **SDG** Sustainable Development Goals
- **SEM** State Enrolled Midwife
- **SEN** State Enrolled Nurse
- **TTPU** Tanka-Tanka Psychiatry Unit
- **UN** United Nations
- **VSO** Volunteering Service Overseas
- **WHO** World Health Organization
- **YEP** Youth Empowerment Project
-

EXECUTIVE SUMMARY

The Gambia is an emerging democracy under the leadership of recently elected president who pledged to ensure the safety and security of Gambian citizens. However, a historically difficult social, political, and economic environment under former regime created high levels of insecurity that led many young Gambians to leave the country on irregular migration routes in search of better lives. While an estimated 23 percent emigrate to neighboring ECOWAS states, a large share travel along the Central Mediterranean route from North Africa to Italy as irregular migrants. In 2016, arrivals in Italy (11,929) were 41 percent higher than in 2015 (8,454). By the end of August 2017, 5,525 Gambian nationals were accounted for in Italy (constituting 5.6 percent of Italy's total case load of 99,127 migrants) of which 24 percent of these were unaccompanied minors. These figures do not account for the thousands more migrants whose journeys were halted at the North African border (European Union External Action, 2013).

The context of migration and reintegration in The Gambia is underscored by two characteristics that set it apart from most other West African countries: the impact of the recent transition in the government and the most long-standing influence of tourism and mobility in shaping migration dynamics. The transition of power in January 2017 from the autocratic government to the democratically elected incumbent president ushered in a new era of migration governance. As a consequence of 22 year-rule, which led to the corruption and weakening of state institutions, the present government inherited a bankrupt state, with high unemployment rates –especially among the youth –and a dysfunctional labor market and educational sector (Amnesty International (2015, 2016)).

Among a host of formidable challenges, the primary objectives of the "New Gambia", in relation to migration, are to simultaneously stem irregular outward migration of low-skilled Gambians and to reintegrate returnees in The Gambia society. Firstly, as is the case for many of the government's initiatives, these goals are yet to be realized. Nevertheless, Gambians have high hopes and expectations that these poignant domestic issues will be resolved. These prevailing political dynamics –in conjunction with aspirations to participate in the "advanced economies" and cosmopolitan societies in Western states formed the foundation upon which many youths, primarily young men, have taken the 'Back Way' en-route to Europe in recent years. Secondly, Gambians constitute a disproportionately high percentage of the arrivals in Europe, considering the small size of the country. They embark on journeys to Europe (rather than other African states) at a higher rate than is the case for migrants from other West African countries (who tend to migrate within Africa). This strong culture of mobility northward is specifically attributed to the influence of the deeply embedded European tourism sector, which is said to have influenced Gambians' aspirations and decision-making. This legacy, which is most firmly rooted in the Upper River Region and the Kombos, has had a profound impact on the migration routes that young men have taken over the past decades, up to the recent past. It follows that in a country that is relatively small in size and population, virtually everyone has been affected by the impacts of emigration, often across multiple generations. There are a number of additional push and pull factors that overlap with those observed in neighbouring countries.

Bearing these two considerations in mind, the reflection debate government actors, civil society, international organizations, and migrants themselves, yet economically fragile government: “The return of too many (Gambians) too quickly could have a harmful effect on both the development and stability of the country.”

In view of the above, this strategic plan is developed bearing in mind that it is vital not only to address rhetorically why people should not leave the country but also to create reasons to stay in a more comprehensive and inclusive way. These are well spelt in the various sections of the strategic plan and it seeks to contribute to the understanding and resolution of such concerns.

SECTION ONE (1)
INTRODUCTION

COUNTRY PROFILE

The Gambia is located on the West African coast and extends 450 km along the Gambia River. Its 10, 689 sq. km area is surrounded by Senegal, except for a 60 km Atlantic Ocean front. With 176 people per square kilometer, it is one of the most densely populated countries in Africa[1]. The country has a tropical climate characterized by two seasons: rainy season (June – October) and dry season (November-May).

As estimated by the World Bank, in 2019[2], the Gambia had a population of 2,347,706 million people. This has shown a significant increase in the country's population compared to the figure obtained during the Population and Housing Census in 2013[3] wherein The Gambia had an estimated population of 1,882,450 persons. Most of the population (57 percent) is concentrated around urban and peri-urban[4]. The population growth rate and infant mortality rate in The Gambia are among the highest in western Africa. The population is young, with about two-thirds under age 30. Life expectancy is comparable to the regional average but lower than that of the world[5].

During the last National Population Census in 2013, it was confirmed that about 60 percent of the population lived in the rural area; and women constitute 51 percent of the total population. The crude birth rate was 46 per 1000 population while the total fertility rate was 5.4 births per woman. The high fertility level has resulted in a very youthful population structure. Nearly 44 percent of the population was seen to be below 15 years and 19 percent between the ages 15 to 24. Average life expectancy at birth was 64 years overall with females constituting 59 and males 55 (The Population and Housing Census, 2013). From 2013 till date is a long time and the trend is likely to have changed. A new and updated national population survey would possibly highlight updated figures on the country's demographics.

The unprecedented rate of population growth registered for the rural areas can also be attributed to the influx of migrants from other regions of the country and from outside the country creating policy implications for all sectors particularly the education, health, housing and agriculture sectors, respectively. With the consistent increase in the population, there is an increasing demand

[1] https://www.worldbank.org/en/country/gambia#:~:text=The%20Gambia%20At%2DA%2DGlance&text=The%20country%20has%20a%20population,densely%20populated%20countries%20in%20Africa.
[2] https://data.worldbank.org/indicator/SP.POP.TOTL?locations=GM
[3] National Population and Housing Census was last conducted in 2013.
[4] https://www.worldbank.org/en/country/gambia#:~:text=The%20Gambia%20At%2DA%2DGlance&text=The%20country%20has%20a%20population,densely%20populated%20countries%20in%20Africa
[5] https://www.britannica.com/place/The-Gambia/Demographic-trends

for services and land both for residential and agricultural use.

The Gambia is a cohesive society with five major ethnic groups: Mandinka, Fula, Wolof, Jola, and Sarahuleh. Traditionally, tribal groups have a “Joking Relationships” which is an important asset for social cohesion by fostering peaceful co-existence. These interpersonal and inter-group bonds—referred to as “joking kinships”, “joking relationships”, “special affinities”, “cousinage" and “parenté à plaisanterie"—are found in various parts of African continent (Radcliffe 1940; Stevens 1978; (Wilson-Fall 2000). The significance of joking alliances in conflict management became obvious during an extended study of societal patterning in dispute mediation. It quickly became apparent that joking relations were a prominent part of Senegambia conflict management

Beside the above, the youth labour market is also an important factor influencing migration trends. Findings of the Gambia Labour Force Survey (GLFS, 2018) shows that there are 377,326 youth (44 percent) that are actively engaged in the Labour force. Out of this, 205,112 are males (54.4 percent) and 172,214 are females (45.6 percent). The data further shows the population of youth in the urban areas participate more in the work force than those in the rural areas. At Local Government Areas (LGA), Brikama (38.3 percent) and Kanifing (19.1 percent) had the highest proportions of youth actively participating in the labour force and that 220,616 youth were employed (58.5 percent). The findings show that youth employment to population ratio is higher in the urban areas (54.7 percent) than the rural areas (45.3 percent). It is observed that employment: population ratio is lower in the rural areas for both sexes compared to the urban areas. At LGA level, the data shows that there is not much difference of youth to employment population ratio between males and females. Across all the employment status, there are more youth employed in the urban than rural areas. Analysis of the data by LGA shows that, Brikama (51.1 percent) and Kanifing (26.2 percent) have the highest proportions of youth employed in all the employment status.

The findings of the survey also show that the youth unemployment rate is 41.5 per cent. The data shows that unemployment is higher in the rural (69.4 percent) than in the urban areas (30.6 percent). At LGA level, the data shows that, Basse (24.6 percent), Brikama (21.7 percent) and Kerewan (16.3 percent) had the highest proportions of unemployed youth. Efforts to improve technical and vocational education need to reflect the demands of the labour market. Analysis of unemployed youth with respect to level of education aims at showing how employable youth are, given their education. It also helps policy makers and skills providers to review their curricula and allocate relevant resources for labour market demand driven skills.

Similarly, the 2018 GLFS data shows that the unemployment rate for youth aged 15-35 years is 44.7 per cent for males and 55.3 per cent for females. However, the population of males with diploma (62.3 percent) and upper secondary (57.5 percent) education have the highest proportions of unemployed youth. While for females, those with early childhood education (73.7 percent) and tertiary (66.6 percent) education had the highest proportions of youth that are unemployed. The rural areas (69.4 percent) have a higher proportion of unemployed youth than the urban areas (30.6 percent). At LGA level, Basse (24.6 percent) and Brikama (21.7 percent) have the highest proportions of unemployed youth. These unemployed mostly stay at home doing nothing productive, instead, they keep on drinking Chinese green tea “ATAYA” the whole day

contributing to poverty in the society. Despairing of The Gambia's political and economic situation, many of these youths had lost hope in the future of the country. These attitudes among the youth influence the back-way and dependency syndrome amongst them. These youths and some of their families sometimes believe so strongly that Europe is the solution for them that they spend the last of their money to sponsor the trip.

Hence, the unemployment rate shows the magnitude of unutilized labour supply. It reflects the inability of the economy to generate employment for those who want to work. Owing to economic and other challenges enumerated above, thousands of Gambians have begun the difficult journey across Africa to Libya, where they hope to cross the Mediterranean and enter Europe looking for alternatives.

Unfortunate, many migrants do not succeed in this journey and often find themselves stuck in Libyan prisons, where they are exposed to various human rights abuses (desperate and dangerous, UN High Commissioner for Human Rights, report, 2018). Women are particularly vulnerable, some of whom have been kidnapped and sold while attempting to reach Europe.

Since January 2017, the International Organization for Migration (IOM) has assisted in the voluntary returns of more than 5,246 Gambian migrants stranded in Libya, Niger and other parts of Africa and Europe[6]. With successful voluntary returns of stranded migrants back to The Gambia, the International Organization of Migration has also assisted in the reintegration of these returnees. Through the EU-IOM Joint Initiative for Migrant Protection and Reintegration, so far, 3,273 returnees have been assisted with different reintegration packages[7].

Similarly, under the UN Peace Building Project[8] "Strengthening the Holistic Reintegration of Returnees in The Gambia" IOM launched complementary efforts to further fortify the sustainable reintegration of returnees and their communities. This project through its community-based mobile health outreaches has provided migrants and their communities with medical consultations including basic primary health care medications, health and psychoeducation, and other integrated psychosocial support interventions, targeting communities of high returns.

Despite the supports provided to address the challenges faced by returnees in The Gambia returnees faced a varying degree of conditions further affecting their sustainable reintegration. The economic support provided to returnees is still insufficient, considering the number of family dependents earning a living through the same resources. This has created new responsibilities on the returnees, despite the limited resources they possess. Also, returnees face varying degrees of stigma and discrimination within their communities, undermining their ability to reintegrate in their respective communities. Migrants who return to The Gambia because they are unable to get to Europe, perhaps due to detention in Libya, are often looked down upon by other Gambians, who believe that they simply did not try hard enough. The perception of returnees as failures create

[6] IOM The Gambia EUTF Monthly Report: 30 September 2020.
[7] IOM The Gambia EUTF Monthly Report: 30 September 2020
[8] Through UN Peace Building Fund, IOM has deployed 7 mobile health caravans to communities of high returns, aimed at strengthening the holistic reintegration of returnees in The Gambia and to further de-escalate conflict drivers relating to migration and return.

more pressure and imbalance in the lives of the returnees, further destabilizing their psychosocial reintegration in their communities.

Most recently, the COVID 19 pandemic has disrupted activities globally. The impacts of the COVID 19 pandemic are felt across different countries including The Gambia. A large part of the world's population is affected by the virus in different ways, including uncertainties about the future, loss of livelihoods opportunities, financial hardship, loss of loved ones, stigma and the perduring effects of isolation as well as heightened anxieties[9] and The Gambia is not an exception. The economic consequences posed by the COVID 19 pandemic cannot be underemphasized especially that The Gambia's economy depends primarily on agriculture, tourism, and remittances which are all affected by the pandemic. The Gambia's Gross Domestic Product (GDP) growth is projected to decline to between 2.5 and -2.4 percent in 2020. Heavily dependent on tourism, The Gambia is mainly impacted by a reduction in tourists, particularly from key markets in Europe, but also from trade disruption and lower commodity prices[10]. This will further compound the challenges faced by the labour market in creating jobs for most vulnerable people who seek to be employed, including migrant returnees.

[9] https://eea.iom.int/publications/covid-19-guidance-and-toolkit-mental-health-and-psychosocial-support-mhpss-teams

[10] https://www.worldbank.org/en/country/gambia/overview

SECTION TWO (2)
MENTAL HEALTH AND THE HEALTH SYSTEM

THE BURDEN OF MENTAL ILLNESSES

According to the World Health Organization (WHO), mental, neurological and substance use disorders make up 10% of the global burden of diseases and 30 percent of non-fatal disease burden. Around 1 to 5 of the world's children and adolescents have a mental disorder, with depression as one of the leading causes of disability affecting 264 million people. About 1 in 9 in settings affected by conflict has a moderate or severe mental disorder and with a rate of mental health workers varying from 2 per 100,000 population for low-income countries to over 70 per 100,000 in high-income countries. Less than half of the 139 countries that have mental health policies and plans report having this aligned with human rights conventions[11].

The Gambia is not spared from the global phenomenon. Communities in The Gambia are faced with numerous, mental, neurological, and psychosocial disorders that undermine development. Based on WHO's report for 2004, it is estimated that approximately 27,000 people in The Gambia (or 3 percent of the population aged 15 years and more) are suffering from a severe mental disorder and a further 91,000 (or 10 percent of the population aged 15 years and more) are suffering from moderate to mild mental disorder. This means that at least 118,000 people in The Gambia (or 13 percent of the adult population) are likely to be affected by mental disorders which require varying degrees of treatment and care.

There is a huge gap between the numbers of people affected by a mental disorder and those receiving treatment. While the prevalence rate is estimated to be between 27,300 (severe disorders) and 91,000 for all mental disorders (WHO, World Mental Health Survey, 2004). This is conservative since there has been no other research or survey conducted after WHO survey in 2004. The maximum number of people receiving treatment in 2005 was estimated to be 3,278. In the years 2013 and 2018 there were approximately 1,207 and 1,424 annual admissions respectively for treatment to the Tanka Tanka Psychiatric Unit (TTPU)[12] of the Edward Francis Small Teaching Hospital (EFSTH). Additionally, a total number of 1,654 and 1,854 patients received outpatient treatment in the seven health regions for the years 2013 and 2018, respectively.

The global COVID 19 pandemic has negatively affecting the mental health and wellbeing of persons global of which The Gambia is not an exception. In a recent survey by the World Health Organization (2020) among 130 countries on how the provision of mental, neurological and substance use services have changed due to COVID-19, the types of services that have been disrupted, and how countries are adapting to overcome these challenges, countries reported widespread disruption of many kinds of critical mental health services: over 60% reported disruptions to mental health services for vulnerable people, including children and adolescents (72

[11] WHO(2019) https://www.who.int/news-room/facts-in-pictures/detail/mental-health

[12] Tanka-Tanka Psychiatric Unit. This is the only Psychiatric outpatient facility in The Gambia. It is part of the Edward Francis Small Teaching Hospital.

percent), older adults (70 percent), and women requiring antenatal or postnatal services (61 percent); more than a third (35 percent) reported disruptions to emergency interventions, including those for people experiencing prolonged seizures, severe substance use withdrawal syndromes and delirium, often a sign of a serious underlying medical condition; 30 percent reported disruptions to access for medications for mental, neurological and substance use disorders; around three-quarters reported at least partial disruptions to school and workplace mental health services (78 percent and 75 percent respectively)[13]. Community-based services and mental health prevention and promotion programmes, already limited in availability, are reported to be disrupted at a time when society needs them the most due to the adverse mental health impacts of COVID-19[14].

Other many factors are fueling the growing mental health problems in The Gambia. Poverty remains a pervasive problem in the country. In addition to poverty, poor housing, inadequate access to basic health services and educational facilities, insecure jobs and low salaries constitute important factors affecting the mental wellbeing of the population. Host and migrant groups will compete for jobs and business opportunities. In the context of political uncertainty and institutional dysfunction, a combination of long-term structural vulnerabilities and short-term economic shocks is exacerbating food insecurity. These events can perpetuate existing psychological, social and economic problems within the country and increase the risk of mental problems as well as illicit substance abuse (Veldman, Reijneveld, Ortiz, Verhulst, & Bultmann, 2014). These factors may have implications on the Gambian migrant returnees.

[13] The impact of COVID-19 on mental, neurological and substance use services: resultsof a rapid assessment. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO

[14] WHO (2020)

SECTION THREE (3)
MENTAL HEALTH AND THE HEALTH SYSTEM

- **COORDINATION**

The Ministry of Health (MoH) is responsible for the overall coordination of the health services. However, the National Mental Health Programme under the Directorate of Health Services coordinates all mental health services in the country. Its main function, therefore, is to work in close liaison with other health units, considering the link between physical and mental health, as well as with critical stakeholders.

At the National level, the Edward Francis Small Teaching Hospital has a psychiatric unit responsible for inpatient psychiatric care. The hospital, established in 2009, has a 100-bed capacity and composed of male and female wing, occupational therapy unit, laundry and kitchen services, Community Mental Health Team (CMHT) office, consultation room, conference hall, medication store, records office and recreational facility.

The Tanka-Tanka Psychiatric Unit (TTPU) is headed by a Matron who reports to the EFSTH at the central level and liaises with the National Mental Health Programme Office. TTPU offers free mental health services to both Gambians and non-Gambians with an average admission of about 80 patients. The available human resource comprises three Cuban Doctors on technical assistance, three registered nurses, two enrolled nurses, two records clerks, 11 auxiliary nurses, 13 orderlies, seven securities and other support staff.

However, due to the limited-bed capacity, it is sometimes difficult to accommodate vagrant patients from the streets. This calls for an increase in bed capacity in the unit. Inadequate access to and provision of general health care services to patients has been a long-standing and recurrent concern.

At the regional level, all the seven health regions have each a mental health and psychiatric nurse responsible for providing mental health services. They all work in their various regional hospitals and report directly to their hospitals, with technical support from the National Mental Health Programme Office.

- **COMMUNITY MENTAL HEALTH SERVICES**

A community mental health service is in place which is delivered predominantly by the community mental health team. The team is headed by a registered psychiatric nurse, supported by two Enrolled Nurses (EN).

CMHT also offers monthly outreach services to the central prisons. They provide inmates with mental health services including diagnostic assessments, medications, treatment interventions, case monitoring and follow-ups.

Additionally, health workers of the CMHT also conduct home and community visits to assess persons living with mental illnesses. Furthermore, community health workers including the community birth companions and the village health workers embark on community awareness-raising activities, educating communities on health issues and referring cases to the next referral levels. However, they have not been fully utilized for mental health services delivery.

- **PSYCHIATRIC SERVICES INTEGRATED INTO GENERAL HOSPITALS**

The polyclinic has a unit (two rooms) allocated for outpatient mental health services, which is headed by a psychiatrist, supported by a community psychiatric nurse, a registered nurse, state enrolled nurse and a senior nurse attendant. The unit provides curative and preventive services to all outpatients who come for monthly follow-ups. It also serves as the first point of call for almost all patients admitted at the Tanka-Tanka Psychiatric Unit (both new cases and re-admissions). This unit provides services during weekdays only between the hours of 8 am to 2 pm. On average, a total of sixty patients are seen per day.

The polyclinic is integrated within EFSTH and is administratively independent of the TTPU. People with mental disorders are sent to the polyclinic for an assessment before being admitted to the Tanka-Tanka Psychiatric Unit.

There are currently services for people with mental disorders through the outpatient departments in the general hospitals. These services are limited to psychiatric follow-up by the general nurses attached to the outpatient departments, with the support of the medical officer in charge, who does not have specific mental health training. In the past, the community mental health team would provide monthly clinical services to the staff and patients. Now inpatient mental health service is available in general hospitals. Presently there are trained psychiatric nurses manning mental health services at all the public hospitals.

The hospitals have their own pharmacy store with a few basic psychotropic medicines. The Regional Health Directorate (RHD) now supplements these supplies with additional medicines when there is a shortfall and where patients require medicines that were not routinely stocked in these pharmacy stores. Only a few health care providers in the minor health facilities have the knowledge, skills and motivation to provide follow-up treatment and care for people with mental disorders.

- **INFORMAL COMMUNITY CARE (INCLUDING TRADITIONAL AND RELIGIOUS HEALERS)**

Traditional healers are respected members of the community and first points of contact for many people with mental disorders. They provide care to patients in their facilities using their traditional methods, including chaining of their patients.

During the last few years, the Ministry of Health and Social Welfare has been working in close partnership with traditional healers in some districts to provide treatment and care to people with mental disorders.

Essentially traditional healers, through the programme, are introduced to modern medications and treatment methods alongside traditional methods. The programme has been successful with good clinical outcomes.

In Bakindiki village, four traditional healers have been trained to enhance their capacity to identify people with mental disorders and to provide treatment (psychotropic medications and care). The programme started with epileptic patients and was later extended to patients with psychosis. Follow-up treatment and support is organized through the closest health center and/or through regular appointments/consultations with traditional healers. To date a total of 300 patients have been treated through the programme, with very encouraging clinical outcomes.

Similar treatment programmes are running in the villages of Buiba, Japenni, Bullock, Numu-el and Busura.

To date, a total of fifteen (15) traditional healers have been trained by the Community Mental Health Team and twelve (12) are formally certified and working in collaboration with the Traditional Medicine Programme Unit and the Mental Health Programme, Ministry of Health. Furthermore, six traditional healers, who provide "village care" (where patients live in the traditional healer's home on a long -term basis) receive allowances (financial incentives) from the Ministry of Health and department of Social Welfare for their contribution towards mental health care.

Traditional healers are provided with ongoing supervision and support by health workers. In the past the CMHT used to conduct monthly visits to the villages.

This relationship has proven beneficial to patients, families and communities in the following ways:

- ✓ Improved access to mental health services in the community
- ✓ Good treatment outcome
- ✓ Reduction in the use of chains/logs for physical restraint of agitated patients
- ✓ Improved awareness and knowledge about mental disorders and their treatment,
- ✓ Reduction in stigma towards the mentally ill
- ✓ Improved follow-up and support of people with mental illness and their family
- ✓ Re-integration of the mentally ill within the community

➥ Spiritual healers: Spiritual healers' treatment of mental disorders is mainly based on prayers and spiritual rituals whereas traditional healers use concoctions and traditional oral medications. There are spiritual healers who are available for consultation at TTPU upon request by the patient or family and/or agreement of the health team. However, there is no active collaboration between them and the formal mental health services which needs to be strengthened.

➥ Mental Health Promotion: Media interventions on issues relating to mental health are conducted through print and electronic medium. This is coordinated by the programme officer for mental health information and education at the programme office. Additionally, awareness raising campaigns on mental health are also done using community-based structures such as folk media

➥ School interventions mainly consist of one week "train the trainers" workshops, for pupils to be able to identify and appropriately refer people developing mental disorders, including substance abuse in their various schools.

➥ Identification of and collaboration with Non-Governmental Organizations (NGOs): Many non-governmental organizations are presently making a difference in improving mental health care and reducing the exclusion of those in need of help. VSO, Peace Corps and Rotary Club International have all supported the mental health programme in previous years, particularly in the supply of psychotropic medicines and mopeds (small motorbikes) for community follow-up. Notwithstanding, collaboration with NGOs has been very positive and successful. Presently we have the IOM and COOPI as the new international organizations liaising with the mental health program in dealing with issues pertaining to Gambian returnees. Further collaborative initiatives should be encouraged and supported.

SECTION FOUR (4)

MENTAL HEALTH CAPACITY

- **MENTAL HEALTH WORKERS**

Overall, qualified human health resources currently providing mental health care in The Gambia are sparse, overburdened and insufficient to meet basic population mental health needs. There are presently only twenty (20) trained Gambian psychiatric nurses countrywide and one medical doctor with the support of four Cuban psychiatrists. This workforce is supported by three generals and three enrolled nurses with other support staff.

The above implies a critical shortage of trained psychiatric nurses due to lack of funds to sponsor the training and the high attrition rate of trained staff to leave the government system. As already mentioned, there is only one qualified psychiatric nurse personnel in the Regional Health Directorates, the general hospitals and none at minor health centres.

Due to lack of trained psychiatric and mental health lecturers and clinical supervisors the mental health programme is responsible for teaching the mental health component of the nurse curriculum for Registered Nurses (RN), the universities, Enrolled Nurses (EN) and Enrolled Community Health Nurses (ECHN) at the nursing school. This is to equip other health workers with basic knowledge of mental health care and service delivery.

The shortage of qualified mental health service providers has contributed to the provision of limited mental health services to most of the clientele. Poor service provision at the clinical areas and lack of regular follow-ups in the community contribute negatively to the increased relapse rate of the patients untimely attended.

- **NON-HEALTH WORKERS**

Non-health professional groups, for example, prison staff, traditional healers, health journalists, and military officers have participated in a one-week orientation workshop based on the identification and first-line management and referral of people with mental and behavioural disorders in the communities, during 1997 and 2005, sponsored by WHO, The Gambia. Additionally, the participants were also been trained to provide basic psychosocial services to persons in distress in their facilities or within their various communities. Similarly, in 2019, IOM[15] trained Immigration officials on psychological first aid (PFA), aimed at providing frontline immigration officials with the necessary skills to provide humane assistance to migrant returnees at different points of entry. Despite the support provided to non-health workers to complement the roles played by the professionals in providing psychosocial support to persons in distress, the needs have become increasingly available with the paucity of trained personnel.

[15] In December 2019, IOM trained 21 frontline Gambian Immigration Officials on PFA. This was shortly after the December 2019 Shipwreck- involving Gambian Migrants - off the coast of Mauritania. They were trained to provide PFA in their frontline operations.

- **AVAILABILITY OF PSYCHOTROPIC MEDECINS**

There is a National Drug Policy in The Gambia, which was formulated for the period covering 1994-2000. The Central Medical Review Board periodically reviews this essential drug list.

Drug procurement and distribution is the responsibility of the Ministry of Health (MoH). The transportation of medicines and procurement is handled by the Directorate of Pharmaceutical Services (DPS). There are ongoing difficulties in both the procurement and distribution of medications (both psychotropic and general medications). These difficulties arise both as a consequence of insufficient availability and supply/production of psychotropic drugs at national and international levels.

This has affected recovery rate of people with mental health and psychosocial problems. This also pose further challenges considering the upsurge of migrant returnees. They are challenged with the supply and continuity of their medicines leading to either worsening conditions, relapse and/or poor recovery rate.

MENTAL HEALTH INFORMATION SYSTEM

In general, the Health Management Information System (HMIS) of the Ministry of Health is responsible for the collection of health information gathered from the different levels of health services delivery (both major and minor facilities) and informal community level, but due to poor capturing of data indicators, the information system does not feed in the relevant data on mental health.

Currently, the mental health service information is not adequately incorporated into the general Health Management Information System (HMIS). Demographic data and diagnostic information of patients is available from the polyclinic at EFSTH, and Tanka-Tanka Psychiatric Unit. In addition, Tanka-Tanka Psychiatric Unit keeps a record of patient data pertaining to admission and discharge. This information is collated and available centrally.

Although demographic, general health and basic mental health (case identification) information is collected at the level of the health center facilities, mental health data included in the data sets of the Health Management Information System (HMIS) only indicates whether the patient has a mental or neurological problem.

MENTAL HEALTH POLICY AND LEGISLATION

The Gambia National Mental Health Policy 2016 - 21 and Strategic Plan 2017 - 2022 are in place and mental health is captured in the National Health Policy, however, **the implementation of the policy and the strategic plan is a big challenge.**

There is a current reviewed and updated new mental health bill**.** It does not have provisions to protect patients against involuntary admission and treatment or any requirement for consent to admission, treatment or subsequent review of continued treatment.

FINANCIAL RESOURCES AND BUDGET FOR MENTAL HEALTH

General health care in The Gambia is funded through a "global health budget". There is no separate budget line for mental health. The budget for mental health care spending is embedded within the general health care budget. This makes it impossible to source any fund for programme implementation as planned strategies are left unimplemented within the planned period. The entire allocated budget is for salaries, allowances and procurement of office materials at the national level. Some funds are provided for the running of the EFSTH polyclinic and for the running of Tanka-Tanka Psychiatric Unit and for providing basic supplies of psychotropic medicines. Information regarding the percentage of the overall health budget spent on mental health is not available. The lack of well-coordinated mental health financing hampers the equitable and appropriate dispensation of the programme.

The financing of mental health services is provided through the government budget, supplemented by individual donation, private insurance, non-profit organizations, and grants. These forms of funding are not reliable neither readily available as a result it affects the timely delivery of mental health services across the board.

The limited human resources, lack of existing mental health budget for the implementation of planned activities, the poor infrastructure of the facilities, shortages of psychotropic medications and lack of research funding to support research are the major challenges confronting mental health service delivery in The Gambia.

MIGRATION AND MENTAL HEALTH

SITUATION ANALYSIS ON MIGRATION AND MENTAL HEALTH

History has shown that human migration is a long-standing phenomenon that spans back to the earliest periods of human existence.

Migration is now a global phenomenon with close to **244 million international migrants** (UNDESA, 2014) and an estimated **740 million internal migrants** on the move (IOM, 2015), and must be recognized as a social determinant of health; mobility not only impacts upon an individual's physical vulnerability, but also on mental and social well-being. Migrants and mobile populations face many obstacles in accessing essential health care services due to a number of factors including irregular immigration status, language barriers, a lack of migrant-inclusive health policies and inaccessibility of services[16].

In 2017, it was globally estimated that 258 million people were counted as living in countries other than their country of origin, representing 3.45% of the world's population. Out of this figure, those who were displaced as a result of persecution, generalized violence, conflict, violation of human rights or other reasons stood at 68.5 million. Women accounted for 124.8 million with 36.1 million as children. Migrant workers, international students and registered refugees stood at 150.3 million, 4.8 million and 25.4 million respectively (Global Migration Indicator, 2018).

[16] https://www.iom.int/migration-health

Migrants and refugees face a variety of challenges which can negatively impact their mental health. Despite this heightened risk of developing mental health problems, migrants and refugees may not have access to quality mental health support in their host countries. They face barriers to accessing mental healthcare and support. Furthermore, once they arrive, they may also encounter distressing situations such as detention in camps, deportation, denial of basic services and protection, poverty, discrimination, and social exclusion. Experiencing mental health problems can further lead migrants and refugees to encounter additional intersectional barriers to social inclusion thereby negatively impacting on their prospects for the future, including employment[17].

Migration and return further predisposes migrants to a lot of adversities affecting their mental health and psychosocial wellbeing. Looking at the large number of returned migrants in recent years, The Gambia faces some key challenges managing the impact of high returns and ensuring their reintegration. Key among the challenges faced by migrants upon return include poor living conditions; limited availability and access to basic services such as health care and psychosocial support; limited economic resources; stigma and discrimination; poor or limited family support; and lack of understanding among the communities of experiences that migrants have endured as well as their mental health and psychosocial needs.

In the view of multifaceted and dynamic migration flows, the discussions on return and reintegration have gained transformed eminence in both national and international political agenda in recent years. The adoption of the Global Compact for Safe, Orderly and Regular Migration (Global Compact for Migration) in 2018, pledges were made by governments to cooperate "in assisting safe and distinguished return, as well as viable reintegration" (Anha Nguyen, Migration Policy and Practice, 2019).

The Gambia benefits from remittances sent home by around 87,500 Gambians living abroad. This benefit accounts for 15% of the country's gross domestic product (GDP)[18], therefore, making migration a very vital catalyst for development. However, despite the benefits of the remittances to development in The Gambia, the country still has limited capacity to attend to the needs of migrants in the areas in the context of a holistic and sustainable reintegration.

The Gambia is emerging as a test case for international efforts to reverse irregular migration across the Mediterranean. Concerns remain over the capacity to assist large numbers of returnees, but the strategy appears to be working: recent IOM data shows that The Gambia has dropped out of the top 10 league of migrant nationalities arriving in Italy for the first time since the Mediterranean crisis began in 2014-2015. Anecdotally, there is a consensus that fewer people appear to be leaving, but there is no hard data[19].

MENTAL HEALTH AND PSYCHOSOCIAL CHALLENGES

At every level, irregular migration erodes protective supports that are normally available, increase the risks of diverse problems and tend to amplify preexisting problems. While social and

[17] https://www.mhe-sme.org/position-paper-on-mental-health-and-migration/
[18] **https://www.theglobaleconomy.com/Gambia/remittances_percent_GDP/**
[19] https://allafrica.com/stories/201808170266.html

psychological problems occur in most groups, it is important to note that every individual will experience the same event in a different manner and will have different resources and capacities to cope with the event.

The incidence of psychosocial problems significantly increases during the migration continuum. Exposure to violence, the disruption of social networks, the loss of and/or separation from relatives and friends, deteriorating living conditions, poverty and limited access to support can have both a short and a long-term impact on the well-being of returnees, families, communities and helpers.

Irregular migrants suffer serious physical, social and emotional consequences in host and transit countries. These symptoms on the returnees may not be visible and the trauma can extend to their close relations. The unfavorable experience, violation and abuse meted on these returnees can lead to anxiety, depression, fear, sadness, post-traumatic stress disorder, aggression, withdrawal, substance/drug abuse, anti-social behaviors, self-harm and an extreme feeling of hopelessness, nihilism and even suicide.

Upon return to their countries of origin, most at times, the society often respond to returnees with damaging stigma and discrimination thereby worsening their condition and further affecting their holistic and sustainable reintegration in their respective communities of return. More so, being a returnee increases the chances of being perceived to exhibit delinquent behaviors, which is also discriminatory and further affects the psychosocial reintegration of returnees. The psychosocial reintegration of returnees is further hampered by lack of access to psychosocial support and health care services that they require. This can have dangerous psychological and health implication leading to acute or chronic problems. The traumatic effect of being a returnee on families is huge and needs to be equally managed to develop social support networks at the level of the household.

Some returnees are also challenged with the problem of not finding their families fulfilling their investment plans despite remitting money to that effect during their migration. This has led to mistrust and conflicts among certain families and communities.

CHALLENGES:

- The limited availability of jobs to offer young Gambians more reasons to stay home.
- The inadequacy of systematically designed reintegration programmes, including both practical and emotional support.
- The limited vocational schemes in sectors ranging from agriculture to information technology and other skill training.
- Absence of a well-centralized data system on the prevalence of mental health in The Gambia.
- Limited supply of psychotropic medicines
- The deficiency of knowledge and awareness in helping returnees at community level
- The perverted and negative attitudes of community members towards the returnees
- Limited micro-credit funds for the youth with skills

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT STRATEGIC PLAN FOR THE REINTEGRATION OF MIGRANT RETURNEES

RATIONALE

1) The "pervasive **negative attitudes and prejudices towards returnees**" within all sectors of society which adversely affect the resources provided to treat and care for people with mental health and psychosocial problems at all levels including within the family, community and at national level is an issue of great concern.

2) The **limited infrastructure** available for mental health and psychosocial treatment and care in the country results in patients traveling long distances from their homes to access treatment. Poor facilities and lack of a therapeutic environment further worsen patients' conditions.

3) Inadequacy **of human resources** for mental health.

The inadequacy and inequity of human resources available to deliver appropriate mental health and psychosocial care for returnees is a major challenge for The Gambia. The inequitable distribution of mental health personnel in The Gambia becomes a great challenge for people living with mental illnesses, including migrant returnees who seek for mental health care.

Recruitment and training of health workers and non-health workers in mental health is a central component of the MHPSS strategic plan. The inadequacy of specialized staff with sufficient skills to provide training to other health workers is of concern.

4) The **current socio-economic context** associated with **migration** disrupting traditional family and social networks. Some family would have borrowed funds to facilitate the journey of their family member(s). In the event the funds are not recovered, this may become cumbersome on the family, further increasing their chances to mental health problems and poor family interpersonal relationships.

5) **The limited financial resources available**.

The limited and untimely availability of financial resources hampers the timely implementation of planned activities leading to ineffective service delivery. Training and sensitization of professionals in primary care is essential and must precede reform strategies to decentralize mental health and psychosocial support services.

6) **Primary Care:** Few primary care workers are currently available in The Gambia, with the necessary competencies to provide mental health care to patients suffering from mental disorders (this includes assessment, diagnostic, intervention, management, and monitoring skills). This lack of skills in providing mental health services has contributed immensely in the relapse and poor recovery of patients at the community level. It has also contributed to the inability of clients to integrate successfully in their individual communities due to care provided and the stigma associated with their poor conditions.

7. Lack of mental health and psychosocial regulatory framework for migrants and returnees places a burden in the timely and appropriate implementation of psychosocial support activities.

GUIDING PRINCIPLES

Guiding Values and Principles

VALUES	PRINCIPLES
i. Mental Health Indivisible from General Health	➔ Mental health and psychosocial care should be an integral part of the primary health care system. ➔ Mental health services should be integrated into "usual" health care services at all levels (primary, secondary and tertiary). Stand-alone mental health services should not be encouraged. All health care professionals should be trained to provide mental health care appropriate to their role in the health care system. ➔ Mental health services provided within the health sector should be appropriately linked to other sectors (such as social services, justice, housing, education).
ii. Accessibility and Equity	➔ Government services should be free of charge and accessible to all people, regardless of their geographical location, economic status, gender, race or social condition, or physical or mental disability. ➔ Mental health services should have parity with general health services. ➔ People with mental disorders, including mental retardation should not be discriminated against on the basis of their mental status. ➔ Mental health services should be available across the life span and across all levels of severity and need. ➔ People with mental disorders may require unique services designed to address their needs because of the nature of the mental disorders (for example: social rehabilitation for those individuals whose mental illness significantly affects their ability to understand or appropriately act in social situations).

	➔ People with mental disorders may require affirmative actions due to the long-standing and pervasive stigma held by the public, professionals and policy makers against the mentally ill. ➔ Services must be as close to the homes of patients as possible and favour outpatient care.
iii. Human Rights	➔ People with mental disorders should enjoy full human rights, including the right to appropriate health care, education, shelter and employment, and the freedom from discrimination and abuse. ➔ Mental health treatment and care should promote and protect the autonomy and liberty of people with mental disorders. ➔ People with mental disorders have the right to be treated in the most effective least restrictive and least intrusive manner. ➔ People with mental disorders, due to their particular vulnerability to human rights violations, may require specific legal and quasi-legal frameworks and safeguards to ensure that their human rights are promoted and protected. ➔ Care delivered to people with mental disorders should be strictly confidential.
iv. Quality Services and Management	➔ Services provided to people with mental disorders should reflect the highest standard possible according to the state of scientific knowledge and the resources available.
v. Decentralization	➔ Authority, resources and services should be devolved from the central level to primary and community levels, allowing for more participatory decision-making. ➔ The provision of community care alternatives should be tried before inpatient care is taken.

vi. Community Involvement and Participation	➔ Mental health care should be provided in the community whenever possible. ➔ People with mental disorders should participate in the design and implementation of mental health projects from which they will benefit. ➔ Families of people with mental disorders should be considered as partners in mental health care and therefore actively participate in it, being educated and trained. ➔ Individuals with mental disorders, families and communities should be participants in mental health education programs. ➔ Media will be engaged to promote awareness and the active participation of the community.
vii. Rehabilitation	➔ There should be equal employment opportunities for people who have or have had mental disorders compared with other medical conditions. ➔ Community Based Rehabilitation activities for people with mental disorders should be encouraged in order to reduce their disability and improve their quality of life.
viii. Protection of Vulnerable People	➔ The mental health needs and rights of vulnerable groups should be upheld, including the disabled, women, children, youth and adolescents and the elderly.
ix. Cultural Sensitivity	➔ Activities promoting mental health should be designed with particular attention to cultural values of communities. ➔ Traditional healers should be involved in the prevention, detection and care of people with mental disorders, in collaboration with the formal mental health care system.
x. Evidence-Based Care	➔ Scientifically validated evidence is the primary source of information used to inform decision-making for services and interventions. ➔ When scientifically validated evidence is not available, commonly accepted "best practices" may be utilized.

	➔ Ongoing validation of services and interventions should be implemented and used to refine services and interventions and to inform resource allocations.

VISION

A country where mental disorders and psychosocial problems ceased to be a public health burden especially for migrant returnees.

MISSION

To deliver equitable, accessible and cost-effective mental health and psychosocial care for migrant returnees living in the Gambia through the provision of quality mental health care integrated into all levels of care, by skilled and motivated personnel, with the involvement of all stakeholders.

GOAL

To provide mental health psychosocial support services to migrant returnees to further enhance their sustainable reintegration.

In keeping with the vision, values and principles expressed above, the following objectives shall be realized:

OBJECTIVES

i. To improve access to equitable and quality mental health and psychosocial services care to migrant returnees in The Gambia.
ii. To promote and protect the human rights of migrant returnees.
iii. To change the negative perceptions of migrant returnees through the sensitization of communities on mental health issues.
iv. To strengthen the integration of mental health and psychosocial services to migrant returnees at different levels of care.
v. To decentralize authority, resources and services for mental health care, allowing for more participatory decision-making at the lowest levels of care (community levels).

FIVE-YEAR NATIONAL STRATEGIC PLAN FOR DELIVERY OF MENTAL HEALTH PSYCHOSOCIAL SUPPORT SERVICES FOR THE REINTEGRATION OF GAMBIAN RETURNEES AND MIGRANTS

PRIORITY AREAS FOR ACTION

1. COORDINATION AND GOVERNANCE

Under the Ministry of Health (MoH) and through the Directorate of Health Services (DHS), the mental health program, led by the National Mental Health Program Manager (NMHPM), will coordinate all the mental health and psychosocial support activities in the country, including supervision and collaboration with NGOs and related institutions involved in rendering mental health and psychosocial support activities/services for returnees and migrants in the country.

In addition, the Office of the Mental Health Program Manager will be responsible for fostering inter-sectoral collaboration in sectors outside health including government sectors such as social welfare, housing, immigration and police, education, employment/labour, justice and the Ministry of Youths and Sports as well as NGOs and community organizations such as faith-based organizations, media (radio, television and newspaper), business organizations, traditional healers groups, women and youth organizations.

This strategic framework commits to provide better coordination of care and more equitable access to treatment for people with mental health and psychosocial problems - migrant returnees inclusive - by providing inpatient and outpatient services in the hospitals and the health centers. Both hospitals and the health centers will also provide adequate outpatient services for those with mental health disorders. Outpatient services will be provided at minor health centers.

At the village level, outpatient treatment and care of people with mental health and psychosocial problems will be provided in collaboration with families, CBOs, village development committee. Families will be considered partners in mental health care and will be offered appropriate education and training. Traditional healers will be involved in the prevention, early detection and care of people with mental disorders in collaboration with formal mental health services. Community health workers shall help to identify people with mental health and psychosocial problems, make an initial assessment and appropriate referrals to the major health centres (or minor when appropriate) and/or divisional health team. Community health workers will also be responsible for following-up and supporting patients and their family when they return to the community. They will also be supported to monitor the collaboration between traditional/religious healers and formal mental health care services in order to optimize benefits for people with mental disorders and their families.

Integration of mental health and psychosocial services will be accompanied by the decentralization of authority, resources, services and responsibilities from the central level to the primary and community care levels. Decentralization will occur in phases, starting with the onsite training of health workers in the community, villages, minor health centres and general hospitals.

A national association of mental health psychosocial rehabilitation, comprising representatives from all the advocacy agencies, will be set up. The main role of the association will be to collaborate in rehabilitation activities and to disseminate information and sensitize the community on mental health and substance abuse activities

Central to the re-organization of services and the effective treatment of people with mental disorders, is the availability of psychotropic medicines at the different levels of the health system and the training of the health workers who will be prescribing these medicines

Strategy 1: To strengthen governance and coordination for the delivery of mental health and psychosocial support services.

Related Activities:

Activity 1: Procurement of administrative vehicles, computers, printers, scanners, photocopiers, overhead projectors, flipchart stand, stationeries, and office furniture to support the mental health coordinating unit and the operationalization of the coordinating committee.

Activity 2: Draft Terms of Reference (TOR) for the technical advisory committee, including frequency of meetings.

Activity 3: Create a multidisciplinary technical advisory committee to implement, monitor and evaluate the mental health-psychosocial framework implementation.

Activity 4: Conduct three (3) advocacy meetings for the government to allocate resources for MHPSS.

Activity 5: Secure funding from government, fund raising and other donors to fund the strategic plan.

Activity 6: Keep foundations and bi-laterally and regularly inform government and partners of progress through brief written updates and courtesy visits and meetings.

Activity 7: Prepare at least five grant applications over the next five years in ensuring sustainability of mental health care.

Targets:

- ✓ Establish a technical advisory committee for mental health-psychosocial services within a month.
- ✓ Create a functional and well-equipped office to support the work of the mental health-psychosocial coordinating unit within the planned period.
- ✓ Clearly define and make available an annual budget for mental health-psychosocial services (including sources of funding) within one year.

Indicators:

- o Clearly defined roles and functions of the technical advisory committee available.
- o Technical advisory committee in place and functioning with TOR.

- Allocation and availability of budget and resources (secretary, administrative vehicle computer, office supplies and internet access).
- An existing budget for mental health-psychosocial services will be available.

2. ADVOCACY

Advocacy actions will be taken to raise awareness about mental and substance abuse disorders as well as their effective treatment, to change the negative perceptions of the public about people with disorders (mental, behavioral and insanity). Similarly, the advocacy will also focus on the stigma and discrimination faced by migrant returnees aimed at further strengthening their access to mental health care delivery. An active collaboration will be sought for, through various partners and stakeholders. The media will be a primary tool in raising awareness and advocacy efforts and the Office of the Mental Health Program Manager will facilitate these advocacy actions.

Strategy 2: To raise awareness and reduce negative perceptions about those suffering from mental health-psychosocial and substance abuse disorders including migrant returnees, through the use of advocacy and Information, Education and Communication (IEC) strategies.

Related Activities:

Activity 1: Conduct periodic assessments to identify misconceptions, common fears, and stigmatization and negative attitudes towards people with mental health-psychosocial disorders.

Activity 2: Develop an advocacy and communication plan on MHPSS.

Activity 3: Develop appropriate messages and strategies on MHPSS for public consumption.

Activity 4: Engage print and electronic media for sensitization campaigns on an ongoing basis.

Activity 5: Develop and produce billboards, posters, pamphlets and factsheets on mental health and behavioural disorders including substance use and abuse-related messages.

Activity 6: Train and engage traditional communicators to disseminate relevant MHPSS messages in their local communities.

Activity 7: Conduct community sensitization on mental health and psychosocial needs of migrant returnees.

Targets:

- ✓ (Establish nationwide media campaign platforms (broadcasting, TV, radio, newspaper)

Indicators:

- Proportion of the general population, including returnees, who are reached via one or more of the messaging platforms.

3. PROCUREMENT AND DISTRIBUTION OF ESSENTIAL MEDICINES

Effective medications make it possible for people with mental health and psychosocial problems to live active productive lives in the community. The most cost-effective drugs with minimal side effects will be procured and distributed to all health facilities in a way that maximizes benefit to those who need them. This requires a sustained supply of essential psychotropic medicines and protection of budgets and distribution networks for these medications. Protocols for the correct administration and monitoring of medications will be established. Health workers at all levels of care will receive the appropriate training and supervision to manage the prescription and monitoring of psychotropic medication.

Strategy 3: To strengthen the availability, distribution and use of cost-effective psychotropic and essential medicines.

Related Activities:

Activity 1: Review and update the current list of psychotropic medicines included in the National Essential Drugs List.

Activity 2: Revise recommended list of psychotropic medicines to be available in the different health facilities and send for expert review.

Activity 3: Improve the distribution of psychotropic medicines to the different facilities.

Activity 4: Develop and put in place treatment protocols and guidelines for the use of psychotropic medicines in each health facility where medicines will be made available.

Activity 5: Put in place a stock monitoring system for psychotropic medicines in each health facility where medicines will be made available.

Targets:

- ✓ Implement national standards for mental health-psychosocial care (services and treatment).
- ✓ Make those medicines identified in the national essential drug list available in relevant health facilities.

Indicators:

- o Availability of guidelines and protocols for mental health-psychosocial treatment and services in all health facilities.
- o Percentage of patients with access to a constant supply of psychotropic medicines.

4. INFORMATION SYSTEMS

Key mental health indicators will be integrated in the Health Management Information System (HMIS) of The Gambia in consultation with managers, mental health specialists, health service providers and service users. This will require patient record forms to be designed or modified in facilities where data will be collected, the standardization of data collection, processing and

analysis for mental health across all health centers. This information collected will also include information on migrant returnees visiting the health facilities. Relevant staff will be trained to collect process and report on the information. Some of the core data to be collected at each service level will include basic patient demographic information; diagnosis; type of medication and other treatments, number of visits and clinical outcomes. Additional data relevant to specific facilities will also be collected.

Strategy 4: To strengthen the Health Management Information System to adequately address mental health issues.

Related Activities:

Activity 1: Establish a Multi-disciplinary Task Team (MTT) responsible for designing and implementing the mental health-psychosocial component of the HMIS.

Activity 2: Review current HMIS to incorporate mental health and psychosocial support.

Activity 3: Organize a consultation of stakeholders in order to identify the key indicators for the HMIS and a minimum mental health-psychosocial data set to be collected in each health facility.

Activity 4: Design and incorporate mental health-psychosocial information into the HMIS (instruction procedure manuals, data collection forms) for use in the different health facilities at all levels of care.

Activity 5: Pilot the tools in selected health facilities, to test feasibility and implementation problems.

Activity 6: Scale up the use of mental health and psychosocial HMIS at all level of delivery, including the training of all staff involved.

Targets:

- ✓ Record key information on all patients accessing mental health-psychosocial services (symptoms, diagnosis, treatment, hospitalization, follow-up and rehabilitation activities).

Indicators:

- o A minimum data set is collected and processed.
- o The proportion of mental health facilities from which the government health department receives data, per year.

5. COMMUNITY EMPOWERMENT AND PARTICIPATION

The mental health unit will be responsible for the coordination of community psychosocial support services using community structures. The local communities will be engaged in providing psychosocial support services through the associations in individual communities. The community leaders and traditional healers will be engaged in the psychosocial support to the returnees. This will be done through the creation of community-based associations in collaboration with community leaders.

Strategy 5: To strengthen community involvement and participation in mental health care delivery.

Related activities:

Activity 1: Create local associations of psychosocial rehabilitation involving formal health care.

Activity 2: Support health providers, community leaders and traditional healers within each health region to provide MHPSS care to returnees and their communities.

Activity 3: Establish a mental health-psychosocial rehabilitation facility.

Activity 4: Organize meetings of each local association of psychosocial rehabilitation in order to define modalities for work in the area of mental health-psychosocial services at the primary health care level.

Activity 5: Create a national association of psychosocial rehabilitation with representatives from local associations, with a clear mandate and TOR.

Activity 6: Procure trekking vehicles for community services.

Activity 7: Establish tailoring workshops and procure tailoring equipment for identified returnees.

Activity 8: Strengthening existing social institutions and networks.

Activity 9: Train and engage community-based organizations including women and youth groups.

Targets:

- ✓ Make a local association of psychosocial rehabilitation available in each region within three years.
- ✓ Establish the national association.
- ✓ Establish a mental health-psychosocial rehabilitation facility.

Indicators:

- o Local associations established and several meetings held.
- o National association established and at least one meeting held.
- o A mental health-psychosocial rehabilitation facility available.

6. LEGISLATION AND HUMAN RIGHTS

The new mental health legislation will be a useful and effective instrument to improve the situation of people with mental disorders and ensure their protection against human rights violations as well as the promotion of autonomy, liberty and access to health care.

Strategy 6: To strengthen treatment and human rights conditions of people with mental health-psychosocial problems at treatment facilities.

Related Activities:

Activity 1: Set up an independent visiting committee. Composition includes representatives of the University of The Gambia (UTG), medical and dental council, Ombudsman, Attorney General's office, human rights commission) to assess the degree to which the services meet human rights standards on an annual basis and to make the findings publicly available.

Activity 2: Discuss the results of the assessment with staff in the service areas or facilities and train staff in human rights.

Activity 3: Put in place a mechanism to improve the conditions according to assessment results and recommendations.

Activity 4: Conduct a qualitative community survey to understand the acceptability of discharging clients including returnees, into the community both before and after they have been discharged in order to address the obstacles identified.

Activity 5: Assess the level of disability, risk of relapse and home conditions of each client including migrant returnees, admitted in mental health-psychosocial rehabilitation facility.

Activity 6: Discharge the least disabled back to their families and communities with the appropriate monitoring and support from Regional community mental health nurses, social workers.

Activity 7: Refurbish Tanka-Tanka psychiatric facility to standard to support the inpatient MHPSS care of migrant returnees and their communities.

Activity 8: Establish one mental health and psychosocial rehabilitation facility.

Targets:

- ✓ Discharge 20% into their families.
- ✓ Improve on all standards relating to human rights in the service places.

Indicators:

- o Proportion of clients discharged.
- o Proportion of successful discharges (e.g. no relapse and no readmission within six months).
- o Ratings on WHO human rights instrument.

7. HUMAN RESOURCES AND TRAINING

Training of Health Workers and Non-Health Workers

Investing in human resources is essential to mental health services which rely on the skills, knowledge and motivation of their staff. Training programmes would be conducted to improve the knowledge and competencies of health workers to detect, treat and support people with mental disorders. They will also address the need to change the role and orientation of psychiatrists and other health workers engaged in mental health care towards a more social and team-based

approach. Before any further training is planned in The Gambia, an initial assessment will be undertaken in order to identify training needs in all the facilities.

The Office of the Mental Health Programme Manager, in collaboration with academic institutions, shall be responsible for the assessment of training needs, the development of the mental health and psychosocial support service training curriculum, modules and the training of all cadres of health workers in mental health and substance abuse issues. In addition, the mental health programme manager, in collaboration with academic institutions will be responsible for integrating modules on mental health and the prevention of substance abuse into the training curriculum for health workers (such as doctors, nurses, social workers, occupational therapists, public health officers and nurse attendants).

Additionally, the Mental Health Programme Office will be responsible for ensuring the effective training of non-health workers including, police, traditional healers, legal professions, religious leaders, teachers, social institutions, youth organizations and community leaders. Training in mental health will be conducted, through seminars and workshops, and will aim to provide an appropriate level of knowledge and skills for the identification of people with mental disorders and their referral to appropriate level of the health service for treatment and care. Additionally, training will aim to increase their awareness and knowledge of the human rights of people with mental disorders and their role concerning the planned enactment of a new mental health law.

Strategy 7: Strengthen national capacity for the delivery of mental health and psychosocial services.

Related Activities:

Activity 1: Develop and adapt MHPSS curriculum on migrant returnees and training materials, including for substance and alcohol abuse, for health workers at all levels.

Activity 2: Train mental health-psychosocial workers: Within the first year, per unit: one registered psychiatric nurse, five general nurses with four-weeks of orientation work and on-the-job training, and one medical doctor who has completed a mental health orientation workshop.

Activity 3: Train Community Health Nurses on MHPSS care delivery to returnees.

Activity 4: General Nurses are taken through orientation courses on MHPSS (duration of sessions: 4 weeks).

Activity 5: Train social workers in mental health-psychosocial care in regions.

Activity 6: Train the MHPSS focal point at each RHD.

Activity 7: Train health education officers in mental health-psychosocial well-being promotion.

Activity 8: Train security officers, health journalists, and legal practitioners.

Activity 9: Train teachers in schools to identify and refer mental health-psychosocial problems, including problems faced by migrant returnees.

Activity 10: Review/update curricular of training institutions to incorporate mental health and psychosocial modules.

Activity 11: Incorporate mental health and psychosocial support modules in the curricular of lower basic and upper basic schools.

Activity 12: Train all volunteer traditional healers to identify and treat people with mental health-psychosocial disorders.

Activity 13: Hold teaching and exchange sessions on mental health-psychosocial diagnosis and treatment in traditional medicine (organized by traditional healers for primary health care workers).

Activity 14: Set up a referral and support system for Policy makers and Law makers, Social workers, Mental health advocacy and psychosocial support groups, Security forces (police and the army), Health care providers, Traditional communicators, and Teachers.

Targets:

- ✓ Develop training materials for each health system level.
- ✓ Train at least 50% of the traditional healers identified in the country on basic mental health psychosocial services delivery.
- ✓ Recruit and train MHPSS providers.

Indicators:

- o Number of health workers recruited and trained.
- o Number of non-health personnel trained.
- o Proportion of trained traditional healers.
  Proportion of traditional healers actively collaborating with local formal health services.

8. MONITORING AND EVALUATION OF POLICIES AND SERVICES

Monitoring and evaluation are the key processes used in determining whether the goals set in the strategic plan are being realized. This allows decision makers to make short- and longer-term services and policy-related decisions and changes.

Monitoring and evaluation tools will be developed to enhance the smooth monitoring and evaluation of the planned activities. The implementation of the strategic plan will be evaluated on an ongoing basis via an examination of whether activities are being carried out as intended and whether the desired outputs are being produced. Additionally, evaluation of the achievement of strategies will be assessed in terms of whether targets and indicators for each have been achieved. At the end of the planned period the plan itself will be evaluated for its relevance and appropriateness as well as the degree to which each of the objectives had been met.

Strategy 8: To monitor and evaluate the planned mental health and psychosocial support activities.

Related Activities:

Activity 1: Develop monitoring and evaluation tools.

Activity 2: Create a technical advisory committee and a timetable for the regular monitoring of activities.

Activity 3: Regular monitoring and evaluating of mental health-psychosocial activities by the technical advisory committee.

Activity 4: Prepare an operational plan for impact evaluation.

Activity 5: Organize and support evaluation visits to community leaders, enterprises and associations to follow up mental health-psychosocial support activities.

Activity 6: Evaluate the impact of the collaboration with traditional healers on the mental health-psychosocial support outcomes in the community.

Activity 7: Prepare quarterly reports and a report at the end of each activity implementation.

Activity 8: Conduct research in assessing the prevalence of mental and behavioral disorders, communication behavioral impact, and issues related to substance use disorders.

Activity 9: Publication, sharing and dissemination of research findings

Targets:

- ✓ Monitor all activities and outputs and produce a short quarterly and yearly report on each.
- ✓ Produce a five-year report on the evaluation of the mental health policy and plan.
- ✓ Number of researches conducted.
- ✓ Number of research publications published shared and disseminated.

Indicators:

- o Quarterly and yearly reports on all the activities will be in place/available.
- o A yearly report assessing the degree to which targets were met for each of the planned strategic objectives.

ROLES AND RESPONSIBILITIES IN GENERAL AS THEY RELATE TO THE OBJECTIVES

ROLES AND RESPONSIBILITIES	**GOVERNMENT**	**PARTNERS**
Coordination	Lead	Collaborate
Resource mobilization	Lead	Collaborate and supplement
Finance	Lead	Supplement
Capacity	Facilitate and lead	Facilitate and supplement
Medications	Procure	Procure and supplement
Enlightening communities and sensitization	Lead and facilitate	Support and supplement
Monitoring and evaluation	Lead and facilitate	Support and supplement

IMPLEMENTATION PLAN:

Through the Ministry of Health, and under the Directorate of Health Services, The National Mental Health Programme Office (NMHPO) will coordinate the implementation of the MHPSS activities captured on the framework.

To buttress further, these roles further include coordinating NGOs and related institutions involved in rendering mental health activities/services to migrant returnees and their communities. To coordinate the efforts of mental health traditional healers, liaise and work closely with the 7 regional health directorates – where the 7 mental health focal persons are situated – and to work closely with migration coordination agencies and platforms in The Gambia.

In addition, the Office of the Mental Health Program Manager will be responsible for fostering inter-sectoral collaboration in sectors outside health including government sectors such as social welfare, housing, education, employment/labour, justice and the Ministry of Youths and Sports as well as NGOs and community organizations such as faith-based organizations, media (radio, television and newspaper), business organizations, traditional healers' groups, women and youth organizations.

Furthermore, the NMHPO coordinates capacity strengthening of all stakeholders on MHPSS in The Gambia.

Additionally, the NMHPO to facilitate the establishment of National Coordination Mechanisms – aimed at coordinating MHPSS response for migrants and their communities – creation of a National Committee, creation of Regional Coordination Committees (either to strengthen existing ones or to create new ones). Consequently, define the roles and responsibilities of each of the committees.

For the smooth running of the activities and the impact evaluation of the framework, a monitoring and evaluation plan would be developed by the NMHPO for effective monitory and evaluation of the activities.

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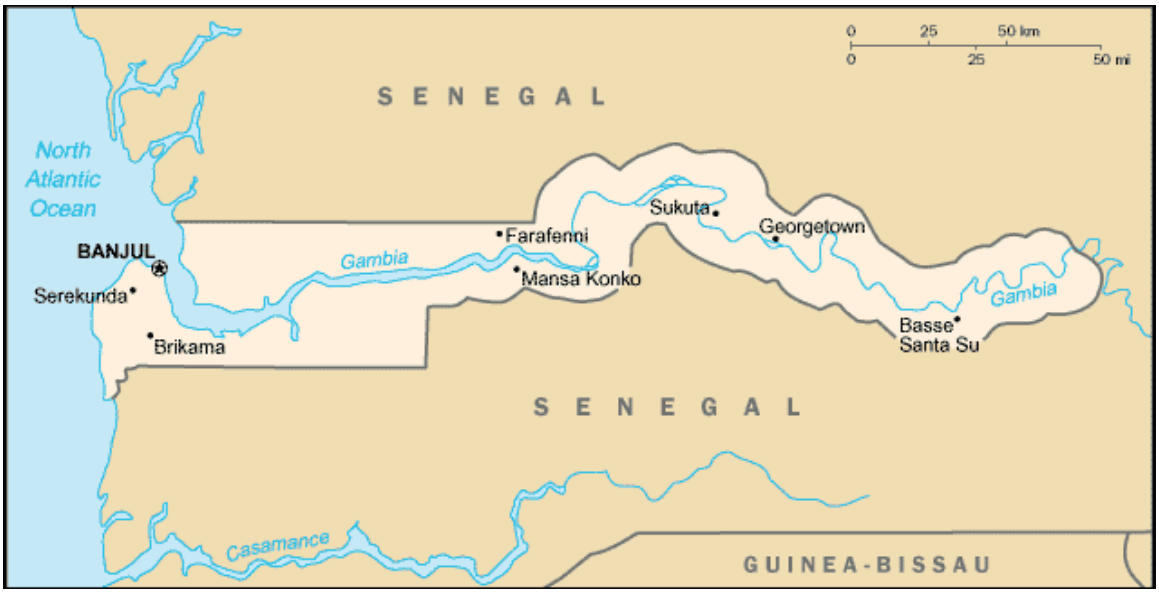
Annex: 1

Figure1: MAP OF THE GAMBIA



*Annex: **2***

TABLE 1: MENTAL DISORDERS BY AREA 2013 TO 2018

MENTAL DISORDERS DATA BY YEAR AND BY REGION

	2013			2014			2015		
Mental Disorders	Outpatient cases	Inpatient cases	Deaths	Outpatient cases	Inpatient cases	Deaths	Outpatient cases	Inpatient cases	Deaths
Mania	**357**	**1**	**0**	**231**	**11**	**0**	**121**	**1**	**0**
Depression	**794**	**12**	**0**	**550**	**6**	**0**	**877**	**1**	**0**
Drug induced psychosis	**836**	**2**	**0**	**882**	**4**	**0**	**2475**	**3**	**0**
Organic psychosis	**834**	**17**	**1**	**790**	**9**	**0**	**744**	**10**	**1**
Epilepsy	**11032**	**89**	**2**	**6146**	**103**	**4**	**4989**	**81**	**2**
Schizophrenia	**1417**	**1**	**0**	**770**	**3**	**0**	**3413**	**14**	**0**
Phobia	**0**	**0**	**0**	**0**	**0**	**0**	**190**	**0**	**0**
Anxeity disorder	**0**	**0**	**0**	**0**	**0**	**0**	**321**	**0**	**0**
Pregnancy related mental disorders	**0**	**0**	**0**	**0**	**0**	**0**	**11**	**2**	**0**
Childhood mental Disorders	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**0**	**0**
Malaria related mental disorders	**0**	**0**	**0**	**0**	**0**	**0**	**48**	**0**	**0**
Dementia the elderly	**0**	**0**	**0**	**0**	**0**	**0**	**281**	**7**	**0**
Other mental disorders	**1506**	**8**	**0**	**847**	**12**	**0**	**1136**	**21**	**0**

	2016			2017			2018		
Mental Disorders	Outpatient cases	Inpatient cases	Deaths	Outpatient cases	Inpatient cases	Deaths	Outpatient cases	Inpatient cases	Deaths
Mania	**98**	**3**	**0**	**48**	**0**	**0**	**22**	**1**	**0**
Depression	**459**	**0**	**0**	**341**	**1**	**0**	**205**	**1**	**0**
Drug induced psychosis	**1862**	**1**	**0**	**2262**	**1**	**0**	**2012**	**0**	**0**
Organic psychosis	**775**	**10**	**0**	**875**	**3**	**0**	**795**	**3**	**0**
Epilepsy	**5427**	**52**	**4**	**6727**	**87**	**3**	**4683**	**78**	**2**
Schizophrenia	**3415**	**1**	**0**	**4243**	**2**	**1**	**3233**	**0**	**0**
Phobia	**373**	**0**	**0**	**330**	**0**	**1**	**344**	**0**	**0**
Anxeity disorder	**406**	**6**	**0**	**387**	**2**	**0**	**252**	**3**	**0**
Pregnancy related mental disorders	**11**	**2**	**0**	**5**	**5**	**0**	**10**	**2**	**0**
Childhood mental Disorders	**3**	**7**	**0**	**1**	**0**	**0**	**5**	**1**	**0**
Malaria related mental disorders	**2**	**0**	**0**	**2**	**1**	**0**	**11**	**1**	**0**
Dementia the elderly	**96**	**0**	**6**	**271**	**2**	**0**	**142**	**3**	**0**
Other mental disorders	**48**	**1**	**1**	**77**	**0**	**0**	**74**	**0**	**0**

Annex: 3

CHART 1: ORGANOGRAM OF THE MINISTRY OF HEALTH