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Strengthening Somalia's Mental Health Workforce:

A Case Study of Puntland

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March 2025

Abstract

The global shortage of mental health professionals is particularly severe in countries such as Somalia, revealing the urgent need for innovative solutions. This study investigated the barriers to the mental health workforce development in Puntland, Somalia, focusing on inadequate training programs, financial constraints, and cultural resistance to mental health careers. Using a qualitative research design, Semi-structured interviews were conducted with nine mental health professionals from Puntland, Somalia using a qualitative research design. The findings revealed severe infrastructure deficiencies, an absence of specialized training programs, and a widespread stigma discouraging entry into the field. Government inaction, underfunding, and cultural misconceptions further limit access to quality mental health services and restrict professional development in this sector.

To address these challenges, this study underscores the urgent need for government-led policy reforms, including investment in mental health education, workforce development, and the integration of psychiatric services into Somalia's broader healthcare system. Additionally, targeted public awareness campaigns are essential for reducing stigma and fostering cultural acceptance of psychiatric care. Without substantial policy interventions and long-term financial commitments, Somalia's mental health crisis will persist, leaving vulnerable populations without access to essential resources.

1. Background

Mental health challenges encompass a range of conditions that affect an individual's thoughts, emotions, and behaviors. Mental health challenges range in severity and can significantly impact daily life, social interactions, and employment stability (WHO 2022). Mental, neurological, and substance use disorders significantly contribute to global disability and economic losses. In Africa, they account for 17.6% of the annual socioeconomic burden due to reduced productivity and increased healthcare costs.

In response to the growing burden, East African countries like Kenya and Uganda have implemented structured mental health policies. Kenya's Mental Health Policy (2015–2030) expands services and reduces stigma, while Uganda's Child and Adolescent Mental Health Guidelines emphasize early intervention. These proactive frameworks integrate mental health into public health systems—an approach that Somalia still lacks.

In contrast, Somalia continues to face significant barriers in developing a structured and sustainable mental health system. The country's history of conflict, displacement, and socioeconomic instability has contributed to a high prevalence of mental health disorders, including depression, anxiety, post-traumatic stress disorder (PTSD), and substance abuse (Marquez, 2018; Abdillahi et al., 2020; Ibrahim et al., 2022; Salat et al., 2023). While some progress has been made, particularly through NGO-led psychosocial support programs, counseling services, and community-based mental health interventions (WHO 2021), Somalia lacks a national mental health policy, limiting service integration into primary care. Government efforts, such as task-shifting—where general healthcare workers provide basic mental health services—have not been effective due to severe underfunding, minimal training, and high caseloads.

One of the primary government-led strategies to mitigate the shortage of mental health professionals is task shifting, in which general healthcare workers are trained to provide basic mental health services, including screenings and referrals (Ibrahim et al., 2022). However, this approach places an additional burden on already overstretched healthcare providers, many of whom lack specialized training in psychiatry and psychology. Furthermore, professionals in the sector struggle with limited financial resources, inadequate healthcare infrastructure, security concerns, and deep-rooted cultural stigma surrounding mental health (MoH, 2021; Ibrahim et al., 2022; UHC, 2019-2023). The absence of adequately staffed community mental health centers and specialized psychiatric hospitals exacerbates these challenges, leaving healthcare workers to manage increasing caseloads with minimal institutional support.

A critical underlying factor contributing to the shortage of mental health professionals is Somalia's educational system. The country faces severe gaps in oversight, resource allocation, and quality control within its higher education sector (Salad, 2022). Somalia's higher education system lacks accredited psychiatric programs, forcing aspiring professionals to study abroad—an option unaffordable for most. Additionally, pervasive stigma and religious misconceptions discourage career entry, exacerbating the workforce shortage.

Beyond resource limitations, social and cultural factors further discourage individuals from entering the mental-health profession. Stigma and discrimination remain pervasive, with negative societal perceptions associated with mental illnesses with supernatural causes or weak faith. Additionally, many individuals rely on religious interventions, such as Quranic healing, rather than evidence-based psychiatric treatment (Ibrahim et al., 2022). These deep-seated cultural beliefs limit the perceived legitimacy of mental health careers, leading to a continuous shortage of psychiatrists, psychologists, and social workers.

2. Objectives

This study aims to:

- Assess the availability and accessibility of mental health education and training programs in Puntland, Somalia, and their impact on workforce capacity and professional development.
- Investigate socio-cultural and financial barriers, including stigma and underfunding, that hinder individuals from pursuing careers in mental health, using Puntland as a case study.
- Evaluate existing policies and propose evidence-based interventions to strengthen mental health workforce development and its integration into Puntland's healthcare system.

3. Methodology

This study employs qualitative research design with a phenomenological approach, focusing on the lived experiences of mental health professionals in Puntland. This approach is particularly suited for capturing complex social, cultural, and institutional barriers that hinder workforce development beyond what quantitative data can reveal.

Data was collected through semi-structured interviews, allowing for flexibility in exploring participants' perspectives. The demographic of the participants were professionals from Garowe, Bosaso and Qardho.These participants included 5 psychiatrists,1 medical doctor who tasks shifts permanently as a mental health provider and 3 medical doctors. Interviews were conducted in Somali and English, ensuring linguistic accessibility. Given to logistical challenges, interviews were conducted both in-person and through online platforms. The interviews were audio-recorded with consent, transcribed verbatim, and stored securely. Thematic analysis was employed, which involved coding, pattern identification, and synthesis into overarching themes. To ensure validity and reliability, the findings were triangulated with existing literature on mental health workforce challenges in Somalia and similar post-conflict settings.

The study adhered to SIDRA´S Ethical Policy, ensuring informed consent, confidentiality, and research integrity. Information was anonymized to protect participants' privacy. By maintaining rigorous ethical and methodological standards, this research provides valuable insights into the structural and socio-cultural barriers limiting mental health workforce development in Somalia.

4. Results

The findings of this study highlight significant structural and systemic barriers that impede the development of a robust mental health workforce in Puntland, and why such barriers exist.

4.1 Inadequate healthcare infrastructure

The findings of this study highlight that Puntland lacks a comprehensive mental health infrastructure, significantly limiting access to quality care. Participants reported that the region had no dedicated mental health clinics or specialized psychiatric units within general hospitals, leaving individuals with mental health conditions with minimal professional support. This structural deficiency restricts access to psychiatric treatment and overburdens general healthcare practitioners who lack specialized training in mental health care.

A critical concern raised by participants was the severe shortage of trained mental health professionals, particularly psychiatric nurses. One participant emphasized this challenge, stating:

"The problem we face is that there are no well-trained psychiatric nurses in the country. Even when you are working as a mental health provider, it is difficult when you don't have a specialist nurse, a registered nurse in psychiatry.

The absence of structured psychiatric training programs further exacerbates this issue, as aspiring professionals have limited opportunities for specialized education and clinical practice.

Beyond human resource shortages, the participants noted inadequate medical infrastructure and equipment as major barriers.

The region lacks psychiatric facilities, inpatient care centers, and community-based mental health programs, making service provision both fragmented and ineffective. Without targeted investment, diagnosis, treatment, and long-term management of mental health conditions remain severely constrained.

Addressing these challenges requires systematic investment in mental health infrastructure, workforce development, and policy implementation. Strengthening government support, international collaboration, and integration of mental health services into the broader healthcare system is essential to ensure sustainable and accessible mental healthcare in Puntland.

4.2 Stigma & Misconceptions

Participants identified stigma as a major barrier to mental healthcare and the pursuit of careers in psychiatry and psychology in Puntland. Deeply rooted cultural, religious, and societal beliefs shape negative perceptions of mental illness and of those who provide psychiatric care. These misconceptions deter individuals from seeking professional treatment while simultaneously contributing to the marginalization of mental health professionals. A particularly pervasive belief is that mental health practitioners themselves may be mentally unstable, reinforcing skepticism toward the field and discouraging potential entrants.

4.2.1 Mental Illness as a Reflection of Weak Faith

One of the most entrenched forms of stigma is the belief that mental illness is a sign of weak faith or moral failure. Many individuals view mental disorders as a consequence of insufficient religious devotion, disregarding psychological, genetic, or environmental determinants. Consequently, affected individuals often choose to internalize distress rather than seek medical intervention, fearing societal judgment. One participant in this research highlighted this issue.

> *"A lot of people do not come to the clinic. They would rather meet you in a hotel because if they are seen leaving a mental health facility, people will assume they are mentally ill. That perception alone stops many from seeking help.*

This reluctance to engage in formal psychiatric services perpetuates the cycle of untreated mental health conditions and further reinforces societal discrimination. The stigmatization of mental illness as a religious failing prevents individuals from accessing appropriate treatment, exacerbating long-term psychological distress.

4.2.2 Cultural Beliefs and the Over-Reliance on Religious Interventions

Cultural interpretations of mental illness significantly influence treatment-seeking behavior. In many Somali communities, mental disorders are attributed to supernatural causes, including spirit possession, the evil eye, or divine punishment, rather than being recognized as legitimate medical conditions. As a result, individuals experiencing mental health challenges frequently turn to traditional healers and religious figures instead of trained mental health professionals.

While spiritual practices such as ruqya (Quranic recitation) may offer emotional relief and social support, exclusive reliance on these methods can be detrimental. One participant described this phenomenon as follows. *"Most people believe mental disorders can only be treated with the Quran and see scientific methods as useless. Many religious leaders discourage people from visiting psychiatrists.*

This reliance on spiritual healing, at the expense of evidence-based treatment, often delays appropriate medical intervention and exacerbates psychiatric conditions.

4.3 Policy gaps and underfunding

The absence of a comprehensive mental health policy in Somalia remains a major barrier for the development and delivery of effective mental health services.

While policy discussions exist at the federal level, no concrete or actionable framework has been implemented, leaving mental healthcare fragmented and uncoordinated. Without a structured policy, stakeholder collaboration, resource allocation, and the standardization of interventions remain inconsistent, further marginalizing mental health within the broader healthcare system.

One participant underlined this policy gap, stating:

"There is no working policy for mental health. There are draft policies around, but nothing specific to help people. I work closely with different ministries, especially the Ministry of Health, and they don't have a dedicated section for mental health. At the federal level, there is some mention of mental health, but in Puntland, there is no clear agenda or structured framework.

The absence of clear regulations and procedural guidelines has resulted in inconsistent service provision and overreliance on non-governmental organizations (NGOs) and private actors to fill the gap. Participants emphasized the urgent need for a formalized strategy to define how individuals with mental health conditions can access appropriate care. Without government oversight, access to services remains unequal and unsustainable, further deepening disparities in mental health care provision.

Another key challenge is chronic underinvestment in mental health infrastructure and services. Participants reported that both federal and state governments have consistently failed to allocate sufficient funding for mental health initiatives, resulting in a severe shortage of psychiatric institutions, trained professionals, and specialized facilities. One participant described the consequences of this neglect: *"The lack of commitment also extends to psychiatric institutions. Mental health services require multiple components, including specialized healthcare provision. However, government hospitals do not offer dedicated mental health services, and there is no policy to integrate mental healthcare into the broader system.*

In Puntland, participants highlighted the limited budget allocations for mental health.This negligible allocation is grossly inadequate given the growing demand for psychiatric interventions and specialized mental health care. Additionally, a lack of clarity regarding fund distribution raises concerns about whether these allocations contribute to meaningful service expansion or improved accessibility.

4.4 Limited educational infrastructure

The scarcity of formal psychology and psychiatry training programs in Puntland presents a significant barrier to the development of a skilled mental-health workforce in Somalia. Although some psychology programs have been introduced in Mogadishu, they remain in their early stages and lack the capacity to meet demand. The absence of established programs in Puntland forces students to seek training abroad, which is financially prohibitive for many. One participant emphasized this challenge: *"There are no medical universities that offer psychiatry programs. If someone wants to specialize in psychiatry, they must go abroad, which often imposes financial difficulties.*

This limited access to professional education has contributed to a severe shortage of mental health specialists, further restricting the availability of quality mental healthcare. Another participant noted that few medical graduates pursue psychiatry because of uncertain job prospects and the stigma surrounding mental health professions.

While NGO-supported training programs exist, participants expressed concerns about their lack of depth in the nature of said programs. Although these programs are helpful in addressing workforce shortages, do not provide sufficient theoretical and clinical competency for specialized practice. One participant explained this as follows: "There is one university collaborating with UNICEF to develop a curriculum for social work programs. These institutions can offer social support courses, but awareness and funding challenges continue to hinder progress.

A critical issue is the absence of structured clinical training. Somalia has few dedicated mental health clinics and no psychiatric inpatient facilities in general hospitals, preventing students from gaining essential hands-on experience. One participant described the severity: "The absence of well-organized community mental health care and the lack of psychiatric beds in most general hospitals reflect the extent of the crisis.

Additionally, the shortage of qualified mental health educators and clinical supervisors further limits their professional development. Many Somali mental health professionals are forced to seek education abroad because of a lack of local mentorship and training facilities, creating a reliance on foreign institutions and preventing the establishment of a self-sustaining mental health education system within Somalia.

5. Discussion

The findings highlight systemic barriers impeding the development of mental health as a profession in Somalia, particularly workforce shortages, reliance on traditional healing, policy deficiencies, and educational gaps. While these challenges are consistent with global patterns in underfunded mental health systems, Somalia's institutional fragility, weak financial commitment, and cultural resistance exacerbate these barriers, making psychiatric care largely inaccessible.

Workforce and Infrastructure Deficiencies

The absence of specialized psychiatric training programs and dedicated mental health institutions in Somalia has created a crippling shortage of professionals, with only three psychiatrists serving the entire public healthcare system (WHO 2024). Unlike other medical disciplines, psychiatry lacks a structured academic pathway, forcing students to either pursue training abroad—an option few can afford—or abandon the field entirely. This failure to institutionalize psychiatric education has left mental health care dependent on general practitioners with no formal psychiatric training, increasing the risk of misdiagnosis and inadequate treatment.

Moreover, the lack of psychiatric hospitals and supervised clinical training deters specialization, even among those interested in mental health. This study reinforces the global finding that the absence of professional training environments leads to workforce stagnation (Ibrahim et al., 2022). Without investment in mental health facilities and training programs, Somalia will remain trapped in a cycle where limited professional capacity perpetuates service gaps, reinforcing the neglect of psychiatric care.

Cultural Reliance on Traditional Healing and Stigma

Somalia's heavy reliance on traditional healing reflects both healthcare inaccessibility and deep-seated cultural narratives. Mental illness is widely attributed to evil supernatural causes, delayed medical intervention, and reduced treatment adherence, a pattern observed in other low-resource settings where religious frameworks shape health-seeking behaviors (WHO, 2021).

However, the challenge is not just the preference for traditional healers but their increasing role in discouraging biomedical treatment. Some religious leaders actively oppose psychiatric care, reinforcing stigma and misinformation. Unlike societies in which traditional and modern psychiatric practices have been integrated, Somalia lacks structured collaboration between these systems, creating a polarized environment where individuals must choose between faith-based healing and medical care.

This binary approach exacerbates stigma, forcing many individuals into secrecy rather than seeking professional treatment. These findings indicate that mental health interventions must account for the cultural legitimacy of traditional healing while promoting medically sound treatment pathways. Without such integration, Somalia risks maintaining a mental health system that is both underutilized and distrusted by the population.

Policy Gaps and Underfunding

The absence of a national mental health strategy reflects a broader governance failure where mental health remains politically nonexistent despite the growing public health burden. This severely limited financial commitment mirrors the trends in fragile states, where low mental health investment results in overreliance on NGOs and foreign donors, leading to an unsustainable, externally dependent service model (Ibrahim et al., 2023).

Compounding this issue is the lack of financial transparency, raising concerns over whether even the minimal allocated funds are effectively utilized. Without policy coherence and financial accountability, mental health will remain an afterthought in Somalia's healthcare agenda, preventing the institutionalization of psychiatric care. Furthermore, the absence of domestic financial commitment reinforces Somalia's dependence on humanitarian aid, thus hindering the development of a self-sustaining mental health system.

Educational Gaps and Mental Health Literacy

The absence of structured psychiatric education is not merely an academic shortcoming but a major contributor to workforce stagnation. Unlike other medical fields, psychiatry lacks formalized curricula, clinical training sites, and mentorship programs, forcing students to seek training abroad or abandon mental health professions entirely. This persistent talent drain prevents the establishment of a sustainable, locally trained mental health workforce.

Additionally, mental health literacy remains critically low, as mental health education is virtually absent from school curricula (Salad, 2022). Without early exposure to mental health awareness, misconceptions persist, reinforcing stigmatization and avoidance behaviors.

While NGO-led mental health campaigns exist, they are fragmented, donor-dependent, and short-lived, failing to drive long-term behavioral change.

These findings highlight that mental health education must be embedded within Somalia's broader public health and education policies. Until mental health is integrated into formal education and community awareness programs, stigma and misinformation continue to deter individuals from seeking care.

6. Study Limitations

Data collection for this study presented significant challenges due to the remote location of the participants in Somalia. Conducting interviews exclusively through online platforms like Teams was hindered by frequent internet connectivity issues. These technical difficulties impacted on the quality and efficiency of the data collection process. Due to the lack of general health professionals in Somalia it was also extremely difficult to schedule interviews with participants due to their busy schedules.

7. Conclusion

This study revealed deep-rooted systemic barriers that hinder the development of a sustainable mental health workforce in Somalia, particularly in Puntland. The findings underscore severe infrastructure deficiencies, an absence of specialized training programs, financial constraints, and pervasive stigma, all of which restrict access to quality mental healthcare and discourage career entry into the field. Without institutional support, aspiring mental health professionals face insurmountable challenges, perpetuating the cycle of underdevelopment in psychiatric services.

The absence of formalized psychiatric education and structured career pathways forces many people to seek training abroad, a financially unfeasible option. Simultaneously, chronic underfunding and a lack of national policy frameworks leave mental health care heavily dependent on NGOs and external donors, an unsustainable and fragmented model of service delivery. Additionally, the dominance of traditional healing practices, while culturally significant, further marginalizes biomedical psychiatric care, reinforcing stigma and treatment avoidance.

Addressing these challenges requires urgent and coordinated reforms, including:

1. Government-led policy development integrates mental health into Somalia's national healthcare system.Investment in mental health education and professional training programs to build a self-sustaining workforce.
2. Community engagement initiatives to reduce stigma and misinformation while promoting awareness and help-seeking behavior.
3. Collaboration between traditional healers and biomedical practitioners to bridge cultural and scientific approaches, making mental health services more accessible and trusted.

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