Mental health atlas

Review of the Eastern Mediterranean Region

2020

World Health Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean

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Designed by Punto Grafico

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Executive summary

The mental health atlas project was initiated by the World Health Organization (WHO) in 2000 to map mental health resources and provide an up-to-date overview of mental health system profiles in countries around the world. It aims to provide up-to-date information on the availability of mental health services and resources in WHO Member States, by region and country income group, including mental health policies, legislation, financing, the availability and utilization of mental health services, human resources and information/data collection systems.

The first assessment of available mental health resources in WHO Member States was carried out in 2000 to construct global and regional databases, maps and profiles.[1] A number of updates have been published subsequently, and separately published regional reviews have focused on mental health systems in the WHO Eastern Mediterranean Region.

The recently released 2020 edition of the mental health atlas is used to track progress in implementing WHO's Comprehensive Mental Health Action Plan 2013–2020. The 2014 edition of the atlas provided baseline values for the plan's targets for 2013, while the 2017 version provided interim values for its targets for 2016. The 2020 edition is based on 2019 data and enables monitoring of progress towards meeting these targets.[2] Additionally, it provides baseline values for agreed Comprehensive Mental Health Action Plan targets for 2030: further rounds of the mental health atlas will enable monitoring of progress towards meeting these targets. Freshly endorsed indicators include the integration of mental health into primary health care and preparedness in mental health and psychosocial support (MHPSS) during emergencies.

The WHO mental health atlas project has been conducted in close collaboration with WHO's six regional offices and WHO country offices worldwide. During 2020, information was obtained via a questionnaire sent to designated focal points in each WHO Member State, requesting 2019 data. The key findings are presented in Box 1.

Findings for 2019 indicate that there has been progress towards the global targets of the Comprehensive Mental Health Action Plan in the Eastern Mediterranean Region. In 2013 and 2016 (when data for previous editions of the atlas were collected), a smaller percentage of countries and territories in the Region than in the rest of the world had human rights-compliant mental health policies and plans, legislation, and promotion and prevention programmes, but by 2019 the percentage of countries/territories in the Region with these in place had grown to equal or exceed the percentage reported globally. The rate of suicide in the Region is just over half that reported globally, and the rate has reduced by 16% since 2013. The percentage of countries/territories in the Region reporting on a core set of mental health indicators has returned to more than 80%, after dipping in 2013. Baselines for service coverage have been established in some countries of the Region, though due to a lack of relevant data these are not known for the majority of countries. It will require collective commitment in the next 10 years to deliver the substantial investment and expanded efforts needed at the country level to meet the updated targets for 2030.

Despite steady progress in the adoption of policies, plans and laws, as well as an improvement in the capacity to report regularly across years on a set of core mental health indicators, this regional review reveals massive inequalities between countries in terms of the availability and allocation of mental health resources – often, but not always, showing a pattern of the greatest levels of provision in Group 1 countries and the lowest levels in Group 3 countries (for an explanation of country groups, see page 5). As for the rest of the world, the 2020 edition of the atlas also reveals significant gaps between the existence of policies, plans and laws regionally and their implementation and monitoring and the allocation of resources. Similar gaps are seen in the implementation of mental health services at the primary health care level. While guidelines for the integration of mental health into primary health care exist and have been adopted in most countries, with ongoing activities for training and supervision, the integration of interventions for service delivery, such as pharmacological and psychosocial interventions for mental health conditions, remains limited. The *Mental health atlas 2020* shows significant limitations in the capacity of mental health information systems in some countries to report on specific indicators such as service utilization.

A significant limitation to this round of the atlas was that data collection from countries took place during the global COVID-19 pandemic, which may have affected the quality and quantity of data collected. Moreover, the list of countries submitting responses to the different data points within each question was sometimes different from that of previous years, which may limit comparisons with previous editions of the atlas. Finally, it is important to acknowledge the limitations of self-reported data, often submitted by a single focal point.

[1] World Health Organization. Mental health resources in the world 2001. Geneva: WHO; 2001. https://apps.who.int/iris/bitstream/handle/10665/66910/WHO_NMH_MSD_MDP_01.1.pdf?sequence=1&isAllowed=y

[2] WHO. Mental health atlas 2020. Geneva: WHO; 2021. https://www.who.int/publications/i/item/9789240036703

Box 1. Key findings

- 21 of the 22 countries and territories in the WHO Eastern Mediterranean Region (95%) at least partially completed the mental health atlas questionnaire.

Information systems and research for mental health

- 24% of countries in the Region reported regular compilation of data specific to mental health covering at least the public sector. In addition, 62% of countries reported the compilation of mental health data as part of general health statistics only.
- 95% of countries in the Region were able to report on a set of five selected indicators that covered mental health policy, mental health law, promotion and prevention programmes, service availability and the mental health workforce.
- 14% of countries in the Region reported that no mental health data had been compiled and reported in the past two years.
- 599 articles on mental health were published from the Region in 2019. The percentage of research output on mental health relative to the total health research output was 5.6% in 2019.

Mental health system governance

- 81% of countries in the Region reported stand-alone policies/plans for mental health, and 71% reported stand-alone mental health laws. A further 5% of countries have mental health integrated into their general health policies or plans, and 10% have mental health integrated into disability laws.
- 81% of countries in the Region reported updating their policies/plans since 2013, and 43% reported updating their mental health laws.
- Eleven countries, equivalent to 52% of responding countries, or 50% of all countries in the Region, reported full alignment of their policies/plans for mental health with international and regional human rights standards.
- Thirteen countries, equivalent to 62% of responding countries, or 59% of all countries in the Region, reported full alignment of their laws on mental health with international and regional human rights standards.
- Regionally, there is a gap between having a policy, plan or law and the actual implementation of these. 29% of countries in the Region reported that they have mental health policies/plans and legislation implemented and fully compliant with human rights standards.
- There is limited allocation of financial resources for the implementation of mental health policies and plans (43% of countries in the Region); only 33% of countries reported that indicators were available and were used to monitor implementation of most of the components of their policies/plans.
- Three countries reported that they have neither stand-alone mental health policies/plans nor ones integrated into their general health policies/plans, and four countries reported that they have neither stand-alone mental health laws nor ones integrated into their disability laws.
- 76% of countries in the Region have "formal" collaboration with at least one partner to implement mental health actions. Collaboration with nongovernmental organizations (NGOs) is reported by 71% of responding countries. Within governments, the ministry of education was the most frequently reported stakeholder (62%), followed by the ministry of social affairs (57%) and the ministry of justice (43%).
- 81% of ministries of health did not report any formal collaboration with mental health service user groups.

Financial and human resources

- Levels of public expenditure on mental health are low in the Region (1.8% of health expenditure in nine reporting countries). Regionally, 82% of public expenditure on mental health goes to mental hospitals.
- Nine countries, equivalent to 43% of responding countries, or 41% of all countries in the Region, reported that care and treatment of persons with severe mental health conditions (e.g. psychosis, bipolar disorder and depression) were included in national health insurance or reimbursement schemes and in the insurance coverage of inpatient/outpatient mental health services. 78% of these countries, or 32% of all countries in the Region, stated that mental health conditions were explicitly listed as included conditions.
- Regionally, the median number of mental health workers was 8.0 per 100 000 population, but there was large variation (from 1.3 mental health workers per 100 000 population in Group 3 countries to over 22 workers in Group 1 countries).

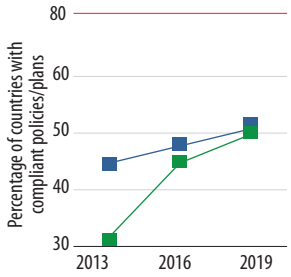
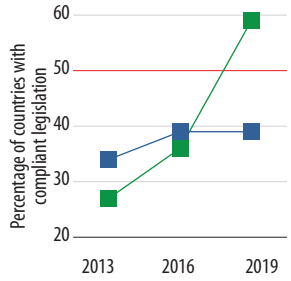
Service availability and uptake

- While guidelines for the integration of mental health into primary health care exist and have been adopted in most Eastern Mediterranean Region countries, with ongoing activities for training and supervision, rates of integration of interventions for service delivery, such as pharmacological and psychosocial intervention for mental health conditions, remain low.
- Five countries, equivalent to 24% of responding countries, or 23% of all countries in the Region, reported a functional integration of mental health into primary health care.
- Nineteen countries, equivalent to 90% of responding countries, or 86% of all countries in the Region, reported that guidelines for mental health integration into primary health care were available and adopted at the national level.
- Eighteen countries, 86% of responding countries, or 82% of all countries in the Region, reported that training on the management of mental health conditions was delivered to health workers at the primary care level.
- Fifteen countries, 71% of responding countries, or 68% of all countries in the Region, reported that mental health specialists were involved in the training and supervision of primary care professionals.
- Five countries, corresponding to 24% of responding countries, or 23% of all countries in the Region, reported that pharmacological interventions were available and were provided in more than 75% of their primary care centres; and two countries, equivalent to 10% of responding countries, or 9% of all countries in the Region, reported that psychosocial interventions were available and were provided in more than 75% of their primary care centres.
- The median number of mental health beds per 100 000 population ranged from below 2.5 beds in Group 3 countries to 9.6 beds in Group 1 countries. Significant disparities also exist for outpatient services and child and adolescent services.
- Mental health facilities for children and adolescents are sparsely available. In the 12 countries in the Region with child and adolescent inpatient facilities, the median number of facilities was 0.08 per 100 000 population. In the 16 countries with child and adolescent outpatient facilities, the median number of outpatient facilities was 0.12 per 100 000 population.
- The service utilization rate for persons with psychosis (the sum of admissions and visits per 100 000 population) was 157, with considerable variation, from 70 in Group 3 countries to 532 in Group 1 countries.
- Service coverage for psychosis was estimated to be 20%, using 12-month service utilization data collected for the *Mental health atlas 2020*.
- The existence of any form of government social support for persons with severe mental conditions was reported to be high (19 countries, or 90% of responding countries in the Region). However, 43% of responding countries reported that such support was available only to a small number of persons and not to the majority of the population. Of Group 3 countries, 40% reported that no social support was provided, and no countries in Group 3 reported that the majority of persons received such support. However, no Group 2 or Group 3 country reported that they did not provide any social support at all.
- Only two countries, equivalent to 10% of responding countries, covered, for at least a proportion of the population, all the categories of social support included in the mental health atlas (education, social care, income, employment, legal and housing).

Mental health promotion and prevention programmes

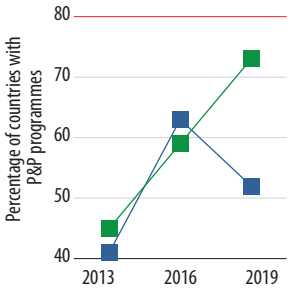
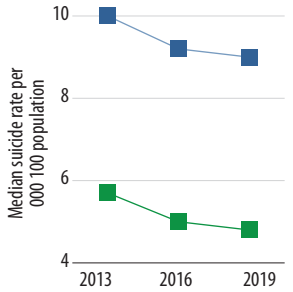
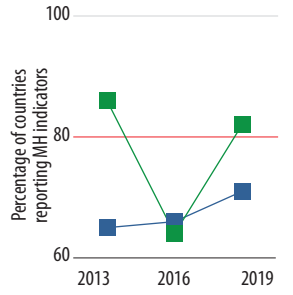
- Sixteen countries, equivalent to 76% of the countries that responded, or 73% of all countries in the Region, have at least two functioning national, multisectoral mental health promotion and prevention programmes.
- Of 65 functioning programmes reported in the Region, 13 aimed to improve mental health awareness and/or fight stigma, 11 were aimed at school-based mental health promotion, and 10 were MHPSS components of disaster preparedness/disaster risk reduction programmes.
- The regional age-standardized suicide rate in 2019 was estimated to be 4.8 per 100 000 population, representing a 16% reduction in the rate of suicide since the 2013 baseline.

Table 1. Comprehensive Mental Health Action Plan 2013–2020: baseline and progress values for original targets for the Eastern Mediterranean Region and globally[1]

Action Plan objectives	Action Plan targets	Findings for 2019 (*Mental health atlas 2020*)	Progress from 2013 (*MH atlas 2014*), through 2016 (*MH atlas 2017*) to 2019 (*MH atlas 2020*)
Objective 1 To strengthen effective leadership and governance for mental health	**Target 1.1** 80% of countries will have developed or updated their policies or plans for mental health in line with international and regional human rights instruments by 2020.	Eleven countries, 50% of all countries in the Eastern Mediterranean Region, have policies or plans for mental health in line with human rights instruments. Value is based on a self-rating checklist.	
	Target 1.2 50% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments by 2020.	Thirteen countries, 59% of all countries in the Region, have laws for mental health that are in line with human rights instruments. Value is based on a self-rating checklist.	
Objective 2 To provide comprehensive, integrated and responsive mental health and social care services in community-based settings	**Target 2** Service coverage for severe mental disorders will have increased by 20% by 2020.	Based on seven countries in the Region with relevant data, median service coverage for psychosis was 20%. Not computable from *Mental health atlas 2014* or *2017* data.	Proxy measure using total mental health outpatient visits per 100 000 population. Eleven countries reported data at two time points: median increase in total outpatient visits of 93%. Eight countries reported > 20% increase in visits between two time points.

[1] Global findings are those reported in the *Mental health atlas 2020* (Executive summary, Table 1).

Table 1. Comprehensive Mental Health Action Plan 2013–2020: baseline and progress values for original targets for the Eastern Mediterranean Region and globally *(concluded)*

Action Plan objectives	Action Plan targets	Findings for 2019 (*Mental health atlas 2020*)	Progress from 2013 (*MH atlas 2014*), through 2016 (*MH atlas 2017*) to 2019 (*MH atlas 2020*)
Objective 3 To implement strategies for promotion and prevention in mental health-based settings	**Target 3.1** 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes by 2020.	Sixteen countries, 73% of all countries in the Region, have at least two functioning mental health promotion and prevention programmes. Value is based on a self-completed inventory of current programmes.	
	Target 3.2 The rate of suicide in countries will be reduced by 10% by 2020.	Median suicide rate of 4.76 per 100 000 population for countries in the Region; 16% reduction from 2013 baseline. Reduction in suicide rate by 10% or more in six countries, 27% in all countries in the Region. Value is based on age-standardized global estimates. Source: WHO Global Health Observatory 2018	
Objective 4 To strengthen information systems, evidence and research for mental health	**Target 4** 80% of countries will be routinely collecting and reporting data on at least a core set of mental health indicators every two years through their national health and social information systems by 2020.	Five countries, 23% of all countries in the Region, compile mental health-specific data. Additionally, 13 Member States (59%) compile mental health data as part of general health statistics only. Total =18 (82%). Value is based on a self-rated ability to regularly compile mental health-specific data that cover at least the public sector.	

Eastern Mediterranean Region — Global — Target

Introduction

The mental health atlas is an ongoing project of the World Health Organization (WHO) Department of Mental Health and Substance Use that is designed to collect, compile and disseminate data on mental health worldwide in order to improve informed decision-making on mental health services at global, regional and country levels.[1] It provides information on mental health policies, legislation, financing, delivery of care, human and financial resources, promotion and prevention programmes and information systems. These resources are required if countries are to provide comprehensive care for people with mental health conditions.

The mental health atlas was first produced in 2001,[2] and information was updated in 2005, 2011, 2014 and 2017.[3] Alongside the update of each global atlas, a review has been produced focusing on the countries of the Eastern Mediterranean Region. The atlas project is a global and regional public health good and resource of information on mental health, which serves as a tool for developing and planning mental health services within countries.

The new edition of the mental health atlas, for which data were collected in 2019, serves as a repository of mental health information from WHO Member States, and illustrates the progress made on the targets and indicators contained in the Comprehensive Mental Health Action Plan 2013–2020.[4] The Action Plan was adopted by the Sixty-sixth World Health Assembly (WHA) in May 2013 to help countries achieve Sustainable Development Goal (SDG) Target 3.4 and promote mental health and well-being. At the Seventy-second WHA in May 2019, it was extended to 2030 to align with the 2030 Agenda for Sustainable Development.[5] The 2020 edition of the mental health atlas assumes additional importance because it provides new baseline data against existing indicators and also includes new ones, based on the extension of the Comprehensive Mental Health Action Plan 2013–2030. The Seventy-fourth WHA in May 2021 recommended endorsement of the updated Action Plan, with due consideration for its updated implementation options and indicators, given the ongoing need to support recovery from the COVID-19 pandemic, including through promoting mental health and psychosocial well-being, building mental health services and psychosocial supports and strengthening preparedness, response capacity and resilience to the ongoing pandemic and future public health emergencies.

A total of 10 global targets, including four new targets and corresponding indicators, have been developed. Some existing targets have been updated for the four objectives of the Action Plan to measure collective actions and achievements by Member States towards the plan's overall goals (see Table 2).

As stated in the Action Plan, the indicators underpinning the global targets are the result of consultations with WHO Member States and non-state actors, conducted through online consultations and a series of regional teleconferences. These indicators represent only a subset of the information and reporting needs required to monitor mental health policies and programmes. Thus, in addition, the WHO Secretariat prepared a more complete set of indicators (the mental health atlas questionnaire) for Member States for data collection and reporting to WHO.

The mental health atlas survey was carried out during 2020, and reflects the situation in countries in 2019. It will be followed by another survey in 2023, so that progress towards meeting the targets contained in the Action Plan can be measured over time.

[1] The Introduction to the global *Mental health atlas 2020* is largely replicated in this section, with minor changes to reflect the focus of the Eastern Mediterranean Regional Review .

[2] World Health Organization. Mental health resources in the world 2001. Geneva: WHO; 2001. https://apps.who.int/iris/bitstream/handle/10665/66910/WHO_NMH_MSD_MDP_01.1.pdf?sequence=1&isAllowed=y.

[3] WHO. Mental health atlas 2005. Geneva: WHO; 2005.
WHO. Mental health atlas 2011. Geneva: WHO; 2011. https://www.who.int/publications/i/item/9799241564359.
WHO. Mental health atlas 2014. Geneva: WHO; 2015. https://apps.who.int/iris/handle/10665/178879.
WHO. Mental health atlas 2017. Geneva: WHO; 2018. https://www.who.int/publications/i/item/9789241514019.
WHO. Mental health atlas 2020. Geneva: WHO; 2021. https://www.who.int/teams/mental-health-and-substance-use/data-research/mental-health-atlas.

[4] World Health Organization. Comprehensive Mental Health Action Plan 2013–2020. Geneva: WHO; 2013. https://www.who.int/publications/i/item/9789241506021.

[5] World Health Organization. Comprehensive Mental Health Action Plan 2013–2030. Geneva: WHO; 2021. https://www.who.int/publications/i/item/9789240031029.

Table 2. Core mental health indicators, by WHO Comprehensive Mental Health Action Plan 2013–2030 objectives and targets

Comprehensive Mental Health Action Plan objectives	Comprehensive Mental Health Action Plan targets	Comprehensive Mental Health Action Plan indicators
Objective 1 To strengthen effective leadership and governance for mental health	**Target 1.1** 80% of countries will have developed or updated their policies/plans for mental health in line with international and regional human rights instruments by 2030.	**1.1** Existence of a national policy/plan for mental health that is being implemented and is in line with international and regional human rights instruments.
	Target 1.2 80% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments by 2030.	**1.2** Existence of a national law covering mental health that is being implemented and is in line with international and regional human rights instruments.
Objective 2 To provide comprehensive, integrated and responsive mental health and social care services in community-based settings	**Target 2.1** Service coverage for mental health conditions will have increased at least by half by 2030.	**2.1.1** The proportion of persons with psychosis using services over the past 12 months (%). **2.1.2** The proportion of people with depression using services over the past 12 months (%)
	Target 2.2 80% of countries will have doubled the number of community-based mental health facilities by 2030.	**2.2** Number of community-based mental health facilities.
	Target 2.3 80% of countries will have integrated mental health into primary health care by 2030.	**2.3** Existence of a system for integration of mental health into primary health care.
Objective 3 To implement strategies for promotion and prevention in mental health-based settings	**Target 3.1** 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes by 2030.	**3.1** Functioning multisectoral programmes for mental health promotion and prevention in existence.
	Target 3.2 The rate of suicide will be reduced by one third by 2030.	**3.2** Number of suicide deaths per year.
	Target 3.3 80% of countries will have a system in place for mental health and psychosocial preparedness for emergencies and/or disasters by 2030.	**3.3** Existence of a system for mental health and psychosocial preparedness for emergencies/disasters.
Objective 4 To strengthen information systems, evidence and research for mental health	**Target 4.1** 80% of countries will routinely be collecting and reporting data on at least a core set of mental health indicators every two years through their national health and social information systems by 2030.	**4.1** Data on the core set of identified and agreed mental health indicators are routinely collected and reported every two years.

Table 2. Core mental health indicators, by WHO Comprehensive Mental Health Action Plan 2013–2030 objectives and targets *(concluded)*

Comprehensive Mental Health Action Plan objectives	Comprehensive Mental Health Action Plan targets	Comprehensive Mental Health Action Plan indicators
	Target 4.2 The output of global research on mental health doubles by 2030.	**4.2** The number of published articles on mental health research (defined as research articles published in databases).

Methodology

The *Mental health atlas 2020* required a number of administrative and methodological steps, starting with updating the questionnaire sent to country focal points and ending with statistical analysis and presentation of the data. The steps followed were similar to those taken for previous editions and are briefly outlined here.[1]

Stage 1: Development and testing of the questionnaire

Questions included in the 2020 questionnaire were developed in line with the recently updated and extended Comprehensive Mental Health Action Plan target indicators for 2030 (see Table 2) and other complementary sets of service development indicators. They were based on consultations with Member States and WHO Regional Office and experts in the measurement of mental health care.

The review of the questionnaire in 2020 led to some questions being modified based on previous response rates for each of its sections, the quality of the reported data and feedback from Member States and the WHO Regional Office and country offices, e.g. questions on service coverage and on prevention and promotion programmes. Other questions were added based on the extension and updating of targets and indicators in the Comprehensive Mental Health Action Plan 2013–2030, e.g. indicators on the integration of mental health into primary health care and the existence of systems for mental health and psychosocial preparedness for emergencies/disasters. The questionnaire was drafted in English and translated into Chinese, French, Portuguese, Russian and Spanish.

Alongside the questionnaire, a glossary of terms (see Annex B) and a completion guide were developed and integrated into the online data collection platform. These provided general tips, explanations and recommendations to help facilitate the collection and completion of data and to ensure the standardization of definitions and descriptions of services. WHO's standard data collection platform (LimeSurvey) was used to host the questionnaire and to collect the data.

Stage 2: Dissemination and submission of the questionnaire

WHO asked ministries of health or other responsible ministries in each country to nominate a focal point to complete the mental health atlas questionnaire. The focal point was encouraged to contact other experts in the country to obtain relevant information to answer the survey questions.

Close contact with focal points was maintained during their nomination and throughout the questionnaire submission process. A WHO staff member was available to respond to inquiries, provide further advice and assist focal points to complete the atlas questionnaire. The questionnaire was available online, and countries were strongly encouraged to use this method for submission. However, an offline Microsoft Word version of the questionnaire was available whenever this was preferred.

Stage 3: Data clarification, cleaning and analysis

Once a completed questionnaire was received, it was screened for incomplete and inconsistent answers (particularly in comparison with 2014 and 2017 responses). To ensure data quality, respondents were (re)contacted and asked for clarification or correction of their responses as appropriate. The majority of countries that submitted completed questionnaires responded actively and engaged in the quality-checking process, ensuring optimal data quality. Upon receipt of the final questionnaires, data were aggregated according to WHO regions; for the Eastern Mediterranean Region, this was also done by the Region's country groups (see Annex A for a list of participating countries and contributors).

Data on age-standardized suicide rates per 100 000 population were taken from the WHO Health Observatory.[2] Estimates of service coverage for depression came from the World Mental Health Surveys.[3]

Frequency distributions and measures of central tendency (e.g. means, medians) were calculated as appropriate for country groupings. Rates per 100 000 population were calculated for a range of data points and for specific age groups, e.g. children and adolescents, using the official United Nations population estimates revision for 2019.[4] Comparisons were made with 2014 and 2017 data concerning global targets and service development indicators. Along with the final text, results of this data-gathering process are presented in tables and figures. Throughout most of this review, percentages are expressed using as the denominator the number of reporting countries, unless otherwise indicated, with N referring to denominators and n to numerators where

[1] The account of the methodology used for the global *Mental health atlas 2020* is replicated in this section, with some regional modifications and additions that were applied to the analysis, for example analysis by country group.

[2] World Health Organization. Global Health Observatory (GHO) data; 2019. http://www.who.int/gho/en/.

[3] Thornicroft G et al. Undertreatment of people with major depressive disorder in 21 countries. The British Journal of Psychiatry, 2017; 210(2):119–124. doi:10.1192/bjp bp.116.188078.

[4] United Nations Department of Economic and Social Affairs. World Population Prospects 2019. https://population.un.org/wpp/.

appropriate. In the two sections reporting on the core indicators for the Comprehensive Mental Health Action Plan targets (Sections 6 and 7), the denominator is the total number of countries in the Eastern Mediterranean Region.

Regional considerations

The data reported in this regional review are based on the same methodology and data as the global *Mental health atlas 2020*; however, in addition, the regional review includes data for occupied Palestinian territory, and some data not highlighted in the global report have been included in this report because of their regional relevance. Since occupied Palestinian territory has been included in the Eastern Mediterranean Region, other entities that completed the *Mental health atlas 2020* questionnaire but do not have the status of a WHO Member State are included in the data reported for the rest of the world. Consequently, direct comparisons between the data reported for the Eastern Mediterranean and the rest of the world in this regional review approximate to but do not exactly correspond with reporting for the Region and the sum of all other regions as reported in the global *Mental health atlas 2020*.

Since the countries of the Region vary widely in terms of their health outcomes, resources and stability, the Regional Office for the Eastern Mediterranean has developed a classification of countries into three groups, with countries in each group having broadly similar health system characteristics (see Table 3).[1] Where sufficient numbers of respondents permit, the key findings of the mental health atlas are presented by country group.

Limitations

A number of limitations should be kept in mind when examining the results. While best attempts have been made to obtain information from countries on all variables, some countries could not provide data for a number of indicators. A significant limitation to this edition of the atlas was that data were being collected from countries during the COVID-19 pandemic. This affected the speed of data collection, the number of countries submitting data for some sections and the completion rate. The pandemic is also likely to have affected in-country consultation processes with various departments within ministries.

The most common reason for data being missing is that such data simply do not exist within the country concerned. For example, some countries had problems

Table 3. Eastern Mediterranean Region country groups

Description of group	Countries
Group 1 Countries where socioeconomic development has progressed considerably over recent decades, supported by high income, generally with the highest densities of health staff per population.	▪ Bahrain ▪ Kuwait ▪ Oman ▪ Qatar ▪ Saudi Arabia ▪ United Arab Emirates
Group 2 Largely middle-income countries which have developed extensive public health service delivery infrastructure but face resource constraints, with mid-range densities of health staff per population.	▪ Egypt ▪ Islamic Republic of Iran ▪ Iraq ▪ Jordan ▪ Lebanon ▪ Libya ▪ Morocco ▪ Occupied Palestinian territory ▪ Tunisia ▪ Syrian Arab Republic
Group 3 Countries which face major constraints in improving population health outcomes as a result of lack of resources for health, political instability and other complex development challenges, with the lowest densities of health staff per population.	▪ Afghanistan ▪ Djibouti ▪ Pakistan ▪ Somalia ▪ Sudan ▪ Yemen

[1] Regional Committee for the Eastern Mediterranean, Fifty-ninth session, Provisional agenda item 3. Health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action. 2013: https://applications.emro.who.int/docs/RC_technical_papers_2012_Tech_Disc_1_14613_EN.pdf?ua=1&ua=1

providing precise data about service utilization and the mental health workforce in voluntary/nongovernmental organization (NGO) and private (for-profit) mental health facilities. Also, some countries had difficulties reporting information in the manner explicitly requested in the atlas questionnaire. For instance, some countries faced issues in providing information about their mental health budgets in the format requested because mental health care is integrated within the primary care system or is broken down using different categories of expenditure or disease. In some situations, the data required to complete a question might have been available at the district or regional level but not aggregated centrally at the national level. For example, in some countries health budgets are devolved down to the subnational level, which can significantly complicate the estimation of consolidated expenditure at a federal level. The tables and figures in this report show the number of countries that were able to respond to an item in the questionnaire, or an equivalent percentage of a total of responding countries or of all the countries of the Region. Expenditure figures in the mental health finances section may be slightly different from WHO health accounts figures. This may be due to the mixing of budget data with expenditure data, differences in country sampling or different data sources e.g. reliance on a single respondent.

A critical limitation of the mental health atlas is that most of the information provided relates to each country as a whole, thereby overlooking potentially substantial variability within countries concerning, for example, the extent of policy implementation, the availability of services or the existence of promotion or prevention programmes in rural versus urban areas or in remote versus central parts of the country. Similarly, few of the reported data provide breakdowns by age, sex or disease category, despite the importance attached to equality of access and universal health coverage in the articulation of the Comprehensive Mental Health Action Plan. This makes it challenging to assess resources and services for specific populations within a country, such as children, adolescents or elderly people.

While best attempts have been made to highlight progress made during the timeframe of the Comprehensive Mental Health Action Plan, some information should be compared with caution over time, because of changes in the structure of questions' variables based on response rates in previous editions and feedback from WHO Regional Office and country offices in Member States, e.g. questions on the main types of promotion and prevention programme. Moreover, the list of countries completing different data points for each of the questions was sometimes different. This imposes some constraints for data comparisons over time between the three editions of the Atlas – 2014, 2017 and 2020.

The mental health atlas aims to provide a comprehensive overview of mental health policies, laws, services and resources. Therefore, it usually includes all countries responding to the questions at different time points. Utilizing its datasets at successive time points can provide important information and insights into emerging trends. However, reporting changes in global or regional values based on differing country datasets has methodological limitations. Accordingly, such data comparisons over time are heavily constrained by the requirement of having the same countries reporting available data at all relevant time points. Although this method was used internally for some variables to understand trends across the different editions of the atlas (e.g. mental health expenditures), the information presented for this edition included all responding countries. Other sections underwent a validity check process whenever reported median values differed significantly from the median values obtained for the same variables reported in similar sections of the 2014 and 2017 editions of the atlas.

Finally, it is important to acknowledge the limitations associated with self-reported data, particularly relating to qualitative assessments or judgements (which were often made by a single focal point); for example, respondents were asked to self-report on the functionality of prevention and promotion programmes as well as on formal collaboration with stakeholders. They were also asked to provide an informed response concerning the implementation status of mental health policies and laws and the extent to which these conformed with international (or regional) human rights instruments. However, we know that policies, plans and laws do not all fully align with international human rights standards. Apart from the fact that they allow involuntary admission and treatment for those with mental health conditions, and seclusion and restraint, most policies, plans or laws do not promote supported decision-making, advance planning or alternatives to coercive practices. For some of these items, it is possible to compare self-reported responses with publicly available information for a country (such as published mental health policies or budgets), but in other cases opportunities for external validation are more limited.

1. Information systems and research for mental health

Member States and the WHO Secretariat have expended considerable effort to complete the mental health atlas questionnaire to measure progress towards the achievement of objectives and targets of the Comprehensive Mental Health Action Plan 2013–2020.

In total, 21 of the 22 countries and territories in the Eastern Mediterranean Region (95%) were able to at least partially complete the atlas 2020 questionnaire. This was fewer than the 100% of countries in the Region that reported for the 2014 edition of the Atlas, but more than the 91% that reported in 2017. The completion rate in countries of the Region was at least as high as the 88% of all WHO Member States that reported for the global *Mental health atlas 2020*. Djibouti, which is a Group 3 country, was unable to submit a completed questionnaire.

1.1 Self-reported ability to compile mental health data

In the past two years, the health department or another responsible government unit in five countries in the Region (24% of the total reporting) has published a report focusing specifically on mental health activities in the public sector. A further 13 countries (62%) have reported mental health data (either in the public system, private system or both) for general health statistics, making a total of 18 countries in the Region (86%) that have published mental health statistics in the past two years. The remaining three countries (14%) have not compiled mental health data in a report for policy, planning or management purposes. No country in the Region has published a report specifically on mental health activities in both the private and public sectors in the last two years.

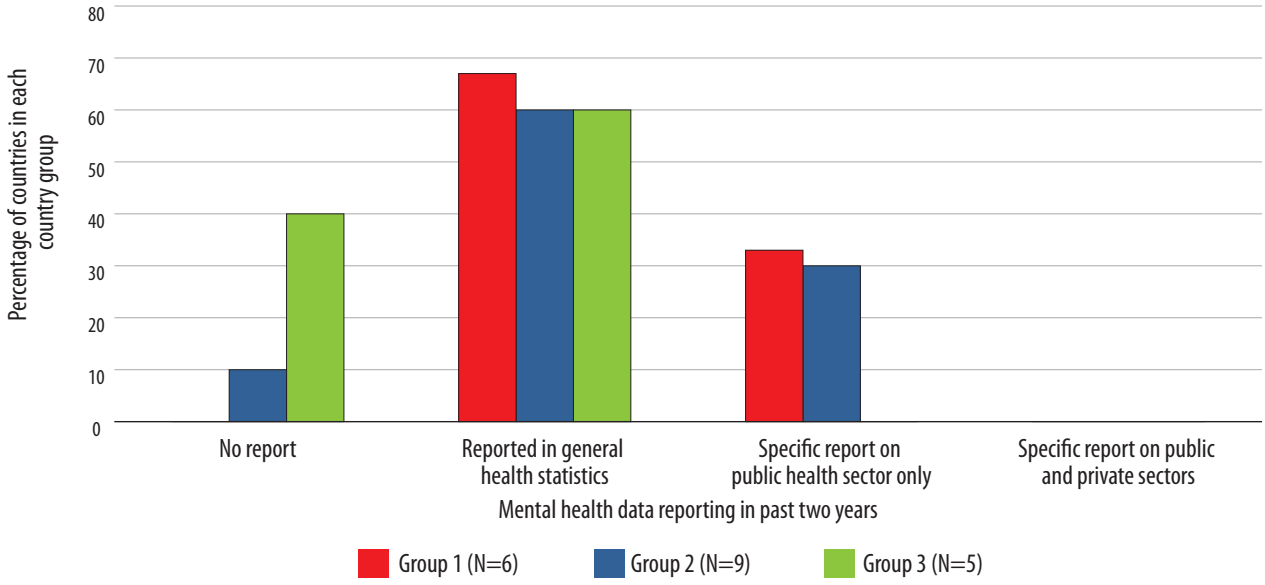
Mental health data have been compiled and reported in the last two years by all Group 1 countries, 90% of Group 2 countries and 60% of Group 3 countries. The majority of these data were reported in general health statistics, and a third were reported in specific mental health reports (see Fig. 1.1). Two Group 3 countries (40%) have not compiled mental health data in a report in the past two years.

Sixteen countries in the Region (76% of those reporting) have compiled and/or reported mental health data that are disaggregated by age. Mental health data disaggregated by age and gender are reported in all six Group 1 countries (100%), six Group 2 countries (60%) and four Group 3 countries (80%).

Seventeen countries (81%) have compiled and/or reported mental health data that are disaggregated by gender. Mental health data disaggregated by age and gender are reported in all six Group 1 countries (100%), seven Group 2 countries (70%) and four Group 3 countries (80%).

Similar proportions of countries in the Region and countries in the rest of the world (about 85%) have

Fig. 1.1. Status of mental health data reporting in past two years, by country group



compiled and reported mental health data in either general health or specific mental health reports in the past two years (see Fig. 1.2). However, more countries in the rest of the world produced specific mental health reports (39% compared with 24% in the Region), while among countries of the Region a greater proportion of reports were in general health statistics. In the rest of the world, 14% of countries published reports on mental health activities in both the public and private sectors, but no country in the Region published reports on the private mental health sector. A higher proportion of countries in the Region reported mental health data disaggregated by age (76% compared with 66%) and by gender (81% compared with 64%) than countries in the rest of the world.

1.2 Reporting on mental health core indicators for the *Mental health atlas 2020*

Reporting within the mental health atlas can also be assessed using a composite indicator defined by the provision of responses to five core indicators: mental health policy (yes/no), mental health law (yes/no), workforce (any data on at least one type), service availability (any data on at least one setting) and promotion and prevention (yes/no in at least one category). A more demanding assessment can be made by adding a sixth key indicator: service utilization (reporting utilization in at least one inpatient or outpatient service).

Twenty countries in the Region (95%) reported on all five core indicators, compared with 85% of countries in the rest of the world (see Fig. 1.3). The percentage of countries reporting on the five core indicators plus one key indicator was lower, at 67%, which is similar to the percentage of 65% in the rest of the world. All of the 21 countries that completed the 2020 questionnaire, or 95% of all countries in the Region, reported on the availability of policies/plans, laws and services (see Fig. 1.4). Twenty of the 21 reporting countries, or 91% of all countries in the Region, reported on workforce and prevention and promotion programmes, while 14 countries, or 64% of all countries in the Region, reported on service utilization. This level of reporting is at least as complete as reporting in the rest of the world and is also consistent with the self-reported data on mental health information submitted for the mental health atlas questionnaire.

1.3 Output of regional research on mental health

The output of research on mental health is a new indicator for the *Mental health atlas 2020*, and measures the output of mental health research as defined by the number of published research studies in biomedical and

Fig. 1.2. Mental health reporting in the Eastern Mediterranean Region and the rest of the world

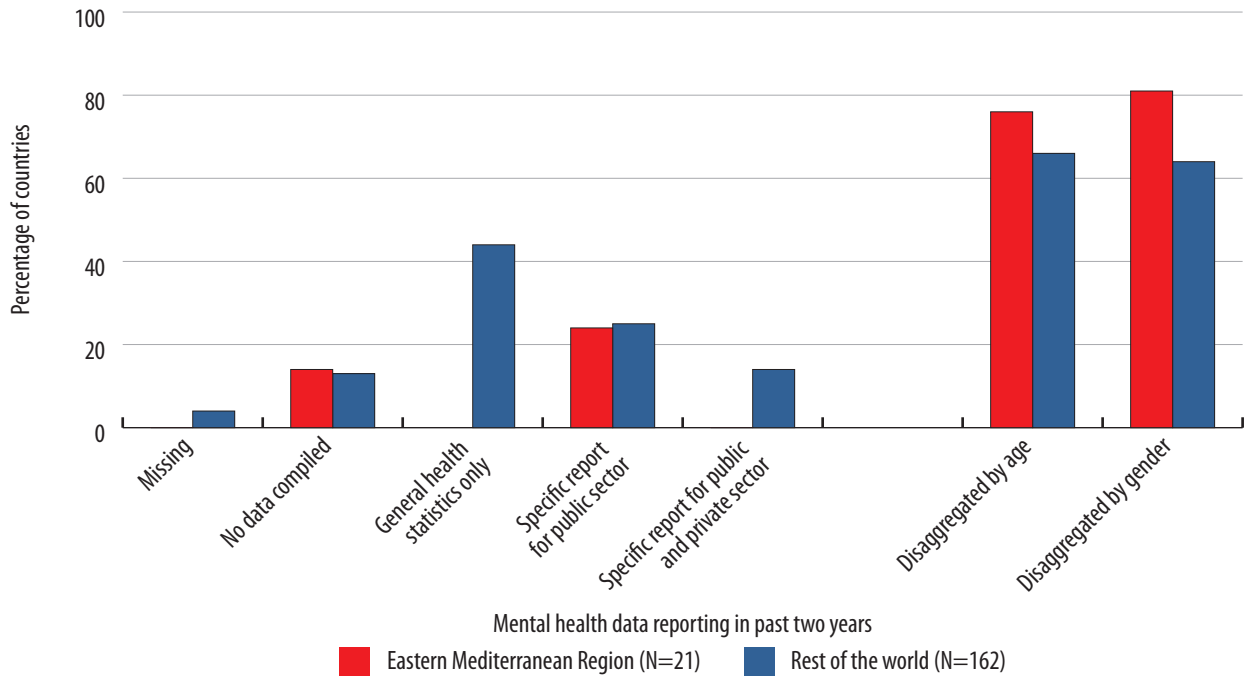
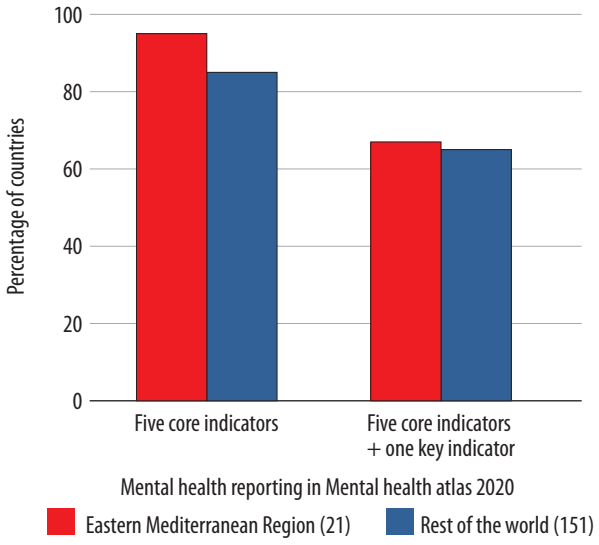


Fig. 1.3. Reporting to the Mental health atlas 2020, for the Eastern Mediterranean Region and the rest of the world



life science research databases.[1] The annual published research output in peer-reviewed and indexed journals is used as a proxy for the amount and quality of mental health research that is being conducted in, or is related to, a given country. It indirectly assesses a country's commitment to mental health research, ultimately having impacts on outcomes for people with mental health conditions.

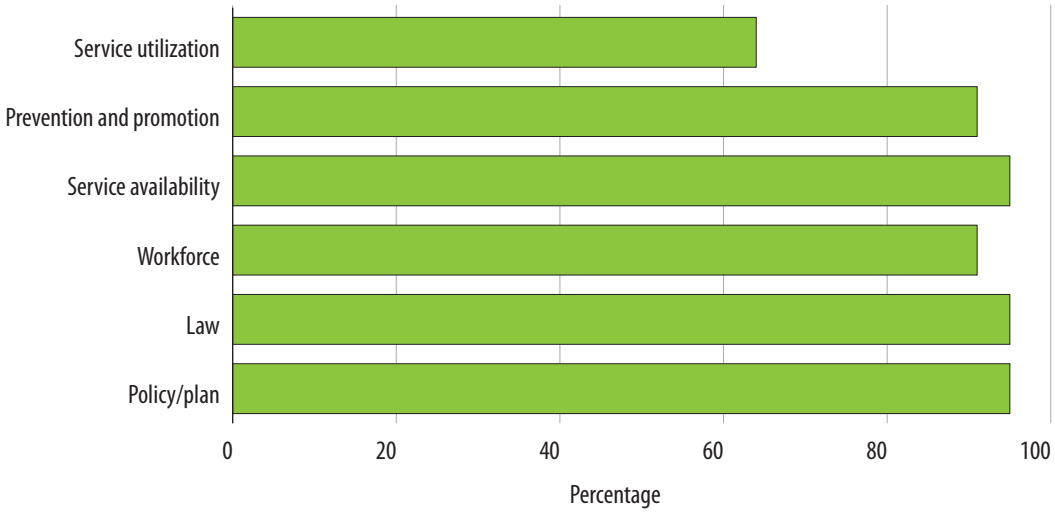
In line with the global target for Objective 4 of the Comprehensive Mental Health Action Plan, the following search strategy in PubMed was developed for obtaining bibliometric data on global mental health research output: "(mental health [MeSH Terms] OR mental disorders [MeSH Terms]) AND "country name/global"[MeSH Terms] AND ("year/month/day"[PDAT]:"year/month/day"[PDAT])".

The goal of the search strategy was to create a methodology for replicable, consistent searches of peer-reviewed publications in mental health research. To produce a comparable indicator, mental health output was standardized against overall general health research output at the global and country levels. This search methodology is intended to be repeated periodically to measure differences in research output over time. It will be used to determine whether countries are collectively approaching the Action Plan's global target 4.2 of doubling the amount of mental health research done by 2030.

A total of 599 research papers on mental health were published from the Eastern Mediterranean Region in 2019, corresponding to 5.6% of the general health research output for the Region. This represented an increase in mental health research of 29% since 2013, when 464 articles on mental health were published in the Region (see Fig. 1.5). Although the absolute values for mental health research outputs in 2019 increased compared with 2013, the relative indicator of the percentage of mental health research in the total health research output fell from 6.3% to 5.6% between 2013 and 2019 (see Fig. 1.6).

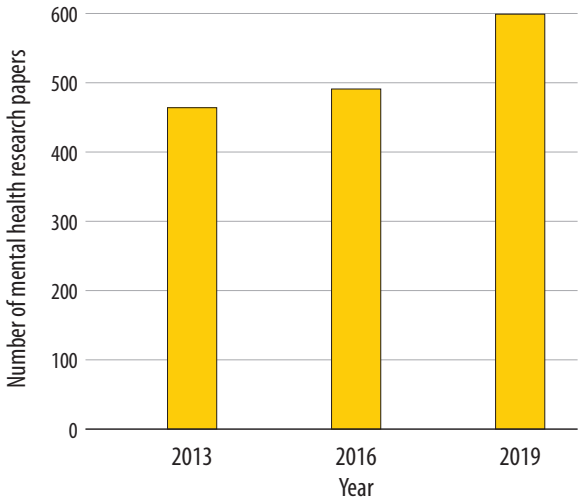
Most mental health research output was generated in Group 2 countries (see Table 1.1). The median mental health research output in Group 2 countries of 29 publications was higher than that of Group 1 countries (median research output = 6.5 papers) and of Group 3 countries (median research output = 5.5 papers) (see Fig. 1.7). The percentages of mental health research in the

Fig. 1.4. Percentage of 22 countries in the Region reporting on specific core mental health indicators



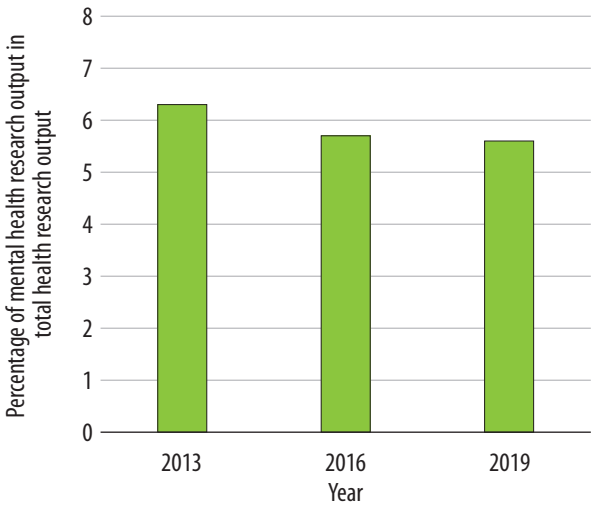
[1] The description of the methodology used to ascertain research output is replicated from the global Mental health atlas 2020.

Fig. 1.5. Number of mental health research paper on mental health published in 21 countries of the Region[1] – a comparison across years



[1] The 21 countries of the Region include Djibouti but do not include occupied Palestinian territory.

Fig. 1.6. Percentage of mental health research output in total health research output in 21 countries of the Region[1] – a comparison across years



[1] The 21 countries of the Region include Djibouti but do not include occupied Palestinian territory.

total research output by country group were between 5% and 7%. This relative consistency between countries in the Region with different levels of resources contrasts with the global trend for the percentage of mental health research to increase with countries' income levels (from 3% in low-income countries to 8% in high-income countries). Two countries doubled their mental health research output between 2013 and 2019: Bahrain (whose output increased from three to six publications) and the Syrian Arab Republic (up from three to 40 publications).

Table 1.1. Mental health research output in 2019 for the Eastern Mediterranean Region, country groups and the rest of the world

Region/country group	Mental health research output		Total health research output		Mental health percentage of total research output
	Median	Total	Median	Total	
Eastern Mediterranean	13	599	166	9584	5.6%
Rest of the world	6	17 172	135	197 882	4.6%
Group 1	6.5	75	152	1714	5%
Group 2	29	429	361	5926	7%
Group 3	5.5	95	130	1944	6%

2. Mental health system governance

The Comprehensive Mental Health Action Plan defines effective governance and strong leadership as crucial factors for developing effective policies and plans addressing mental health.[1] A mental health policy is an official statement by a government that defines a vision with a set of values, principles and objectives and an overall plan of action to achieve that vision and improve the mental health of a population. The policy should have a detailed plan with concrete strategies and activities that will be implemented with established timelines and the resources needed. Policies and plans for mental health may be stand-alone or may be integrated into other general health or disability policies or plans. They are considered valid if they have been approved or published by the ministry of health, other line ministries or the country's parliament.

As with previous editions, the *Mental health atlas 2020* questionnaire assessed whether countries had stand-alone and/or integrated mental health policies/plans and whether these policies/plans had been updated. In order to evaluate the compliance of policies/plans with international human rights instruments, countries completed the following checklist: 1) a transition towards mental health services based in the community (including mental health care integrated into general hospitals and primary care); 2) respect of the rights of people with mental health conditions and psychosocial disabilities as well as at-risk populations; 3) full range of services and supports to enable people to live independently and be included in the community (including rehabilitation services, social services, educational, vocational and employment opportunities, housing services and supports); 4) a recovery approach to mental health care which emphasizes support for individuals to achieve their aspirations and goals, with mental health service users driving the development of their own treatment and recovery plans; and 5) participation of persons with mental health conditions and psychosocial disabilities in decision-making processes about issues affecting them (e.g. policies, laws, service reform, service delivery). Additionally, the 2020 questionnaire inquired about the implementation of policies and plans in WHO Member States. Mental health policies/plans were considered to be in the process of implementation only if at least two of the following three criteria were fulfilled: 1) human resources are estimated and allocated for the implementation of mental health policies/plans; 2) financial resources are estimated and allocated for the implementation of mental health policies/plans; 3) indicators/targets are available and used for evaluation/monitoring of implementation of some or all components of current mental health policies.

Finally, for the first time, the *Mental health atlas 2020* evaluated the available human and financial resources allocated for the implementation and monitoring of policies/plans through a self-rated checklist.

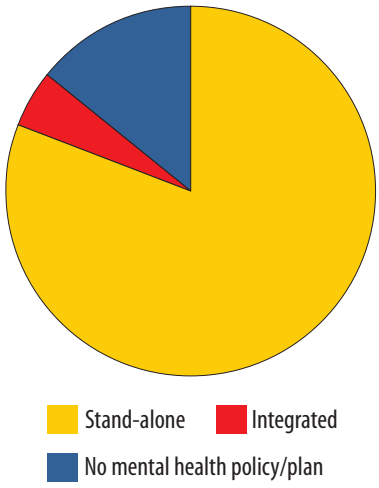
If both a mental health policy and plan were available, countries were asked to assess both documents as one entity and report the latest publication or revision year. Countries with a federated system were asked to refer to policies/plans or laws covering most states and provinces or most of the population in the country.

2.1 Mental health policies/plans

Eighteen countries (86%) in the Eastern Mediterranean Region have mental health policies/plans, compared with 96% of countries in the rest of the world. Seventeen countries in the Region have stand-alone policies or plans and one country has mental health policies or plans that are integrated into those for general health or disability (see Fig. 2.1). Seventeen countries have published their mental health policies and/or plans in or since 2013, and 12 of these were published in 2017 or later.

The percentages of countries with policies/plans by country group are 83% for Group 1 countries, 90% for Group 2 countries and 80% for Group 3 countries.

Fig. 2.1. Mental health policies/plans in countries of the Eastern Mediterranean Region (percentage of 21 responding countries)



[1] The description of methodology and criteria applied in this section on governance has been replicated from the global report of the *Mental health atlas 2020*.

2.1.1 Human resources to implement mental health policies/plans

Estimates of the human resources needed for implementation are included in the policies/plans of 15 countries in the Region (71%). Human resources have been allocated in line with indicated resource needs in 11 countries (52%). Human resources have been estimated and allocated in line with identified needs in 83% of Group 1 countries, but have been allocated in only 40% of Group 2 and Group 3 countries (see Fig. 2.2).

2.1.2 Financial resources to implement mental health policies/plans

Estimates of the financial resources needed for implementation are included in the policies/plans of 12 countries in the Region (57% of those reporting). Financial resources have been allocated in line with indicated resource needs in nine countries (43%). Financial resources have been allocated in line with identified needs in 83% of Group 1 countries, but in only 30% of Group 2 countries and in 20% of Group 3 countries (see Fig. 2.3).

2.1.3 Indicators and targets to monitor implementation of mental health policies/plans

Specified indicators or targets against which the implementation of policies/plans can be monitored are available for the policies/plans of 18 countries in the Region (86%). The indicators or targets have been used for monitoring or evaluating most or all components of current policies/plans in seven countries (33%), and for some or a few components in eight countries (38%). Indicators are available but are not used in three countries (14%).

Indicators have been used to monitor components of policies/plans in five Group 1 countries (83%), eight Group 2 countries (80%) and two Group 3 countries (40%) (for a further breakdown, see Fig. 2.4). Most Group 1 countries use indicators to monitor most or all components, while fewer than half of Group 2 and Group 3 countries use indicators to monitor their policies/plans so extensively.

2.1.4 Compliance of mental health policies/plans with international human rights standards

The 2020 questionnaire asked about the compliance of mental health plans and policies with international human rights instruments. Reporting countries self-rated five items on a checklist that was constructed for this purpose. The five items were that the policy/plan: 1) promotes the participation of persons with mental health conditions in decision-making processes; 2) promotes a recovery approach to mental health care; 3) promotes a full range of services and supports to enable people to live independently and be included in the community; 4) pays explicit attention to respect for the human rights of people with mental health conditions; and 5) promotes a transition towards community-based mental health services.

Eleven countries in the Region (52% of those reporting) have mental health policies or plans that are compliant

Fig. 2.2. Human resource estimates and allocation to enable implementation of mental health policies/plans, by country group (percentage of responding countries)

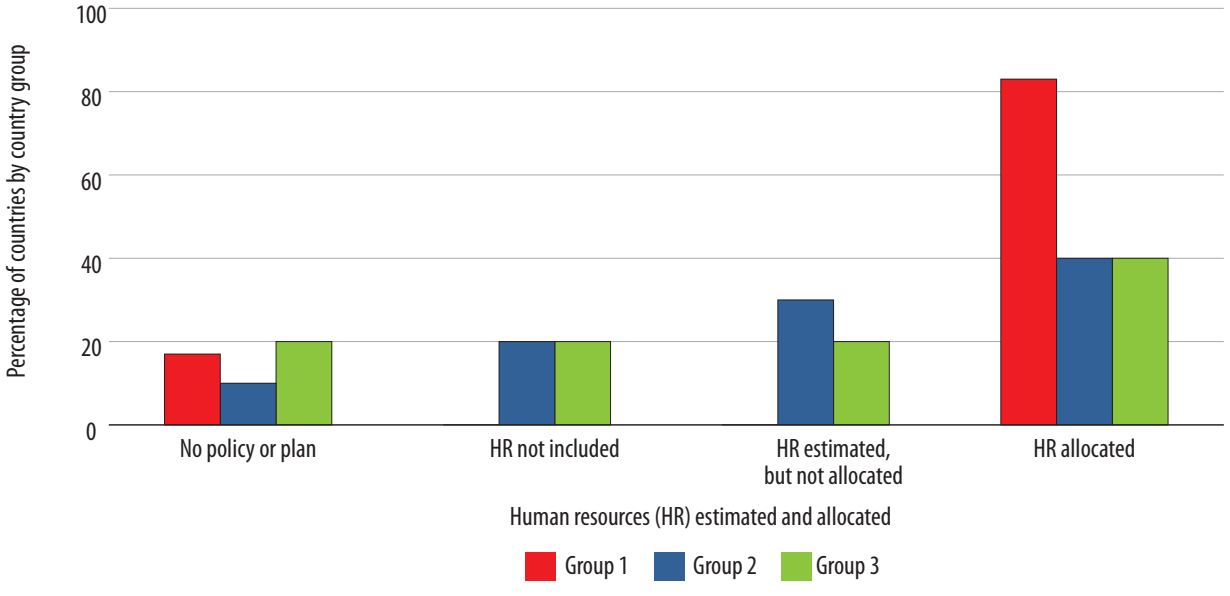


Fig. 2.3. Financial resource estimates and allocation to enable implementation of mental health policies/plans, by country group (percentage of responding countries)

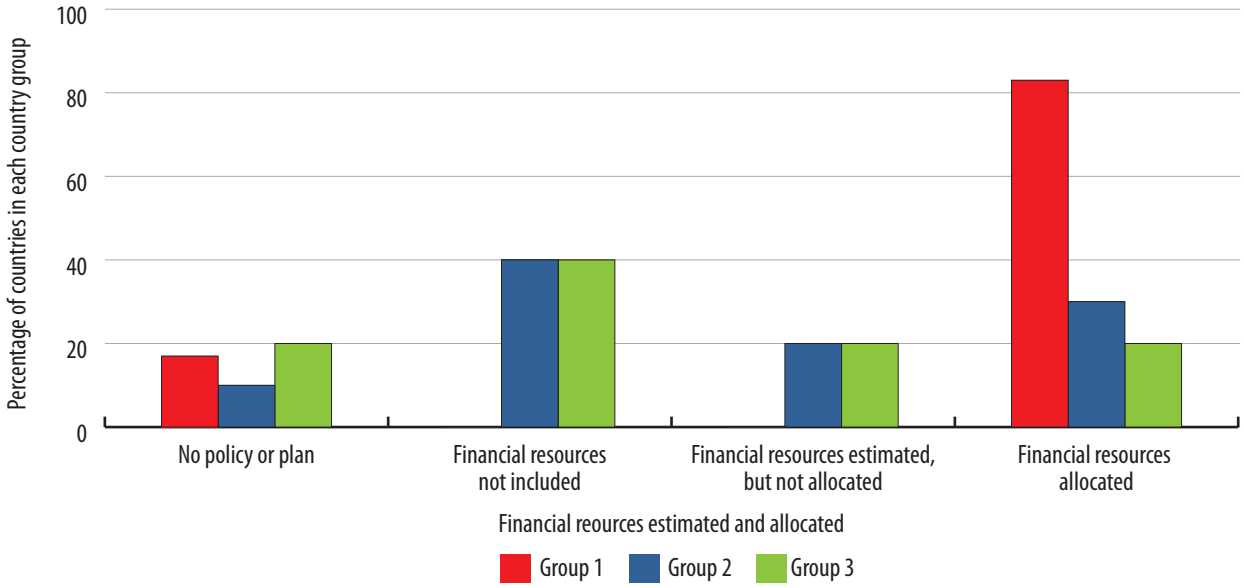
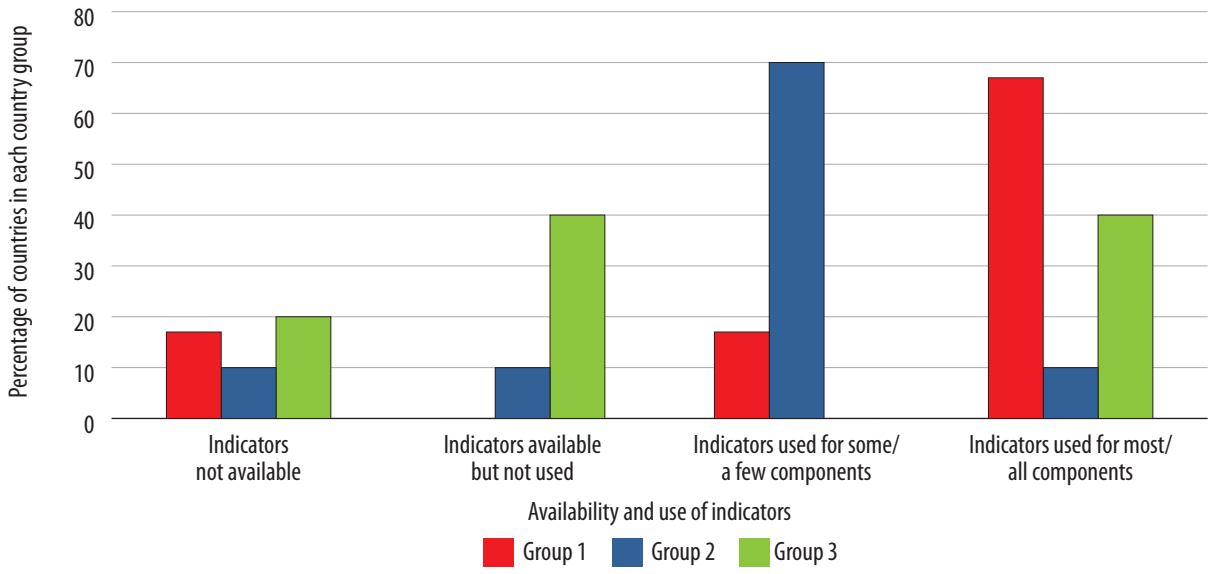


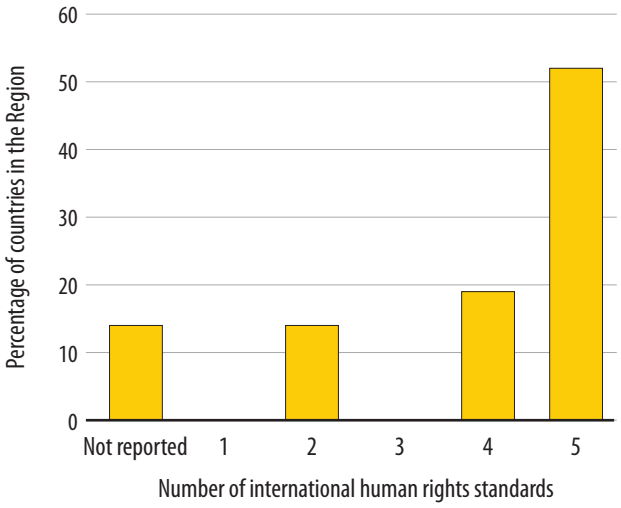
Fig. 2.4. Specified indicators or targets against which implementation of mental health policies/plans can be monitored, by country group (percentage of responding countries)



with all five international human rights standards (see Fig. 2.5). At least half of countries in each country group are compliant with all five standards: three in Group 1 (50%), five in Group 2 (50%) and three in Group 3 (60%) (see Fig. 2.6).

Seventeen countries in the Region (81% of those responding) have mental health policies/plans that promote a transition to community-based mental health services and explicitly respect the human rights of people with mental health conditions (see Fig. 2.7). Fourteen countries (67%) have policies/plans that promote services that support people with mental health conditions to live independently in the community and that promote a recovery approach. Twelve countries (57%) have policies/plans that promote the participation of people with mental health conditions in processes of making decisions on issues that affect them. The percentages of countries meeting each standard in Group 1 and Group 2 are similar for all five standards, whereas fewer Group 3 countries have policies/plans that promote a transition to community-based services or that pay explicit attention to respecting the human rights of people with mental health conditions.

Fig. 2.5. Percentage of countries in the Region compliant with standards of international human rights instruments (checklist = five standards)



2.1.5 Core Comprehensive Mental Health Action Plan Indicators for mental health policies/plans

The Comprehensive Mental Health Action Plan 2013 –2020 set a target for 80% of countries to have developed or updated their policies/plans in line with international human rights standards by 2020.

The indicator used to monitor progress towards this target is the existence of a stand-alone or integrated national policy/plan for mental health that is in line with all five international human rights standards. Eleven countries in the Region, or 52% of the total, have policies or plans in line with international human rights standards, compared with 60% of countries in the rest of the world. The 2020 indicator (existence of a compliant policy/plan) was met by three Group 1 countries (50%), five Group 2 countries (50%) and three Group 3 countries (60%) (see Fig. 2.8).

Progress towards meeting the 2020 target for mental health policies in line with international human rights standards has been monitored by the atlases for 2014, 2017 and 2020 (see Fig. 2.9). Over this period the percentage of countries in the Region with compliant policies/plans has risen progressively from 32% to 52%, though the figure has consistently lagged behind that of the rest of the world.

A revised version of this indicator has been developed for the extended 2030 Action Plan targets. This requires the existence of a stand-alone or integrated mental health policy or plan that is both implemented and compliant with international human rights standards. The revised indicator is more stringent than its predecessor because it has the additional requirement that the mental health policy/plan is being implemented. "Implementation" requires that two of the following three criteria are met: 1) human resources are estimated and allocated; 2) financial resources are estimated and allocated; and 3) indicators/targets are available and used to monitor some/all of the plan.

Six countries in the Region (29%) have mental health policies/plans that are both implemented and compliant with human rights standards. This compares favourably

Fig. 2.6. Number of international human rights standards with which countries are compliant, by country group (percentage of responding countries)

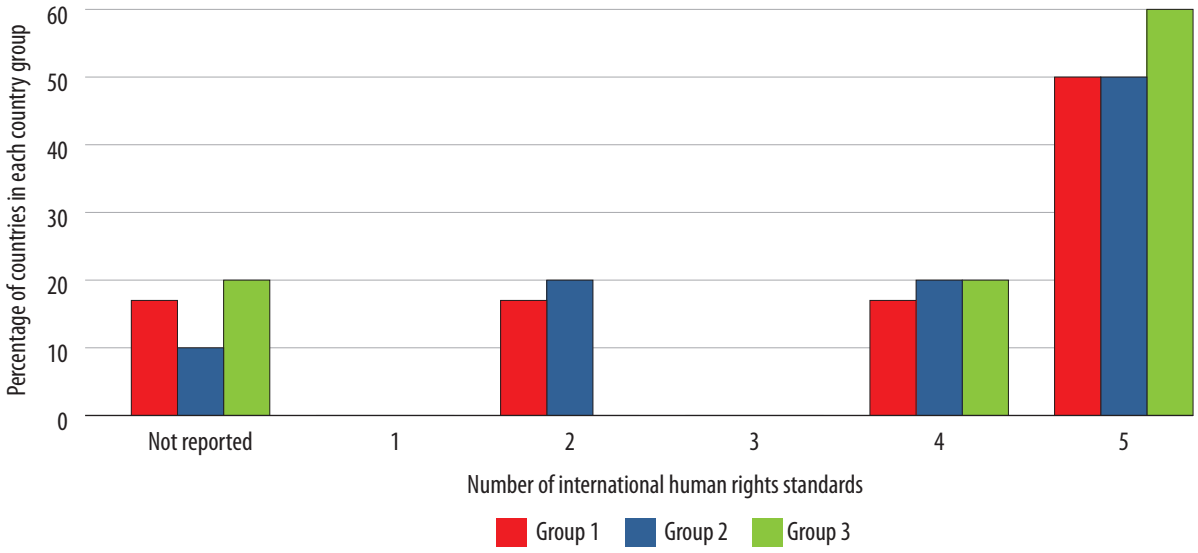


Fig. 2.7. Compliance of mental health policies/plans with international human rights standards in the Eastern Mediterranean Region and by country group (percentage of responding countries)

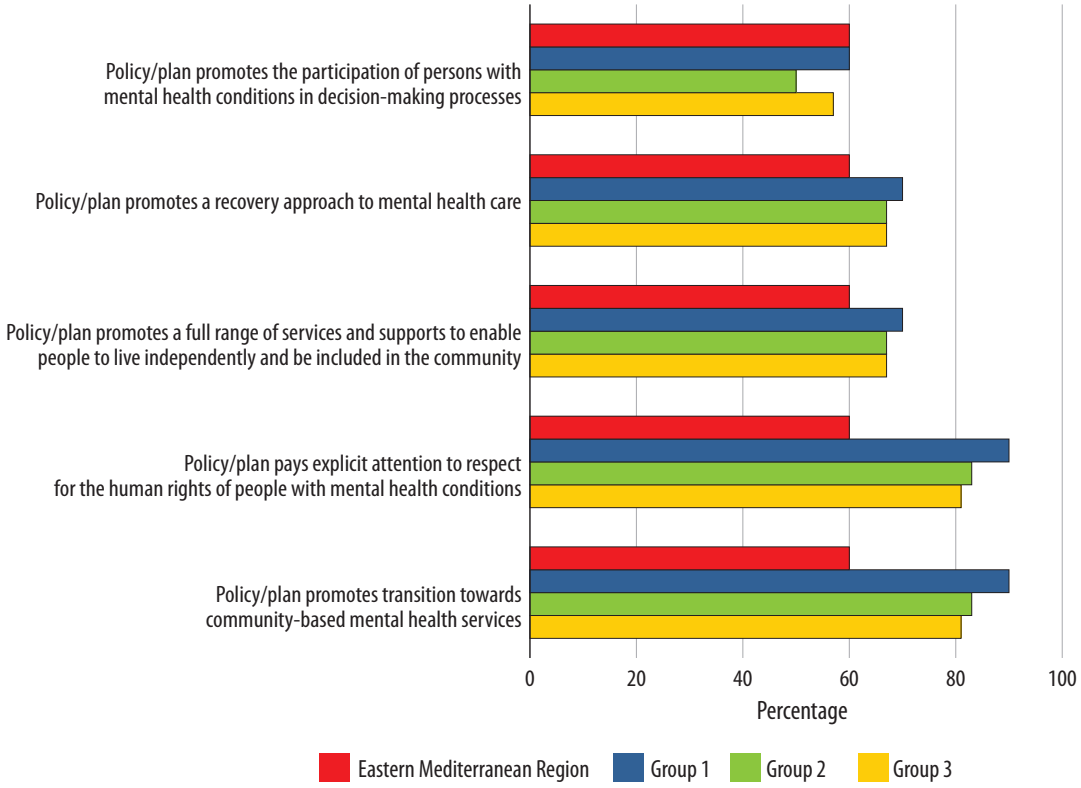


Fig. 2.8. Percentage of countries in each country group meeting the target for mental health policies/plans, according to the criteria set for 2020 and 2030

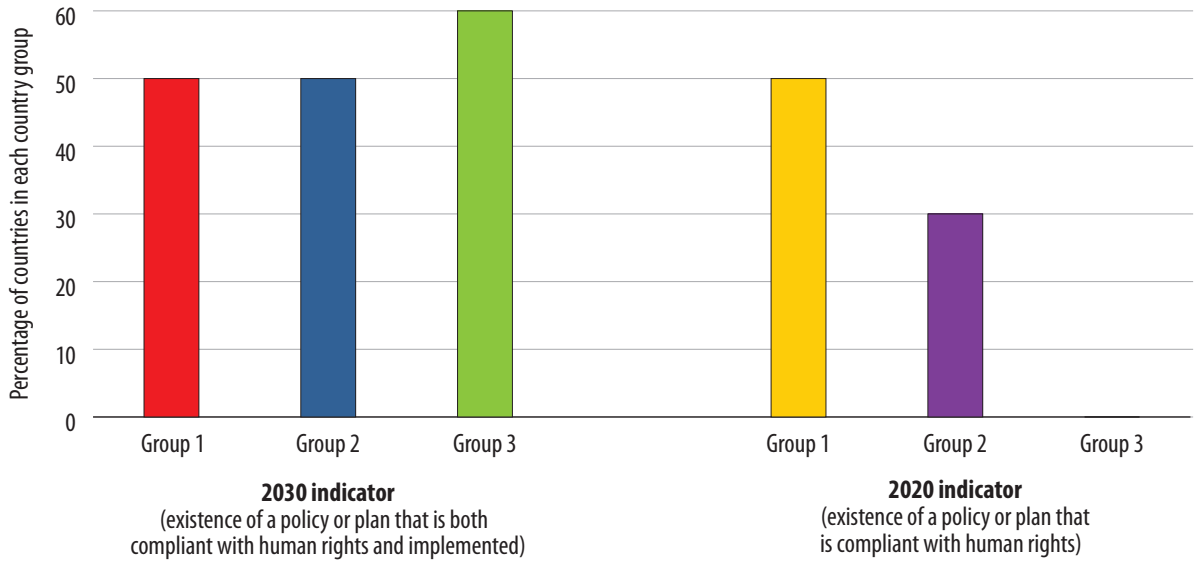
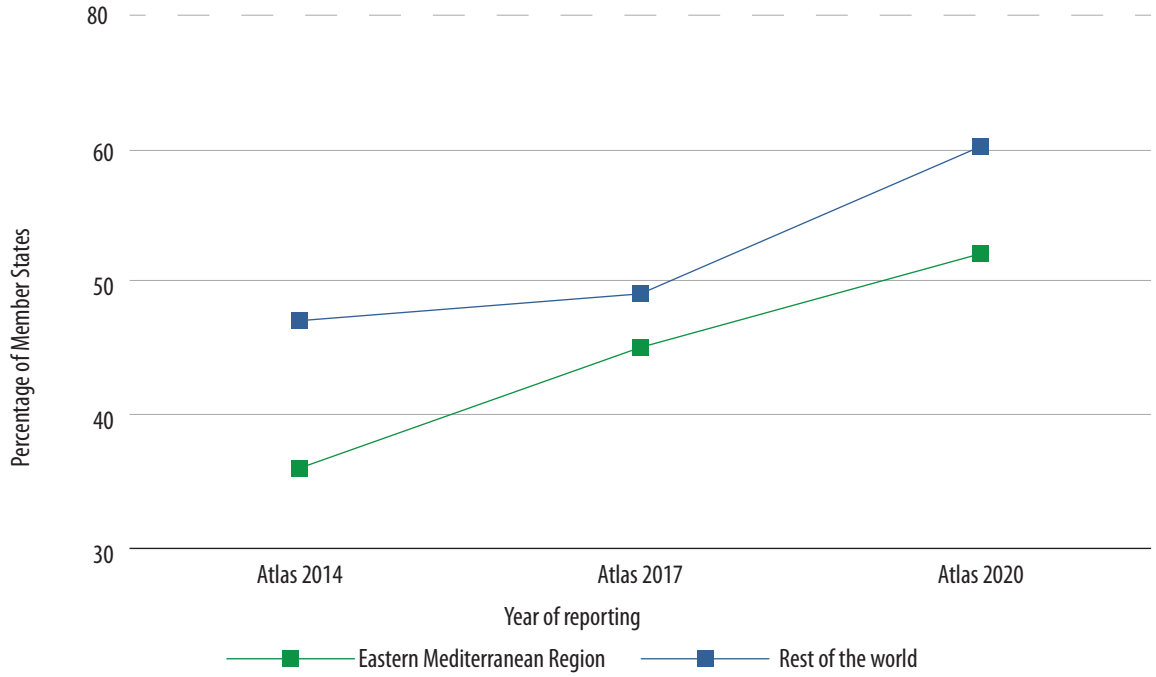


Fig. 2.9. Progress towards meeting the Comprehensive Mental Health Action Plan 2020 target for compliant mental health policies/plans in the Eastern Mediterranean Region and the rest of the world



with the rest of the world, where 24% of countries have implemented compliant policies or plans.

The addition of the implementation criterion reveals a gradation by country group that was not apparent with the simpler 2020 indicator that required only human rights compliance (see Fig. 2.8). The revised indicator (policies/plans that are both compliant and implemented) is met by 50% of Group 1 countries but by only 30% of Group 2 countries and by no countries in Group 3.

2.2 Mental health legislation

Mental health legislation is a crucial component of good governance and concerns the specific legal provisions related to mental health.[1] These provisions should be aligned with the fundamental principles, values and objectives of policies for mental health by promoting the civil and human rights of people with mental health conditions and psychosocial disabilities and establishing oversight mechanisms for monitoring alignment with international human rights standards and limiting coercive treatments. Legislation for mental health should comply with obligations under the Convention on the Rights of Persons with Disabilities and other global and regional human rights instruments.

As with previous editions of the atlas, the 2020 questionnaire assessed whether countries had a stand-alone and/or integrated mental health law and if that law had been updated. As they had done for mental health policies/plans, countries completed a checklist designed to evaluate the compliance of their legislation with international human rights instruments: 1) transition towards community-based mental health services (including mental health being integrated into general hospitals and primary care); 2) promotion of the rights of people with mental health conditions and psychosocial disabilities to exercise their legal capacity; 3) promotion of alternatives to coercive practice; 4) provision for procedures to enable people with mental health conditions and psychosocial disabilities to protect their rights and file appeals and complaints to an independent legal body; and 5) provision for regular inspections of human rights conditions in mental health facilities by an independent body.

Additionally, the updated indicators and targets for the Comprehensive Mental Health Action Plan emphasize the importance of implementing legislation. Since it is difficult to estimate the implementation status of mental health law through a self-reported questionnaire, WHO developed a simple checklist as a proxy indicator in order to understand the status of implementation of mental health legislation in Member States. Mental health legislation was considered to be in the process of implementation only if at least two of the following three criteria were met: 1) a dedicated authority or independent body exists; 2) it undertakes regular inspections of mental health services; and 3) it systematically responds to complaints and reports its findings at least once a year.

Seventeen countries in the Region (81% of the total) have mental health laws in place (see Fig. 2.10). Fifteen countries (71%) have stand-alone mental health legislation. Seven countries (33%) have mental health legislation integrated into other laws; five (24%) of these have a combination of stand-alone and integrated mental health legislation and two (10%) have all their mental health legislation integrated into other laws. The percentage of 81% of countries in the Region with mental health legislation is lower than that in the rest of the world (93%), but the Region has a slightly higher percentage of stand-alone mental health legislation (71% compared with 65% in the rest of the world).

The proportion of countries with mental health legislation is higher in Group 1 and 2 countries than in Group 3 countries (Group 1 = 83%, Group 2 = 90%, Group 3 = 60%).

2.2.1 Year of publication of mental health legislation

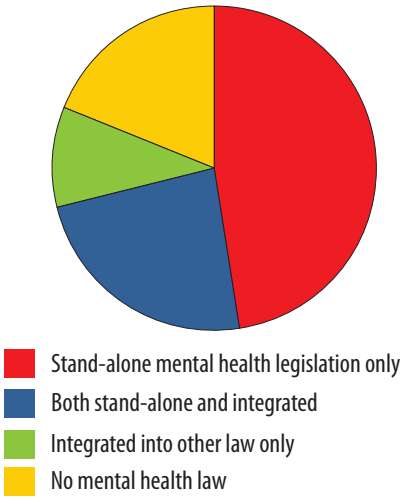
Sixteen countries in the Region reported on the year of publication of their mental health legislation. Six countries (29%) have published legislation since 2017 (see Fig. 2.11). A further three (14%) published legislation between 2013 and 2016.

All five reporting countries in Group 1 have published mental health legislation since 2013, whereas most in Group 2 (six countries) published their legislation before 2013, and three before 2000 (in 1949, 1959 and 1983).

2.2.2 Dedicated authority or independent body to inspect mental health services

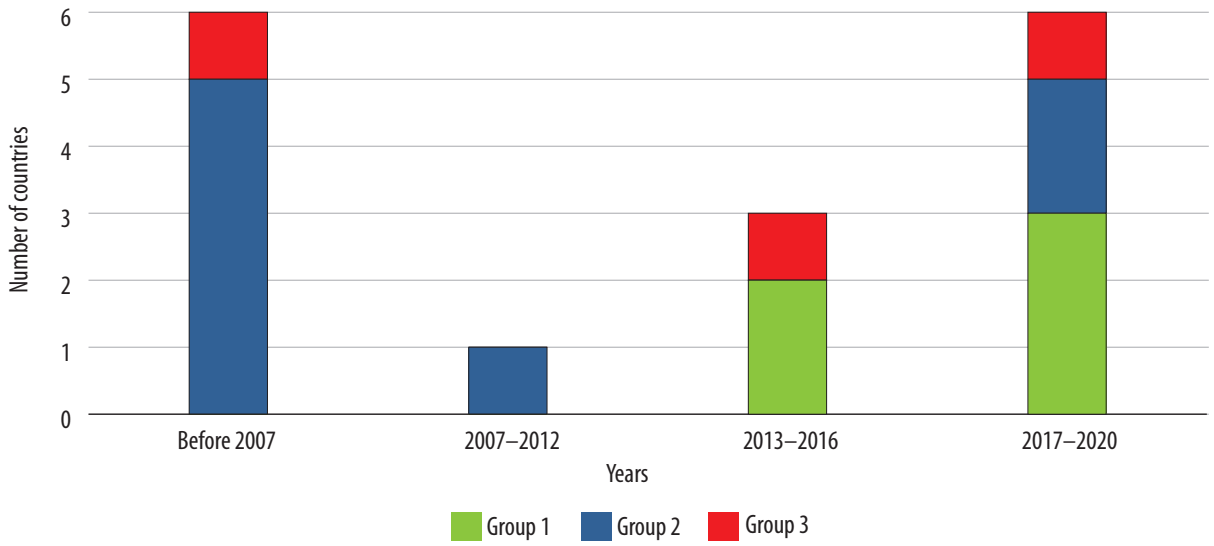
Countries were asked about the existence and activities of a dedicated authority or independent body that undertakes regular inspections of mental health facilities, systematically responds to complaints, and reports its findings. Over half of countries in the Region

Fig. 2.10. Stand-alone and integrated mental health laws in the Eastern Mediterranean Region (percentage of responding countries)



[1] This and the following two paragraphs are replicated from the global report of the *Mental health atlas 2020*.

Fig. 2.11. Date of publication of mental health legislation, by year band for country groups



have functioning dedicated authorities or independent bodies, and in nine countries (43%) these bodies are undertaking some inspections and responding to complaints (see Table 2.1). In five countries (24%) they are functioning well, with regular inspections and systematic response to complaints, and annual reports. The proportion of countries that have dedicated inspection authorities is similar to that of the rest of the world (62% compared with 63%), but more of those in the rest of the world function well and fewer function poorly compared with the Eastern Mediterranean Region.

Seven Group 2 countries (70%) and two Group 1 countries (33%) have dedicated authorities or independent bodies making inspections (see Fig. 2.12). Such bodies exist in two Group 3 countries (40%), but neither is functioning well.

2.2.3 Compliance with human rights instruments

The *Mental health atlas 2020* questionnaire asked about the compliance of mental health legislation with five standards of international human rights instruments.

Thirteen countries in the Region (62%) are compliant with all five items. This is greater than the corresponding percentage of 39% for the rest of the world (see Fig. 2.13). Four countries in Group 1 (67%) have legislation compliant with all five international human rights standards, as do seven countries in Group 2 (70%) and two countries in Group 3 (33%).

Numbers of countries in the Region with mental health laws that are compliant with individual human rights standards are consistent across the five standards (see

Table 2.1. Dedicated authority or independent body to inspect mental health services in the Eastern Mediterranean Region and the rest of the world

Status of dedicated authority or independent body	Eastern Mediterranean		Rest of the world (% of N=162)
	Number	Percentage	
Exists and undertakes regular inspections of mental health services, systematically responds to complaints and reports its findings at least once a year	5	24%	36%
Exists and undertakes irregular inspections of mental health services and irregularly responds to complaints of human rights violations	4	19%	17%
Exists but it is not functioning well (e.g. no budget or staff)	4	19%	10%
Does not exist	3	14%	28%
Not applicable/data missing	5	24%	9%

Fig. 2.12. Existence and activities of dedicated authority or independent body, by country group

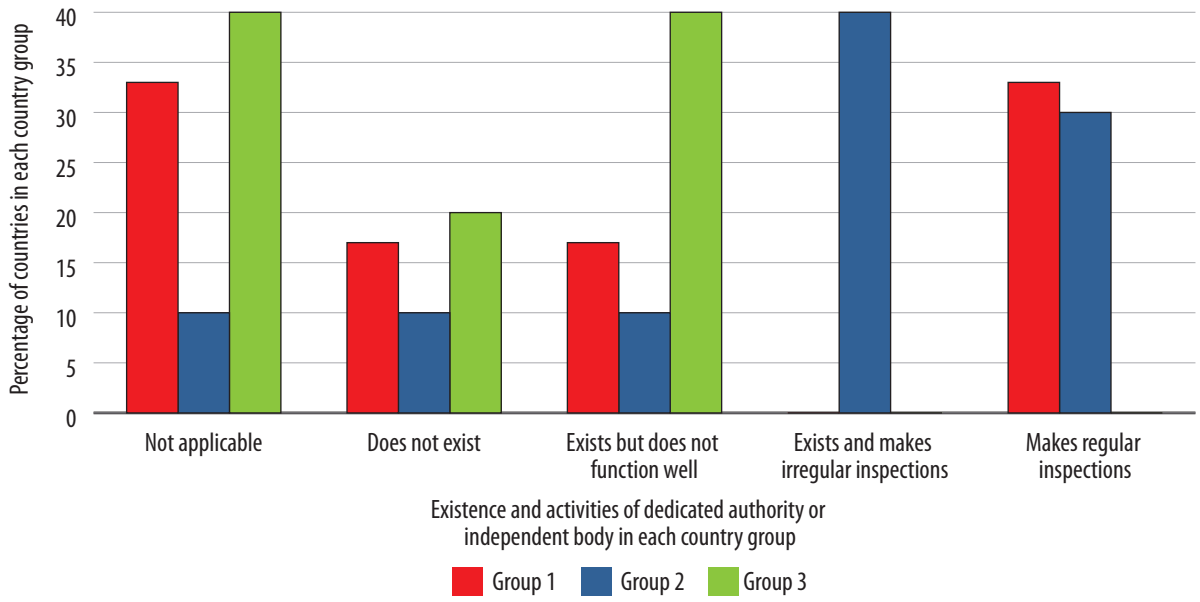


Fig. 2.13. Percentage of countries in the Eastern Mediterranean Region and the rest of the world with legislRtion compliant with international human rights standards

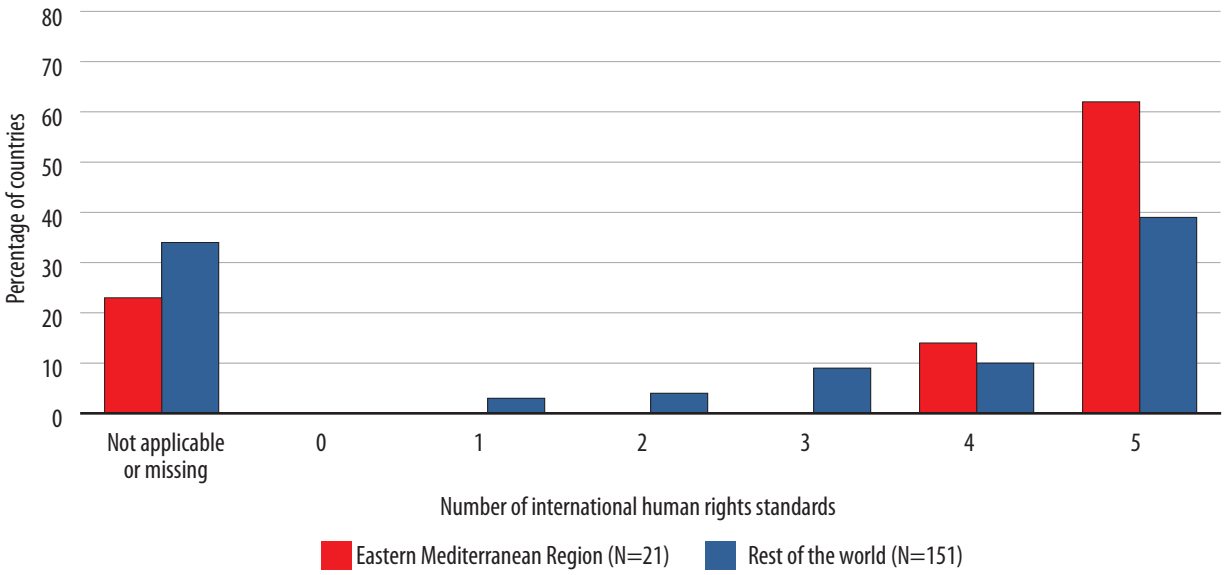
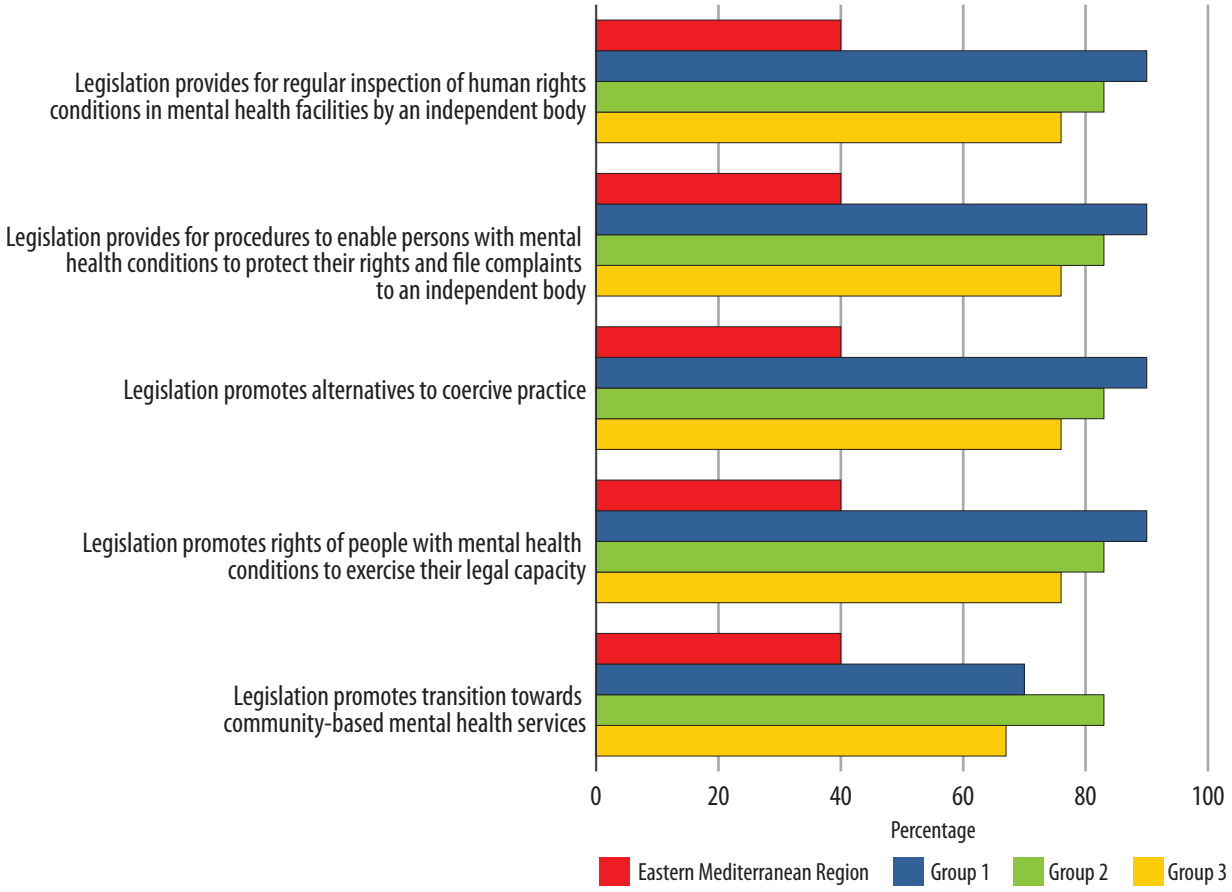


Fig. 2.14). Sixteen countries (76% of those responding) were compliant with four of the five standards. Compliance was higher in Group 1 and 2 countries (76% and 90% respectively) than in Group 3 countries (40%). A slight variation from this pattern is seen for legislation promoting a transition towards community-based mental health services, with which 14 countries (67%) are compliant, including seven in Group 2 (70%).

2.2.4 Core Comprehensive Mental Health Action Plan indicators for mental health legislation

The Comprehensive Mental Health Action Plan 2013–2020 set a target for 50% of countries to have developed or updated their laws for mental health in line with

Fig. 2.14. Compliance of mental health legislation with individual international human rights standards in the Eastern Mediterranean Region and by country group (percentage of responding countries)



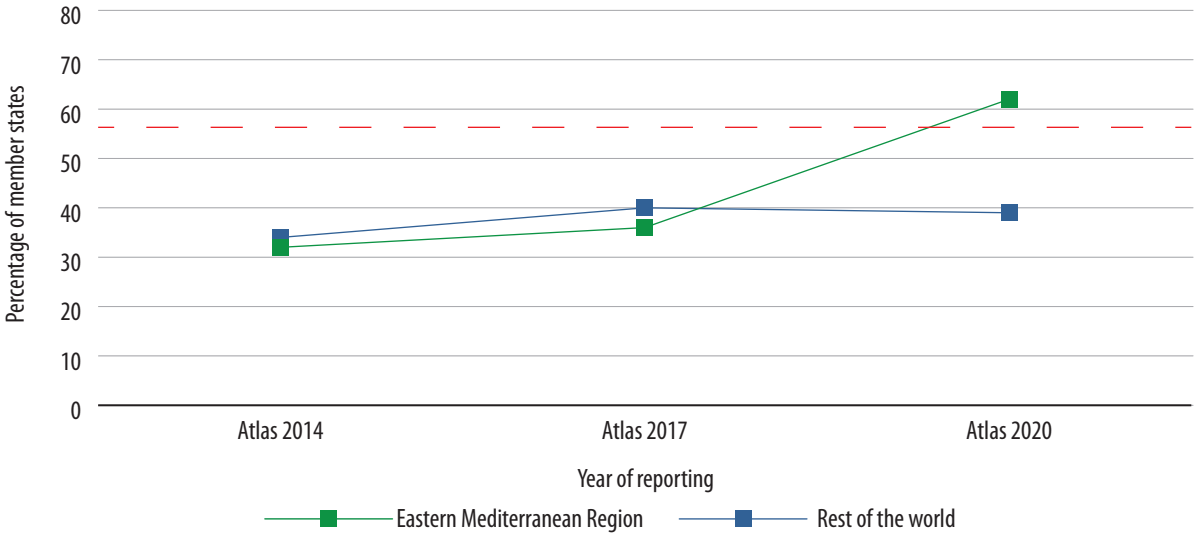
international human rights standards by 2020. The indicator that has been used to monitor progress towards this target is the existence of a national law covering mental health that is in line with five international human rights standards. Thirteen countries in the Region, or 62% of the total, and 39% of countries in the rest of the world have mental health legislation that meets all five human rights standards.

Progress towards meeting the target for having mental health laws that are in line with international human rights instruments has been monitored by the 2014, 2017 and 2020 editions of the atlas (see Fig. 2.15). Over this period the percentage of countries in the Region with compliant legislation has risen from 32% to 62%. The percentage started 2% lower in 2014 than that of the rest of the world, but in 2020 it exceeded that of the rest of the world by 23%. This indicator (existence of compliant mental health legislation) is met by four countries in Group 1 (67%), seven countries in Group 2 (70%) and two countries in Group 3 (40%).

A new version of this indicator has been defined for the extended 2030 Action Plan targets. As well as complying with human rights standards, this has an additional requirement that mental health laws are implemented. Implementation is assessed by the existence and functioning of a dedicated or independent body to assess the compliance of mental health legislation with human rights standards. The implementation component is met if the body undertakes either irregular or regular inspections of mental health facilities and either irregularly or systematically responds to complaints about human rights violations. The extended Action Plan target is that 60% of countries will have developed or updated and implemented their laws for mental health in line with international or regional human rights standards by 2030.

The baseline assessment in 2020 is that six countries in the Region (29%) have compliant mental health legislation that has been implemented. This is a very similar percentage to the 30% reported by countries in the rest of the world. Two Group 1 countries (33%) and four Group 2 countries (40%), but no Group 3 countries, have compliant and implemented mental health legislation.

Fig. 2.15. Progress in the Eastern Mediterranean Region towards meeting the Comprehensive Mental Health Action Plan 2013–2020 target of having mental health laws compliant with human rights standards



2.3 Stakeholder collaboration

Implementation of mental health policies/plans and laws requires collaboration between multiple sectors.[1] This includes a country's ministry of health partnering within and beyond the health sector in order to develop a people-centred system, improve the coordination of services and the implementation of programmes, and strengthen mental health care pathways. Successful stakeholder collaboration requires strong leadership and intersectoral engagement. This involves a range of stakeholders such as ministries/departments for social affairs/social welfare, justice, education, housing and employment, governmental or nongovernmental agencies, media, academia, local and international NGOs who deliver or advocate for mental health services, private sector actors, professional associations, faith-based organizations/institutions, traditional/indigenous healers, and service users and family or carer advocacy groups.

Countries reported on ongoing collaborations between government mental health services at central/national level and other departments, services and sectors. For the purposes of the mental health atlas, a functional collaboration is required to meet two of the following three criteria: 1) a formal agreement or joint plan; 2) dedicated funding from or to the partner; and 3) regular meetings with the partner (at least annually).

The questionnaire asked about collaborations with seven different types of stakeholder in the planning of mental health promotion, prevention, treatment and rehabilitation services (see Table 2.2). Governmental mental health services in more than half of countries in the Region have functional collaborations with NGOs (71%), the ministry/department of education (62%) and the ministry/department of social affairs/social welfare (57%). Services in only a minority of countries have functional collaborations with service users and family or caregiver advocacy groups (19%) or with the ministry/department of housing/urban welfare (5%).

Countries in the Region vary in the extent to which they have established functional collaborations – from countries with no formal collaborations through to one country that has collaborations with all seven stakeholders (see Fig. 2.16).

Group 1 countries have functional collaborations with a median of 4.5 different stakeholder groups and Group 2 countries with 3.5, while Group 3 countries have a median of just one functional collaboration. At least 50% of Group 1 countries have collaborations with all stakeholder groups apart from housing and urban welfare (see Fig. 2.17). The majority of Group 2 countries collaborate with social affairs, education and justice departments and with local/international NGOs, but only a few collaborate with labour/employment and housing/urban welfare departments or with service user/caregiver groups. Few or no Group 3 countries have collaborations with any stakeholder groups except for local/international NGOs, with whom three countries have collaborations (60%).

More countries in the Region have functional collaborative links with social affairs, education, justice and labour/employment departments and with local/international NGOs than do countries in the rest of the world (see Fig. 2.18). However, fewer countries in the Region have links with housing/urban welfare departments and with service user/caregiver groups.

[1] This introductory paragraph is replicated from the global report of the *Mental health atlas 2020*.

Table 2.2. Numbers and percentages of countries in the Region that have functional collaborations between government mental health services at central/national level and other departments, services and sectors

Stakeholder	Number of countries	Percentage*
Nongovernmental organizations (local/international NGOs)	15	71%
Ministry/department of education	13	62%
Ministry/department of social affairs/social welfare	12	57%
Ministry/department of justice	9	43%
Ministry/department of labour/employment	6	29%
Service users (people with lived experience) and family or caregiver advocacy groups	4	19%
Ministry/department of housing/urban welfare	1	5%

* All 21 countries that completed the *Mental health atlas 2020* questionnaire are included in the denominators; if a country did not report a collaboration in this section of the questionnaire, it has been assumed that none exists.

Fig. 2.16. Number of functional collaborations between government mental health services at central/national level and other stakeholders in countries in the Eastern Mediterranean Region

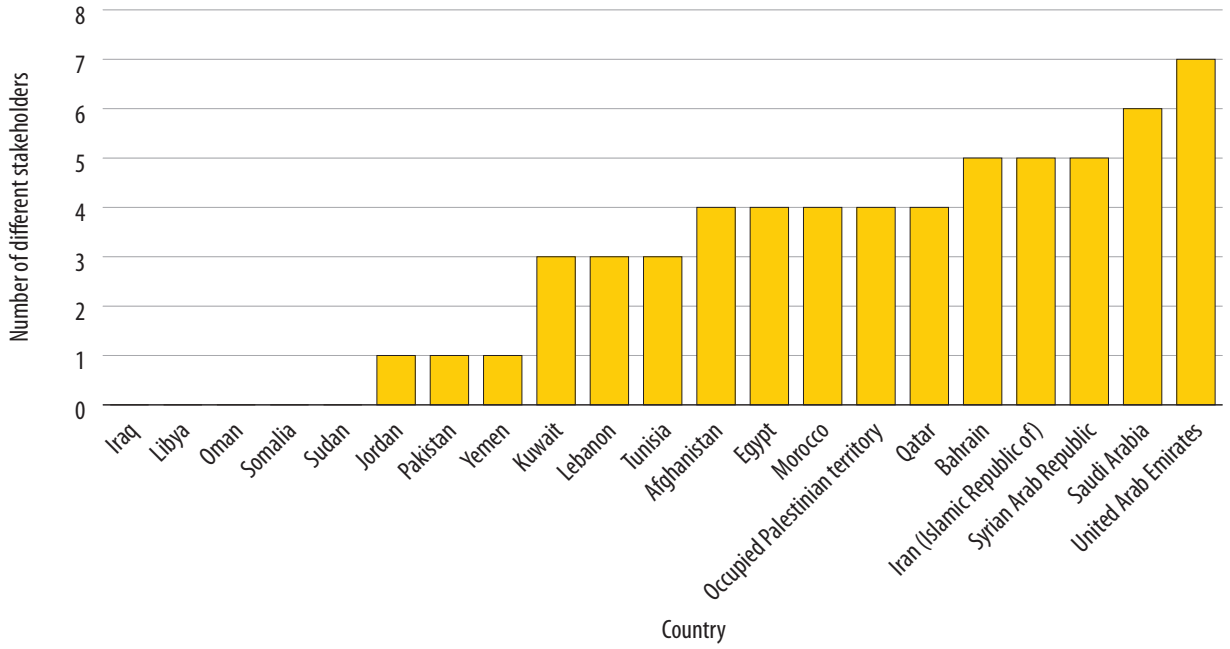


Fig. 2.17. Functional collaborations with stakeholders by country group

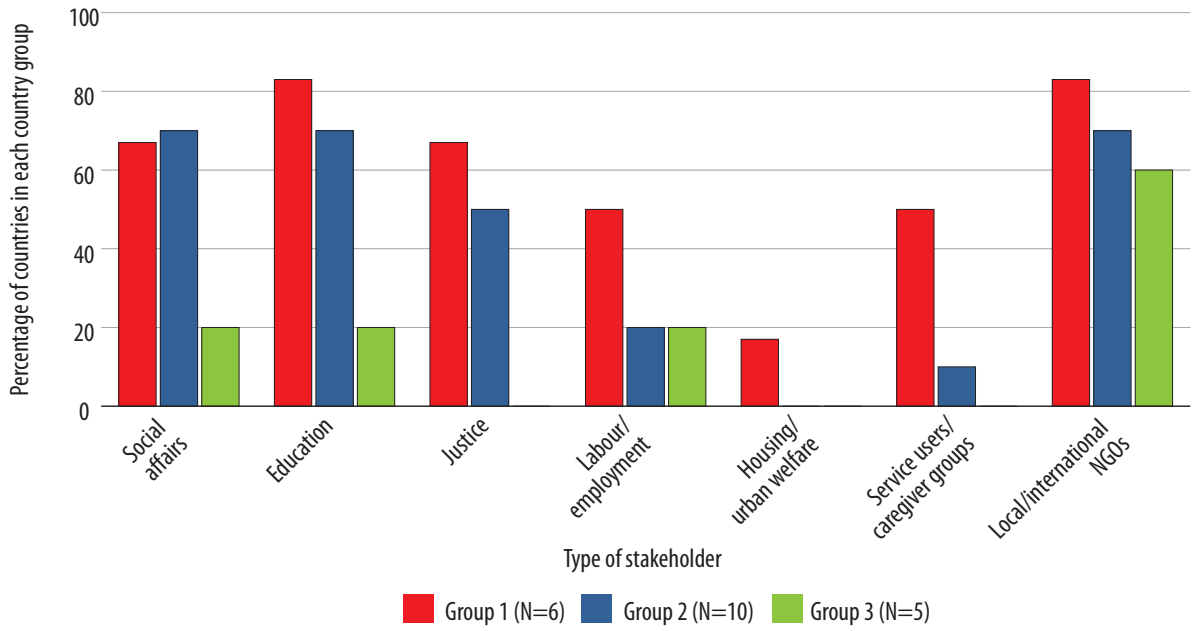
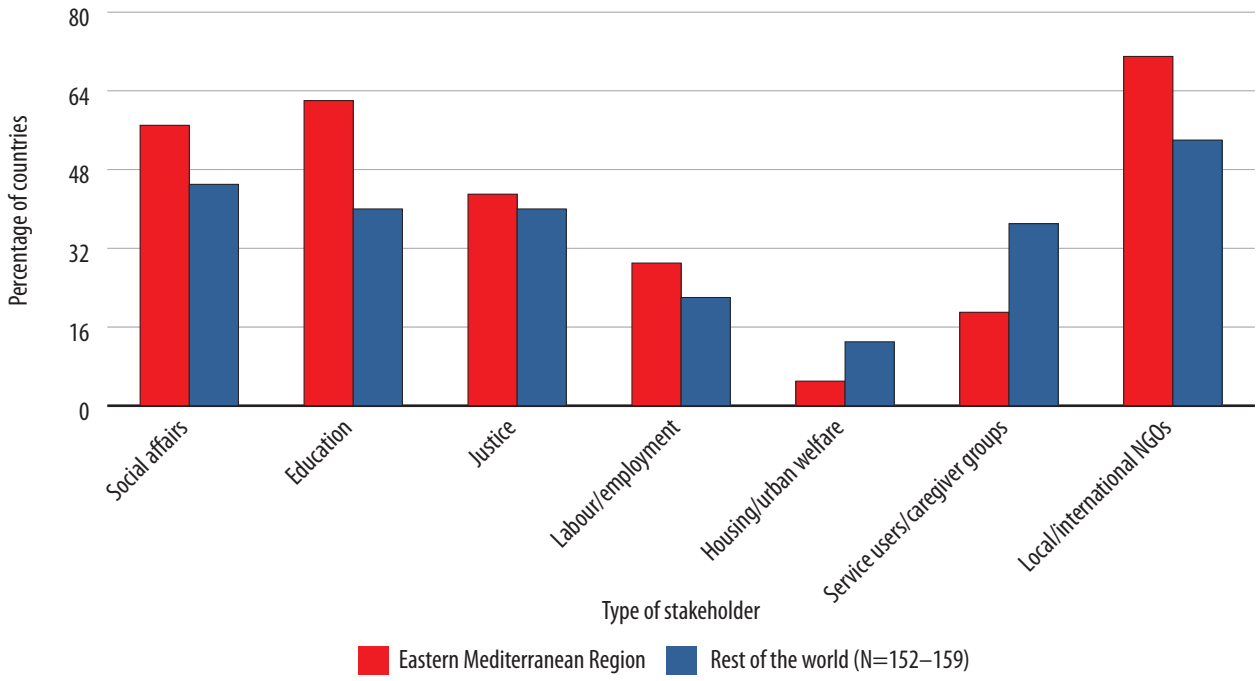


Fig. 2.18. Functional collaborations with stakeholders in the Eastern Mediterranean Region and the rest of the world (expressed as a percentage of responding countries)



3. Financial and human resources for mental health

3.1 Expenditure on mental health

The availability of dedicated financial resources for mental health is critical in developing, implementing and maintaining mental health services and in making progress towards programme goals.[1] Spending on mental health can include a range of activities, including activities delivered in primary or general care and specialist/secondary health care and in social care. It may also include programme costs such as administration/management, training and supervision, and mental health prevention and promotion activities. Estimating mental health expenditure in a country, however, is complex due to the range of potential funding sources (employers and households as well as governmental and nongovernmental agencies), diverse sets of service providers (specialist mental health services, general health services and social care services) and the diversity of services provided. In general, availability of financial resources for mental health, and equity in their distribution and efficiency in their use, are core requirements for enhanced performance of mental health systems.

Countries were asked to report on their government's total expenditure on mental health and mental hospitals. Expenditures were standardized by converting to US dollars and dividing by the country population. Twelve countries in the Eastern Mediterranean Region reported on at least one aspect of their government's mental health expenditure, but among those countries not all items were reported (see Table 3.1).

- The median government total expenditure on mental health in seven reporting countries in the Region was US$ 7.47 per person, compared with US$ 4.73 for 80 reporting countries in the rest of the world.
- Across nine reporting countries, the median mental health expenditure was 1.8% of total government health expenditure, compared with 2.9% in 89 reporting countries in the rest of the world.
- Governments' total expenditure on mental health made up 1.3% of domestic general government health expenditure (GGHE-D) in seven reporting countries in the Region, compared with 1.8% in 80 reporting countries in the rest of the world.
- The median government total expenditure on mental hospitals in six reporting countries in the Region was US$ 2.20 per person, compared with US$ 1.93 for 73 reporting countries in the rest of the world.
- Expenditure on mental hospitals as a percentage of total mental health expenditure in four reporting countries in the Region was 82.1%, compared with a corresponding figure of 62.7% in 75 reporting countries in the rest of the world.
- With such low numbers of countries reporting, it is not meaningful to make country group comparisons. Likewise, inconsistencies between the lists of countries that completed the finances section of the mental health atlas questionnaire in 2014, 2017 and 2020 mean that it is not possible to make meaningful chronological comparisons.

3.2 Inclusion of mental health conditions in national health insurance or reimbursement schemes

Universal health coverage means that all people have access to the health services they need, when and where they need them, without financial hardship.[2] It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care. The *Mental health atlas 2020* questionnaire included a dedicated question to assess whether the care and treatment of persons with mental health conditions (psychosis, bipolar disorder, depression) were included in national health insurance or reimbursement schemes.

National health insurance or reimbursement schemes include mental health conditions in nine countries in the Region (43% of those reporting), and in seven of these countries mental health conditions are explicitly listed as included (see Table 3.2). In five countries (24%), the care and treatment of persons with mental health conditions are not included in national health insurance or reimbursement schemes, and in two of these countries mental health conditions are explicitly excluded. In all countries of the Region where mental health conditions are included, coverage includes both inpatient and outpatient care. Compared with the rest of the world, mental health conditions are included in fewer national insurance or reimbursement schemes within the Region (43% compared with 66%).

[1] This paragraph is replicated from the global report of the *Mental health atlas 2020*.
[2] This paragraph is replicated from the global report of the *Mental health atlas 2020*.

More Group 2 countries (60%) have mental health conditions included in their national health insurance and reimbursement schemes than Group 1 countries (33%) or Group 3 countries (20%) (see Fig. 3.1).

In 11 countries in the Region (52% of those reporting), the majority of persons pay nothing at the point of service for mental health care (see Table 3.3). In a further six countries (29%), persons pay at most 20% towards the cost of services, and in the remaining four countries (19%) persons pay mostly or entirely out of pocket. People in a greater percentage of countries in the rest of the world (63%) pay nothing at the point of mental health services than in countries in the Region (52%). With regard to payment for psychotropic medication, in eight countries (38% of those reporting) persons pay nothing at the point of service, in seven countries (33%) they pay at most 20% and in six countries (29%) they pay mostly or entirely out of pocket (see Table 3.4). As for mental health services, people in a greater percentage of countries in the rest of the world (49%) pay nothing at the point of mental health services than in countries in the Region (38%). Paying nothing at the point of service for mental health services is reported by at least 50% of Group 1 and Group 2 countries, and by at least 40% of Group 1 and 2 countries for psychotropic medicines (see Fig. 3.2 –3.3). Out-of-pocket payments are reported by a greater percentage of Group 3 countries.

3.3 Mental health workforce

Human resources are the most valuable asset of any mental health service. Services rely on the competence and motivation of their workforces to promote mental health, and to prevent and provide care for people with mental health conditions. As with earlier mental health atlas surveys, WHO Member States were asked to provide estimates of the total number of mental health workers in the country, broken down by specific

Table 3.1. Mental health expenditures for Eastern Mediterranean Region countries, and median expenditures for the Region and the rest of the world

Country or region	Mental health expenditure			Expenditure on mental hospitals	
	Per capita (US$)	As % of total government health expenditure	As % of domestic general government health expenditure (GGHE-D) per capita	Per capita (US$)	As % of mental health expenditure per capita
Afghanistan	0.35	4.2%	11.7%	0.01	4.2%
Bahrain	16.68	4.5%	2.9%	16.68	100%
Egypt	0.42	–	1.2%	–	–
Iran (Islamic Republic of)	–	–	–	3.02	–
Lebanon	2.03	5.0%	0.6%	1.39	68.4%
Occupied Palestinian territory	–	1.8%	–	–	–
Oman	7.47	1.8%	1.3%	–	–
Pakistan	12.98	0.04%	86.5%	––	–
Qatar	17.28	1.1%	1.3%	16.57	95.9%
Saudi Arabia	–	4.0%	–	–	–
Somalia	–	–	–	–	–
Tunisia	–	–	–	0.33	–
	–	–	–	–	–
Eastern Mediterranean Region	7.47	1.8%	1.3%	2.20	82.1%
Rest of the world	4.73	2.9%	1.8%	1.93	62.7%

Note: In all tables where cells are empty, data were not available or not reported.

Table 3.2. Inclusion of care and treatment of persons with mental health conditions in national health insurance or reimbursement schemes, in the Eastern Mediterranean Region and the rest of the world

Inclusion of care and treatment of persons with mental conditions in national health insurance or reimbursement schemes	Eastern Mediterranean Region countries (N=21)		Rest of the world (N=162)	
	Number	Percentage	Number	Percentage
Not answered	7	33%	33	20%
Not included, and mental health conditions are explicitly listed as excluded conditions	2	10%	10	6%
Not included in national health insurance or reimbursement schemes	3	14%	13	8%
Included, but mental health conditions are not explicitly listed as included	2	10%	32	20%
Included, and mental health conditions are explicitly listed as included	7	33%	74	46%

Fig. 3.1. Inclusion of care and treatment of persons with mental health conditions in national health insurance or reimbursement schemes, by country group

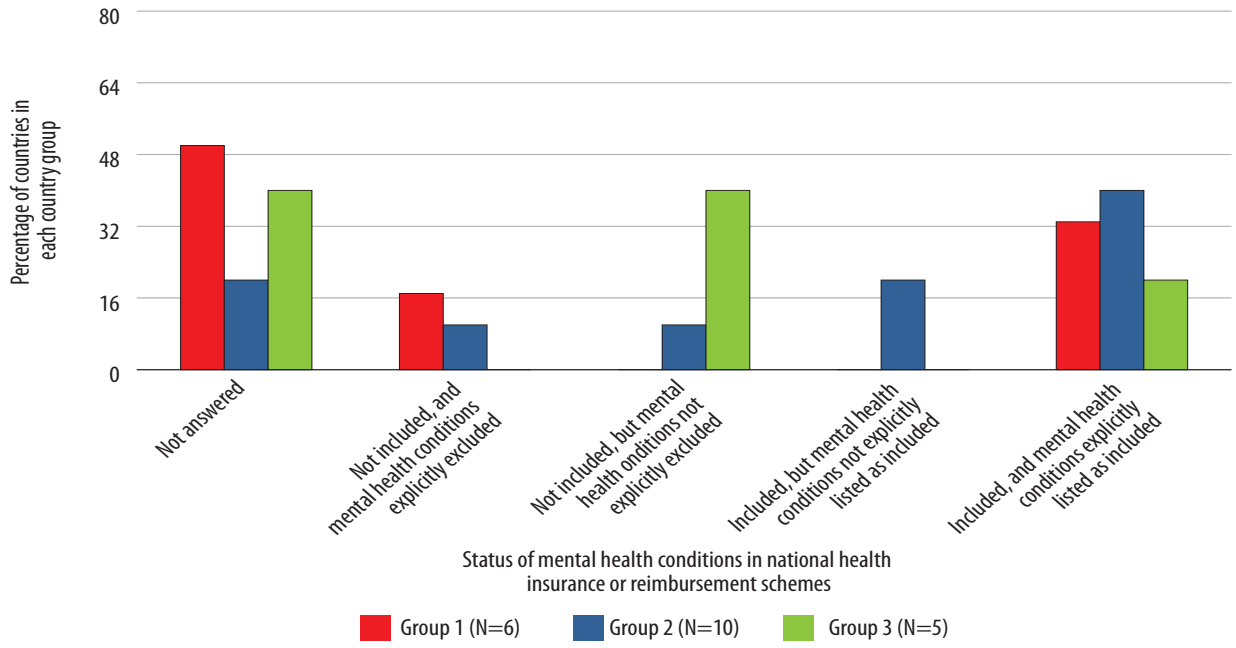


Table 3.3. How the majority of persons pay for mental health services in the Eastern Mediterranean Region and the rest of the world

How the majority of persons with mental health conditions pay for care	Eastern Mediterranean Region		Rest of the world	
	Number of countries	Percentage of countries	Number of countries	Percentage of countries
Persons pay nothing at the point of service use (fully insured)	11	52%	102	63%
Persons pay at most 20% towards the cost of services	6	29%	34	21%
Persons pay mostly or entirely out of pocket for services	4	19%	23	14%
Not reported	0	0%	3	2%

Table 3.4. How the majority of persons pay for psychotropic medicines in the Eastern Mediterranean Region and the rest of the world

How the majority of persons with mental health conditions pay for psychotropic medication	Eastern Mediterranean Region		Rest of the world	
	Number of countries	Percentage of countries	Number of countries	Percentage of countries
Persons pay nothing at the point of service use (fully insured)	8	38%	80	49%
Persons pay at most 20% towards the cost of medicines	7	33%	44	27%
Persons pay mostly or entirely out of pocket for medicines	6	29%	27	17%
Not reported	0	0%	11	7%

Fig. 3.2. How the majority of persons pay for mental health services, by country group

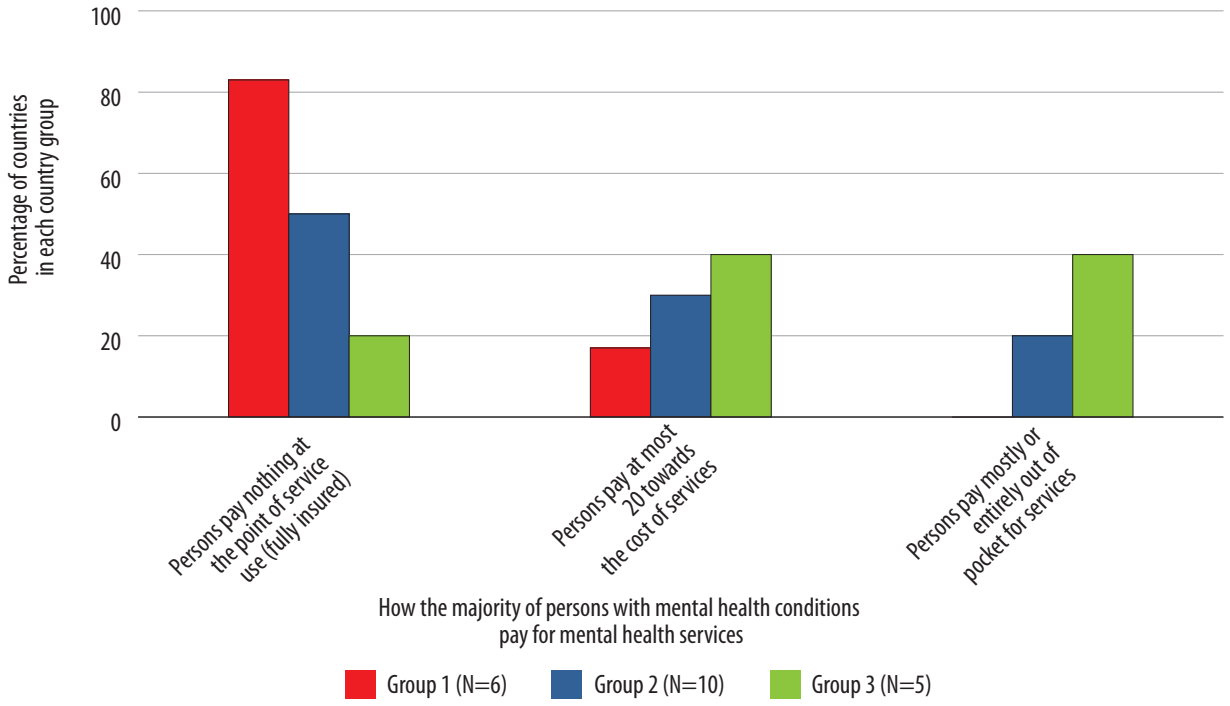
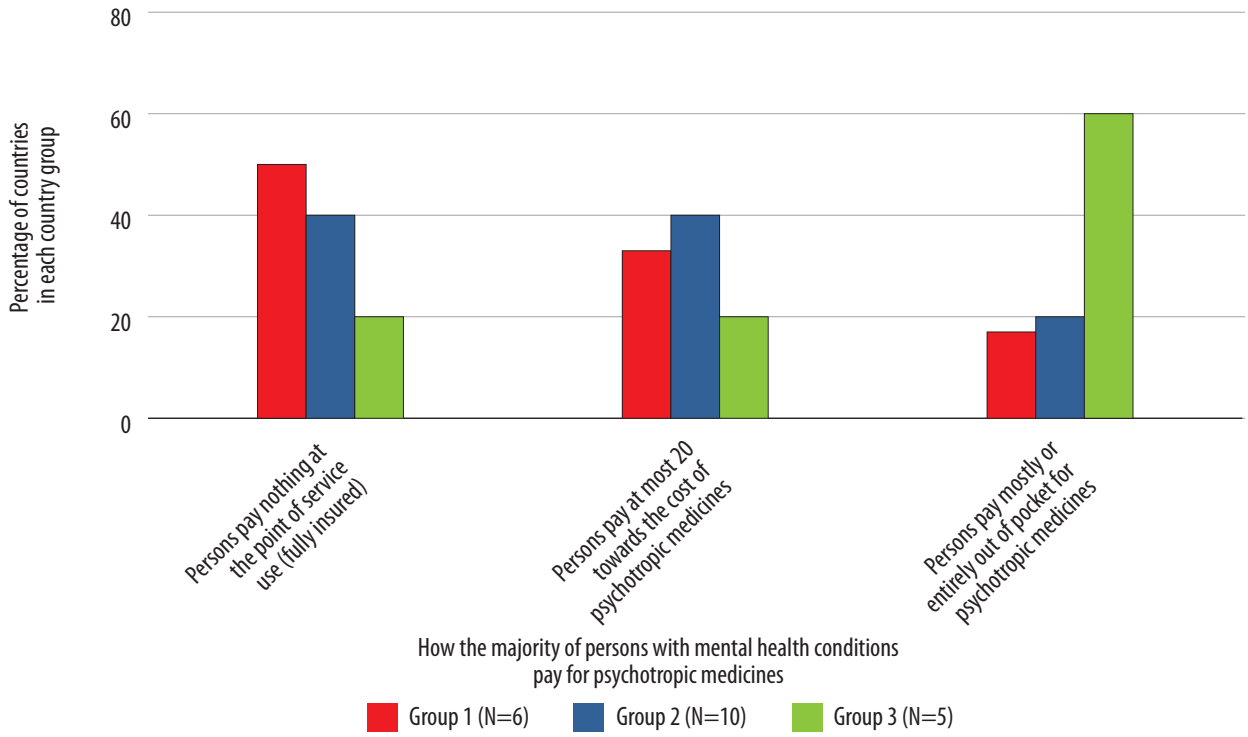


Fig. 3.3. How the majority of persons pay for psychotropic medicines, by country group



cadres (including psychiatrists, child psychiatrists, other medical doctors, nurses, psychologists, social workers, occupational therapists and other paid workers in mental health). Mental health workers who had completed formal training in a recognized teaching institution were included in the professional categories. For the purposes of this report, a psychiatrist is defined as a medical doctor with at least two years of postgraduate training in psychiatry, which may include any subspecialty of psychiatry (see Annex B. Glossary of terms).

Respondents in a total of 20 countries, corresponding to a little over 90% of all countries in the Region, were able to provide some estimation of the mental health workforce in their country. The median total number of mental health staff for countries in the Region was 8.0 per 100 000 population. This is substantially lower than the median of 13.6 workers per 100 000 for countries in the rest of the world. There were lower median numbers of mental health staff of every type except other specialized mental health staff in countries in the Region compared with countries in the rest of the world (see Fig. 3.4).

The provision of government-employed mental health care staff varies greatly across the different countries of the Region (see Fig. 3.5). As expected, Group 1 countries have the most specialized mental health staff (median 22.0 workers per 100 000 population), compared with Group 2 countries (median 7.2 workers per 100 000 population) and Group 3 countries (median 1.3 workers per 100 000 population). This pattern is similar for psychiatrists and mental health nurses, but Group 2 countries have slightly more psychologists, social workers and other specialized mental health workers than Group 1 countries (see Fig. 3.6).

Mental health nurses constitute the majority of the mental health workforce in most countries in the Region (see Fig. 3.7). This is the case for all Group 1 and Group 2 countries except for Syrian Arab Republic and Saudi Arabia, where there are more psychologists and social workers. There are various different compositions in Group 3 countries. The majority of mental health staff in Afghanistan are other specialized mental health workers, while in Pakistan social workers are the largest group; in Somalia it is nurses, in Sudan psychologists and social workers and in Yemen nurses and psychologists.

Fig. 3.4. Median numbers of mental health staff per 100 000 population, in the Eastern Mediterranean Region and the rest of the world

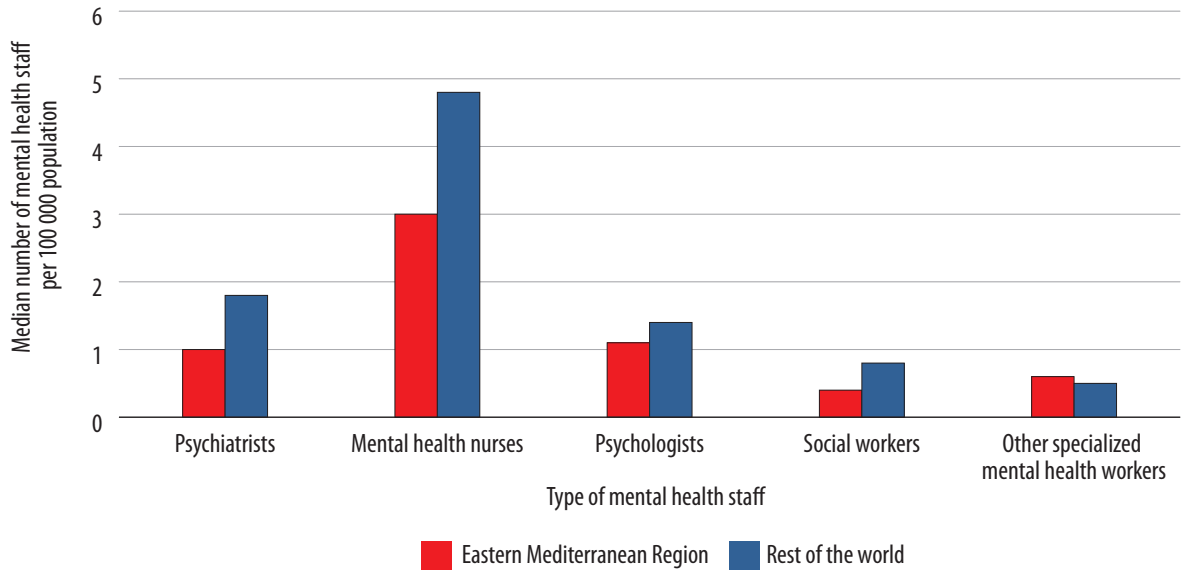


Fig. 3.5. Mental health workers in mental health services per 100 000 population, by country

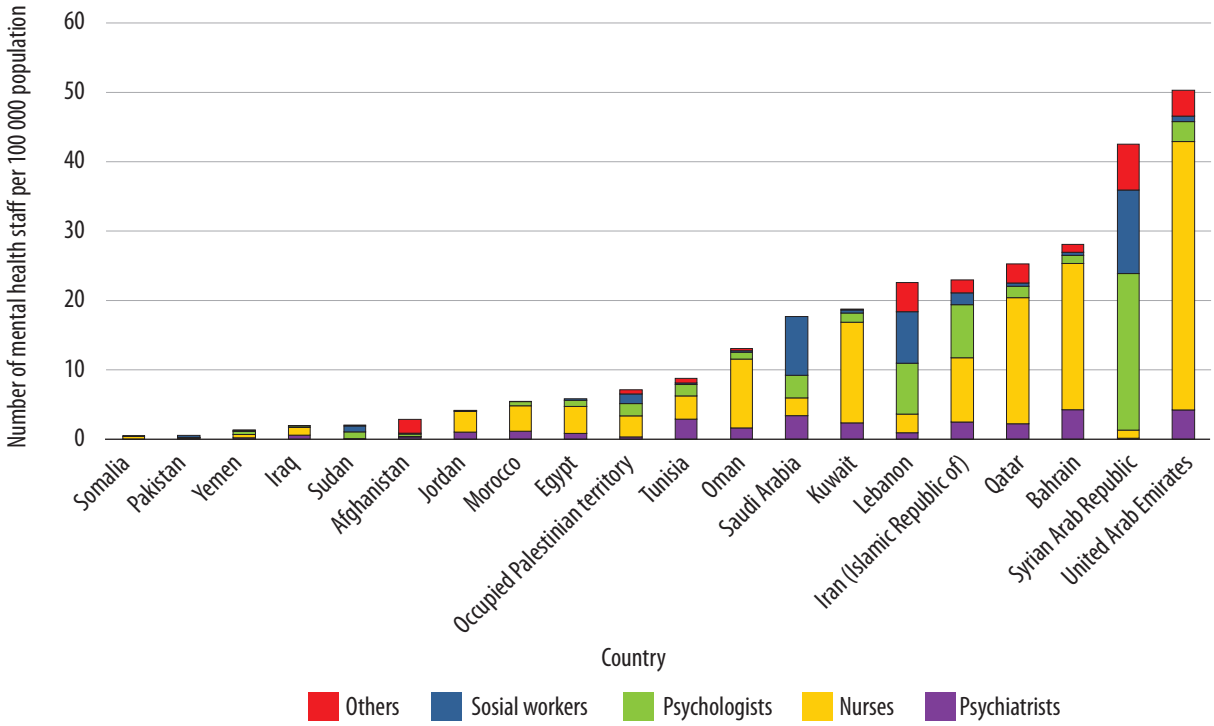


Fig. 3.6. Median numbers of mental health workers in mental health services per 100 000 population, by country group

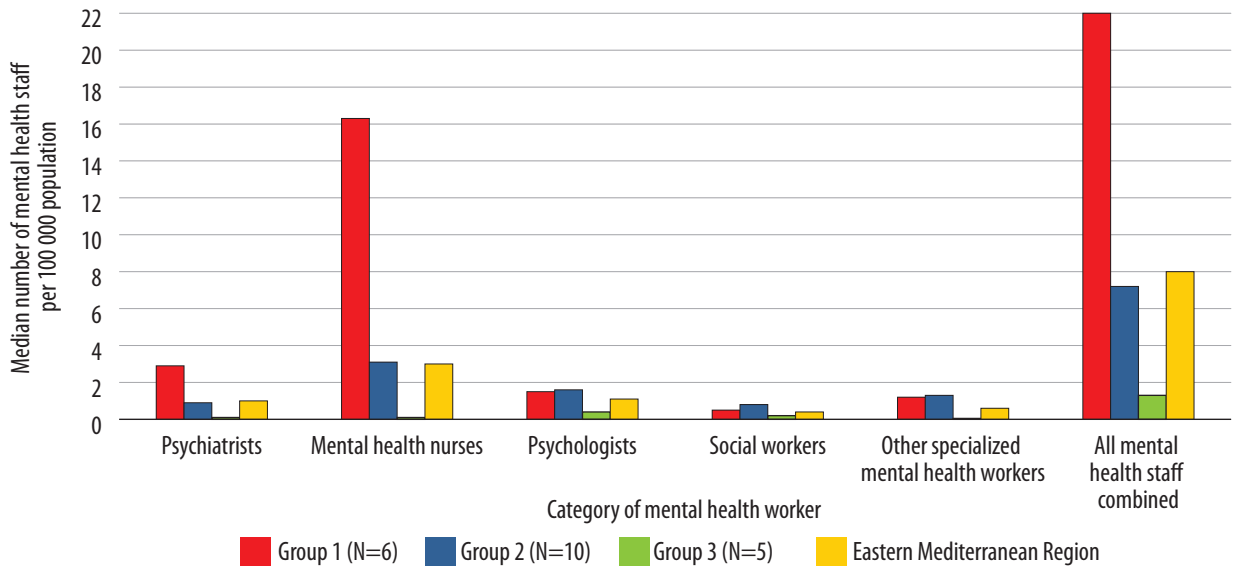
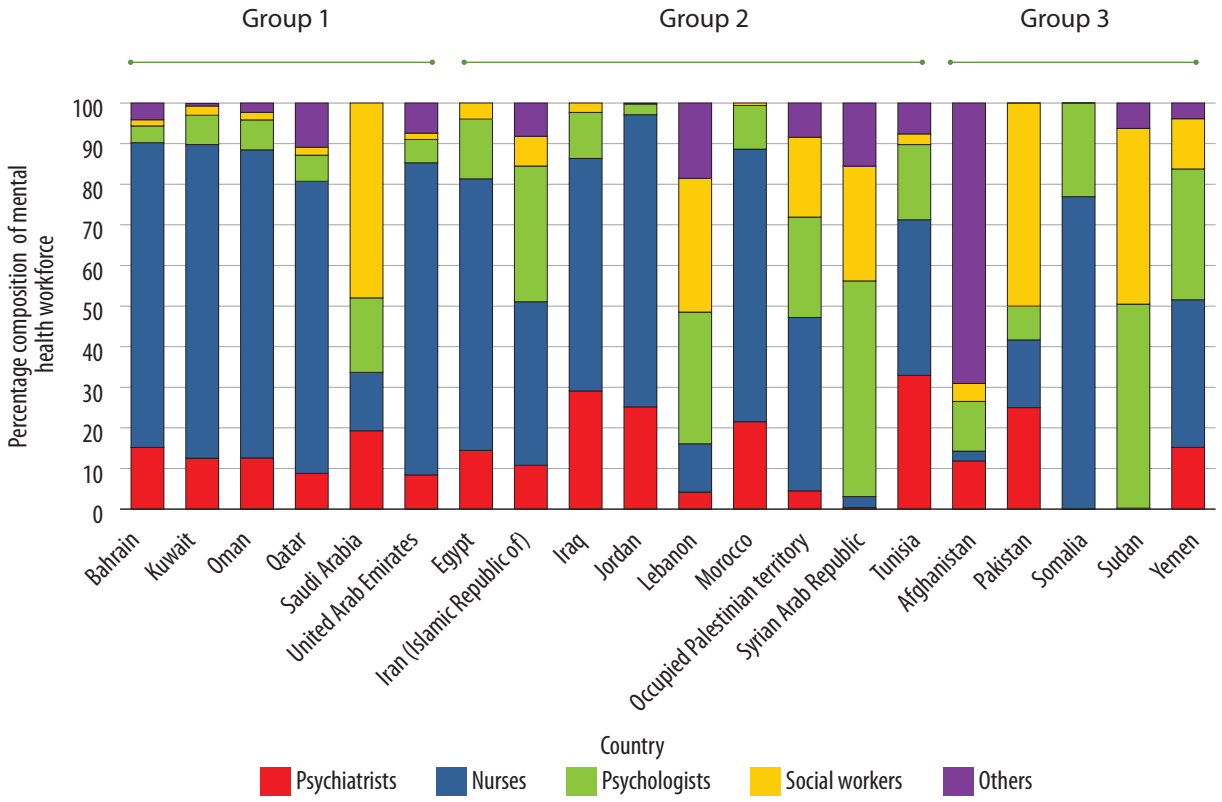
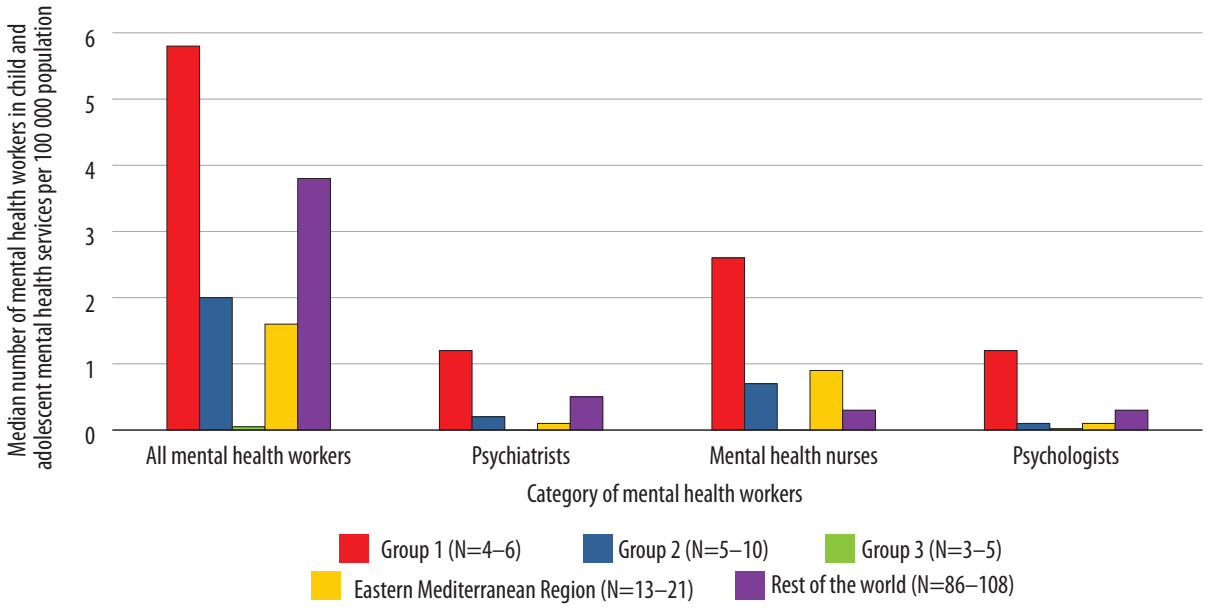


Fig. 3.7. Percentage composition of specialist mental health workforce by country, ordered by country group



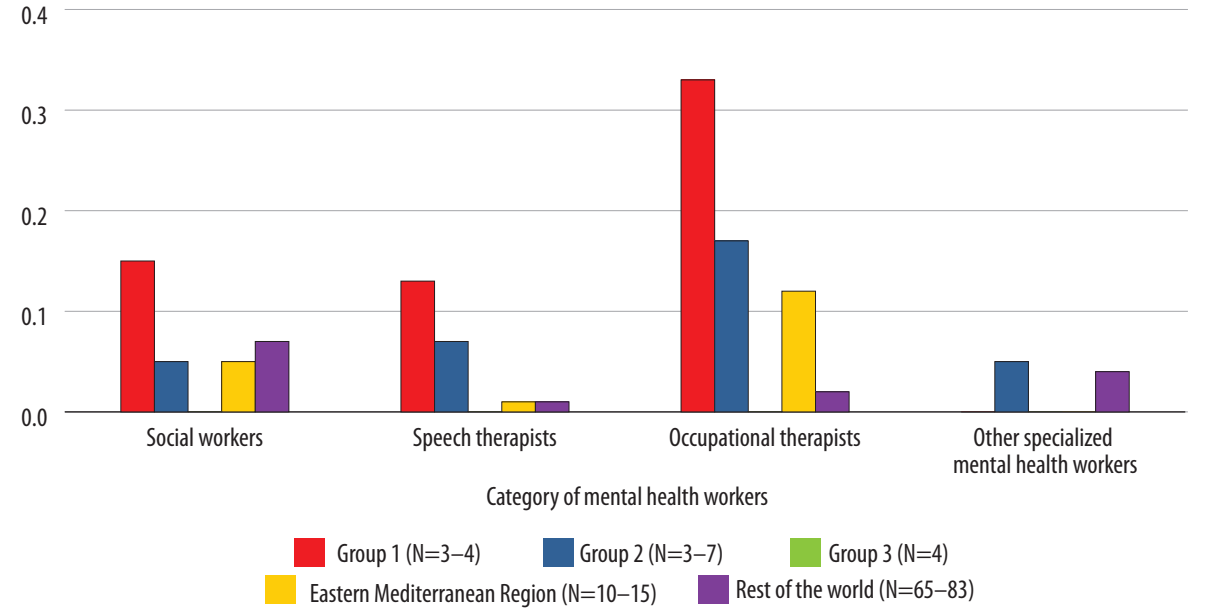
Countries were asked to report on the numbers of mental health workers in government and nongovernment child and adolescent mental health services (CAMHS) (see Fig. 3.8 –3.9). Countries in the Region have a median of 1.6 mental health workers in CAMHS per 100 000 population. This is fewer than half the 3.8 workers per 100 000 reported in the rest of the world. The largest group of specialized staff for child and adolescent mental health are mental health nurses (0.9 per 100 000), followed by occupational therapists (0.12 per 100 000), psychiatrists (0.1 per 100 000) and psychologists (0.1 per 100 000). Countries in the Region reported fewer staff of each type than the rest of the world, except for mental health nurses and occupational therapists. Group 1 countries have the highest provision, with 5.8 workers per 100 000 population, and Group 3 countries have the lowest, at 0.05 workers per 100 000 population. This pattern of Group 1 countries having the highest levels of provision and Group 3 countries the lowest applies to all professional types of specialized mental health workers, except "others" (who were only reported to be working in small numbers in four Group 2 countries).

Fig. 3.8. Median numbers of all mental health workers, psychiatrists, mental health nurses and psychologists per 100 000 population working in CAMHS, by country group, the Eastern Mediterranean Region and the rest of the world



Note: The Y-axis scale is different from that of Fig. 3.9.

Fig. 3.9. Median numbers of social workers, speech therapists, occupational therapists and other specialized mental health workers per 100 000 population working in CAMHS, by country group, the Eastern Mediterranean Region and the rest of the world



Note: The Y-axis scale is different from that of Fig. 3.8.

4. Mental health service availability and uptake

4.1 Integration of mental health into primary health care

The integration of mental health into primary health care was highlighted as part of the Alma-Ata Declaration in 1978 and the Astana Declaration in 2018.[1] There is a need to prioritize investment in strong primary health care, including mental health prevention, promotion and rehabilitation services, to improve the efficiency of health management and to achieve universal health coverage. For this purpose, WHO has developed the Mental Health Gap Action Programme (mhGAP), which aims to scale up services for mental, neurological and substance use (MNS) disorders, especially for countries with low and middle levels of income. Different tools have been developed, among which the WHO mhGAP Intervention Guide (mhGAP-IG) is a vital resource, containing evidence-based interventions to be used by non-specialized general health-care workers to scale up management of priority MNS conditions.

In increasing access to mental health care and improving the quality of mental health services, the Comprehensive Mental Health Action Plan emphasizes the systematic decentralization of the focus of care and treatment from long-stay mental hospitals to primary care settings. The Action Plan emphasizes the increased use of evidence-based interventions and principles of stepped care that offer a holistic approach combining mental and physical health care. This integrated and responsive form of care requires the training and monitoring of non-specialized health workers to identify people with mental health conditions, deliver appropriate treatment and support and refer them, when needed, to other levels of care. Objective 2 of the Comprehensive Mental Health Action Plan concerns the provision of comprehensive, integrated and responsive mental health and social care services in community-based settings, including primary health care settings, as a priority. Global target 2.3 of the Action Plan is for 80% of countries to have integrated mental health into primary health care by 2030.

In the *Mental health atlas 2020*, "primary health care" refers to the provision of mental health care through non-specialized services and workers, including health care services provided by the government and NGOs and private (for-profit) health facilities and services. The integration of mental health into primary health care is considered to be functional only if at least four of the following five criteria are fulfilled: 1) guidelines for mental health integration into primary health care are available and adopted at the national level; 2) pharmacological interventions for mental health conditions are available and provided at the primary care level; 3) psychosocial interventions for mental health conditions are available and provided at the primary care level; 4) health workers at primary care level receive training on the management of mental health conditions; and 5) mental health specialists are involved in the training and supervision of primary care professionals.

4.1.1 Guidelines for the integration of mental health into primary health care

Nineteen countries in the Eastern Mediterranean Region (90%) reported that they have guidelines for the integration of mental health into primary health care available and adopted at the national level. All Group 1 and Group 2 countries have available guidelines, and three Group 3 countries (60%) have guidelines. The two countries without guidelines are Somalia and Yemen.

4.1.2 Pharmacological interventions in primary health care

To assess the provision of mental health services at the primary health care level, the 2020 questionnaire asked countries to estimate the percentage of primary care facilities that typically have available pharmacological and psychosocial interventions for mental health conditions. Seventeen countries in the Region (81%) provide pharmacological interventions for mental health conditions in primary health care, including all Group 1 and Group 2 countries (100%) and three Group 3 countries (60%). However, although most countries in the Region provide pharmacological interventions, in the majority of these countries coverage is limited (see Table 4.1 and Fig. 4.1). Among all countries in the Region, five (24%) have pharmacological interventions available at more than 75% of primary care centres. This wide coverage is provided by three Group 1 countries (50%) and two Group 2 countries (20%), but no Group 3 countries. Coverage is less than 50% in eight Group 2 countries (80%) and in all five Group 3 countries (100%).

4.1.3 Psychosocial interventions in primary health care

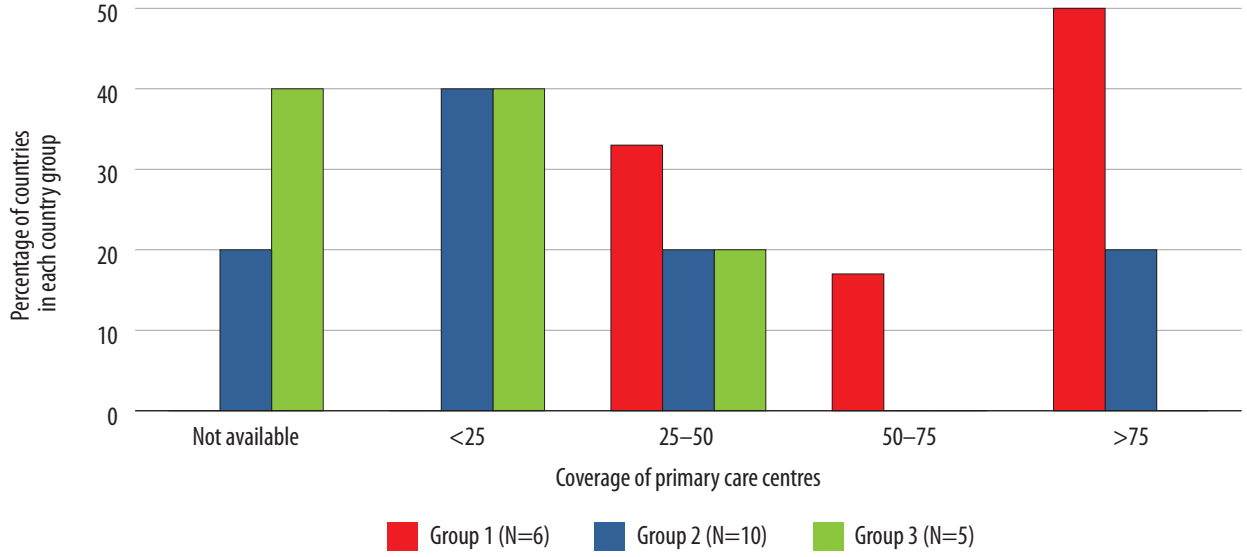
Psychosocial interventions for mental health conditions are available and provided at primary care level in 18 countries in the Region (86%). Such interventions

[1] This and the following two paragraphs are replicated from the global report of the *Mental health atlas 2020*.

Table 4.1. Coverage of pharmacological interventions for mental health conditions available at primary care facilities in the Eastern Mediterranean Region

Coverage	Number	Percentage
Not available	4	19%
Fewer than 25% of primary care centres	6	29%
25–50% of primary care centres	5	24%
50–75% of primary care centres	1	5%
More than 75% of primary care centres	5	24%

Fig. 4.1. Coverage of pharmacological interventions for mental health conditions available at primary care facilities, by country group



are available in all Group 1 countries, in nine Group 2 countries (90%) and in three Group 3 countries (60%).

Coverage for psychosocial interventions is lower than for pharmacological interventions (see Table 4.2 and Fig. 4.2). Among all countries of the Region, only two (10%) have psychosocial interventions available at more than 75% of primary care centres. Coverage of 75% of primary care centres is reported by one Group 1 country (17%) and by one Group 2 country (10%), but by no Group 3 countries.

4.1.4 Training of primary care workers in the diagnosis and management of mental health conditions

Since primary care centres are a common setting for initial care for people with mental health conditions, primary care workers must be trained to diagnose and treat such conditions. The 2020 questionnaire asked WHO Member States about the proportion of primary health workers receiving training on the management of mental health conditions. Eighteen countries in the Region (86%) reported that health workers at primary care level receive training on the management of such conditions. Ten countries (48%) include mental health in pre-service training (as part of formal education before qualification/licensing) and 13 countries (62%) include mental health within in-service training (continuous professional development training courses for professionals already enrolled in providing services). This type of training is available in all Group 1 countries, nine Group 2 countries (90%) and three Group 3 countries (60%) (see Fig. 4.3).

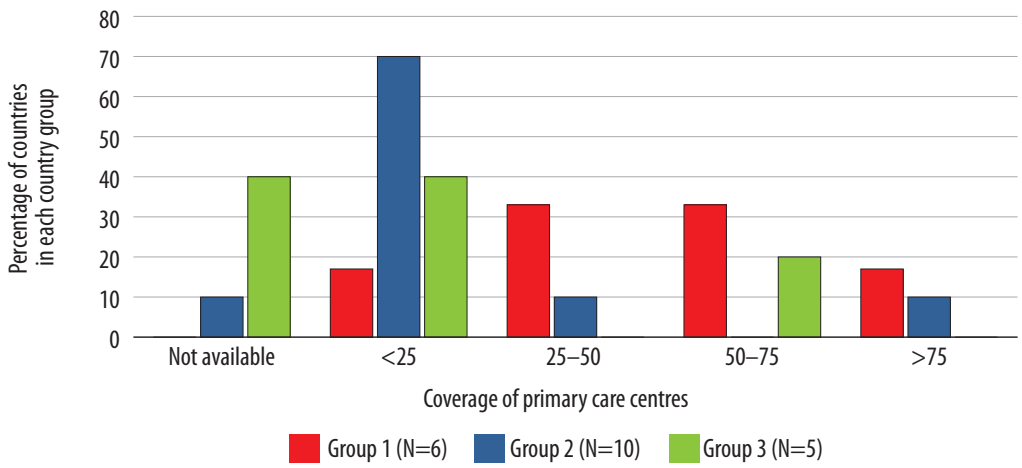
4.1.5 Supervision

WHO mhGAP recommends the engagement of mental health specialists in capacity-building and on-the-job supervision and support of the primary care workforce. Mental health specialists are involved in the training and supervision of primary care professionals in 15 countries in the Region (71%). A greater proportion of Group 1 countries (83% or more) report that this aspect of

Table 4.2. Coverage of psychosocial interventions for mental health conditions available at primary care facilities in the Eastern Mediterranean Region

Coverage	Number	Percentage
Not available	3	14%
Fewer than 25% of primary care centres	10	48%
25–50% of primary care centres	3	14%
50–75% of primary care centres	3	14%
More than 75% of primary care centres	2	10%

Fig. 4.2. Coverage of psychosocial interventions for mental health conditions available at primary care facilities, by country group



training and supervision is present than Group 2 (70%) or Group 3 countries (60%) (see Fig. 4.3).

4.1.6 Functional integration of mental health into primary health care

The five reported components for the integration of mental health into primary health care, including guidelines, coverage of pharmacological and psychosocial interventions, training and supervision, have been combined into a single summary score. Using the available data, this provides an indication of how far countries have travelled towards the target of integrating mental health into primary health care. The summary scores of individual countries, out of a maximum of 5, are shown in Fig. 4.4. Most countries achieve a score of 3 by providing guidelines, training and supervision. The few countries that score more than 3 have also achieved coverage of more than 75% of primary care centres with either pharmacological or psychosocial interventions. The Islamic Republic of Iran and Qatar have achieved all five criteria. The average score for all reporting countries in the Region was 2.8, which compares with an average score of 3.0 for the rest of the world. The average score for Group 1 countries was 3.5, for Group 2 countries 2.9 and for Group 3 countries 1.8.

Within the Region, 50% of Group 1 countries achieved a summary score of 4 or 5; this fell to 20% in Group 2 countries, and no Group 3 country scored 4 or 5 (see Fig. 4.5). The criteria for treatment intervention coverage are the major hurdle to meeting this target. For example, three Group 3 countries (60%) meet each of the guidelines, training and supervision components, but none provide treatment interventions to more than 75% of the population.

The extended Action Plan targets for 2030 include target 2.3, which is for 80% of countries to have integrated mental health into primary health care by 2030. The baseline for the indicator used to monitor progress towards this target, using the summary score, is presented in Fig. 4.6. A total score of 4 or 5 for an individual country indicates that the target has been met. According to this indicator, in 2020 five countries in the Region (24%) had integrated mental health into primary health care; in the rest of the world a higher percentage of 31% of countries had achieved the target threshold. The reason why most countries, in both the Eastern Mediterranean Region and the rest of the world, fall short of this target (at baseline) is the limited extent of coverage of pharmacological and psychosocial interventions.

Fig. 4.3. Training on management of mental health conditions received by health workers at primary care level, by country group

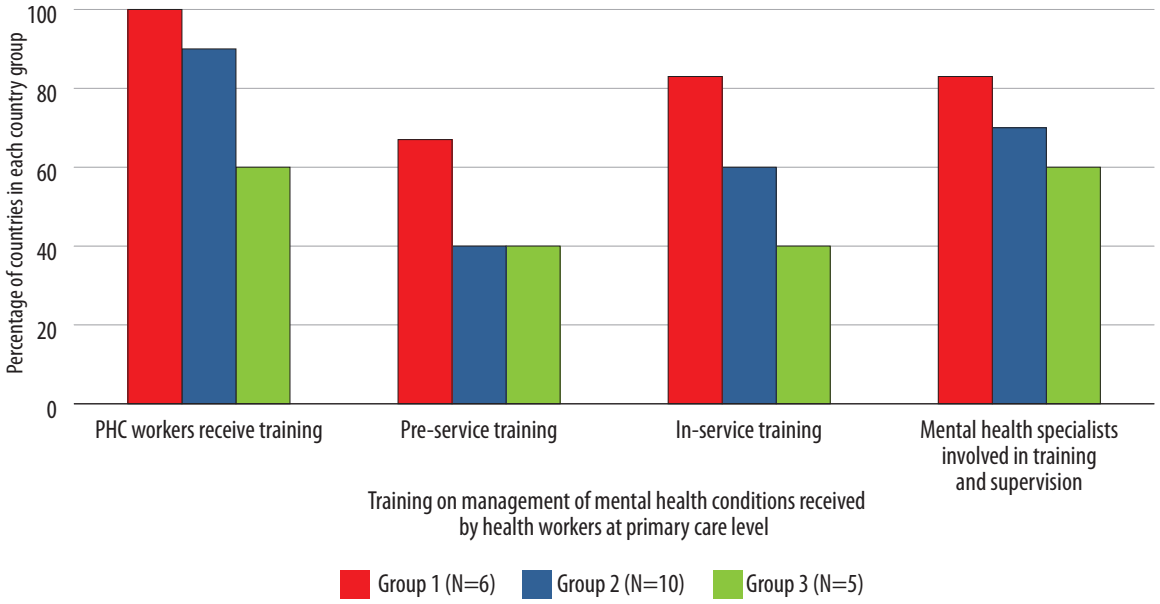


Fig. 4.4. Summary score for mental health integration into primary health care for reporting countries

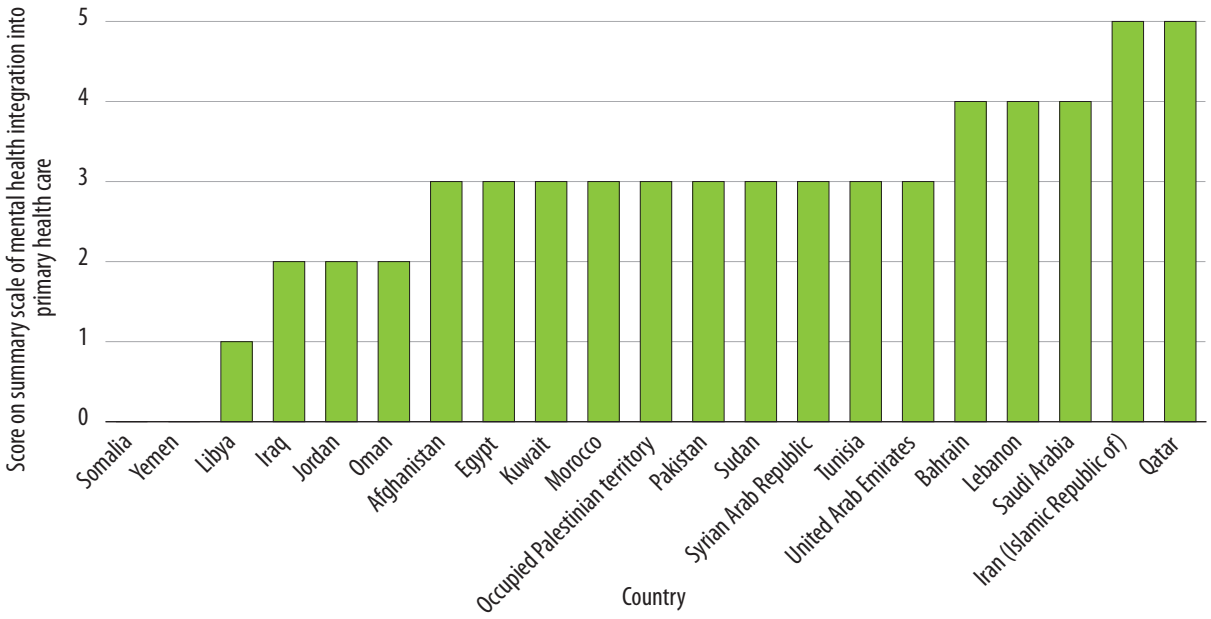
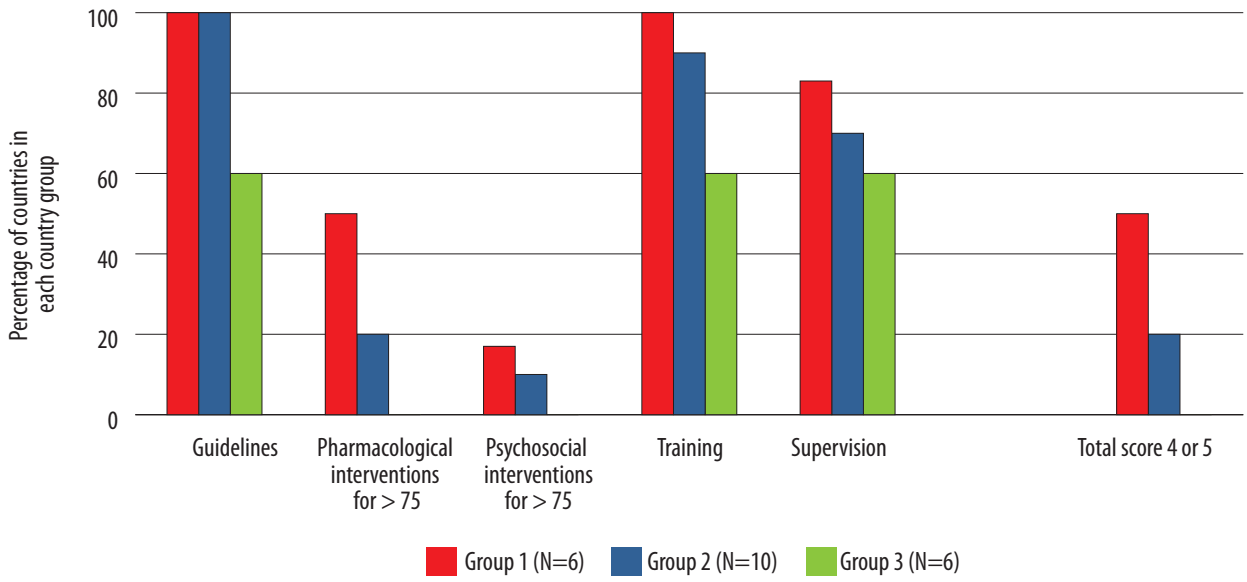


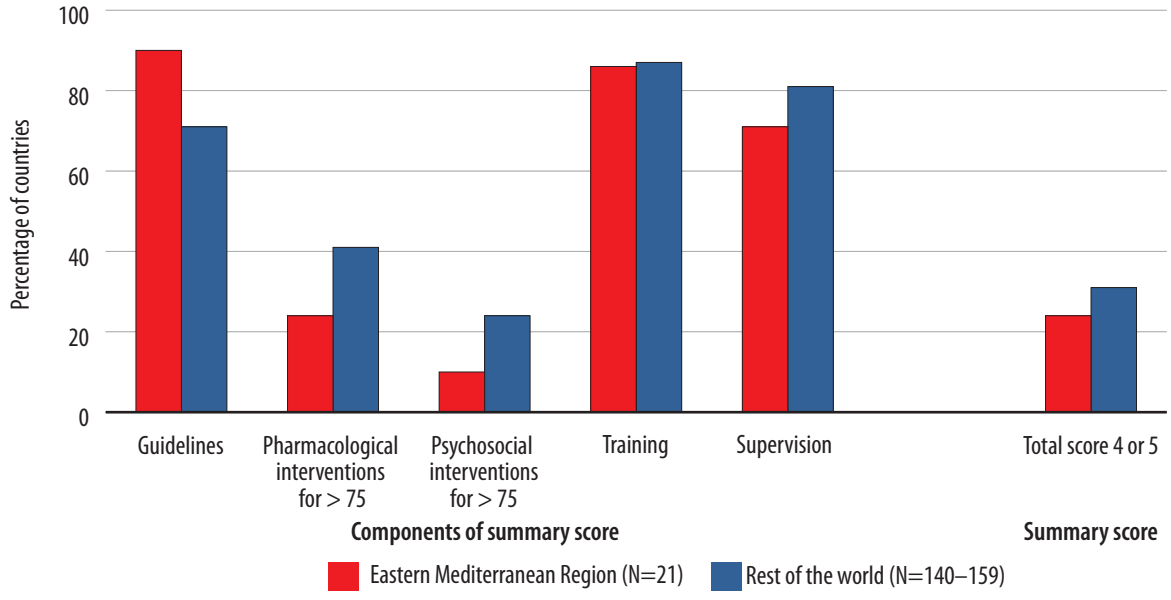
Fig. 4.5. Summary score of 4 or 5 for mental health integration into primary health care, by country group



4.2 Inpatient and residential care for adults

Inpatient and residential care comprises public and/or private, non-profit and for-profit mental hospitals, psychiatric wards in general hospitals, community residential facilities and mental health inpatient facilities (in both mental and general hospitals).[1] Definitions of these facilities are provided in Annex B (Glossary of terms). The Comprehensive Mental Health Action Plan emphasizes the development of interdisciplinary community-based mental health services for people across the life course, for instance through outreach services, home care and support, primary health care, emergency care, community-based rehabilitation and supported housing, and supporting the establishment

Fig. 4.6. Summary score for integration of mental health into primary health care: percentage of all member states in the Eastern Mediterranean Region and the rest of the world scoring over the threshold for component items, and total score



[1] This description of the methodology is largely replicated from the global report of the *Mental health atlas 2020*.

and implementation of community mental health services run by NGOs, faith-based organizations and other community groups, including self-help and family support groups, which protect, respect and promote human rights and are subject to monitoring by government agencies.

The *Mental health atlas 2020* questionnaire asked WHO Member States separately about the level of availability of mental health inpatient services for adults and children, and whether the data collected were disaggregated by sex. It is important to note that significant discrepancies were noted between data reported in 2017 and in 2020 during the analysis and interpretation of the availability of inpatient and residential care services. Consequently, some country data were excluded from the analysis of inpatient care indicators, as the result of a revision process which involved data being checked against 2017 country profiles and reports from the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS)[1] and with the WHO Regional Office and country offices to clarify the reasons for the discrepancies.

Mental hospitals are specialized hospital-based facilities that provide inpatient care and long-stay residential services for people with mental health conditions. Usually, these facilities are independent and stand-alone, although they may have some links with the rest of the health care system. In many countries, they are still the main type of inpatient mental health care facility. Psychiatric wards in general hospitals are psychiatric units that provide inpatient care within a community-based hospital facility. These units provide care to users with acute mental health conditions, and the period of stay is usually relatively short (weeks to months). Community-based residential care facilities typically serve users with relatively stable and chronic mental disorders.

4.2.1 Adult inpatient care indicators

Eleven countries in the Region reported having between three and 10 mental health beds per 100 000 population; eight of these (73%) are Group 2 countries (see Table 4.3 and Fig. 4.7). Five countries have more than 10 mental health beds per 100 000 population; three of these (66%) are in Group 1. Three countries, all in Group 3, have fewer than three beds per 100 000 population. There is a progressive decrease in the median number of mental health beds per 100 000 population when comparing Group 1 with Group 2 and Group 3 countries (see Table 4.3). Median admission rates follow a similar pattern, being highest in Group 1 countries and lowest in Group 3 countries.

In most countries in the Region, the majority of mental health beds are located in mental hospitals (see Fig. 4.8), though Somalia, Afghanistan, the Islamic Republic of Iran and Qatar have fewer than half of their available beds in mental hospitals. Four countries reported that they did not have any beds in mental health units in general hospitals, although such beds accounted for a substantial proportion of provision in several countries, such as United Arab Emirates, Morocco, Tunisia and Somalia. Seven countries reported having mental health beds in residential community facilities, and in three of them (Qatar, the Islamic Republic of Iran and Afghanistan) this was the setting in which the majority of mental health beds are situated. Also, a substantial proportion of mental health beds are in residential community facilities in Somalia (41%) and Yemen (28%). Compared with the rest of the world, the Region has a smaller percentage of beds in mental health units in general hospitals (14% versus 31%). The average percentages of mental health beds located in general hospitals (23%) and community residential facilities (50%) are higher in Group 3 countries than in Group 1 and 2 countries, where approximately 75% of beds are in mental hospitals (see Fig. 4.9).

The percentages of female admissions in almost all countries in the Region and in almost all mental health inpatient settings are below 50% of total admissions; the median female admission rate for all inpatient services across the region is 39%, which is similar to the corresponding rate of 40% in the rest of the world (see Table 4.4). The two exceptions are admissions to psychiatric unit beds in general hospitals in Afghanistan (64% female) and mental hospital admissions in Qatar (63% female). The percentage of female admissions to mental hospitals is lower in Group 2 countries (27%) than in Group 1 and Group 3 countries (both 37%). The numbers of countries reporting are too small to make meaningful country group comparisons for admissions by gender to psychiatric units in general hospitals or community residential facilities.

4.2.2 Length of inpatient stay

Twelve countries in the Region reported fully on the length of inpatient stays in mental hospitals (see Fig. 4.10). In seven of these countries (58%), 80% or more of admissions were for inpatients staying less than one year. Three countries (25%) reported that approximately half of their inpatients had been in hospital for more than five years. The median percentage for inpatients staying less than one year was 83% for countries in the Region, which is lower than the median of 91% for the rest of the world (N=73). The median percentages for stays of less than one year broken down by country group were 86% for Group 1 countries (n=5) and 62% for Group 2 countries (n=6), while the one reporting country in Group 3 (Afghanistan) had 100% of inpatients staying less than one year. The lengths of stay reported

[1] WHO MiNDbank: More Inclusiveness Needed in Disability and Development. WHO-AIMS Country Reports. https://www.mindbank.info/collection/type/whoaims_country_reports/all?page=all.

Table 4.3. Adult inpatient care indicators per 100 000 population (mental hospital, mental health units in general hospitals and community residential facilities) for reporting countries and medians for country groups, the Eastern Mediterranean Region and the rest of the world

	Mental health facilities per 100 000 population	Mental health beds per 100 000 population	Mental health admissions per 100 000 population
Afghanistan	0.03	2.63	20.96
Bahrain	0.06	14.68	73.61
Egypt	0.02	5.15	11.15
Iran (Islamic Republic of)	0.61	40.55	309.34
Iraq	0.06	3.74	11.49
Jordan	0.04	3.70	28.62
Kuwait	0.05	14.69	67.39
Lebanon	0.29	21.54	51.90
Libya	0.03	–	–
Morocco	0.10	5.86	59.82
Occupied Palestinian territory	0.04	3.61	28.59
Oman	0.20	4.42	36.00
Pakistan	0.64	–	–
Qatar	0.14	7.31	52.79
Saudi Arabia	0.06	11.98	–
Somalia	0.06	2.37	–
Sudan	0.03	0.72	30.98
Syrian Arab Republic	0.03	5.27	23.35
Tunisia	0.11	9.35	88.11
United Arab Emirates	0.30	5.08	71.65
Yemen	0.05	4.83	17.60
Group 1 countries	0.10 (N=6)	9.64 (N=6)	67.39 (N=5)
Group 2 countries	0.05 (N=10)	5.27 (N=9)	28.62 (N=9)
Group 3 countries	0.05 (N=5)	2.50 (N=4)	20.96 (N=3)
Eastern Mediterranean Region	0.06 (N=21)	5.15 (N=19)	36.0 (N=17)
Rest of the world	0.31 (N=138)	17.82 N=138)	152.23 (N=115)

* A dash (–) indicates that countries do not have the relevant type of facility or did not provide all of the relevant data.

in previous editions of the *Mental health atlas* can be used to track changes over time. The median percentage of admissions where patients stay less than one year has risen in countries in the Region from 68% in the 2014 edition, through 75% in 2017 to 83% in 2020.

Nine countries reported fully on the length of stay of inpatients in mental hospitals disaggregated by gender. The median percentage of admissions who were female was 31% of total admissions (with a range from 17% to 39%; see Fig. 4.11). This compares with a median

Fig. 4.7. Adult mental health inpatient beds per 100 000 population (mental hospital, mental health units in general hospitals and community residential facilities) for reporting countries, and medians for country groups, the Eastern Mediterranean Region and the rest of the world

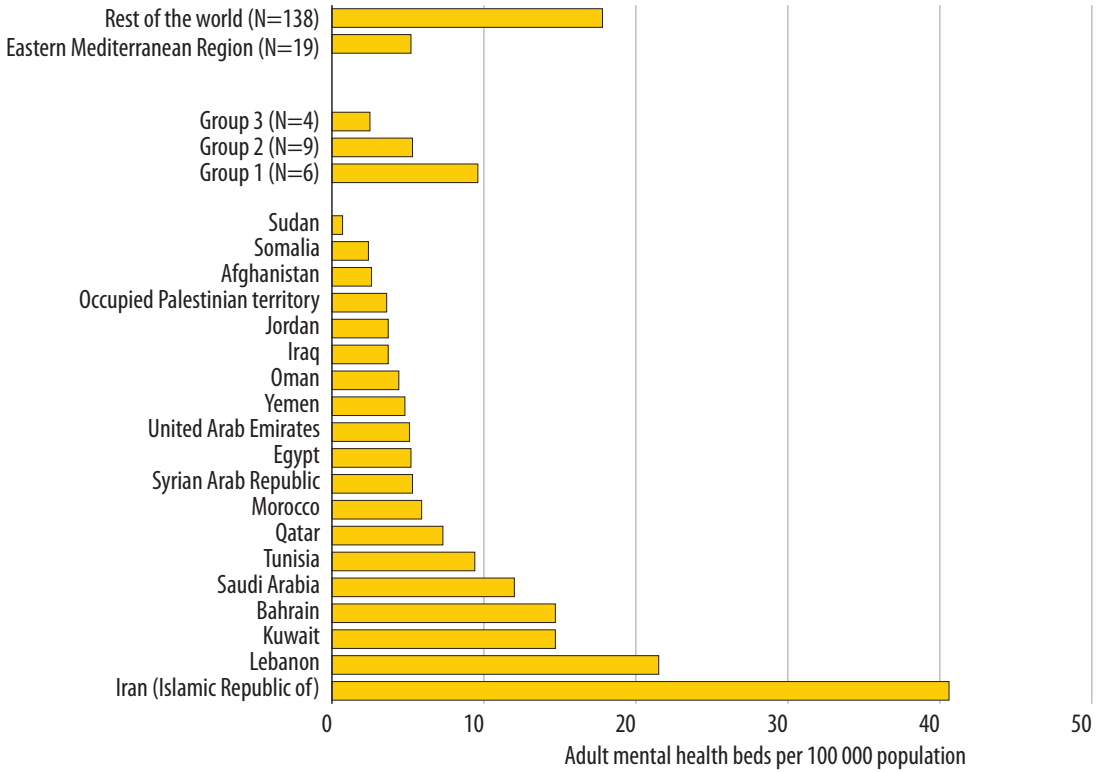


Fig. 4.8. Distribution of mental health beds in reporting countries

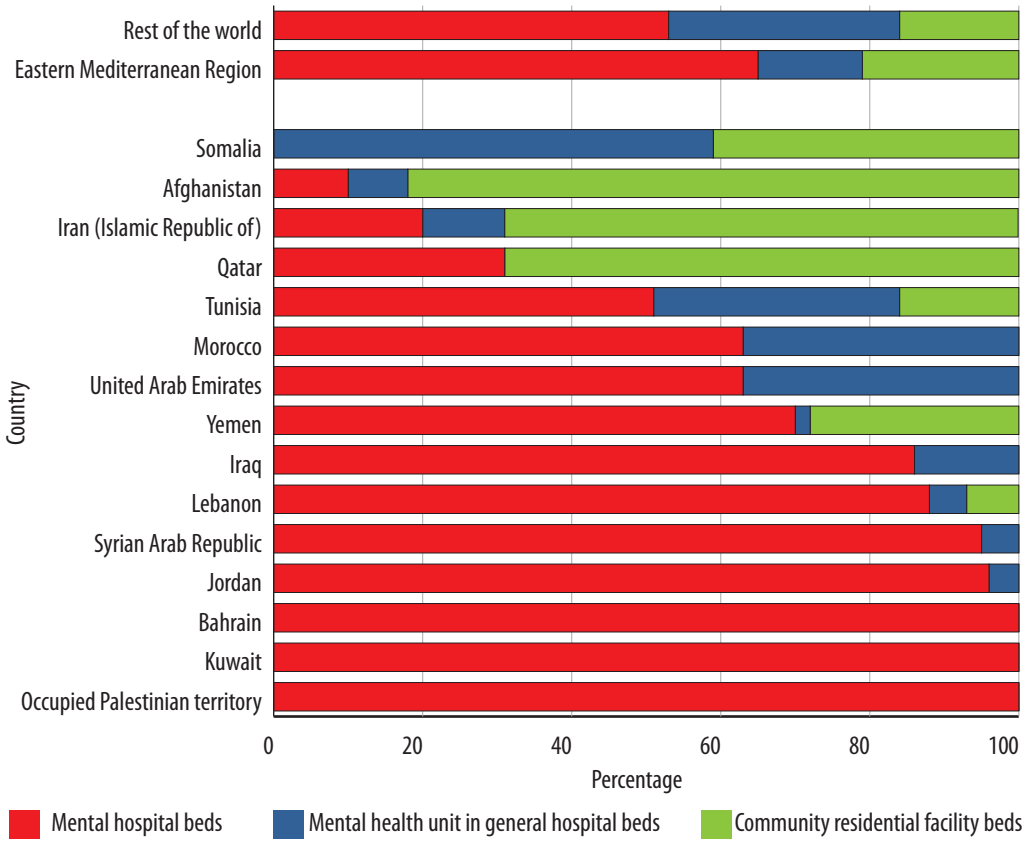


Fig. 4.9. Distribution of mental health beds, by country group

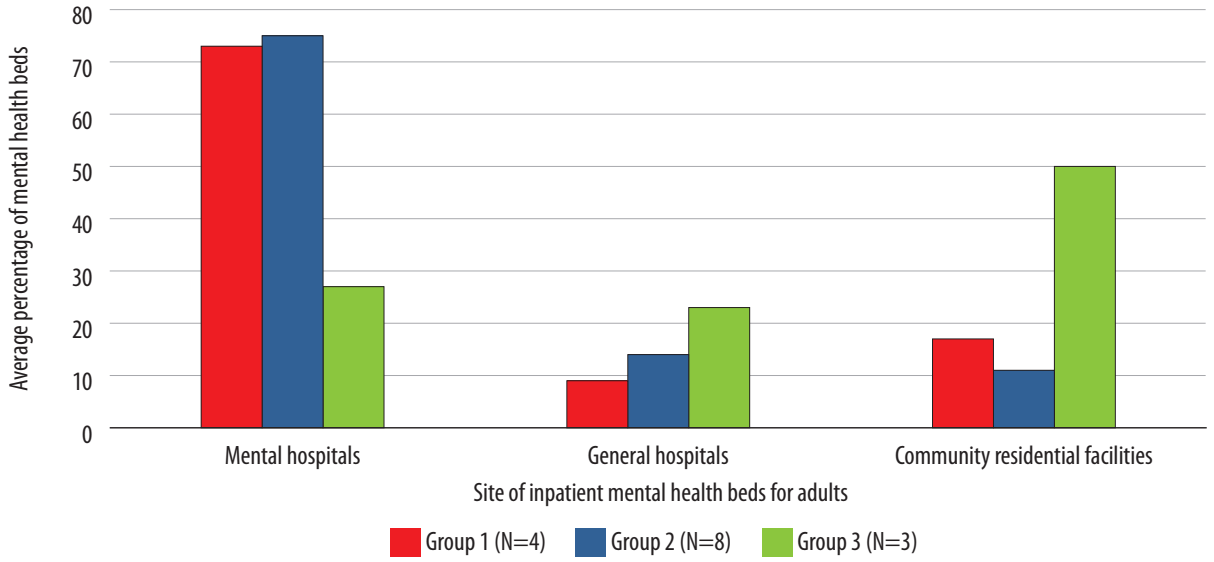


Table 4.4. Percentage of female admissions to mental health inpatient facilities in reporting countries and medians for country groups, the Eastern Mediterranean Region and the rest of the world

Country	Percentage of female admissions*			
	Mental hospitals	Psychiatric units in general hospitals	Community residential facilities	All inpatient services
Afghanistan	28%	64%	36%	55%
Bahrain	31%	–	–	31%
Egypt	13%	–	–	–
Iran (Islamic Republic of)	24%	46%	–	–
Iraq	37%	44%	–	42%
Jordan	33%	0%	–	32%
Kuwait	37%		–	37%
Lebanon	27%	31%	–	–
Morocco	22%	–	–	–
Occupied Palestinian territory	37%	–	–	37%
Oman	23%	–	–	–
Qatar	63%	–	0.5%	47%
Sudan	47%	46%	–	46%
United Arab Emirates	42%	38%	–	39%
Group 1	37% (N=5)			38% (N=4)
Group 2	27% (N=7)	37% (N=4)		37% (N=3)
Group 3	37% (N=2)	55% (N=2)		51% (N=2)
Eastern Mediterranean Region	32% (N=14)	44% (N=7)	18% (N=2)	39% (N=9)
Rest of the world	42% (N=59)	46% (N=56)	44% (N=20)	40% (N=48)

* A dash (–) indicates that countries do not have the relevant type of facility or did not provide all of the relevant data.

Fig. 4.10. Length of inpatient stay in mental hospitals, by reporting country

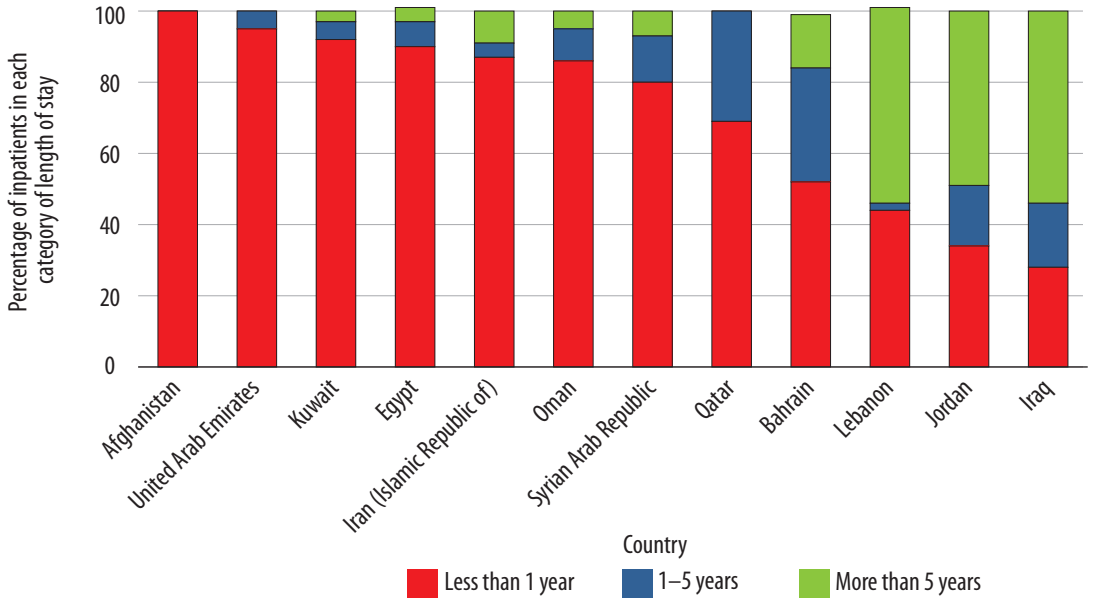
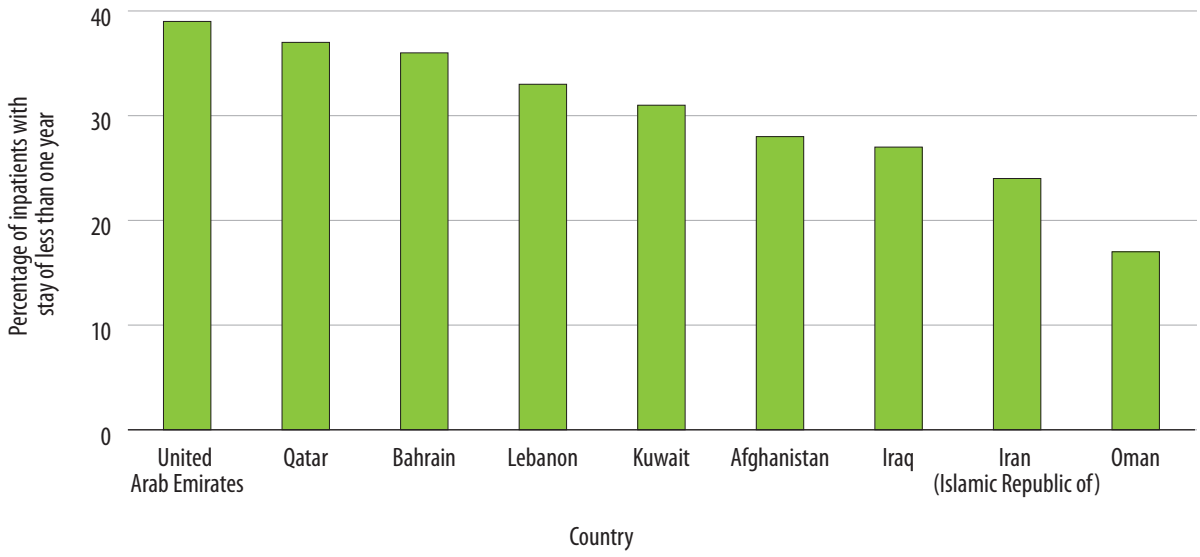


Fig. 4.11. Percentage of female inpatients in mental hospitals in reporting countries

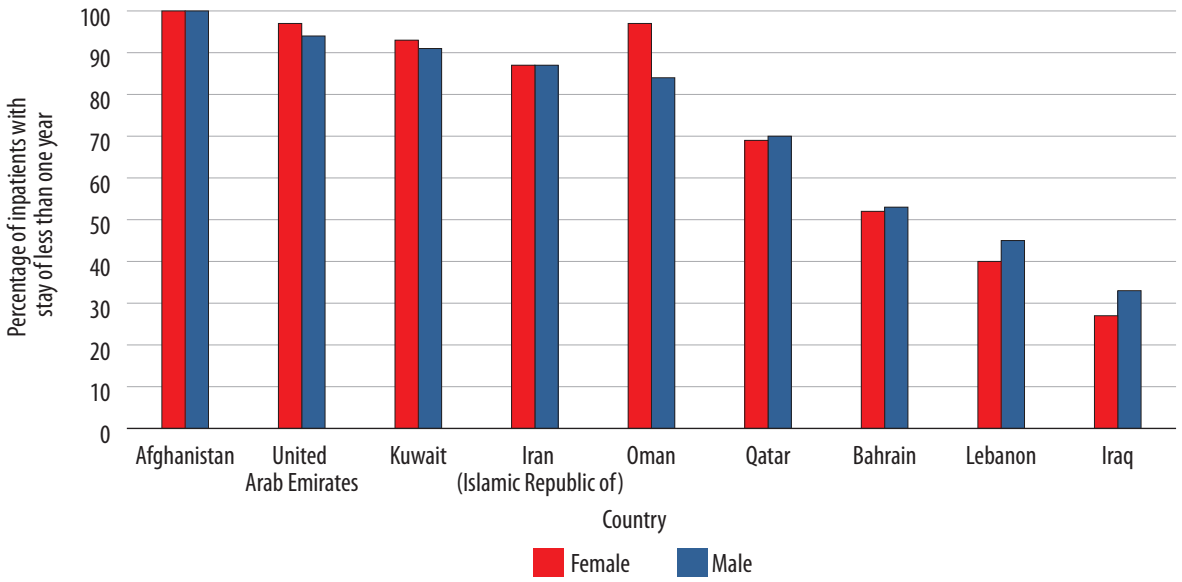


percentage of female inpatients of 41% in countries in the rest of the world (with a range from 7% to 65%, N=41). The percentages of female inpatients and male inpatients with stays of less than one year were similar (within 5%) in most countries in the Region (see Fig. 4.12). The exception was Oman, where 97% of women have stays of less than one year, compared with 84% of men.

4.2.3 Involuntary admissions to mental health facilities

Nine countries in the Region reported on involuntary admissions to inpatient mental health facilities. The median percentage of involuntary admissions was 34%, which is substantially higher than the global median of 9%. Eight countries reported on involuntary admissions to mental hospitals (see the blue columns in Fig. 4.13). The median was 48% involuntary admissions to mental hospitals but the rates varied across a wide range, from 0% in Qatar to 92% in the Islamic Republic of Iran. It is not possible to meaningfully track changes over the past decade because of inconsistent reporting: four of the countries that reported on this item in 2020 also reported on it in 2014, three countries reported on it in 2020 and 2017, and only two countries reported on it in all three years.

Fig. 4.12. Inpatient admissions of less than one year in reporting countries, by gender

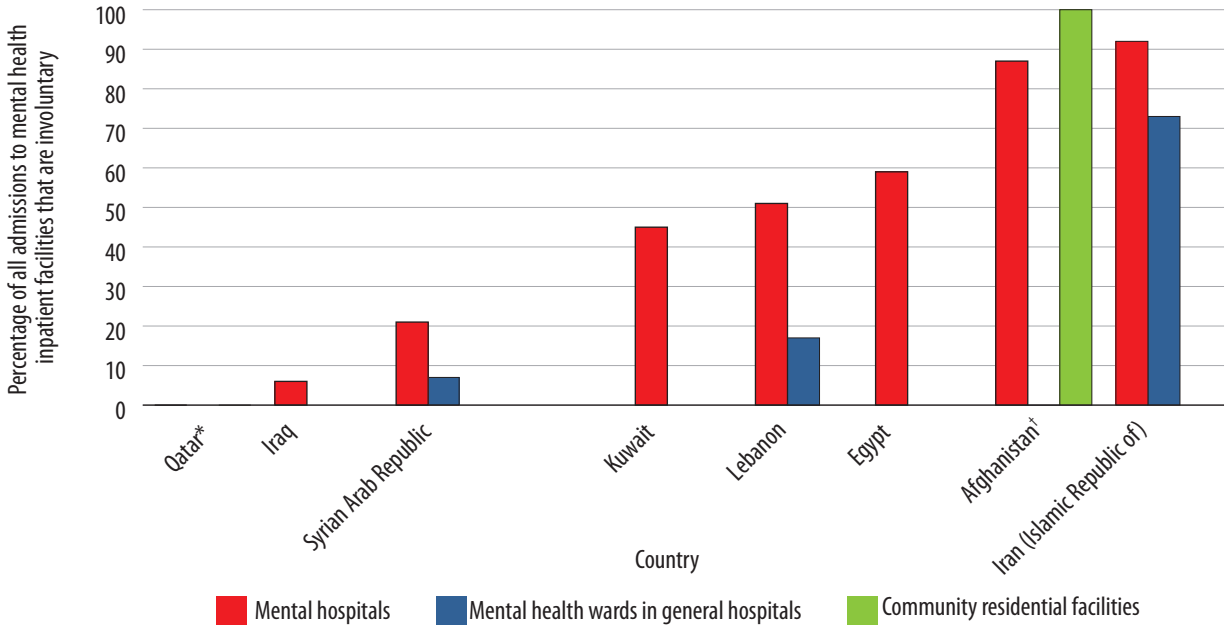


Very few countries in the Region provided data to the *Mental health atlas 2020* on involuntary admissions to mental health wards in general hospitals (N=4) or community residential facilities (N=2). Among those that reported, the range of percentages for involuntary admissions was large: between 0% and 73% for admissions to mental health wards in general hospitals in four countries (blue columns in Fig. 4.13), and between 0% and 100% for admissions to community residential facilities in two countries (green column in Fig. 4.13).

4.2.4 Continuity of care

To assess continuity of care, which is a proxy measure for the quality of the mental health care system, WHO Member States were asked about the proportion of mental health inpatients discharged from hospital who are followed up within one month. Eighteen countries reported on the follow-up of people with mental health conditions discharged from hospital in the last year (see Table 4.5). In 12 countries in the Region (57%), more than half of discharged inpatients returned for a follow-up visit

Fig. 4.13. Involuntary admissions to mental health inpatient facilities in reporting countries



* Qatar reported 0% involuntary admissions to mental hospitals and community residential facilities.
† Afghanistan reported 0% involuntary admissions to mental health wards in general hospitals

Table 4.5. Follow-up of people with mental health conditions discharged from hospital in the last year, in Eastern Mediterranean Region countries and in the rest of the world

Follow-up of discharged inpatients	Number of countries	Percentage of countries (N=21)	Percentage of rest of the world (N=162)
Information not provided	3	14%	22%
25% or fewer returned for a follow-up outpatient visit within one month	2	10%	12%
26–50% returned for a follow-up outpatient visit within one month	4	19%	13%
51–75% returned for a follow-up outpatient visit within one month	9	43%	22%
More than 75% returned for a follow-up outpatient visit within one month	3	14%	31%

within one month, while in two countries (10%) fewer than 25% did so. These rates are similar to those reported in the *Mental health atlas 2017*, when 12 countries also reported that more than half of discharged inpatients were followed up within one month. Approximately half of countries in the Region and in the rest of the world followed up on 51% or more of discharged inpatients within one month. However, a greater proportion of countries in the rest of the world followed up on more than 75% of discharged inpatients within one month than countries in the Eastern Mediterranean Region (31% compared with 14%).

A greater percentage of inpatients were followed up within one month of discharge from hospital in well-resourced countries than in those that are less well resourced. More than 50% of inpatients were followed up within one month in five Group 1 countries (83%), five Group 2 countries (50%) and two Group 3 countries (40%) (see Fig. 4.14). The two countries that reported that 25% or fewer inpatients returned within one month were both in Group 3.

4.2.5 Physical care of people in mental hospitals

WHO Member States were asked for the first time in 2020 to indicate the percentages of inpatients receiving timely diagnosis, treatment and follow-up for physical health conditions (e.g. cancer, tuberculosis, diabetes) in mental hospitals. Nineteen countries reported on this data point (see Table 4.6). In nine countries in the Region (43%), more than half of inpatients in mental hospitals received timely physical health care. However, in six countries (29%) fewer than 25% of inpatients received timely care. A smaller percentage of countries in the Region reported that more than 75% of inpatients received timely physical health care than countries in the rest of the world (29% compared with 36%), while

Fig. 4.14. Follow-up of people with mental health conditions discharged from hospital in the last year, by country group

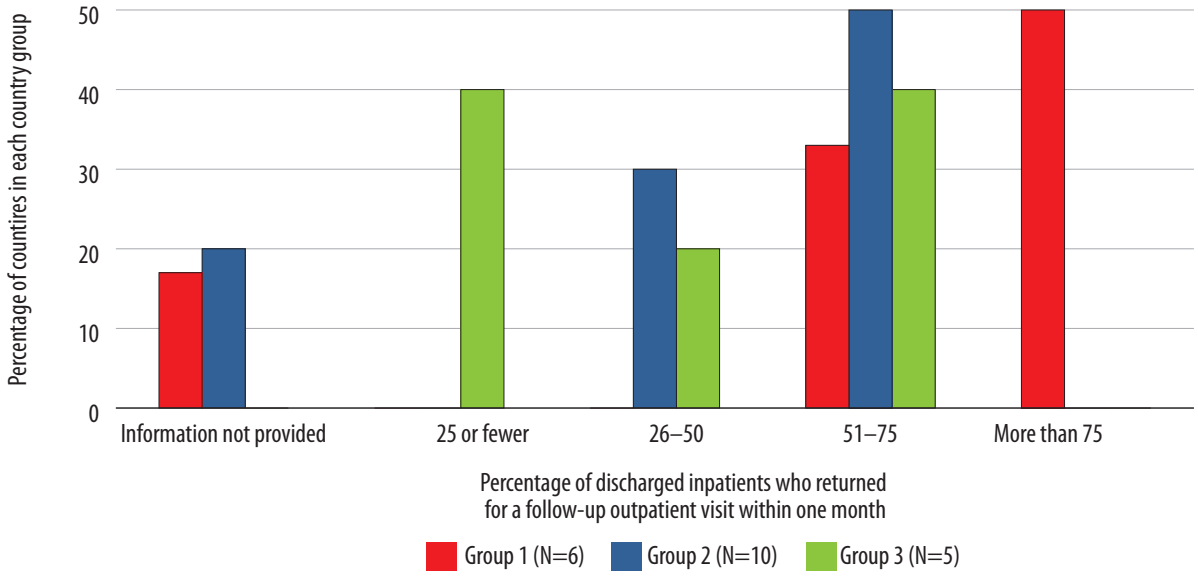


Table 4.6. Physical health care received by mental health inpatients in countries of the Eastern Mediterranean Region and in the rest of the world

Inpatients who received timely diagnosis, treatment and follow-up for physical health conditions (e.g. cancer, diabetes or TB)	Number of countries	Percentage of countries (N=21)	Percentage of rest of the world (N=162)
Information not provided	2	10%	26%
25% or fewer	6	29%	14%
26–50%	4	19%	7%
51–75%	3	14%	16%
More than 75%	6	29%	36%

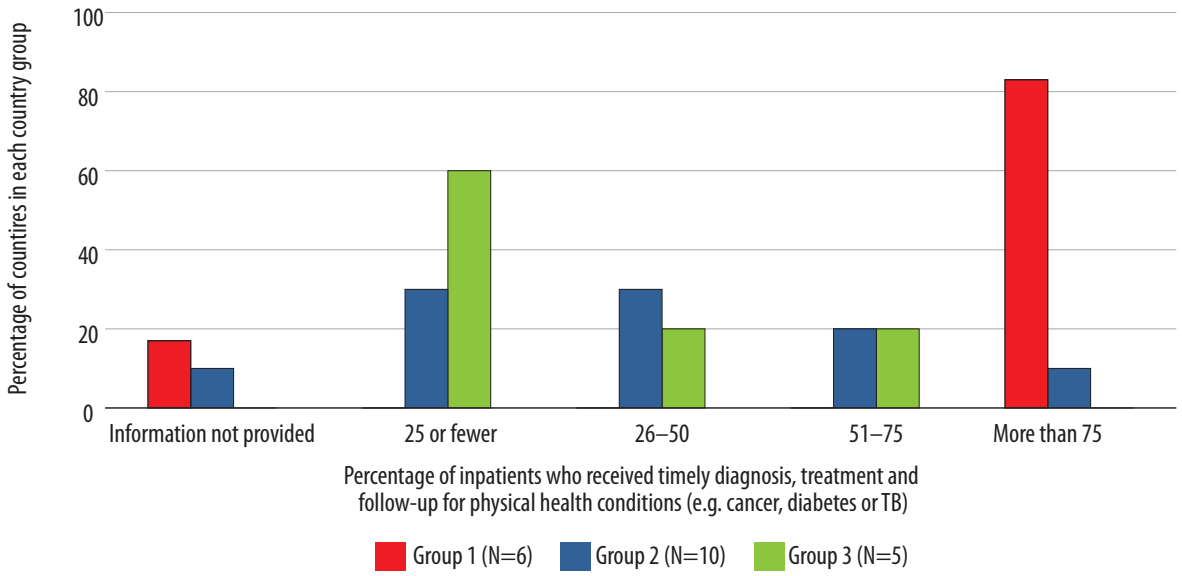
more countries in the Region reported that timely care was provided to only 25% or fewer mental hospital inpatients (29% versus 14%).

Timely physical health care was provided for more inpatients in well-resourced countries in the Region than in their less well-resourced counterparts. Such care was provided for more than 75% of inpatients in the five Group 1 countries (83%) that reported on this item (see Fig. 4.15). Six Group 2 countries (60%) reported that fewer than half of their mental health inpatients received timely physical health care, and three Group 3 countries (60%) reported that 25% or fewer of mental health inpatients received timely physical health care.

4.3 Outpatient care for adults

Outpatient care consists of both public and private and non-profit and for-profit facilities, including hospital-based outpatient facilities (e.g. outpatient departments and/or clinics located in mental and/or general hospitals, including those for specific mental health conditions, treatments or user groups), community-based mental health outpatient facilities (e.g. community mental health centres) and other outpatient facilities (e.g. residential facilities for specific mental health conditions).[1] Definitions for these types of facility are provided in Annex B. Outpatient care serves persons with both chronic and acute, and mild and

Fig. 4.15. Physical health care received by mental health inpatients, by country group



[1] This paragraph on methodology is largely replicated from the global report of the *Mental health atlas 2020*.

severe, mental health conditions, and it focuses on the management of mental health conditions using a bio-psychosocial approach. It is important to note that large discrepancies were noted between data reported in 2017 and 2020 during the analysis and interpretation of responses on the availability of outpatient care services. Consequently, some country data were excluded from the analysis of outpatient care indicators, following a revision process in which data were checked against 2017 country profiles and WHO-AIMS reports[1] and with the WHO Regional Office and country offices to clarify the reasons for discrepancies.

All 21 responding countries indicated that they have hospital-based mental health outpatient facilities. Thirteen (62%) have community-based facilities, and 15 (71%) have other outpatient facilities. Although the majority of Group 1 and Group 2 countries have community-based facilities (67% of Group 1 and 70% of Group 2 countries) and other outpatient facilities (83% of Group 1 and 80% of Group 2 countries), only 40% of Group 3 countries reported having both kinds of facility. More than half of mental health facilities are hospital-based in Bahrain, Jordan, Pakistan, Tunisia and United Arab Emirates (see Table 4.7), while more than half of facilities are community-based in Afghanistan, the Islamic Republic of Iran, Lebanon, Morocco, occupied Palestinian territory, Qatar and Syrian Arab Republic. Kuwait has most of its mental health outpatients in other facilities. The total number of mental health outpatient facilities per 100 000 population in countries in the Region is similar to that in the rest of the world (0.56 compared with 0.63). The median total number of facilities in Group 3 countries is, surprisingly, higher than in Group 1 and 2 countries: this is attributable to the high number of facilities in two of the four reporting Group 3 countries – community-based facilities in Afghanistan and hospital-based facilities in Pakistan.

Not all countries were able to report on the number of visits to the different types of mental health outpatient facilities, particularly other outpatient facilities. This imposes two restrictions on comparison within the region. Firstly, it limits the number of countries that can be included in an analysis of total outpatient visits (see right-hand column of Table 4.8). Secondly, since all countries reported on the presence of facilities and those without such facilities by definition have zero visits, the median values for country groups and the Region as a whole are biased to be low.

The pattern of number of visits per 100 000 population varies from country to country, with different kinds of site predominating in different countries (see Table 4.8 and Fig. 4.16). Almost all outpatients are seen at hospital facilities in Bahrain, Kuwait, Sudan and Tunisia; in Afghanistan, the Islamic Republic of Iran, Lebanon and occupied Palestinian territory the majority are seen at community-based facilities; and in United Arab Emirates more outpatients are seen at other facilities than in either of the other settings. This pattern largely mirrors the pattern of outpatient facilities (shown in Table 4.7), with two exceptions: high proportions of outpatients are seen in hospital-based facilities in Kuwait, and in other facilities in Qatar and United Arab Emirates. There were more outpatient visits to hospital-based outpatient facilities in Group 1 countries, and fewer in Group 3 countries. A similar trend is evident for total outpatient visits. Across the Region, a median of 56% of outpatients were seen at hospital-based facilities and 32% were seen at community-based facilities, a similar proportion to the corresponding rates of 54% and 25% in the rest of the world.

The median percentage of all outpatient visits that were made by female outpatients in the Region was 41%, which is a slightly lower figure than in the rest of the world (49%) (see Table 4.9 and Fig. 4.17). The proportion of female outpatient visits is higher in community-based facilities (53%) than in hospital-based facilities (40%) and other facilities (36%). The two countries in Group 3 that reported on outpatient visits by gender had higher percentages of female visits than Group 1 and 2 countries.

An index of service contacts within inpatient and outpatient services can be calculated as the proportion of all mental health service contacts that are outpatient visits: number of visits ÷ (number of admissions + number of visits). Among countries in the Region that reported all mental health visits (N=8), the index of service contacts was 98%. The corresponding figure for the rest of the world was 93% (N=49). Despite the small number of reporting countries, the index of service contacts was consistently higher than for the rest of the world in all three country groups: Group 1 = 98% (N=4), Group 2 = 98% (N=2) and Group 3 = 94% (N=2).

4.4 Child and adolescent mental health services

4.4.1 Strategy for child and adolescent mental health services

Countries were asked whether they had a policy/plan for child and/or adolescent mental health. The governments of 11 countries in the Region (52%) have adopted such a plan or strategy (see Fig. 4.18); seven of these (70%) have been published since 2017, and three were published between 2013 and 2016. In the rest of the world, 53% of countries have child and/or adolescent mental health plans or strategies; 66% of these have been published since 2017.

[1] WHO MiNDbank: More Inclusiveness Needed in Disability and Development. WHO-AIMS Country Reports. https://www.mindbank.info/collection/type/whoaims_country_reports/all?page=all.

Table 4.7. Mental health outpatient facilities in reporting countries, with medians for country groups, the Eastern Mediterranean Region and the rest of the world

Country	Outpatient facilities per 100 000 population			
	Hospital-based	Community-based	Other	Total
Afghanistan	0.33	6.89	0.00	7.22
Bahrain	0.67	0.24	0.24	1.16
Egypt	0.02	0.00	–	–
Iran (Islamic Republic of)	0.34	6.51	0.15	6.99
Iraq	0.08	0	–	–
Jordan	0.51	0.23	0	0.74
Kuwait	0.05	0	0.48	0.52
Lebanon	0.18	1.21	0.07	1.46
Libya	0.06	0	0.01	0.07
Morocco	0.10	0.23	0.01	0.34
Occupied Palestinian territory	0.04	0.42	0.02	0.48
Oman	0.20	0	0.28	0.48
Pakistan	1.72	0.29	0	2.01
Qatar	0.04	0.49	0.07	0.60
Saudi Arabia	–	–	–	–
Somalia	0.03	0	0	0.03
Sudan	0.03	0	0	0.03
Syrian Arab Republic	0.05	2.34	–	–
Tunisia	0.24	0	0.03	0.27
United Arab Emirates	0.32	0.01	1.16	1.48
Yemen	0.08	0	–	–
Group 1 countries	0.20 (N=5)	0.01 (N=5)	0.28 (N=5)	0.60 (N=5)
Group 2 countries	0.09 (N=10)	0.23 (N=10)	0.02 (N=7)	0.48 (N=7)
Group 3 countries	0.08 (N=5)	0.00 (N=5)	0.00 (N=4)	1.02 (N=4)
Eastern Mediterranean Region	0.09 (N=20)	0.12 (N=20)	0.03 (N=16)	0.56 (N=9)
Rest of the world	0.22 (N=112)	0.13 (N=108)	0.00 (N=103)	0.63 (N=83)

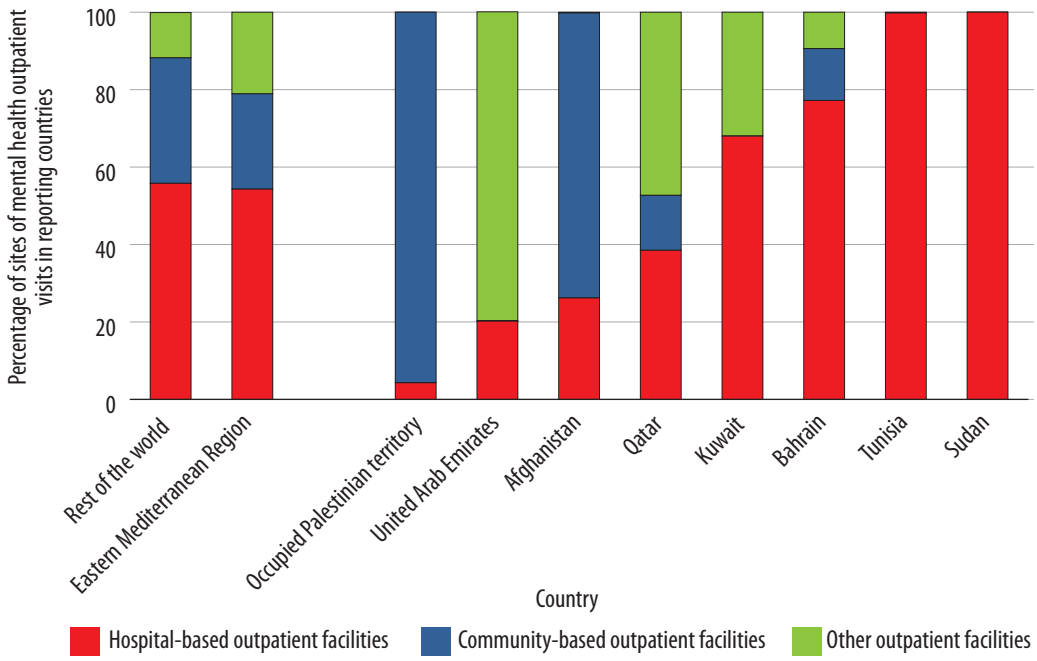
* A dash (–) indicates that countries did not provide all of the relevant data.

Table 4.8. Mental health outpatient visits per 100 000 population to hospital-based mental health outpatient facilities, community-based mental health outpatient facilities and other outpatient facilities in reporting countries, with medians for country groups, the Eastern Mediterranean Region and the rest of the world

Country	Mental health outpatient visits per 100 000 population			
	Hospital-based	Community-based	Other	Total
Afghanistan	1064	2990	10	4065
Bahrain	3286	570	400	4255
Egypt	574	11	–	–
Iran (Islamic Republic of)	1624	5076	–	–
Iraq	283	0	–	–
Jordan	2	–	0	–
Kuwait	1141	0	537	1678
Lebanon	21	1105	–	1125
Libya	–	0	–	–
Morocco	347	358	–	–
Occupied Palestinian territory	164	3664	0.2	3828
Oman	336	0	–	–
Pakistan	–	–	0	–
Qatar	1335	494	1641	3470
Saudi Arabia	–	–	–	–
Somalia	–	0	0	–
Sudan	228	0	0	228
Syrian Arab Republic	792	498	–	–
Tunisia	2383	0	5	2389
United Arab Emirates	600	2	2374	2976
Yemen	194	0	–	–
Group 1 countries	1141 (N=5)	2 (N=5)	1089 (N=4)	3223 (N=4)
Group 2 countries	347 (N=9)	358 (N=9)	0 (N=3)	3108 (N=2)
Group 3 countries	228 (N=3)	0 (N=4)	0 (N=4)	2146 (N=2)
Eastern Mediterranean Region	574 (N=17)	6 (N=18)	5 (N=11)	3223 (N=8)
Rest of the world	871 (N=99)	10 (N=89)	0 (N=91)	1902 (N=58)

* A dash (–) indicates that countries did not provide all of the relevant data.

Fig. 4.16. Percentage of sites of mental health outpatient visits in reporting countries – hospital-based, community-based and other outpatient facilities



4.4.2 Inpatient mental health services for children and adolescents

WHO Member States were asked to report on the availability and provision of mental health services providing inpatient care for children and adolescents. Such inpatient services specifically for children and adolescents (e.g. mental hospitals and/or in general hospitals) are provided in 10 countries in the Region (48%), compared with 56% of countries in the rest of the world (see Fig. 4.19). There are inpatient services in 67% of Group 1 countries compared with 40% of Group 2 and Group 3 countries. Mental health community residential facilities (e.g. group housing for young people with psychosis or developmental disabilities) are provided in six countries in the Region (29%), compared with 23% of countries in the rest of the world. Similar proportions of countries in each country group have community residential facilities for children and adolescents (ranging from 20% to 40%).

Among the 12 countries in the Region with child and adolescent inpatient facilities, the median number of facilities overall was 0.08 per 100 000 population of those aged 0–19, compared with 0.2 facilities per 100 000 population aged 0–19 globally.

There are large variations between countries in the Region in terms of both numbers of mental health beds and the number of admissions per 100 000 population for children and adolescents (see Table 4.10). Bahrain has the largest inpatient provision per head of population, though this is provided by a single 12-bed inpatient unit. The Islamic Republic of Iran has the largest community residential provision per head of population, spread across 271 facilities with a total of 19,171 beds; one of the main activities of the country's State Welfare Organization is providing residential care for the intellectually disabled and those with other forms of developmental disability. Median admission rates are highest in Group 1 countries (11.5 admissions per 100 000 population), compared with Group 2 countries (4.8 admissions per 100 000 population) and Group 3 countries (1.0 admissions per 100 000 population) (see Fig. 4.20). Nevertheless, even in Group 1 countries the median admission rate falls well short of the rate of 46.3 per 100 000 population in the rest of the world.

4.4.3. Outpatient mental health services for children and adolescents

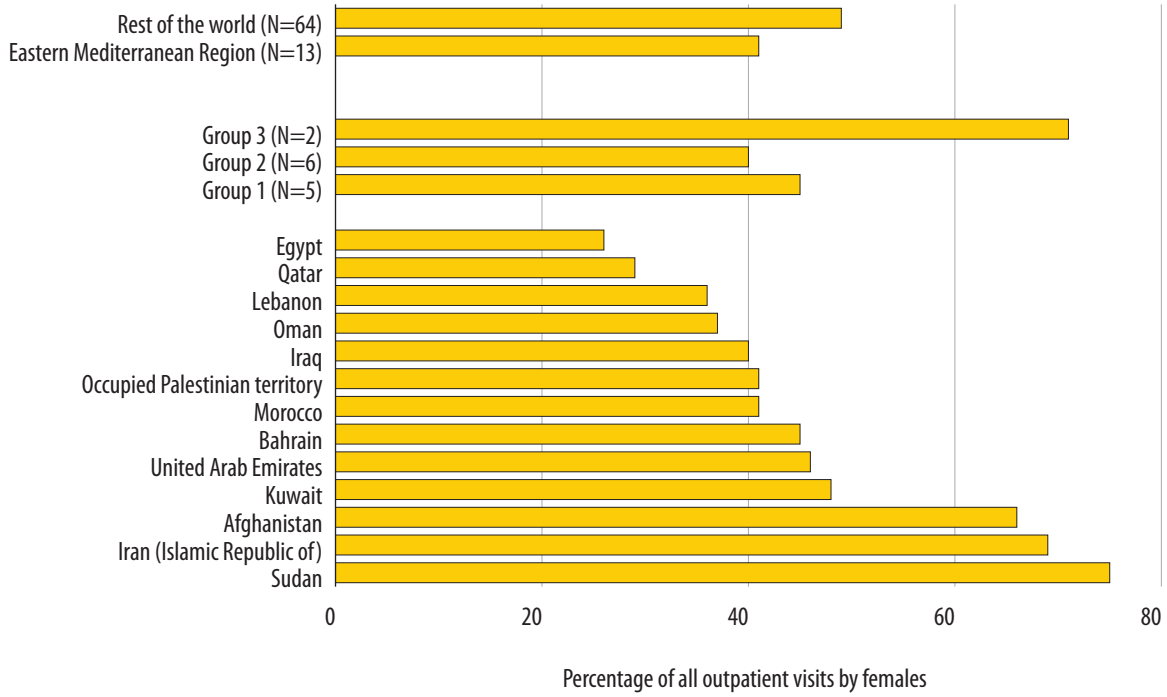
Countries were asked about four types of outpatient mental health services for children and adolescents: 1) hospital-based mental health outpatient services specifically for children and adolescents (e.g. services for developmental disabilities, child development monitoring); 2) community-based mental health outpatient facilities (e.g. community-based parenting support; home visits for children with developmental disabilities or psychosis); 3) school-based mental health services (e.g. group-based psychosocial support for youth); and 4) other outpatient services for children and adolescents (e.g. mental health day treatment facilities).

Table 4.9. Percentage of mental health outpatient visits by females in reporting countries, with medians for country groups, the Eastern Mediterranean Region and the rest of the world

Country	Percentage of outpatient visits to mental health outpatient facilities by females*			
	Hospital-based	Community-based	Other outpatient facilities	All reported outpatient facilities
Afghanistan	65	67	23	66
Bahrain	40	55	66	45
Egypt	25	33	–	26
Iran (Islamic Republic of)	34	80	–	69
Iraq	40	–	–	40
Jordan	–	–	–	–
Kuwait	46	–	56	48
Lebanon	47	35	–	36
Libya	–	–	–	–
Morocco	36	46	–	41
Occupied Palestinian territory	41	41	25	41
Oman	37	–	–	37
Pakistan	–	–	–	–
Qatar	51	61	2	29
Saudi Arabia	–	–	–	–
Somalia	–	–	–	–
Sudan	75	–	–	75
Syrian Arab Republic	–	–	–	–
Tunisia	–	–	–	–
United Arab Emirates	–	53	46	46
Yemen	–	–	–	–
Group 1 countries	43 (N=4)	55 (N=3)	51 (N=4)	45 (N=5)
Group 2 countries	38 (N=6)	41 (N=5)	25 (N=1)	40 (N=6)
Group 3 countries	70 (N=2)	67 (N=1)	23 (N=1)	71 (n=2)
Eastern Mediterranean Region	40 (N=12)	53 (N=9)	36 (N=6)	41 (N=13)
Rest of the world	52 (N=54)	54 (N=35)	42 (N=21)	49 (N=64)

* A dash (–) indicates that countries do not have the relevant type of facility or did not provide all of the relevant data.

Fig. 4.17. Percentage of all reported mental health outpatient visits by females for reporting countries, and medians for country groups, the Eastern Mediterranean Region and the rest of the world



Among 16 countries in the Region with child and adolescent outpatient facilities, the median number of outpatient facilities was 0.12 per 100 000 population, compared with 1.1 per 100 000 population globally. Hospital-based outpatient services are provided in 15 countries in the Region (71%). This includes almost all Group 1 and Group 2 countries, but only 20% of Group 3 countries (see Fig. 4.21). School-based services are found in 11 countries (52%), while community-based and other services are each provided in eight countries (38%). These latter three types of service were most frequently reported by Group 2 countries (50–70%), followed by Group 1 countries (33–50%), and least frequently by Group 3 countries (0–20%).

The median total number of outpatient visits per 100 000 population in countries in the Region with outpatient facilities is 179 per 100 000 population, which is substantially lower than the corresponding figure of 1380 per 100 000 population for the rest of the world (see Fig. 4.22). Within the Region, outpatient visits are highest in Group 1 countries (397 per 100 000 population) and lowest in Group 3 countries (20 per 100 000 population). The majority of outpatient visits for children and adolescents are at hospital-based facilities (226 per 100 000 population), followed by community-based (68 per 100 000), school-based (18 per 100 000) and other facilities (9 per 100 000 population) (see Table 4.11). However, there are large variations between individual countries in the Region. Bahrain, Qatar and Tunisia reported more than 900 hospital-based visits per 100 000 population; Qatar reported 1469 community-based visits per 100 000 population; Bahrain reported 540 school-based visits per 100 000 population; and the Islamic Republic of Iran reported having 25.4 school-based mental health outpatient facilities for children and adolescents per 100 000 population.

An index of service contacts within inpatient and outpatient services for children and adolescents can be calculated as the proportion of all mental health service contacts that are outpatient visits: number of visits ÷ (number of admissions + number of visits). For the 11 countries in the Region that reported on admissions and visits, the index of service contacts was 97%. The corresponding figure for the rest of the world was 98% (N=49). The median index of service contacts for country groups was Group 1 = 97% (N=5), Group 2 = 100% (N=5) and Group 3 = 95% (N=1).

Fig. 4.18. Child and/or adolescent mental health plans or strategies adopted by the governments of reporting countries

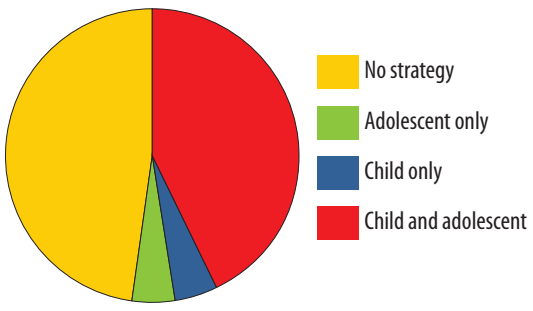
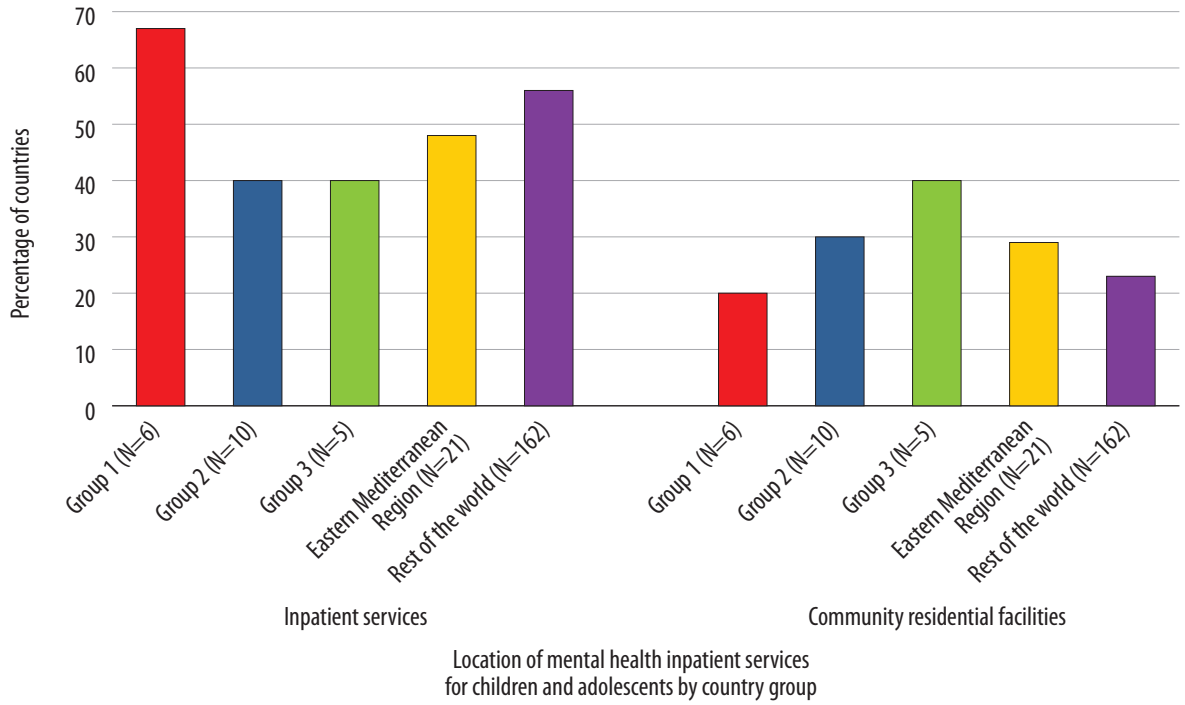


Fig. 4.19. Mental health inpatient and community residential services specifically for children and adolescents, by country group



4.5 Community-based mental health services

A key objective of the Comprehensive Mental Health Action Plan 2013–2030 is to provide comprehensive, integrated and responsive mental health and social care services in community-based settings. A new target, global target 2.2, is for 80% of countries to double their number of community-based mental health facilities by 2030. Data from the *Mental health atlas 2020* provide a baseline for this indicator, which future Atlas reports can use for comparison.

Community-based mental health services are defined as services that are provided in the community, outside a hospital setting. Data for this indicator include a country's reported number of community-based outpatient facilities (e.g. community mental health centres), school-based mental health services, other outpatient services (e.g. day treatment facilities) and mental health community residential facilities for both adults and children and adolescents.

The median number of community-based facilities in countries in the Region is 23. After correcting for population sizes, this translates to a median of 0.48 facilities per 1000 000 population. There are large variations between countries (see Fig. 4.23). The highest numbers of community-based facilities are in the Islamic Republic of Iran and Afghanistan, which both have high levels of provision of community mental health centres, while the Islamic Republic of Iran in addition has high numbers of school-based facilities. There are more than twice the number of community-based facilities per 100 000 population in Group 1 countries (0.61 facilities) than in Group 2 and Group 3 countries (0.24 and 0.29 facilities respectively (see Fig. 4.24). However, the provision of community-based facilities is lower in all three country groups and in the Region as a whole than it is in the rest of the world (1.14 facilities per 100 000 population).

4.6 Treated prevalence

Achieving universal health coverage, including for persons with mental health conditions, is the cornerstone of WHO's Thirteenth General Programme of Work (GPW) Impact Framework.[1] Increased service coverage for persons with severe mental health conditions is one of the core targets of the WHO Comprehensive Mental Health Action Plan 2013–2030. This is defined as the proportion of persons with a mental health condition contacting a mental health service out of those estimated to have the condition over a period of 12 months. It reflects the actual contact between persons with mental health conditions and mental health services and also the quality of health information systems reporting on the utilization of mental health specialist services.

[1] This and the following paragraph on methodology are replicated from the global report of the *Mental health atlas 2020*.

Table 4.10. Provision of and admissions to inpatient and residential services specifically for children and adolescents per 100 000 population in reporting countries, with medians for the Eastern Mediterranean Region and the rest of the world

Country	Inpatient services for children and adolescents per 100 000 population			Community residential services for children and adolescents per 100 000 population		
	Facilities	Beds	Admissions	Facilities	Beds	Admissions
Afghanistan	0.005	0.02	1.01	–	–	–
Bahrain	0.255	3.06	52.72	0	0	0
Egypt	0.007	0.14	0.26	0	0	0
Iran (Islamic Republic of)	0.046	0.76	13.95	1.046	74.00	–
Iraq	0	0	0	0	0	0
Jordan	0	0	0	0	0	0
Kuwait	0.089	1.78	11.47	0	0	0
Lebanon	0	0	0	0.171	–	–
Libya	0	0	0	0	0	0
Morocco	0.008	0.13	4.18	0	0	0
Occupied Palestinian territory	0	0	0	0	0	0
Oman	0.075	0.30	3.67	0	0	0
Pakistan	0.003	–	–	–	–	–
Qatar	0	0	0	0.200	0.40	17.03
Saudi Arabia	–	–	–	–	–	–
Somalia	0	0	0	0	0	0
Sudan	0	0	0	0	0	0
Syrian Arab Republic	0	0	0	0	0	0
Tunisia	0.055	0.86	5.39	0.110	4.45	–
United Arab Emirates	0.054	0.43	1.09	0	0	0
Yemen	0	0	0	0	0	0
Eastern Mediterranean Region*	0.055 (N=10)	0.65 (N=9)	3.24 (N=9)	0.110 (N=4)	4.45 (N=3)	–
Rest of the world*	0.291 (N=64)	3.25 (N=61)	52.81 (N=60)	0.459 (N=13)	8.31 (N=12)	5.48 (N=7)

* For the Eastern Mediterranean Region and the rest of the world, the medians are quoted for countries with the relevant facilities. A dash (–) indicates that countries did not provide all of the relevant data.

Fig. 4.20. Inpatient care for children and adolescents: median total number of admissions per 100 000 population for countries with inpatient facilities, by country group, the Eastern Mediterranean Region and the rest of the world

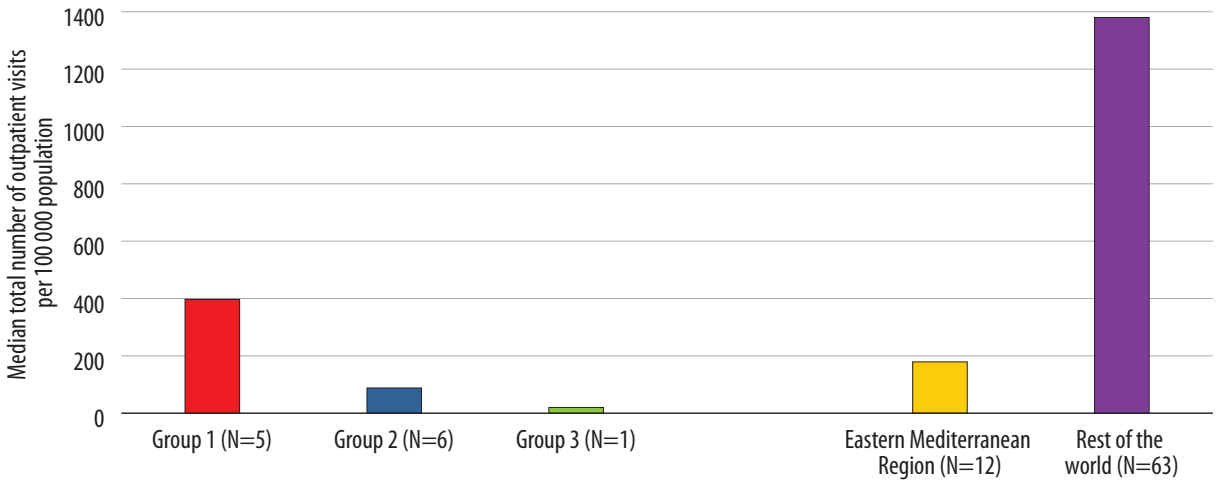


Fig. 4.21. Mental health outpatient and community-based services specifically for children and adolescents, by country group

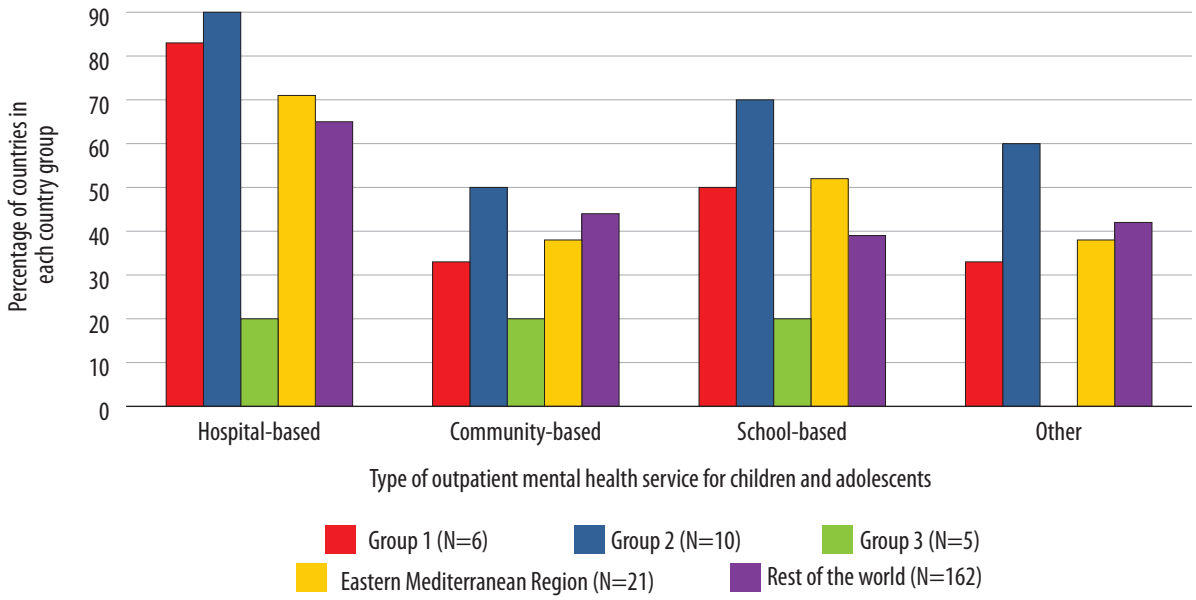
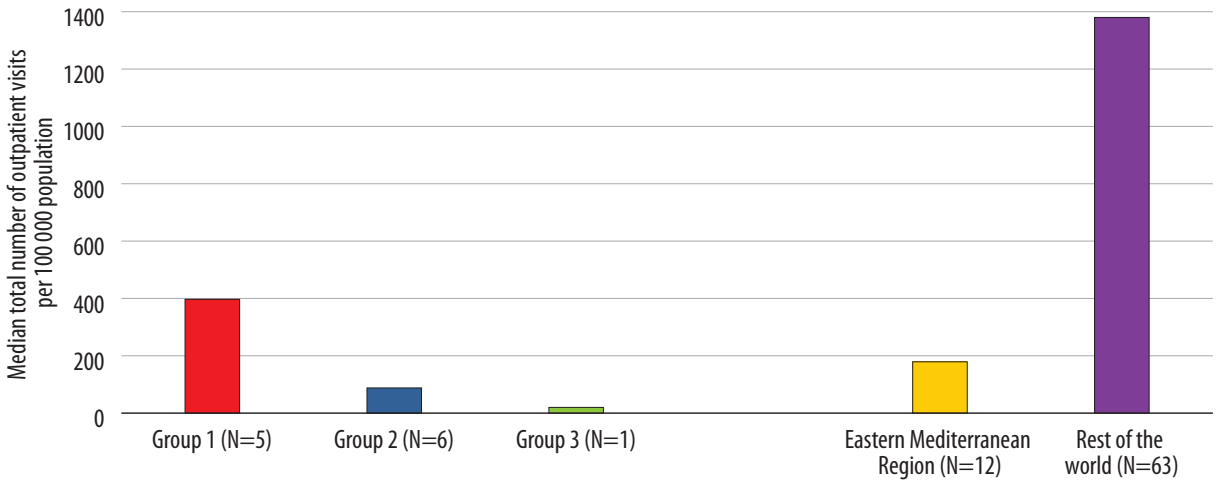


Fig. 4.22. Outpatient care for children and adolescents: median total number of outpatient visits per 100 000 population for countries with outpatient facilities, by, the Eastern Mediterranean Region and the rest of the world



4.6.1 Service utilization

The 2014 and 2017 editions of the Mental health atlas showed that service utilization for persons with depression and bipolar disorders was extremely limited in most countries. For the 2020 edition, Member States were asked to report on service utilization for persons with psychosis, according to ICD-10 case definitions, as a proxy indicator of service coverage for severe mental health conditions. Data were gathered from specialist mental health facilities, run by government and nongovernment (for-profit or not-for-profit) providers. Service utilization, which refers to the number of people per 100 000 population who have received care from inpatient or outpatient mental health facilities over the previous year, served as a proxy for treated prevalence in specialist mental health services.

Fourteen countries in the Region provided relevant data, and their median total service utilization rate for psychosis was 157 per 100 000 population (see Fig. 4.25). This compares with total service utilization of 133 per 100 000 population in the rest of the world (N=107). Surprisingly, the median total rate of service utilization was greater in Group 3 countries (532 per 100 000 population) than in Group 2 (210 per 100 000 population) and Group 1 countries (70 per 100 000 population) – but note that the median for Group 3 was based on just two reporting countries.

4.6.2 Service coverage for psychosis

Service coverage for psychosis was estimated for the *Mental health atlas 2020* using data collected from the 2017 edition of the atlas and estimates of disorder-specific prevalence rates from the Global Burden of Disease Study 2016.[1] The methodology is summarized in Annex C.

Data were available to calculate service coverage for psychosis for seven countries in the Region. The median service coverage for these countries was 20%, compared with 31% in the rest of the world (see Fig. 4.26). Group 1 countries (N=2) had service coverage of 51%, while Group 2 countries (N=5) had coverage of 20%; no countries in Group 3 provided the relevant data.

Changes in service coverage can be tracked between the 2017 and 2020 editions of the *Mental health atlas* (see Fig. 4.27). Coverage appears to be stable in countries in the Region, whereas it has fallen in the rest of the world. However, these trends over time must be interpreted with caution, because different countries reported relevant data in 2017 and 2020: only four countries in the Region and 23 in the rest of the world reported in both 2017 and 2020.

Eleven countries in the Region reported on the number of persons with psychosis who received mental health care from mental health services in the previous year disaggregated by gender. Of persons with psychosis who received mental health care in countries in the Region, 38% were female (see Fig. 4.28). In reporting countries in the rest of the world, 45% of persons receiving care for psychosis were female (N=76). The percentage of females among persons with psychosis receiving care was similar in Group 1 and Group 2 countries (38% and 37% respectively).

[1] Jaeschke K, Hanna F, Ali S, Chowdhary N, Dua T, Charlson F. Global estimates of service coverage for severe mental disorders: findings from the WHO Mental Health Atlas 2017. Global Mental Health. 2021;8. doi:10.1017/gmh.2021.19.

Table 4.11. Facilities and visits to outpatient mental health services for children and adolescents per 100 000 population in reporting countries

Country	Outpatient mental health services for children and adolescents per 100 000 population							
	Hospital-based		Community-based		School-based		Other	
	Facilities	Visits	Facilities	Visits	Facilities	Visits	Facilities	Visits
Afghanistan	0	0	0.005	3	0.05	17	0	0
Bahrain	0.25	1079	0.25	–	0.25	540	–	–
Egypt	0.03	205	0	0	0.002	3	0.01	1
Iran (Islamic Republic of)	0.16	40	1.29	–	25.42	–	–	–
Iraq	0.05	43	0	0	0	0	0	0
Jordan	0.14	–	–	–	–	–	–	–
Kuwait	0.09	247	0	0	0.09	18	0	0
Lebanon	0.13	–	–	–	–	–	–	–
Libya	–	–	0	0	0	0	0	0
Morocco	0.04	59	–	–	–	–	–	–
Occupied Palestinian territory	0	0	0.04	117	–	–	0	0
Oman	0.22	143	0	0	0	0	–	–
Pakistan	0.002	-	0	0	0	0	0	0
Qatar	0.20	1202	0.20	1469	0	0	0	0
Saudi Arabia	–	–	–	–	–	–	–	–
Somalia	0	0	0	0	0	0	0	0
Sudan	0	0	0	0	0	0	0	0
Syrian Arab Republic	0.01	–	0	0	0	0	0.01	–
Tunisia	0.17	905	0.06	19	0.28	254	0.03	16
United Arab Emirates	0.11	397	0	0	–	–	0	0
Yemen	0	0	0	0	0	0	0	0
Eastern Mediterranean Region*	0.12 (N=14)	226 (N=10)	0.13 (N=6)	68 (N=4)	0.17 (N=6)	18 (N=5)	0.01 (N=3)	9 (N=2)
Rest of the world*	0.34 (N=72)	637 (N=57)	1.44 (N=34)	999 (N=26)	18.52 (N=19)	71 (N=11)	0.48 (N=26)	66 (N=15)

* For the Eastern Mediterranean Region and the rest of the world, the medians are quoted for countries with the relevant facilities. A dash (–) indicates that countries did not provide all of the relevant data.

Fig. 4.23. Number of community-based mental health facilities per 100 000 population for reporting countries

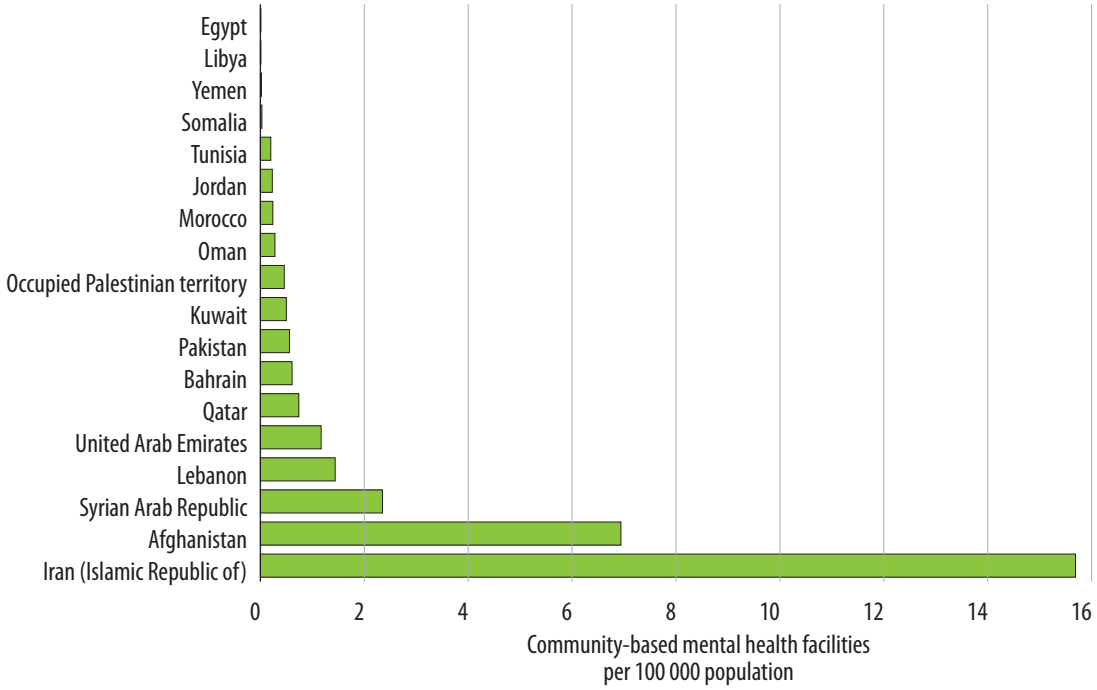


Fig. 4.24. Community-based mental health facilities per 100 000 population: median values for country groups, the Eastern Mediterranean Region and the rest of the world

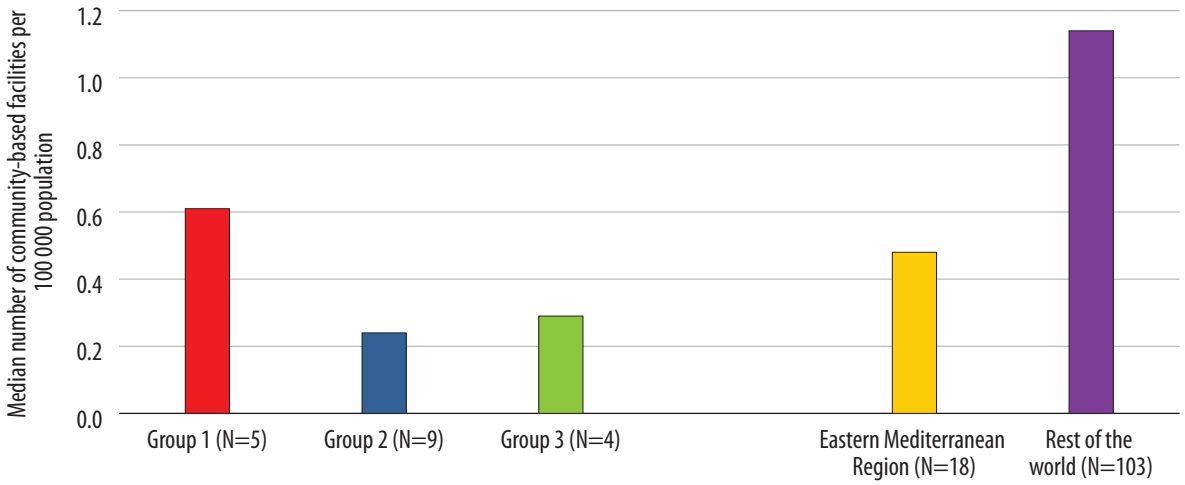


Fig. 4.25. Total service utilization for psychosis per 100 000 population by country group, the Eastern Mediterranean Region and the rest of the world

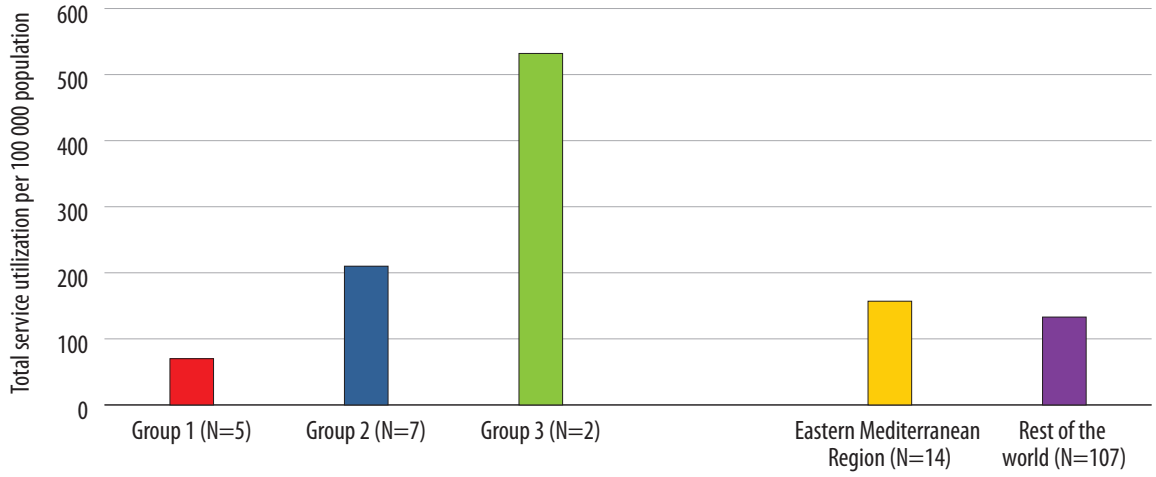


Fig. 4.26. Service coverage for psychosis, by country group, the Eastern Mediterranean Region and the rest of the world

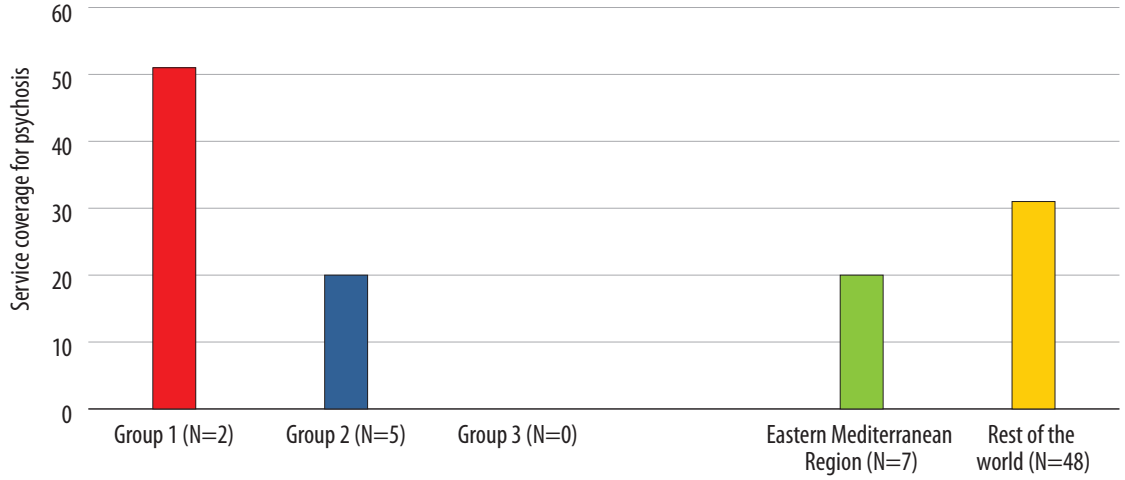


Fig. 4.27. Service coverage for psychosis in 2017 and 2020 for countries in the Region and the rest of the world

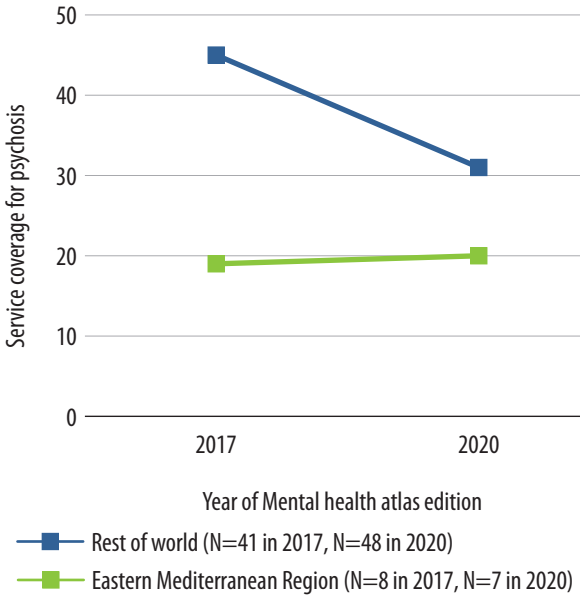
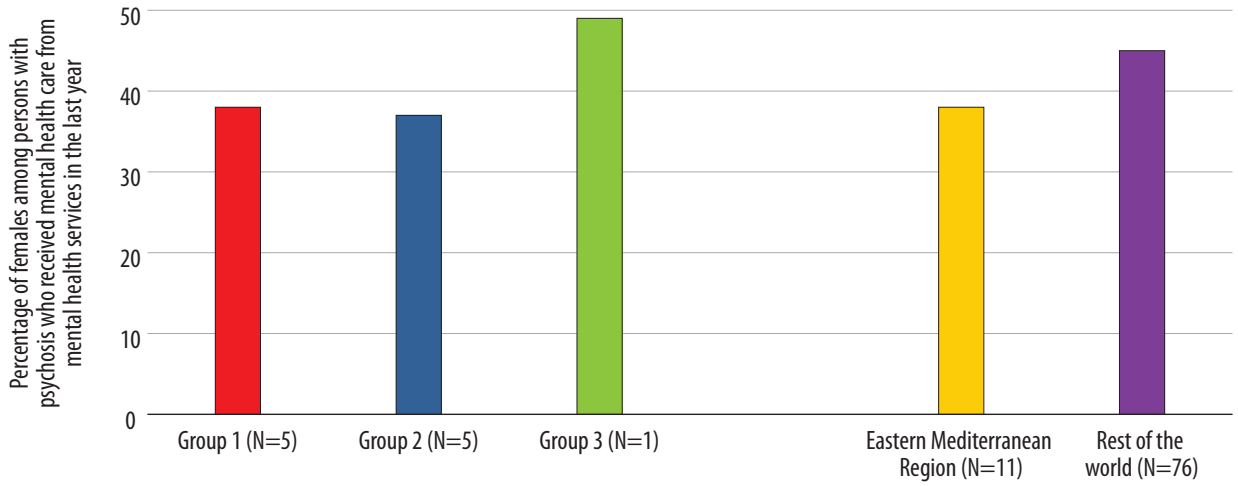


Fig. 4.28. **Percentage of females among persons with psychosis who received mental health care from mental health services in the last year, by country group, the Eastern Mediterranean Region and the rest of the world**



4.6.3 Service coverage for depression

The mental health atlas does not appear to be reliable in terms of estimating service coverage for depression.[1] This is not unexpected given that people living with depression tend to seek help first from general physicians and other primary health care facilities.[2] There is also a relative lack of help-seeking behaviour by people with depression compared with people with psychosis. A compounding issue is the general notion that mental health information systems are weak in outpatient services, which are the most appropriate type of facility for the management of depression.

At the time of writing, the most comprehensive and comparable estimates of service coverage for depression come from the World Mental Health Surveys administered in 21 countries to 51 547 respondents. These include two countries in the Region, Iraq and Lebanon, with data from 4332 and 1031 nationally representative respondents, collected in 2006–2007 and 2002–2003 respectively. These surveys estimated that, of people with a 12-month diagnosis of major depressive disorder, 2.5% in Iraq received minimally adequate treatment and 7% in Lebanon. These results compared with a total figure for all 21 countries that participated in the World Mental Health Surveys of 16.5% receiving minimally adequate treatment (22.4% in high-income countries, 11.4% in upper-middle-income countries and 3.7% in low-/lower-middle-income countries).[3]

4.7 Social support for persons with mental health conditions

Social support refers to monetary or non-monetary welfare benefits from public funds that may be provided, as part of a legal right, to persons with health conditions that reduce their ability to function.[4] For the *Mental health atlas 2020*, Member States were asked to report on the availability of government social support for persons with mental health conditions and to include specifically persons with mental health conditions who are officially recorded/recognized as receiving government support (e.g. disability payments or income support), but to exclude persons with a mental health condition who receive monetary/non-monetary support from family members or from local charities or other NGOs. Social support can be provided in the form of income, housing, employment, education, social care or legal support.

4.7.1 Existence of government social support for persons with mental health conditions

In 10 countries, or approximately half the countries in the Region, the majority of persons with severe mental health conditions receive social support from the government (see Table 4.13). Government support is also provided for some people with non-severe mental health conditions in three countries (14%) and for the majority

[1] Jaeschke K, Hanna F, Ali S, Chowdhary N, Dua T, Charlson F. Global estimates of service coverage for severe mental disorders: findings from the WHO Mental Health Atlas 2017. Global Mental Health. 2021;8. doi:10.1017/gmh.2021.19

[2] Bifftu BB, Takele WW, Guracho YD, Yehualashet FA. Depression and Its Help Seeking Behaviors: A Systematic Review and Meta-Analysis of Community Survey in Ethiopia. Depress Res Treat, 2018; 1592596. doi: 10.1155/2018/1592596

[3] Thornicroft G, Chatterji S, Evans-Lacko S et al. Undertreatment of people with major depressive disorder in 21 countries. Br J Psychiatry, 2017; 210(2):119-124.

[4] This paragraph is replicated from the global report of the *Mental health atlas 2020*.

Table 4.12. Main forms of government social support available for persons with severe mental health conditions in the Eastern Mediterranean Region

Forms of government support available	Eastern Mediterranean Region (N=21)		Rest of the world (N=159)	
	Number	Percentage	Number	Percentage
Income support	14	67%	110	69%
Housing support	5	24%	64	40%
Employment support	5	24%	66	42%
Education support	7	33%	70	44%
Social care support	14	67%	119	75%
Legal support	7	33%	71	45%

of people with non-severe mental health conditions in five countries (24%). In the remaining countries, few or some persons with severe mental health conditions receive social support from the government, and in two countries no person receives such support.

A smaller proportion of governments in the Region provide support for the majority of persons with severe mental health conditions than in the rest of the world (48% compared with 66%) and for at least some persons with non-severe mental health conditions (38% compared with 47%).

The governments of most Group 1 countries provide social support for the majority of persons with severe mental disorders and for at least some, and often the majority, of persons with non-severe mental health conditions (see Fig. 4.29). Half of countries in Group 2 provide government support to a few or some persons with severe mental health conditions, while the remaining Group 2 countries are divided between those providing support to most persons with severe mental health conditions and those in addition including support for persons with non-severe mental health conditions. Of countries in Group 3, 60% provide social support for a few or some persons with severe mental health conditions, but in the remaining 40% of Group 3 countries no persons with mental health conditions receive social support from the government.

4.7.2 Main forms of government support provided for people with mental health conditions

Mental health focal points for each country were asked about the main forms of social support provided by the

Table 4.13. Availability of government support for persons with mental health conditions in the Eastern Mediterranean Region

Availability of government support	Eastern Mediterranean Region (N=21)		Rest of the world (N=154)	
	Number	Percentage	Number	Percentage
No persons with mental health conditions receive social support from government	2	10%	21	14%
Few or some persons with severe mental health conditions receive social support from government	9	43%	31	20%
The majority of persons with severe mental health conditions receive social support from government	2	10%	30	19%
The majority of persons with severe mental health conditions, and also some with non-severe mental health conditions, receive social support from government	3	14%	41	27%
The majority of persons with severe and non-severe mental health conditions receive social support from government	5	24%	31	20%

Fig. 4.29. Availability of government support for persons with mental health conditions, by country group

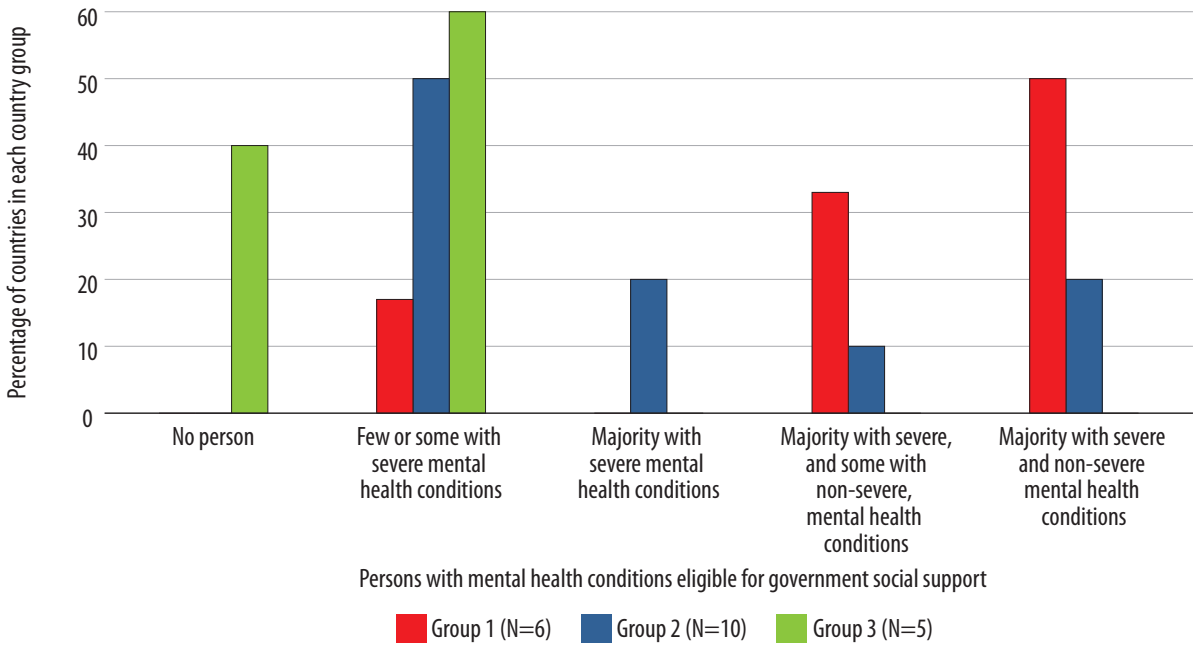
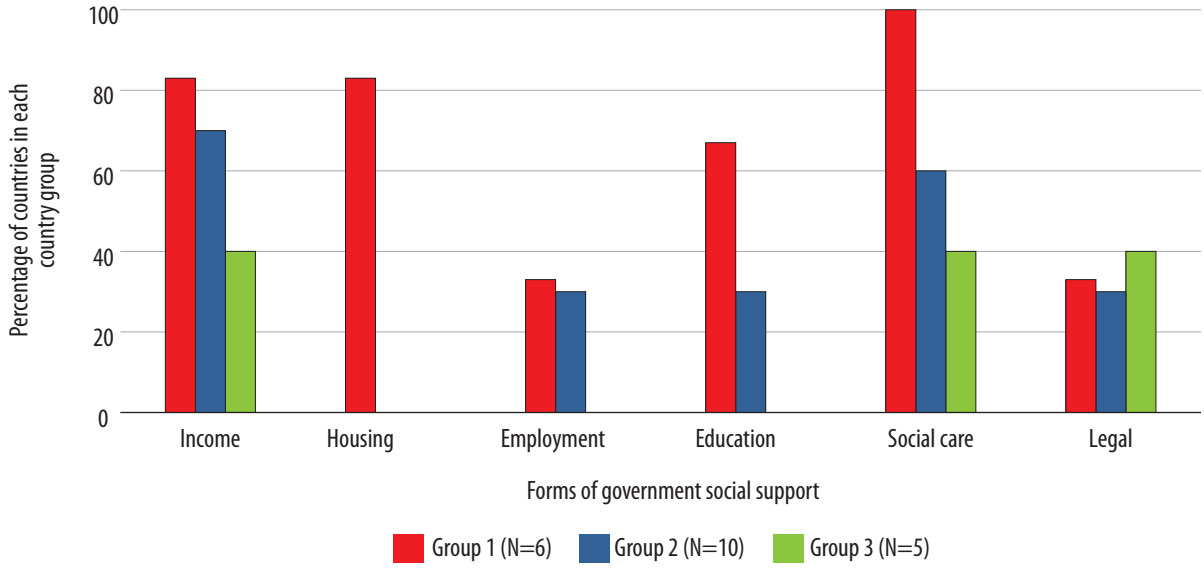


Fig. 4.30. Main forms of government social support available for persons with severe mental health conditions, by country group



government to persons with mental health conditions. Income support and social care support are available for persons with severe mental health conditions in two thirds of countries in the Region (see Table 4.12). One third of countries provide legal support and education support, and about one quarter provide support for housing and employment. Only two countries in the Region (10%) cover, at least for a proportion of the population, all six categories of social support.

Each form of government support is provided by a smaller proportion of countries in the Region than by countries in the rest of the world.

For most forms of support there is a similar pattern of provision, with a higher percentage of availability in Group 1 countries than in Group 2 countries, and a smaller percentage of provision by Group 3 countries (see Fig. 4.30). The exception is legal support, which is provided by 30–40% of countries in all three country

groups. Housing, employment and education support are not provided by any Group 3 countries.

The governments of the best-resourced countries in the Region provide more forms of social support for people with severe mental health conditions. Among Group 1 countries, 83% have more than two forms of support available, whereas 70% of Group 2 countries and all Group 3 countries have two or fewer forms of support (see Fig. 4.31). The median number of forms of government social support for persons with severe mental health conditions in countries of the Region is two, compared with three in the rest of the world (see Fig. 4.32).

Fig. 4.31. Number of forms of government support, by country group

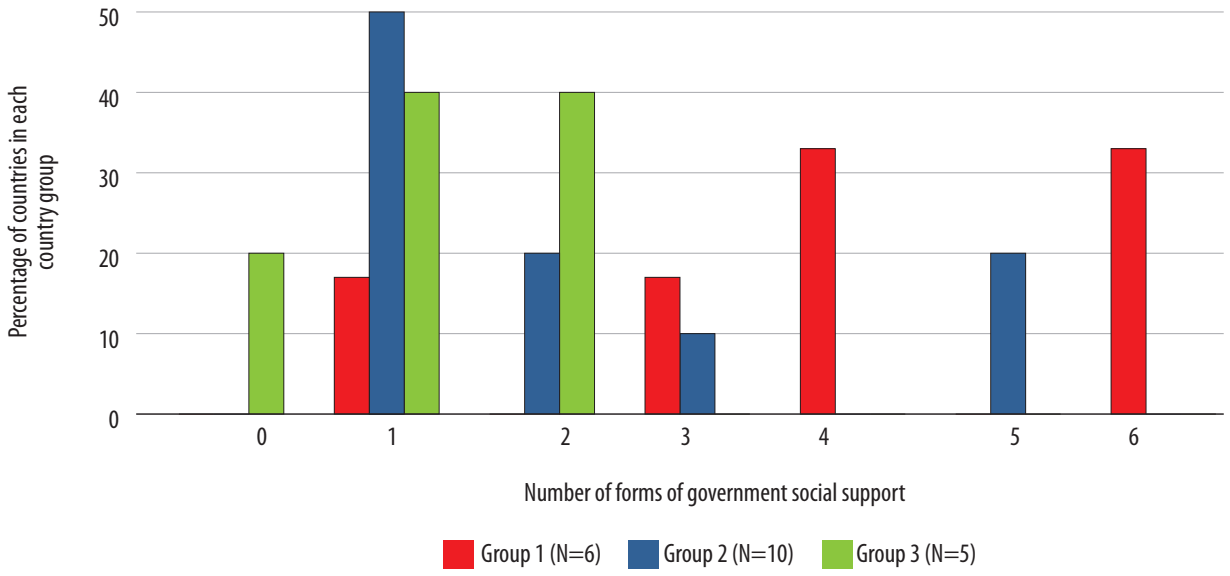
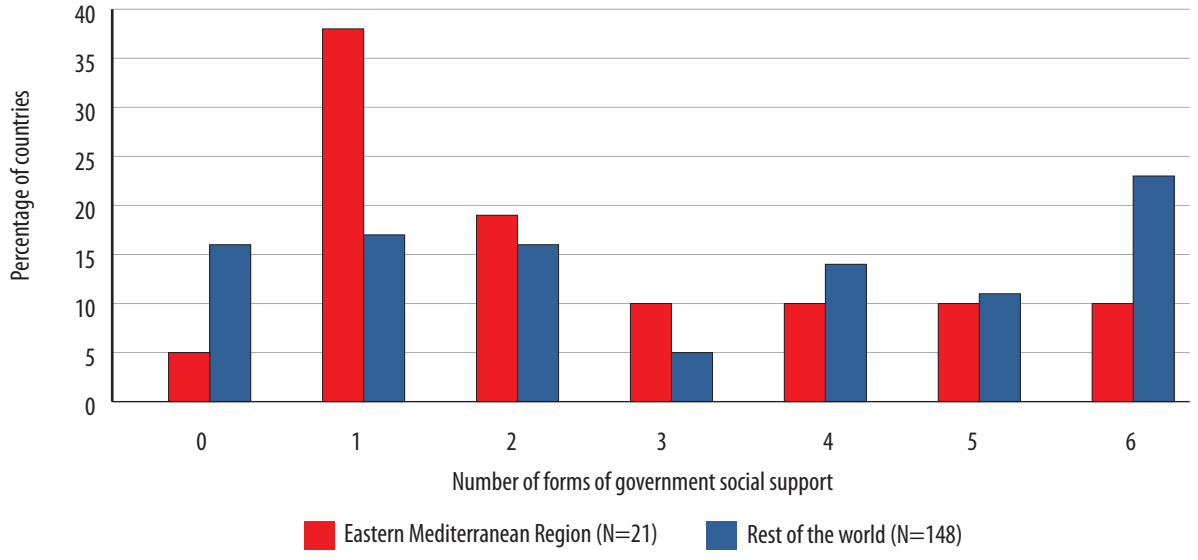


Fig. 4.32. Number of forms of government support in the Eastern Mediterranean Region and the rest of the world



5. Mental health promotion and prevention programmes

National health authorities have a major role to play in the treatment and promotion of mental health and the prevention of mental health conditions in all sectors and across the life course.[1] The WHO Comprehensive Mental Health Action Plan recommends that Member States lead and coordinate universal and targeted interventions from the early stages of life and across the life span to prevent mental health conditions and to reduce stigmatization, discrimination and human rights violations. It emphasizes the importance of integrating such interventions into national health promotion strategies and also the responsiveness of such strategies to core individual attributes in the different formative stages of life and adaptation to the needs of specific vulnerable groups.

The promotion of mental health and the prevention of mental health conditions was highlighted in the Sustainable Development Agenda adopted at the United Nations General Assembly in September 2015. SDG 3 aims to ensure healthy lives and, among other targets, to promote mental health and well-being. SDG Target 3.4 is, by 2030, to reduce by one third premature mortality from noncommunicable diseases (NCDs) through prevention and treatment and promotion of mental health and well-being, the suicide rate being an indicator (3.4.2) for this target. This is matched by Objective 3 of the Comprehensive Mental Health Action Plan, which focuses on developing and implementing strategies for promotion and prevention in mental health, including prevention of suicide and self-harm as a priority. Global target 3.1 of the Action Plan is for 80% of countries to have at least two functioning national, multisectoral prevention and promotion programmes in place by 2030.

Similar to previous versions of the *Mental health atlas*, in the 2020 edition a mental health promotion and prevention programme is considered to be "functional" only if at least two of the following three characteristics are fulfilled: 1) dedicated financial and human resources; 2) a defined plan of implementation; and 3) evidence of progress and/or impact. Programmes that did not meet this threshold or were obviously associated with treatment or care were excluded from the analysis.

5.1 Functioning mental health promotion and prevention programmes

Countries were asked to report on programmes specifically addressing seven areas: mental health awareness/anti-stigma, early childhood development, school-based mental health promotion and prevention, parental/maternal mental health promotion and prevention, workplace-based mental health promotion and prevention, disaster preparedness/disaster risk reduction (DRR), and suicide prevention (also reported in Section 5.3.3).

Altogether, 65 specific and functioning mental health promotion and prevention programmes were reported in the Eastern Mediterranean Region (see Fig. 5.1). Of these, 13 aimed to improve mental health awareness/anti-stigma, 12 were aimed at school-based mental health promotion and 11 were MHPSS components of disaster preparedness/DRR programmes.

Twenty countries in the Region completed this section of the *Mental health atlas* questionnaire. Their level of provision ranged from one country with functioning programmes addressing all seven areas to one country with functioning programmes in none of these areas (see Fig. 5.2).

The median number of different areas in which there were functional national programmes in all countries of the Region was three, which is the same as the median number in the rest of the world. All three country groups are represented among countries with six or more functioning programmes, and also among those with one or no programmes. Group 1 countries have a median of four functional promotion and prevention programmes, Group 2 countries have a median of three such programmes and Group 3 countries have a median of two functional programmes.

Sixteen countries in the Region (76%) have two or more functioning national programmes, including five countries in Group 1 (76%), eight in Group 2 (80%) and three in Group 3 (60%). In the rest of the world, 91

[1] This and the following two paragraphs are reproduced from the global report of the *Mental health atlas 2020*.

Fig. 5.1. Types of functioning mental health promotion and prevention programmes in the Eastern Mediterranean Region

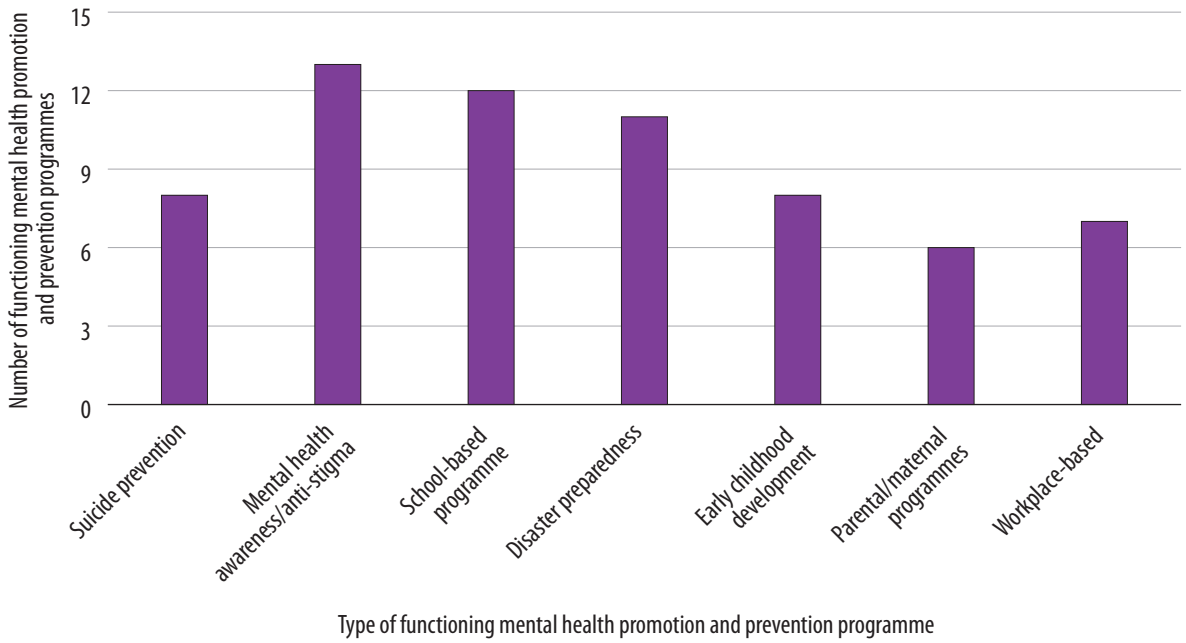
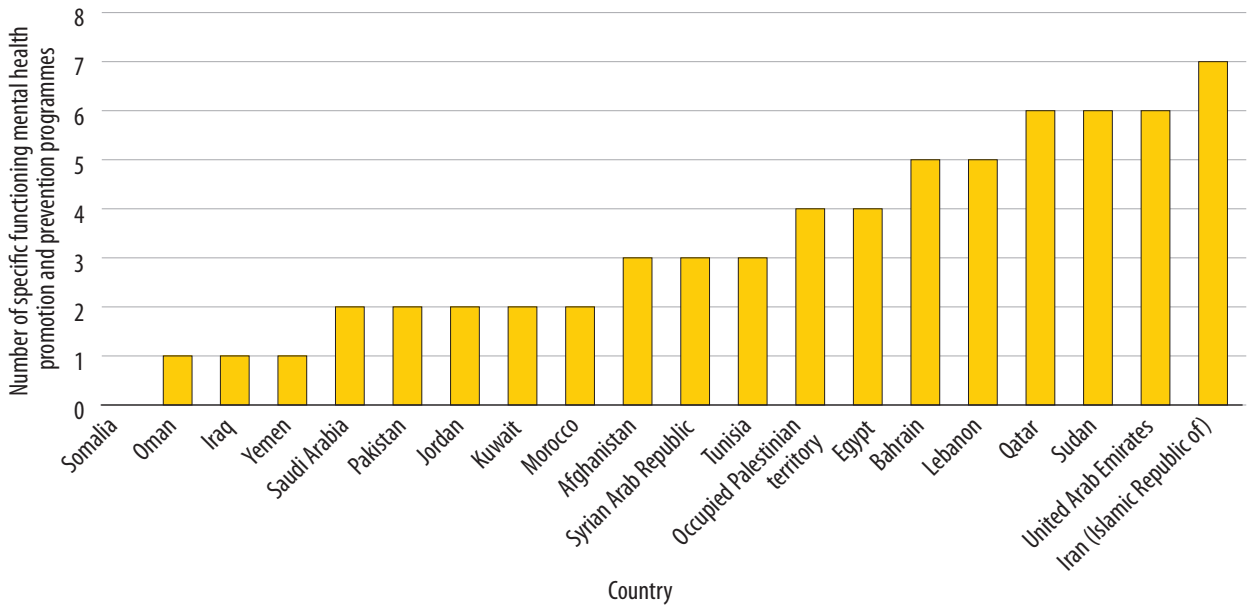


Fig. 5.2. Number of functioning mental health promotion and prevention programmes by reporting country



countries have two or more functioning programmes, which equates to 56% of all the countries that returned the atlas questionnaire and to 67% of those that completed the section on promotion and prevention programmes.

Although programmes are distributed across all three country groups, three patterns of distribution emerge for individual types of programme (see Fig. 5.3):

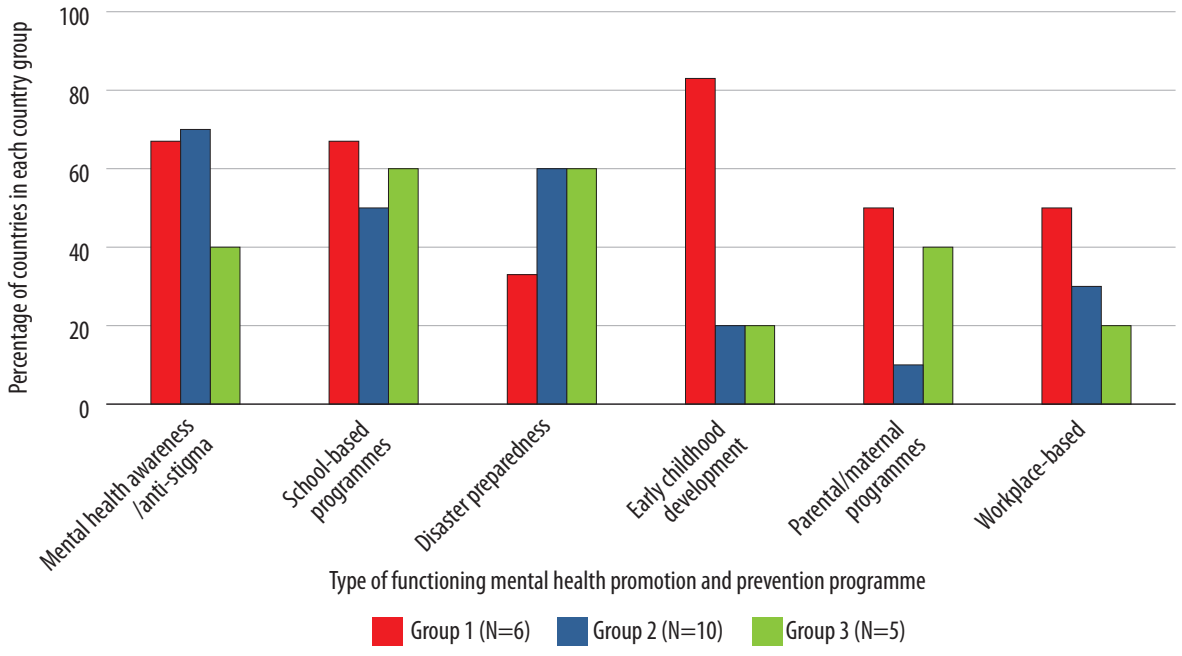
- **Functioning programmes exist in most countries.** Programmes in this category include mental health awareness/anti-stigma (in 62% of countries) and school-based mental health prevention and promotion programmes (57%); they are present in 40–70% of countries across the three country groups.
- **Functioning programmes exist in most countries, but in more Group 2 and Group 3 countries than Group 1 countries.** The one type of programme in this category is disaster preparedness and DRR (52% of countries).
- **Functioning programmes exist in a minority of countries, and are found in more Group 1 countries than Group 2 and Group 3 countries.** Programmes in this category include early childhood development (38%), parental/maternal mental health promotion and prevention (29%) and workplace-based mental health promotion (33%).

5.2 Existence of systems for mental health and psychosocial preparedness for emergencies/ disasters

Reporting on systems in place for mental health and psychosocial preparedness for emergencies/disasters was a measure recommended by the Seventy-fourth World Health Assembly in May 2021 and adopted in the updated Comprehensive Mental Health Action Plan 2013–2030, given the need to also support recovery from the COVID-19 pandemic[1] Objective 3 of the Action Plan includes strengthening preparedness, response capacity and resilience for future public health emergencies. Target 3.3 of the Action Plan is for 80% of countries to have a system for MHPSS in place by 2030.

The composite term MHPSS is used in the Inter-Agency Standing Committee (IASC) guidelines on mental health preparedness and social support in emergency settings to describe "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder".[2] The global humanitarian system uses the term MHPSS to unite a

Fig. 5.3. Functioning mental health promotion and prevention programmes in each country group (percentage of countries)



[1] This and the following two paragraphs are largely reproduced from the global report of the *Mental health atlas 2020.*

[2] IASC. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. 2007; p.1. https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf.

broad range of actors responding to emergencies such as the COVID-19 outbreak, including those working with biological approaches and sociocultural approaches in health, social, education and community settings, as well as to "underscore the need for diverse, complementary approaches in providing appropriate support".[1]

While traditionally MHPSS services have been focused primarily on the response and recovery phases of emergencies, research has suggested a clear need for the development of MHPSS with a DRR perspective, thus shifting paradigms towards "upstream" approaches targeting preparedness and prevention. This integrated approach focuses on capacity- and system-building; preparedness; policy development, consensus-building and awareness-raising; school- and child-focused initiatives; inclusive DRR; and the promotion of resilience as mandatory elements for the mainstreaming of MHPSS and DRR.

In the *Mental health atlas 2020* questionnaire, countries were asked for the first time about the existence of functioning programmes on mental health and psychosocial preparedness with a designated component focused on DRR. Eleven countries in the Eastern Mediterranean Region, representing 52% of responding countries and 50% of all countries in the Region, reported the existence of such programmes. These programmes represent 17% of total functioning promotion and prevention programmes in the Region. A higher percentage of Eastern Mediterranean countries have disaster preparedness programmes than countries in the rest of the world (28%). More Group 2 and Group 3 countries (both 60%) have disaster preparedness programmes than Group 1 countries (33%) (see Fig. 5.3 above).

The questionnaire also asked about COVID-19 mental health and psychosocial support (COVID-MHPSS) promotion and prevention programmes. Twelve countries in the Region (57%) had COVID-MHPSS programmes, compared with 77 countries in the rest of the world (48% of countries that returned the Atlas questionnaire, or 57% of countries that completed the section on promotion and prevention programmes). COVID-MHPSS programmes were functional in three Group 1 countries (50%), six Group 2 countries (60%) and three Group 3 countries (60%).

5.3 Suicide prevention

In 2019 suicide accounted for an estimated 703 000 deaths worldwide,[2] and it is therefore a prevention priority area in mental health.[3] Suicide is the fourth most common cause of death among young people worldwide, and it affects in particular vulnerable and marginalized populations. People with mental health conditions experience disproportionately higher rates of disability and mortality than the general population, owing to physical health problems but also to suicide. Target 3.2 of the Comprehensive Mental Health Action Plan 2013–2020 called for a 10% reduction in the rate of suicide in countries by 2020, while SDG Target 3.4, addressing NCDs and mental health, includes an indicator for the reduction of mortality due to suicide by one third by 2030 (the only SDG indicator for mental health). Following this lead, the extended Comprehensive Mental Health Action Plan 2013–2030 revised this target to also aim for a reduction of one third in the rate of suicide by 2030. As there are many risk factors associated with suicide beyond mental health conditions, such as chronic pain or acute emotional distress, or access to means of suicide, the Action Plan calls for comprehensive national suicide prevention strategies with collaboration not only by the health sector but also by other sectors simultaneously. Data on age-standardized suicide rates per 100 000 population were taken from the WHO Global Health Observatory.[4]

5.3.1 Age-standardized suicide rates per 100 000 population

The median age-standardized suicide rate in the Eastern Mediterranean region in 2019 was estimated to be 4.76 per 100 000 population. Over the 2000–2019 period there was a downward trend in the rate of suicide in the Region (see Fig. 5.4). Target 3.2 of the Comprehensive Mental Health Action Plan 2013–2020 is for the rate of suicide in countries to be reduced by 10% by 2020. The baseline median rate of suicide in 2013 in the Region was 5.7 per 100 000 population, and the fall to 4.76 per 100 000 population in 2019 represents a 16% reduction in the suicide rate. The suicide rate in Group 1 countries declined by 12% over the same period and that in Group 2 countries by 10% (see Table 5.1). However, having fallen by 11% between 2004 and 2011, the suicide rate in Group 3 countries fell by only 2% between 2013 and 2019.

The median suicide rate among females declined by 19% across the Region, and by 15% in Group 1 countries. There were smaller reductions of 3% in Group 2 countries and 4% in Group 3 countries. Among males, the reduction in the suicide rate was 8% across the Region. In country groups, the suicide rate for males in Group 2 countries fell by 11%, while in Group 1 it declined by 8% and in Group 3 by just 1%.

[1] IASC. Interim Briefing Note Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak (circulated on 17 March 2020). https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/interim-briefing-note-addressing-mental-health-and-psychosocial-aspects-covid-19-outbreak.

[2] World Health Organization. Suicide worldwide in 2019: Global Health Estimates. Geneva: WHO; 2021. https://www.who.int/publications/i/item/9789240026643.

[3] This paragraph is largely reproduced from the global report of the *Mental health atlas 2020*.

[4] World Health Organization. Global Health Observatory (GHO) data; 2019. http://www.who.int/gho/en/

Fig. 5.4. Suicide rates per 100 000 population between 2000 and 2019, in the Eastern Mediterranean Region and by country group

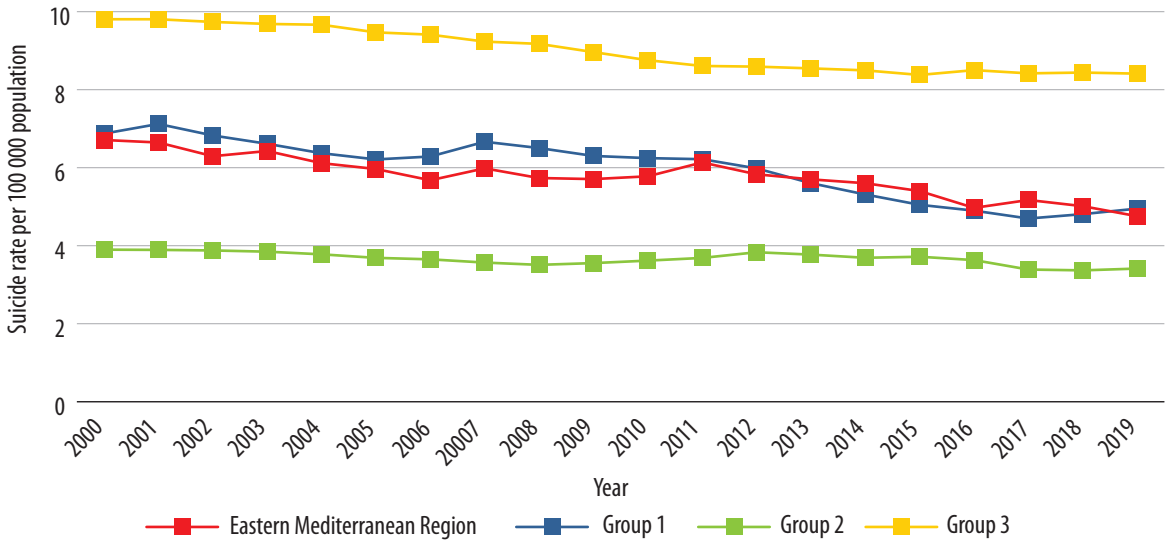


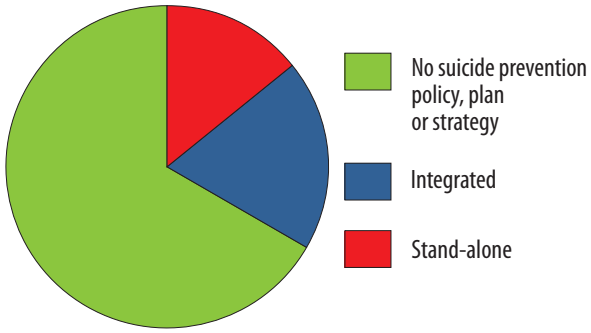
Table 5.1. Suicide rates per 100 000 population in 2013 and 2019 in the Eastern Mediterranean Region, by country group and by gender

Region/country group	Suicide rate per 100 000		Percentage reduction in rate
	2013	2019	
All			
Eastern Mediterranean	5.70	4.76	16%
Group 1	5.60	4.95	12%
Group 2	3.77	3.41	10%
Group 3	8.55	8.41	2%
Female			
Eastern Mediterranean	2.95	2.40	19%
Group 1	2.13	1.80	15%
Group 2	2.33	2.27	3%
Group 3	5.68	5.47	4%
Male			
Eastern Mediterranean	6.88	6.34	8%
Group 1	6.91	6.36	8%
Group 2	5.24	4.65	11%
Group 3	11.83	11.75	1%

5.3.2 Suicide prevention policies, plans and strategies

WHO Member States were asked in the questionnaire whether they had a national suicide prevention policy, plan or strategy, either stand-alone or integrated. Seven countries in the Eastern Mediterranean Region (33%) responded that they had such a policy, plan or strategy. The corresponding percentage for the rest of world was 40% of countries with national suicide prevention policies, plans or strategies. Four of the suicide prevention strategies in countries of the Region are stand-alone and three are integrated into mental health or other health strategies (see Fig. 5.5). Five have been published since 2017, and the other two were published between 2013 and 2016. Six of the seven suicide prevention strategies have been published in Group 2 countries (60% of Group 2 countries). One has been published by a Group 3 country (20%), but no Group 1 country has published a suicide prevention strategy.

Fig. 5.5. Number and type of suicide prevention policies, plans or strategies in countries in the Region



5.3.3 Suicide prevention programmes

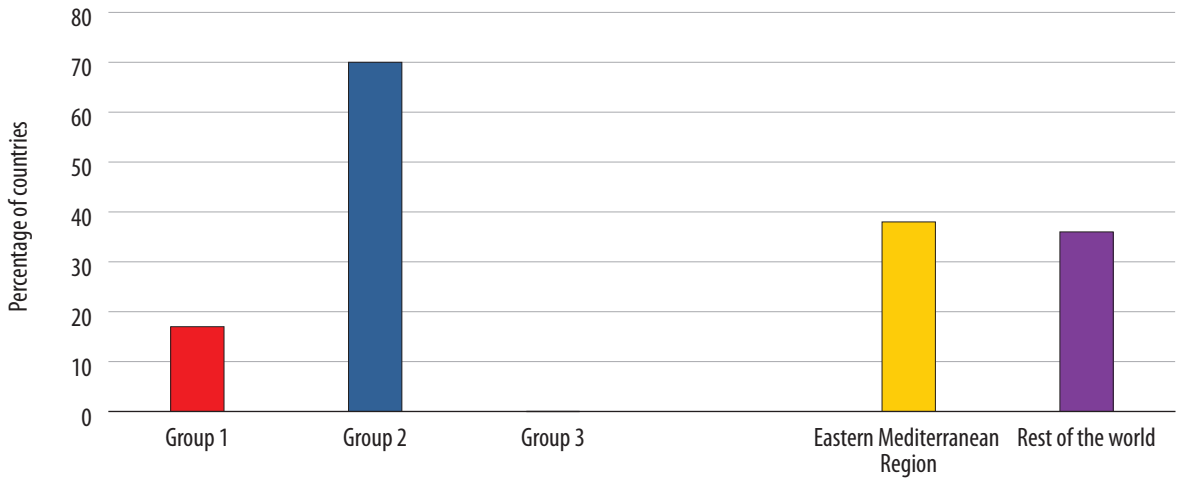
Countries were asked to report on their suicide prevention programmes. For the purposes of this review, for a programme to be considered functional its focus must be suicide prevention and it must meet at least two of the following three criteria: 1) dedicated financial and human resources; 2) defined plan of implementation; and 3) documented evidence of progress and/or impact.

Eight countries in the Region (38%) reported having at least one functional suicide prevention programme, which is similar to the 36% of countries in the rest of the world reporting that they had such programmes (see Fig. 5.6). Seven Group 2 countries (70%) have functional suicide prevention programmes and one Group 1 country (17%) has a suicide prevention programme, though no Group 3 country has such a programme. The programmes reported included the following: national hotline for emotional support and suicide prevention, schools-based project offering support following a suicide attempt or deliberate self-harm, training of primary care physicians to deal with suicide attempts, suicide training project in emergency general hospitals, and suicide registration.

5.3.4 Training on suicide prevention

The *Mental health atlas 2020* questionnaire asked countries to report on whether they have training programmes focused on suicide prevention for four key groups of workers. More than half of countries in the Region (57%) have training for non-specialized health workers, but only a minority of countries provide training for media professionals (38%), gatekeepers such as teachers or emergency services personnel (29%) and pesticide registrars and regulators (10%) (see Table 5.2).

Fig. 5.6. Percentage of countries with functional suicide prevention programmes, by country group and in the Eastern Mediterranean Region and the rest of the world



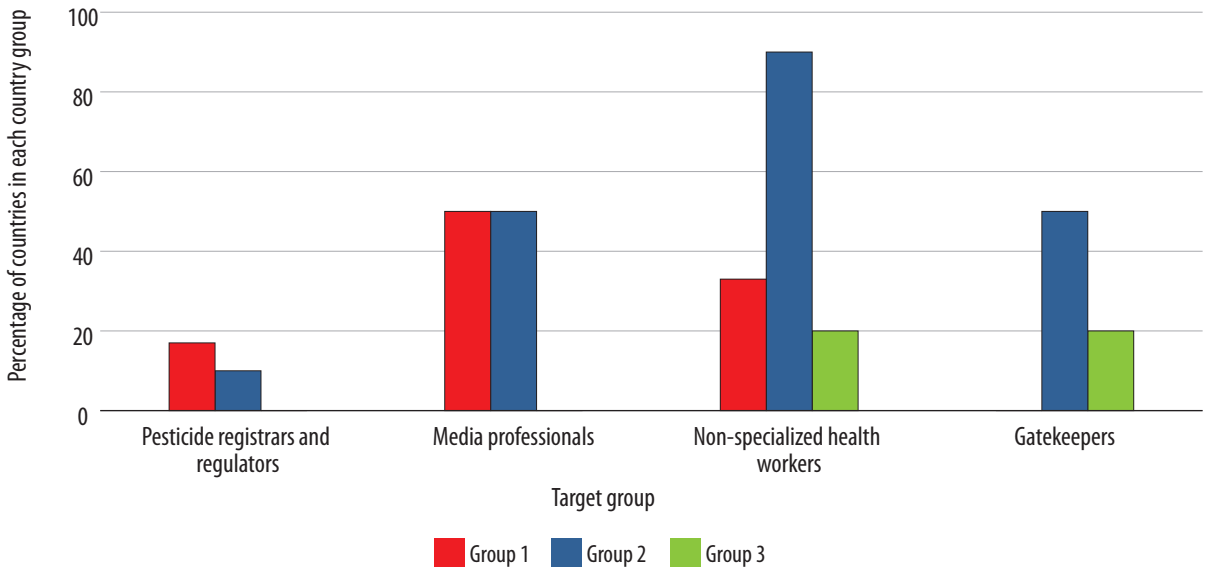
Compared with the rest of the world, more countries in the Eastern Mediterranean Region have training for media professionals (38% compared with 29%), but fewer have training for gatekeepers (29% compared with 41%).

More Group 2 countries have training for these key groups than Group 1 or Group 3 countries (see Fig. 5.7). Nine Group 2 countries (90%) have training for non-specialized health workers, five (50%) have training for both media professionals and gatekeepers, and one (10%) has training for pesticide registrars. Three Group 1 countries (50%) have training for media professionals, two (33%) for non-specialized health workers and one (17%) for pesticide registrars, but no Group 1 country offers training for gatekeepers. Just one Group 3 country has training for non-specialized health workers and gatekeepers (both 20%), and no Group 3 country has training for pesticide registrars or media professionals.

Table 5.2. Number and percentage of Eastern Mediterranean Region countries with training focused on suicide prevention for key groups of workers

Target group	Eastern Mediterranean Region (N=21)		Rest of the world (N=162)	
	Number	Percentage	Number	Percentage
Pesticide registrars and regulators	2	10%	16	10%
Media professionals	8	38%	47	29%
Non-specialized health workers (e.g. general physicians, nurses, community health workers)	12	57%	92	57%
Gatekeepers (e.g. teachers, police, firefighters, other first responders, faith healers)	6	29%	66	41%

Fig. 5.7. Suicide prevention training for target groups, by country group



6. Progress towards the targets of the Comprehensive Mental Health Action Plan 2013–2020

The mental health atlas is used to monitor progress on the targets and indicators identified in the Comprehensive Mental Health Action Plan. In this section, the extent to which countries in the Eastern Mediterranean Region measure up against the Action Plan's six global targets for 2020 is examined.

Four of the targets are based on a percentage of countries meeting the relevant target. For the purposes of this analysis, the denominator for this percentage is the total number of countries in the Region, i.e. 22 (including Djibouti). This denominator has been used even where a country did not provide relevant data on a target. In other words, if specific data on a target were not provided, it is assumed that the target has not been met.

Progress in the Region towards meeting each target of the Action Plan is presented in Table 6.1. In the Region as a whole, three of the six targets have been met:

- 59% of countries in the Region have developed or updated their laws for mental health in line with international and regional human rights instrument (target of 50% exceeded).
- The median reduction in the suicide rate was 16% between 2013 and 2019 (target of 10% reduction exceeded).
- 82% of countries in the Region routinely collect and report on at least a core set of mental health indicators every two years through their national health and social information systems (target of 80% exceeded).

There is further work to be done to reach two of the targets:

- 50% of countries in the Region have developed or updated their policies or plans for mental health in line with international and regional human rights instruments (to reach the target of 80%, seven more countries need to update their policies or plans accordingly).
- 73% of countries in the Region have at least two functioning national, multisectoral mental health promotion and prevention programmes (to reach the target of 80%, two more countries need to develop at least two functioning programmes).

The sixth target, a 20% increase in service coverage for severe mental health conditions, was difficult to assess since it was not possible to compute the values from earlier editions of the *Mental health atlas*. Therefore, in the Eastern Mediterranean Regional Review of the atlas for 2013 and 2017, outpatient visits were used as a proxy measure for coverage. Outpatient visits can give an indication of changes in coverage: more outpatient visits suggest greater coverage. Outpatient visits were reported on by 14 countries in 2014 and by six countries in 2017. Eleven countries reported on outpatient visits for at least two time points, permitting calculation of a percentage change in outpatient visits per 100 000 population (see Table 6.2). In eight countries in the Region (36%), there was an increase in visits of more than 20%, with similar rates seen in each country group (Group 1 = 33%, Group 2 = 40%, Group 3 = 33%).

Table 6.1. Targets, indicators, baseline and level of achievement in meeting Comprehensive Mental Health Action Plan objectives for 2020

Action Plan objectives	Action Plan targets	Action Plan indicators	Baseline value for 2013 (*MH atlas 2014*)	Progress value for 2016 (*MH atlas 2017*)	Progress value for 2019 (*MH atlas 2020*)
Objective 1 To strengthen effective leadership and governance for mental health	**Target 1.1** 80% of countries will have developed or updated their policies or plans for mental health in line with international and regional human rights instruments by 2020.	**Indicator 1.1** Existence of a national policy/plan for mental health that is in line with international and regional human rights instruments.	Seven countries, 32% of all countries in the Region. Value is based on a self-rating checklist.	Ten countries, 45% of all countries in the Region. Value is based on a self-rating checklist.	Eleven countries, 50% of all countries in the Region. Value is based on a self-rating checklist.
	Target 1.2 50% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments by 2020.	**Indicator 1.2** Existence of a national law covering mental health that is in line with international and regional human rights instruments.	Six countries, 27% of all countries in the Region. Value is based on a self-rating checklist.	Eight countries, 36% of all countries in the Region. Value is based on a self-rating checklist.	Thirteen countries, 59% of all countries in the Region. Value is based on a self-rating checklist.
Objective 2 To provide comprehensive, integrated and responsive mental health and social care services in community-based settings	**Target 2** Service coverage for severe mental disorders will have increased by 20% by 2020.	**Indicator 2** Number and proportion of persons with a severe mental disorder who received mental health care in the last year.	Not computable from *MH atlas 2014* data.	Proxy measure using total mental health outpatient visits per 100 000 population. Seven countries reported data in *MH atlas* 2014 and 2017. Median increase in total outpatient visits of 52%. Five countries reported > 20% increase in visits.	Proxy measure using total mental health outpatient visits per 100 000 population. Eleven countries reported data at two time points. Median increase in total outpatient visits of 93%. Eight countries reported > 20% increase in visits.
Objective 3 To implement strategies for promotion and prevention in mental health-based settings	**Target 3.1** 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes by 2020.	**Indicator 3.1** Functioning programmes of multisectoral mental health promotion and prevention in existence.	Ten countries, 45% of all countries in the Region. Value is based on a self-completed inventory of current programmes.	Thirteen countries, 59% of all countries in the Region. Value is based on a self-completed inventory of current programmes.	Sixteen countries, 73% of all countries in the Region. Value is based on a self-completed inventory of current programmes.

Table 6.1. Targets, indicators, baseline and level of achievement in meeting Comprehensive Mental Health Action Plan objectives for 2020 *(concluded)*

Action Plan objectives	Action Plan targets	Action Plan indicators	Baseline value for 2013 (*MH atlas 2014*)	Progress value for 2016 (*MH atlas 2017*)	Progress value for 2019 (*MH atlas 2020*)
	Target 3.2 The rate of suicide in countries will be reduced by 10% by 2020.	**Indicator 3.2** Number of suicide deaths per year.	Median suicide rate 5.70 per 100 000 for countries in the Region. Value is based on age-standardized global estimate.	Median suicide rate 4.97 per 100 000 for countries in the Region; 13% reduction from 2013 baseline. Value is based on age-standardized global estimate.	Median suicide rate 4.76 per 100 000 for countries in the Region; 16% reduction from 2013 baseline. Reduction in suicide rate by 10% or more in six countries, 27% of all countries in the Region. Value is based on age-standardized global estimate.
Objective 4 To strengthen information systems, evidence and research for mental health	**Target 4** 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems by 2020.	**Indicator 4** Core set of mental health indicators routinely collected and reported every two years.	Eleven countries, 50% of all countries in the Region, compile mental health-specific data. Additionally, eight countries in the Region (36%) compile mental health data as part of general health statistics only. Total=19 (86%). Value is based on a self-rated ability to regularly compile mental health-specific data that cover at least the public sector.	Ten countries, 45% of all countries in the Region, compile mental health-specific data. Additionally, four countries in the Region (18%) compile mental health data as part of general health statistics only. Total=14 (64%). Value is based on a self-rated ability to regularly compile mental health specific data that cover at least the public sector.	Five countries, 23% of all countries in the Region, compile mental health-specific data. Additionally, 13 Member States (59%) compile mental health data as part of general health statistics only. Total =18 (82%). Value is based on a self-rated ability to regularly compile mental health-specific data that cover at least the public sector.

Table 6.2. Total numbers of outpatient visits per 100 000 population reported in 2013, 2016 and 2019, by country

Country	Year of reporting			Percentage change between earliest and latest report
	2013	2016	2019	
Afghanistan	–	124	4065	+3178%
Bahrain	3749	426	4255	+13%
Egypt	485	571	–	+18%
Iran (Islamic Republic of)	2647	5114	–	+93%
Iraq	369	659	–	+79%
Jordan	786	–	–	–
Kuwait	12 203	–	1678	-87%
Lebanon	–	40	–	–
Libya	1619	–	–	–
Morocco	436	661	–	+52%
Occupied Palestinian territory	1560	3281	3828	+145%
Oman	2581	–	–	–
Pakistan	373	–	–	–
Qatar	990	1299	3470	+251%
Saudi Arabia	–	1571	–	–
Somalia	–	4	–	–
Sudan	–	0	228	Not calculable*
Syrian Arab Republic	–	606	–	–
Tunisia	–	–	2389	–
United Arab Emirates	–	454	2976	+555%
Yemen	–	–	–	–

* Increase from zero is not calculable as a percentage.
Note: A dash (–) indicates that countries did not provide all of the relevant data.

6.1 Individual countries and Eastern Mediterranean Region country groups

The extent to which individual countries have met the targets set out in the Comprehensive Mental Health Action Plan is shown in Table 6.3. Ticks show countries that have reported information, indicating that they have fully met the target or its proxy. Some countries that did not fully complete the whole *Mental health atlas 2020* questionnaire may have met more targets in reality but did not submit the relevant information. Summary scores for the total number of targets met by each country are shown according to country group in Table 6.4.

Four countries – Qatar and United Arab Emirates in Group 1 and the Islamic Republic of Iran and Morocco in Group 2 – met all six of the targets. One Group 3 country, Afghanistan, and the occupied Palestinian territory met five of the six targets. Twelve countries (55%) were clustered together, meeting between two and four targets. There was at least one country in each group that met only one target or no targets. The median number of targets met by Group 1 countries was 3.5, for Group 2 countries it was four targets and for Group 3 countries 2.5 targets.

The total number of country targets met across the Region was 72 (55%) out of a possible 132 (six targets x 22 countries). Collectively, countries in both Group 1 and Group 2 met 60% or more of the targets, whereas Group 3 countries met 36% of the targets (see Fig. 6.1).

In 2017 a total of 57 targets were met, or 43%; therefore, in the Region as a whole, 12% more Action Plan targets were met in 2020 than in 2017. Positive progress in meeting targets is evident in all three country groups (see Fig. 6.2). Progress has been most rapid in Group 1 countries (an increase of 20%), followed by Group 3 countries (an increase of 14%), while there has been a more modest increase of 5% in Group 2 countries.

Table 6.3. Targets set out in the Comprehensive Mental Health Action Plan 2013–2020 met by countries in the Region

Country	Targets set out in the Comprehensive Mental Health Action Plan						Total
	Plan	Legislation	Coverage[1]	Prevention	Suicide[2]	Information	
Afghanistan	✓	✓	✓	✓		✓	5
Bahrain	✓	✓		✓		✓	4
Djibouti[3]	–	–	–	–	–	–	–
Egypt				✓		✓	2
Iran (Islamic Republic of)	✓	✓	✓	✓	✓	✓	6
Iraq		✓	✓		✓	✓	4
Jordan	✓	✓		✓		✓	4
Kuwait		✓		✓		✓	3
Lebanon		✓		✓		✓	3
Libya[4]							0
Morocco	✓	✓	✓	✓	✓	✓	6
Occupied Palestinian territory	✓	✓	✓	✓		✓	5
Oman						✓	1
Pakistan	✓	✓		✓			3

[1] Change in total mental health outpatient visits used as a proxy measure for coverage for severe mental health conditions.
[2] Based on change in estimated age-standardized suicide rates between 2010 and 2017 reported through the Global Health Observatory.
[3] Did not report in the *Mental health atlas 2020*.
[4] Reported in *Mental health atlas 2020*, but did not meet any of the targets.

Table 6.3. Targets set out in the Comprehensive Mental Health Action Plan 2013–2020 met by countries in the Region *(concluded)*

Country	Targets set out in the Comprehensive Mental Health Action Plan						Total
	Plan	Legislation	Coverage[1]	Prevention	Suicide[2]	Information	
Qatar	✓	✓	✓	✓	✓	✓	6
Saudi Arabia				✓	✓	✓	3
Somalia[4]							0
Sudan			✓	✓		✓	3
Syrian Arab Republic	✓	✓		✓		✓	4
Tunisia				✓		✓	2
United Arab Emirates	✓	✓	✓	✓	✓	✓	6
Yemen	✓					✓	2
Total	11	13	8	16	6	18	72

Table 6.4. Number of Comprehensive Mental Health Action Plan targets met by countries in the Region, by country group

Number of targets met	Group 1	Group 2	Group 3
6	Qatar United Arab Emirates	Iran (Islamic Republic of) Morocco	
5		Occupied Palestinian territory	Afghanistan
4	Bahrain	Iraq Jordan Syrian Arab Republic	
3	Kuwait Saudi Arabia	Lebanon	Pakistan Sudan
2		Egypt Tunisia	Yemen
1	Oman		
0		Libya	Somalia
Did not report in 2020			Djibouti

Fig. 6.1. Percentage of Comprehensive Mental Health Action Plan targets met, by country group

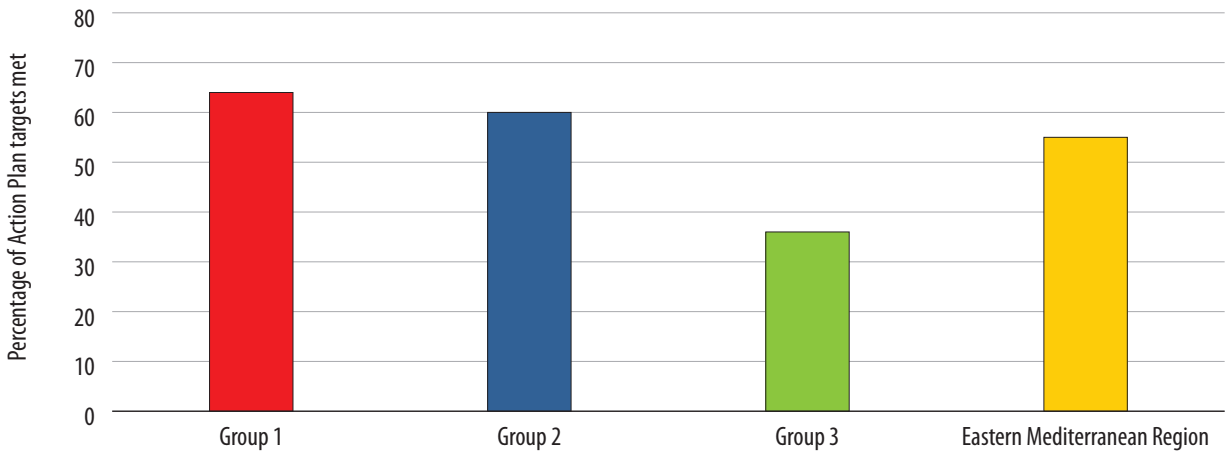
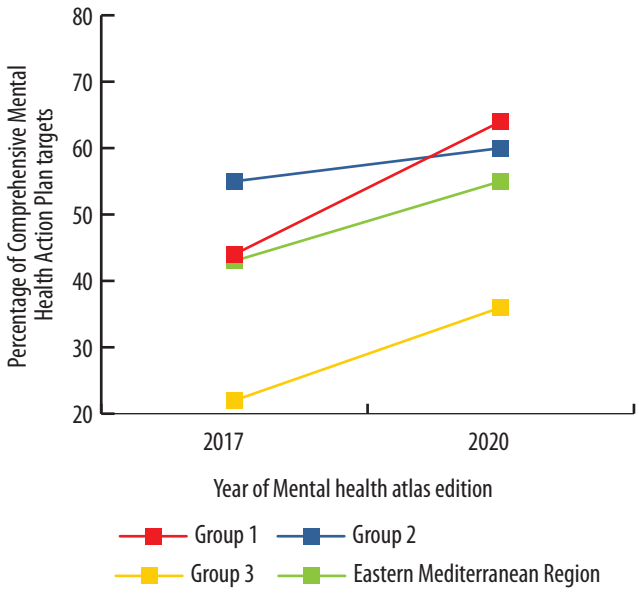


Fig. 6.2. Progress towards meeting Comprehensive Mental Health Action Plan targets between 2017 and 2020, by country group



7. Updated Comprehensive Mental Health Action Plan targets for 2030

In 2019 the Seventy-second World Health Assembly (WHA) confirmed the objectives of the Comprehensive Mental Health Action Plan 2013–2020 and extended its implementation period to 2030. The WHA requested updates to the indicators for measuring progress towards the defined targets of the Action Plan, revised appropriately for 2030. The original six indicators have been revised, and an additional five indicators have been developed (see Table 7.1).

Objective 1: To strengthen effective leadership and governance for mental health

The two indicators on mental health policies/plans and legislation have both been made more stringent by the addition of a criterion on implementation, in addition to the existing requirement for compliance with human rights instruments. Implementation of policies/plans requires that two of the following three criteria are met: 1) human resources are estimated and allocated; 2) financial resources are estimated and allocated; and 3) indicators/targets are available and used to monitor some or all of the plan. The implementation component for legislation is met if the body undertakes either irregular or regular inspections of mental health services and responds to complaints of human rights violations, either irregularly or systematically. Furthermore, the target for mental health legislation has been increased from 50% to aim for coverage of 80% of countries.

- Target 1.1: In 2019 six countries (27%) in the Eastern Mediterranean Region fulfilled indicator 1.1 for mental health policies/plans. A further 12 will need to implement compliant polices by 2030 to meet the updated target of 80%.
- Target 1.2: Six countries (27%) fulfilled indicator 1.2 for mental health legislation. A further 12 countries will need to implement compliant legislation to meet the updated target of 80%.

Objective 2. To provide comprehensive, integrated and responsive mental health and social care services in community-based settings

Previously there was one target for Objective 2, to increase coverage for severe mental health conditions by 20%. This will now be assessed by two indicators: 2.1.1, the proportion of persons with psychosis who have used services over the past 12 months; and 2.1.2, the proportion of persons with depression who have used services over the past 12 months. In addition, there are two new targets: target 2.2, that 80% of countries will have doubled the number of community-based mental health facilities by 2030; and target 2.3, that 80% of countries will have integrated mental health into primary health care by 2030.

- Target 2.1: The baseline median service coverage for psychosis (Indicator 2.1.1) in 2016 was calculated to be 19% (based on data for eight countries). In 2019 this had risen by 1% to 20% (based on data for seven countries). In order to increase service coverage by half, this percentage will need to rise to 29% by 2030. Proportion of persons with depression who have used services over the past 12 months (Indicator 2.1.2) – suitable data were not collected in the *Mental health atlas 2020* questionnaire.
- Target 2.2: Data collected for the *Mental health atlas 2020* will be used as the baseline for this target to be achieved by 2030. Targets for each country will be based on their own baselines. Some countries already have extensive community-based facilities, and it is unlikely and perhaps inappropriate that the target of doubling the number of facilities is applied to them. Four countries have not submitted data for a baseline. Countries in the Region have a median of 0.48 community-based mental health facilities per 100 000 population which, if this figure is doubled, suggests a target of a median of 0.96 community-based mental health facilities for countries in the Region by 2030.
- Target 2.3: Five countries in the Region (23%) met four or more of the five components of mental health integration into primary health care (guidelines, pharmacological interventions available to > 75% of primary care centres, psychosocial interventions available to > 75% of primary care centres, training and supervision). A further 13 countries need to integrate mental health into primary health care to meet the 2030 target of 80%.

Objective 3: To implement strategies for promotion and prevention in mental health-based settings

The two previous targets for Objective 3 have been extended for 2030. For target 3.1, the number of functioning national, multisectoral mental health promotion and prevention programmes remains at least two. Target 3.2, to reduce the suicide rate by 10% by 2020, has been updated to reduce the suicide rate by one third by 2030. In addition, a new target 3.3 has been introduced: that 80% of countries will have a system in place for mental health and psychosocial preparedness for emergencies and/or disasters by 2030.

- Target 3.1: Sixteen countries in the Region (73%) have at least two functioning multisectoral programmes for mental health promotion and prevention. A further two countries will need to implement functioning programmes to meet the target by 2030.
- Target 3.2: The median suicide rate for countries in the Region in 2019 was 4.76 per 100 000 population. This is a 16% reduction from the 2013 baseline of 5.7 per 100 000 population. Reduction by at least one third sets the target as a suicide rate of 3.8 per 100 000 population or lower by 2030.
- Target 3.3: Eleven countries in the Region (50%) have a system in place for mental health and psychosocial preparedness for emergencies/ disasters. A further seven countries will need to implement such programmes to meet the new target of 80% by 2030.

Objective 4. To strengthen information systems, evidence and research for mental health

Target 4.1, that 80% of countries will be routinely collecting and reporting on at least a core set of mental health indicators every two years through their national health and social information systems, remains as it was, except that the year is updated to 2030. An additional target 4.2 has been introduced: that the output of global research on mental health doubles by 2030.

- Target 4.1: Five countries in the Region (23%) currently compile and publish a specific mental health report. Additionally, 13 countries (59%) compile mental health data as part of general health statistics. In total, 18 countries in the Region (82%) are routinely collecting and reporting on a core set of mental health indicators, which meets the updated target of 80% of countries by 2030.
- Target 4.2: The total mental health research output for the Region has increased by 29%, from 464 publications in 2013 to 599 publications in 2019. The median research output for countries in the Region was 13 articles. In order to double research output, the target for 2030 will be 928 mental health publications in a year.

7.1 Individual countries and Eastern Mediterranean Region country groups

The extent to which individual countries have met the updated 2030 targets for the Comprehensive Mental Health Action Plan is shown in Table 7.2. Ticks show countries that have reported information, indicating that they have fully met the target. Some countries that did not fully complete the 2020 questionnaire may have met more targets in reality but did not submit the relevant information. Summary counts of the total number of targets met by each country are shown according to country group in Table 7.3.

At this point in time, only nine targets could possibly be met by individual countries. This is because analysis is not available for the coverage of depression, and data reported in this edition of the *Mental health atlas* are being used as baselines for the targets relating to the doubling of community-based facilities. The Islamic Republic of Iran and Bahrain have met six of the nine possible targets. Half of the Group 1 countries have met five or more targets, while most Group 2 countries are clustered at between two and four targets met. No Group 3 country has met more than three targets, though four have met two or more. Three countries did not report meeting any of the 2030 targets in 2019. The median number of targets met by Group 1 countries was four, for Group 2 countries it was 3.5, and for Group 3 countries it was two.

The total number of country targets met across the Region as a whole is 64 (32.3%) out of a possible 198 (nine targets x 22 countries). Country Groups 1 and 2 met a similar percentage of targets, 40.7% and 36.7% respectively, while Group 3 countries met less than half as many (16.7%) (see Fig. 7.1).

Table 7.1. Targets, indicators and level of achievement in meeting Comprehensive Mental Health Action Plan objectives for 2030

Action Plan objectives	Action Plan targets	Action Plan indicators	Value for 2019 (*Atlas 2020*)
Objective 1 To strengthen effective leadership and governance for mental health	**Target 1.1** 80% of countries will have developed or updated their policy/ plan for mental health in line with international and regional human rights instruments by 2030.	**Indicator 1.1** Existence of a national policy/plan for mental health that is being implemented and is in line with international human rights instruments.	Six countries, 27% of all countries in the Eastern Mediterranean Region. Value is based on a self-rating checklist.
	Target 1.2 80% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments by 2030.	**Indicator 1.2:** Existence of a national law covering mental health that is being implemented and is in line with international and regional human rights instruments.	Six countries, 27% of all countries in the Region. Value is based on a self-rating checklist.
Objective 2 To provide comprehensive, integrated and responsive mental health and social care services in community-based settings	**Target 2.1** Service coverage for mental health conditions will have increased at least by half by 2030.	**Indicator 2.1.1** Proportion of persons with psychosis who have used services over the last 12 months (%).	Based on seven countries for which relevant information was available, median service coverage for psychosis was 20%.
		Indicator 2.1.2 Proportion of persons with depression who have used services over the last 12 months (%).	Data for this indicator were not collected in the *Mental health atlas 2020* questionnaire.
	Target 2.2 80% of countries will have doubled the number of community-based mental health facilities by 2030.	**Indicator 2.2.1** Number of community-based mental health facilities.	Countries in the Region have a median of 0.48 community-based mental health facilities per 100 000 population (or a median number of 23 community-based mental health facilities per country).
	Target 2.3 80% of countries will have integrated mental health into primary health care by 2030.	**Indicator 2.3.1** Existence of a system for integration of mental health into primary health care.	Five countries, 23% of all countries in the Region, met four or more of five components of mental health integration into primary health care. Value is based on a self-rated checklist.

Table 7.1. Targets, indicators and level of achievement in meeting Comprehensive Mental Health Action Plan objectives for 2030 *(concluded)*

Action Plan objectives	Action Plan targets	Action Plan indicators	Value for 2019 (*Atlas 2020*)
Objective 3 To implement strategies for promotion and prevention in mental health-based settings	**Target 3.1** 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes by 2030.	**Indicator 3.1** Functioning programmes of multisectoral mental health promotion and prevention in existence.	Sixteen countries, 73% of all countries in the Region, have at least two functioning programmes. Value is based on a self-completed inventory of current programmes.
	Target 3.2 The rate of suicide in countries will be reduced by one third by 2030.	**Indicator 3.2** Suicide rate (per 100 000 population) in a given calendar year.	Median suicide rate: 4.76 per 100 000 population. 16% reduction from 2013 baseline. Value is based on age-standardized global estimate.
	Target 3.3 80% of countries will have a system in place for mental health and psychosocial preparedness for emergencies and/or disasters by 2030.	**Indicator 3.3** Existence of a system for mental health and psychosocial preparedness for emergencies and/or disasters.	Eleven countries (50%) of all countries in the Region have a system in place for mental health and psychosocial preparedness for emergencies and/or disasters. Value is based on a self-completed inventory of current programmes.
Objective 4 To strengthen information systems, evidence and research for mental health	**Target 4.1** 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems by 2030.	**Indicator 4.1** The core set of identified and agreed mental health indicators is routinely collected and reported every two years.	Five countries, 23% of all countries in the Region, currently compile a specific mental health report. Additionally, 13 countries (59%) compile mental health data as part of general health statistics only. Total =18 (82%) Value is based on a self-rated ability to regularly compile mental health-specific data that cover at least the public sector.
	Target 4.2 The output of global research on mental health doubles by 2030.	**Indicator 4.2** The number of published articles on mental health research (defined as research articles published in databases).	There were 599 mental health publications in 2019 compared with 464 in 2013, which represents an increase of 29%. Values are based on a literature search conducted centrally by WHO.

Table 7.2. Comprehensive Mental Health Action Plan targets for 2030 met by countries in the Eastern Mediterranean Region

Country	Comprehensive Mental Health Action Plan targets for 2030											Total
	1.1 Plan	1.2 Legislation	2.1.1 Psychosis cover-age[1]	2.1.2 Depression cover-age[2]	2.2 General hospital units	2.3 Integration into PHC	3.1 P&P programmes	3.2 Suicide[3]	3.3 Disaster programmes[4]	4.1 Information	4.2 Research[5]	
Afghanistan							✓			✓		2
Bahrain	✓	✓				✓	✓			✓	✓	6
Djibouti[6]												0
Egypt							✓			✓		2
Iran (Islamic Republic of)	✓	✓				✓	✓		✓	✓		6
Iraq		✓								✓		2
Jordan		✓					✓			✓		3
Kuwait							✓			✓		2
Lebanon						✓	✓		✓	✓		4
Libya												0
Morocco		✓					✓		✓	✓		4
Occupied Palestinian territory	✓						✓		✓	✓		4
Oman										✓		1
Pakistan							✓		✓			2
Qatar	✓					✓	✓		✓	✓		5
Saudi Arabia						✓	✓			✓		3
Somalia												0
Sudan							✓		✓	✓		3
Syrian Arab Republic	✓						✓		✓	✓	✓	5
Tunisia							✓		✓	✓		3
United Arab Emirates	✓	✓					✓		✓	✓		5
Yemen									✓	✓		2
Total	6	6	0			5	16	0	11	18	2	64

[1] Data on coverage for psychosis were available for both 2017 and 2020 for three countries (Iraq, Kuwait and Syrian Arab Republic), but none of these achieved an increase in service coverage of 50% or more.

[2] Data on coverage for depression and mental health units in general hospitals are not available from the Mental health atlas questionnaire.

[3] Suicide rates are based on changes in estimated age-standardized suicide rates between 2013 and 2019 reported via the Global Health Observatory. No country achieved a reduction of at least one third from the 2013 baseline.

[4] Mental health and psychosocial support (MHPSS) components of disaster preparedness and/or disaster risk reduction (DRR).

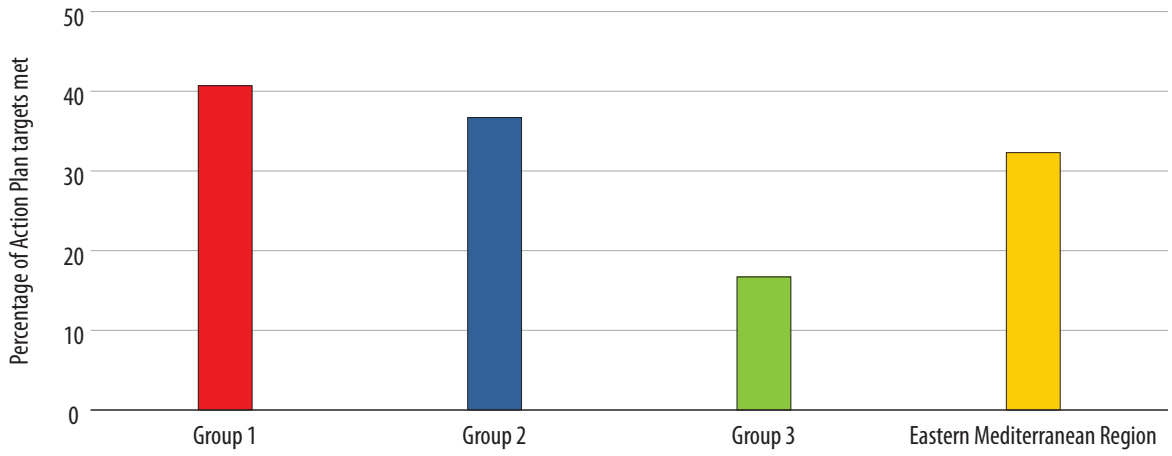
[5] Baseline for research output established in 2019. Changes in research output will only be measurable in future years.

[6] Djibouti did not report in the *Mental health atlas 2020*.

Table 7.3. Number of Comprehensive Mental Health Action Plan targets for 2030 met by countries in the Region, by country group

Number of targets met	Group 1	Group 2	Group 3
6	Bahrain	Iran (Islamic Republic of)	
5	Qatar United Arab Emirates	Syrian Arab Republic	
4		Lebanon Morocco Occupied Palestinian territory	
3	Saudi Arabia	Jordan Tunisia	Sudan
2	Kuwait	Egypt Iraq	Afghanistan, Pakistan Yemen
1	Oman		
0		Libya	Somalia
Did not report in 2020			Djibouti

Fig. 7.1. Percentage of Comprehensive Mental Health Action Plan targets for 2030 met in the Eastern Mediterranean Region, by country group (based on nine achievable targets)



Annex A. Participating countries and contributors

Country	Contributors to *Mental health atlas 2020*
Afghanistan	Bashir Ahmad Sarwari
Bahrain	Eman Ahmed Haji
Egypt	Menan Abd Al Maksoud
Iran (Islamic Republic of)	Ahmad Hajebi
Iraq	Emad Abdulrazaq Abdulghani
Jordan	Fateen Fakhri Janem
Kuwait	Najah Alenezi
Lebanon	Rabih Chammay
Libya	Wesam Abdalla Daab
Morocco	Bouram Omar
Occupied Palestinian territory	Samah Jabar
Oman	Amira Al Raidan
Pakistan	Malik Muhammad Safi
Qatar	Susan Clelland
Saudi Arabia	Neif El Subhi and Hassan Elkhobrani
Somalia	Abdirazak Farah Hassan Baraco
Sudan	Zienat Sanhori
Syrian Arab Republic	Amal Shakko
Tunisia	Fatma Charfi
United Arab Emirates	Muna Alkuwari
Yemen	Abdulqodos Abdulwahab Harmmal

Annex B. Glossary of terms used in the *Mental health atlas 2020*

TYPES OF FACILITY

Mental hospital

A specialized hospital-based facility that provides inpatient care and long-stay residential services for people with mental health conditions. Other names include mental health hospital and psychiatric hospital. **Includes:** Public and private non-profit and for-profit facilities; forensic inpatient facilities; mental hospitals for children and adolescents and other specific groups (e.g. older adults). **Excludes:** Community-based psychiatric inpatient units; facilities that treat only people with alcohol and substance use problems or intellectual disability; psychiatric units in general hospitals; and mental health community residential facilities.

Psychiatric unit in a general hospital

A psychiatric unit that provides inpatient care within a community-based hospital facility (e.g. general hospital); the period of stay is usually short (weeks to months) and the hospital also provides services related to other medical specialties. **Includes:** Public and private non-profit and for-profit facilities; psychiatric wards or units in general hospitals, including those for children and adolescents or other specific groups (e.g. older adults). **Excludes:** Mental hospitals; community residential facilities; facilities for alcohol and substance use problems or intellectual disability only.

Mental health community residential facility

A non-hospital, community-based mental health facility providing overnight residence for people with mental health conditions. Both public and private non-profit and for-profit facilities are included. **Includes:** Staffed or unstaffed group homes or hostels for people with mental health conditions; halfway houses; therapeutic communities. **Excludes:** mental hospitals; facilities for alcohol and substance use problems or intellectual disability only; residential facilities for older adults; institutions treating neurological disorders or physical disability problems.

Mental health day treatment facility

A facility providing care and activities for groups of users during the day that last for half a day or one full day (including those for children and adolescents only or other specific groups, e.g. older adults). **Includes:** Day or day-care centres; sheltered workshops; club houses; drop-in centres. Both public and private non-profit and for-profit facilities are included. **Excludes:** Day treatment facilities for inpatients; facilities for alcohol and substance use problems or intellectual disability only.

Mental health outpatient facility

An outpatient facility that manages mental health conditions and related clinical and social problems. **Includes:** Community mental health centres; mental health outpatient clinics or departments in general or mental hospitals (including those for specific mental health conditions, treatments or user groups, e.g. older adults). Both public and private non-profit and for-profit facilities are included. **Excludes:** Private practice; facilities for alcohol and substance use problems or intellectual disability only.

Other residential facility

A residential facility that houses people with mental health conditions but does not meet the definition for community residential facility or any other defined mental health facility. **Includes:** Residential facilities specifically for people with intellectual disability, for people with substance use problems or for people with dementia; residential facilities that formally are not mental health facilities but where most residents have diagnosable mental health conditions.

Primary health care clinic

A clinic that often offers the first point of entry into the health-care system. Primary health care clinics usually provide the initial assessment and treatment for common health conditions and refer those requiring more specialized diagnosis and treatment to facilities that have staff with a higher level of training.

TYPES OF WORKER

Nurse

A health professional who has completed formal training in nursing at a recognized, university-level school for a diploma or degree in nursing.

Occupational therapist

A health professional who has completed formal training in occupational therapy at a recognized, university-level school for a diploma or degree in occupational therapy.

Other specialized mental health worker

A health or mental health worker who possesses some training in health care or mental health care (e.g. occupational therapist) but does not fit into any of the defined professional categories (e.g. medical doctors, nurses, psychologists, social workers). **Includes:** Non-doctor/non-nurse primary care workers, psychosocial counsellors, auxiliary staff. **Excludes:** General staff for support services within health or mental health care settings (e.g. cooking, cleaning, security).

Primary health care doctor

A general practitioner, family doctor or other non-specialized medical doctor working in a primary health care clinic.

Primary health care nurse

A nurse working in a primary health care clinic.

Psychiatrist

A medical doctor who has had at least two years of postgraduate training in psychiatry at a recognized teaching institution. This period may include training in any subspecialty of psychiatry.

Psychologist

A professional who has completed formal training in psychology at a recognized, university-level school for a diploma or degree in psychology. The mental health atlas questionnaire asks for information only on psychologists working in mental health care.

Social worker

A professional who has completed formal training in social work at a recognized, university-level school for a diploma or degree in social work. The mental health atlas questionnaire asks for information only on social workers working in mental health care.

Speech therapist

A professional who has completed formal training in speech therapy at a recognized, university-level school for a diploma or degree in speech therapy. In some countries, speech therapy is a part of audiology training. The mental health atlas questionnaire asks for information only on speech therapists working in mental health care.

OTHER TERMS USED

Admissions

The number of admissions in one year is the sum of all admissions to the facility within that year. This number is a duplicated count; in other words, if one user is admitted twice, it is counted as two admissions.

Legal capacity

The UN Convention on the Rights of Persons with Disabilities recognizes that people with disabilities, including mental disabilities, have the right to exercise their legal capacity and to make decisions and choices about all aspects of their lives, on an equal basis with others. The Convention promotes a supported decision-making model, which enables people with mental disabilities to nominate a trusted person or a network of people with whom they can consult and discuss issues affecting them.

Mental health conditions

This term refers to a broad range of problems, with different symptoms including mental, neurological and substance use (MNS) disorders, encompassing a wide range of conditions of the brain from depression to epilepsy to alcohol use problems. However, such conditions are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others.

Mental health legislation

Legal provisions related to mental health. Such provisions typically focus on issues such as civil and human rights protection for people with mental health conditions, along with treatment facilities, personnel, professional training and service structure.

Mental health plan

A detailed scheme for implementing strategic actions that addresses the promotion of mental health, the prevention of mental health conditions, and treatment and rehabilitation. Such a plan allows the implementation of the vision, values, principles and objectives defined in mental health policy.

Mental health policy

Mental health policy is an organized set of values, principles and objectives for improving mental health

and reducing the burden of mental health conditions in a population. It defines a vision for future action.

National health insurance or reimbursement scheme

Refers to a system of health insurance that insures a national population against the costs of health care. It may be administered by the public sector, the private sector or a combination of both. Funding mechanisms vary with the particular programme and country. National or statutory health insurance does not equate to government-run or government-financed health care but is usually established by national legislation.

Persons treated in a mental hospital

(a) The number of users in the mental hospital at the beginning of the year plus (b) the number of admissions during the year.

Persons treated in a community residential facility

(a) The number of users in the facility at the beginning of the year plus (b) the number of admissions to the facility during the year.

Persons treated through a mental health day treatment facility

The number of users with at least one attendance for treatment at the facility within the year.

Persons treated in a mental health outpatient facility

The number of users with at least one outpatient contact with the facility. A contact refers to a mental health intervention provided by a staff member of a mental health outpatient facility, whether the intervention occurs within the facility or elsewhere.

Pharmacological interventions for mental health conditions

Pharmacological interventions involve psychotropic medicines to reduce the symptoms of mental health conditions and improve functioning. Four main groups of medicines are used in mental health conditions and are recommended in the mhGAP-IG version 2.0 for use in non-specialized health-care settings (e.g. primary health care): antipsychotics for psychotic disorders, drugs for mood disorders (depression or bipolar), anticonvulsants and antiepileptics, and medicines for management of substance withdrawal, intoxication or dependence. Psychotropic medicines are on the WHO Model List of Essential Medicines, which defines the minimum medicine requirements for a basic health system.

Psychosocial disabilities

This term refers to people who have received a mental health diagnosis and who have experienced negative social factors including stigma, discrimination and exclusion. People living with psychosocial disabilities include ex-users and current users of mental health care services, as well as persons who identify themselves as survivors of these services or with the psychosocial disability itself.

Psychosocial interventions for mental health conditions

This refers to interpersonal or informational activities, techniques or strategies that target biological, behavioural, cognitive, emotional, interpersonal, social or environmental factors with the aim of improving health functioning and well-being. The term is applied to psychoeducation, psychotherapy, counselling and other non-pharmacological interventions.

Recovery approach

From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding one's abilities and disabilities, engaging in an active life and having personal autonomy, social identity, meaning and purpose in life and a positive sense of self. Recovery is not synonymous with cure.

Seclusion and restraint

"Seclusion" means the voluntary placement of an individual alone in a locked room or secured area from which he or she is physically prevented from leaving. "Restraint" means the use of a mechanical device or medication to prevent a person from moving his or her body. "Alternatives to seclusion" include prompt assessment and rapid intervention in potential crises; and using problem-solving methods and/or stress management techniques such as breathing exercises.

Coverage

Service coverage is defined as the proportion of people with a mental health condition contacting a mental health service (from service utilization data) among those estimated to have the condition (population prevalence) during a 12-month period.

At-risk populations

Certain groups have an elevated risk of developing mental health conditions. This vulnerability is brought about by societal factors and the environments in which they live. Vulnerable groups in society will differ across countries, but in general they share common challenges related to their social and economic status, social supports and living conditions, including stigma and discrimination; violence and abuse; restrictions in exercising civil and political rights; exclusion from participating fully in society; reduced access to health and social services; reduced access to emergency relief services; lack of educational opportunities; exclusion from income generation and employment opportunities; increased disability and premature death.

Service user

A person who is receiving mental health care. This term is used in different places and by different groups of practitioners and people with mental health conditions.

Mental health and psychosocial support

The composite term "mental health and psychosocial support" (MHPSS) is used in the Inter-Agency Standing Committee (IASC) Guidelines for MHPSS in Emergency Settings to describe "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder". The global humanitarian system uses the term MHPSS to unite a broad range of actors responding to emergencies (such as the COVID-19 pandemic), including those working with biological approaches and sociocultural approaches in health, social, education and community settings, as well as to "underscore the need for diverse, complementary approaches in providing appropriate support".

Work-related mental health prevention and promotion programme

Programmes coordinated by health (occupational and/or mental health), labour or employment sectors with the intention of promoting mental health and preventing mental health conditions in workers.

Annex C. Methodology for estimation of service coverage in the *Mental health atlas 2020*

Service coverage for psychosis was estimated in the Mental Health Atlas 2020, globally and regionally, using data collected for the *Mental health atlas 2017* and methodology developed by Jaeschke et al., 2021.[1]

Service coverage was defined as the proportion of people with a mental health condition contacting a mental health service among those estimated to have the condition during a 12-month period. This drew upon 12-month service utilization data from the *Mental health atlas 2017* according to the following formula:

Total service coverage = total treated cases/expected cases.

Treated cases of psychosis drew upon 12-month service utilization data from the *Mental health atlas 2017 questionnaire* (Section 8), specifically data from specialist (inpatient and outpatient) mental health facilities for psychosis. Data were excluded if not reporting on service utilization of both inpatient and outpatient services for psychosis and/or representativeness of the population. As a validity check, data were excluded if the number of visits (Section 7) per individual case (from Section 8) was less than one. Total treated cases were calculated as follows:

Total treated cases = inpatient cases + outpatient cases

Total treated cases per 100 000 population = 100 000 x (total treated cases/total population).

Expected cases of psychosis were estimated using the disorder-specific prevalence rate estimates of the Global Burden of Disease Study 2016 and total population sizes.

Expected cases = prevalence rate x total population.

Schizophrenia prevalence rates were adjusted to non-affective psychosis prevalence rates based on a 0.49 ratio derived from the literature. United Nations population estimates were used whenever a country did not report its population size, or its population size was dramatically different from UN population estimates.

Case definitions

Global Burden of Disease prevalence estimates and mental health atlas service utilization data adhere to ICD-10 case definitions for schizophrenia (ICD-10; F20-29: adjusted to non-affective psychosis).

Service utilization data adjustment

Countries were categorized into either inpatient- or outpatient-prioritized countries based on reported data. To prevent double-counting of individuals, it was assumed that all individuals utilizing inpatient facilities also used outpatient facilities in outpatient-prioritized countries. Total unique case adjustment was based on question 9.3 of the *Mental health atlas 2017* questionnaire, which provides a follow-up rate for the percentage of discharged inpatients receiving a follow-up outpatient visit within a month, ranging from 1 (25% or fewer) to 4 (more than 75%). The adjusted outpatient estimate was calculated by averaging a follow-up range, multiplying this by the inpatient cases and subtracting this product from the reported outpatient utilization value, as follows:

Total unique treated cases = (outpatient cases) – (follow-up rate x inpatient cases) + inpatient cases

Adjusted total treated cases per 100 000 = (unique cases/total population)/100 000

The median follow-up rate for the respective Global Burden of Disease world region was used for countries with no reported follow-up rate. The original reported outpatient utilization value was used if the adjusted outpatient utilization value was negative.

Service coverage thresholds

A validity check method was designed to determine whether countries reported cases or visits by applying lower and upper service coverage thresholds derived from published literature. The lower threshold for psychosis was based on the World Mental Health Survey country with the lowest service estimate for severe mental health conditions. No upper threshold was set, to acknowledge that there is potential for service coverage in specialist mental health services to be high.

[1] Jaeschke K, Hanna F, Ali S, Chowdhary N, Dua T, Charlson F. Global estimates of service coverage for severe mental disorders: findings from the WHO Mental Health Atlas 2017. Global Mental Health. 2021;8. doi:10.1017/gmh.2021.19

Calculation of uncertainty and meta-analysis

Standard errors around service estimates of each country were calculated, and country-level data were aggregated by World Bank income group, WHO region and Global Burden of Disease super-region using random-effects meta-analyses.

Mental health conditions have a profound effect on individuals, their families and society. *The Mental health atlas 2020: review of the Eastern Mediterranean Region* provides up-to-date information on the availability of mental health services and resources in the Region, including information on mental health policies, legislation, financing, the availability and utilization of mental health services, human resources and information/data collection systems. The results provide an invaluable resource that will assist stakeholders to identify gaps and inform decisions around strengthening policy and legislative frameworks, scale up services for mental health and support the monitoring of progress towards global and regional targets.