The Royal Tropical Institute

A POLICY ANALYSIS OF MENTAL HEALTH INTEGRATION INTO PRIMARY CARE IN LIBYA

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Libya

56th Master of Public Health/International Course in Health Development (MPH/ICHD)
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Policy Analysis of Mental Health Integration into Primary Care in Libya

A thesis submitted in partial fulfilment of the requirement for the degree of Master of Public Health by

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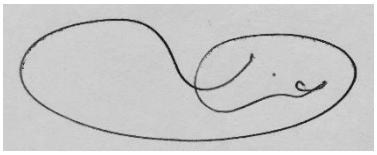
Signature: 

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Abstract

Background: Assuring the good mental health (MH) of a population is a human right, especially in post-conflict contexts, where the policymaking is often complicated. The World Health Organization post-conflict estimations, show that for every five people, one is affected by a mental condition. Integration of MH into primary care (PC) is the best proved policy. However, it is a hard process that needs solid evidence for each specific context. Therefore, policy review and analysis are critical for successful integration. MH and PC policies in Libya have neither been reviewed nor analysed.
Purpose: Evidence is crucial to develop effective policies. For this reason, results of this research will help policy-makers to address MH needs, including vulnerable groups, such as internally displaced, returnees and migrants.
Scope: The study included MH and PC policy documents in Libya, between 2010-2020, including approved and non-approved, finalized and non-finalized documents. In regard to literature, the study included English literature, which was published between 2000-2020.
Methodology: The study used a literature review to analyse 26 health policy documents in Libya, with a focus on MH and PC, using the Walt and Gilson policy model, in addition to this, complementary, semi-structured interviews, with eight key informants, were conducted and lessons learned from other countries were used.
Results: The context is a centralised with rapid turnover of governments and scarcity of financial resources. Stigma is a big issue, however, combating stigma was rarely mentioned. MH policies did not adequately reflect the ongoing conflict and the needs of the vulnerable groups. Multiple national and international actors were identified and coordination amongst them is a huge challenge. The policy process is a top-down approach that lacks the evidence and usually limited to individual agendas. A mix of PC and community-based combined model, is proved to work effectively in other countries of similar settings.
Conclusion: The policies of MH integration into PC in Libya, showed gaps in context, actors, process and content. These gaps can be addressed and lessons learned from other countries can support this task.
Keywords: Mental Health, Primary Care, Policy, Libya, Conflict and Fragile Context.

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Abbreviations

BSC:	Bureau of Statistics and Census
CHE:	Current Health Expenditure
CRA:	Civil Registration Authority
DHIS2:	District Health Information System 2
DALYs:	Disability-Adjusted Life Years
DOH:	District of Health
EGA:	Environment General Authority
EPHS:	Essential Package of Health Services
EMRO:	East Mediterranean Regional Office of WHO
EU:	European Union
GDP:	Gross Domestic Product
GGHE-D:	Domestic General Government Health Expenditure
GGE:	General Government Expenditure
GIA:	General Information Authority
GIZ:	German Society for International Cooperation
GP:	General Practice
HIC:	Health Information Centre
HRP:	Humanitarian Response Plan
IMC:	International Medical Corps
IRC:	International Rescue Committee
IDPs:	Internally Displaced People
IOM:	International Organization of Migration
KIT:	Royal Tropical Institute
KIs:	Key Informants
LMIC:	Low and Middle Income Countries
LBMS:	Libyan Board of Medical Specialties
MH:	Mental Health
MOCC:	Ministry of Culture and Civil Society
MOE:	Ministry of Education
MOF:	Ministry of Finance
MOH:	Ministry of Health
MOI:	Ministry of Information
MOJ:	Ministry of Justice
MOLG:	Ministry of Local Government
MOP:	Ministry of Planning
MOSA:	Ministry of Social Affairs
MOY:	Ministry of Youth
NCD:	Non-communicable diseases
NCDC:	National Centre of Disease Control
NCHSR:	National Centre for Health System Reform
NGOs:	Non-Governmental Organizations
OCHA:	United Nations Office for the Coordination of Humanitarian Affairs
OOP:	Out of Pocket
PC:	Primary Care

PHC:	Primary Health Care
PHCI:	Primary Health Care Institute
PMO:	Prime Ministry Office
PTSD:	Post Traumatic Stress Disorder
RT:	Research Team
SDGs:	Sustainable Developmental Goals
UHC:	Universal Health Coverage
UNFPA:	United Nations Population Fund
UNICEF:	United Nations Children's Fund
WAA:	Worriers Affairs Authority
WHO:	World Health Organization
YLDs:	Years Lived with Disability

Glossary

Policy is the process of priority setting and assignment of resources (1).
Public Policy is the strategic intervention that is developed by the public official leadership to enhance or reduce a specific issue at population level (2).
Policy Adequacy might be evaluated through the effect of the policy on people (1).
Policy Making Process is the process that formulates the final policy and it has different aspects; political, social and economic. There are formal and informal parts of the process and it is led by interested actors (1).
Health Policy includes decision-making, planning, measures and activities that target a well-defined health care objective. Policies can be short, medium or long term and aiming to set priorities, divide tasks and communicate with professionals and/or the public (3).
Mental Health (MH) is a state of wellbeing that enables individuals to deal with normal life stress, using cognitive and social skills, be productive and positively participate in the community, with the ability to recognize, express and manage emotions. It is not only the absence of mental disease or disability (4).
Many factors influence the MH status, including biological, psychological and social elements. Moreover, it is well know that MH is affected by economic crises and violent contexts (4).
Primary Care (PC) is the first level of care and first point of contact that delivers integrated, comprehensive, coordinated and contextualized services to all people equally and equitably to address most of their needs and expectations in regard to promotion, protection, prevention, treatment, rehabilitation and palliative care (5,6).
General Practice is a primary care oriented clinical and academic specialty that includes teaching curricula, research activities, evidence-based interventions and clinical practice (7). In many countries, this specialty is known as Family Medicine.
General Practitioner is a physician trained in the general practice to provide a full range (promotion, protection, prevention, curative, rehabilitation and palliative) of services in a continuous and coordinated way (7).
Health Centre is a primary care facility that provides services for a defined population in a locality. In Libya, each health centre covers a catchment population of 20,000-30,000 (85).
Primary Care Polyclinic is a primary care facility where more specialized services are provided in primary care. In Libya, each primary care polyclinic covers a catchment population of 50,000 (85).
Mental Health Global Action Programme (mhGAP) is a strategic approach of health care that relies on evidence-based interventions to address mental, neurological and substance use disorders in developing country contexts and it is a WHO initiative (8).
Effective Coverage Concerns the proportion of the population who have satisfied their health needs with the right health interventions to effectively address their problems (9).

1.0 Introduction

My name is Ghassan Karem, I am a Libyan physician and I had been working in different locations and positions in Libya including a primary care (PC) centre, an Emergency Department, an Internal Medicine Department, a Diabetes Centre and an Intensive Care Department. I held management positions at district level starting from the Health Information Office, to the Health Services Office at District of Health (DOH) level, then as a head of Emergency Department in a teaching hospital and lastly I have been working at the Ministry of Health (MOH) as the director general of PC. In addition, I am working in field hospitals near conflict lines and in Internally Displaced People (IDP) camps' clinics as a volunteer. I have witnessed several conflicts in Libya since 2011 and I can see the impact on mental health of the war, while the health system is collapsing and becoming unable to respond to people's needs. I am also a part of the policy planning process at the national level and I have faced multiple challenges, in identifying and developing the right policies, especially, due to the lack of policy review, analysis and evaluation. The latter makes it hard to build evidence-based policies and develop appropriate alternatives, when they are needed. Persisting with the same health policies and expecting different results is unreasonable and will not relieve the suffering of people. They deserve better services and a better MH status.

This study aims to review and analyse the policies of MH integration into PC in Libya and identify gaps, and in addition, extract the lessons learned from similar post-conflict contexts in order to inform policy makers and support them to develop better policies.

2.0 Background

2.1 Country Context

Libya is a North African country surrounded by Egypt, Sudan, Chad, Niger, Algeria, Tunisia and the Mediterranean Sea. The Libyan population is 6.8 million and they live mainly in urban areas, while the land mark is more than 1.7 million km^2. Table 1 shows general information about the country.

Table 1. Country information, source (21).

Population	6,871,292
Land area	1,759,540 Km2
Municipalities	113
Urban population	78.2%
Median age	28.8 years
Life expectancy	69 years for male and 75 years for female
GDP per capita	10,368 USD
GGHE-D per capita	397 USD
GGHE-D as % of GDP	4%
GGHE-D as % of GGE	6%
OOP as % of CHE	37%

GGHE-D: Domestic General Government Health Expenditure. **GGE:** General Government Expenditure. **CHE:** Current Health

Following the Tunisian and Egyptian revolutions, Libyan unrest against the regime began. Protests were met with violence by Gaddafi's forces which was followed by widespread armed conflict for eight months. This conflict caused hundreds of deaths, and thousands of injuries, disabilities and amputations (20). Conflict renewed since 2014 and resulted in a politically divided country, severely fragmented health system, damaged facilities, disruption of the medical supply chain and health workers migration (22–24). Security represents a major concern for both health workers and clients (28). In addition, there were repeated cuts of water and electricity supply and food insecurity (25). That was further aggravated by poor management of public revenue and insufficient public spending (26). The latter was aggravated by a remarkable reduction in the national petroleum production. In addition to this, decreased petroleum prices have directly affected the General Domestic Product (GDP). The oil production contribution in the GDP dropped from 95% to 47% and it is barely enough to cover salaries (27). Growing displacement, migration and human trafficking further exacerbated the plight of the population. Some vulnerable groups were affected more than others such as children, women, the elderly, families with killed or lost members, fighters, amputees, prisoners, and front-line health workers (20,29). The last update issued by IOM on June 2020, reported vulnerable groups affected by the conflict as summarized in Table 2 (30). In addition, 749,000 civilians still live in locations damaged by the conflict and 345,000 live close to front-llines (26). Since 2019, health facilities were attacked 63 times, resulting in 52 injuries and 76 deaths among health workers (26). Estimates reported that 24% of Libyans are unable to access health services (26), whilst amongst migrants, 74% of those in need, reported having no access to health services (31). According to the Humanitarian Response Plan (HRP) 2020 in Libya, 893,000 people are in need of humanitarian aid, which is mainly health services (30). The current momentum brought

Table 2. Vulnerable groups, source : (30).

Category	**Number**
IDPs	355,672
Migrants	654,081
Returnees	74,000
Non-displaced	267,000
Refugees	48,000

about by freedom and change atmosphere, that were created after the revolution, can be great opportunities to support health sector reform (32).

2.2 Global Burden

Worldwide, 1 billion people are suffering of Mental and substance abuse conditions. Because of their chronicity and related disability, mental conditions greatly influence the worldwide burden of disease (10). Globally, 7% of DALYs and 19% of YLDs are attributed to mental and substance abuse issues (11). Mental Health (MH) affects school enrolment, job opportunities and sustainable development (12,13). Workers' performance, medical leave and workforce out-migration are all influenced by MH issues (14). The conflict-related health issues have remarkably influenced the worldwide burden of diseases (15). Recently MH issues have further increased this burden (16,17).

2.3 Local burden

MH was neglected for 42 years of dictatorship and violation of human rights such as assassination, torture and kidnapping (18,19). After 2011, the prevalence of MH conditions in Libya is high and is estimated to reach 30-40 % of the population, especially at areas around the conflict (55). Studying the trend of estimated burden of health conditions from 2007 to 2017 in Libya, shows that MH disorders are the second highest cause of YLDs and the sixth highest cause of DALYs (66).

2.4 Social Determinants of MH

Multiple determinants influence MH as proved by evidence in literature. Disturbed marital status, being single and widowhood, affects MH, due to feelings of social isolation and loss of family assistance (33). Twenty percent of orphans showed depression and female orphans had a 45 times higher probability of depression, compared to male orphans (34,35). Depression is common in children who live around political conflicts because of stress and anxiety (35,36). A high educational level was reported as a protective factor in all ages and sexes, in addition to employment , high income and better housing (34,37). Religion might contribute to spiritual health and calm emotions which protect against depression (33).

The increased mental issues rates in urban areas, in comparison to rural areas can be attributed to a more stressful life in urban areas (33). Utilization of MH services is influenced by social factors, such as stigma, which impacts especially females (38). Married women might deny needing MH care to avoid divorce or the option of a second wife. Mental illnesses are usually attributed to spirits and the devil in Arab culture, which delays diagnosis and aggravates complications (38,39). Spiritual healers are preferred over formal health care, while PC physicians are the second accepted choice, followed by psychiatrists (39). On the other hand, physicians and nurses are barely exposed to MH during undergraduate education, which affects their perception of MH (42). This can subsequently affect the client's perception through many ways, for instance, trust, respect, stigmatization, discrimination and perception of competencies of health workers (43).

2.5 Health Care System

In 1951, the Libya health system started with 14 hospitals. Two decades later, it was expanded through community health centres (19). After that, the global initiative *''Health for All''* was adapted nationally and resulted in expansion of health facilities all over the country (44). Trials of decentralization started in 2000, but after six years the regime went back to a centralised system due to inefficient and ineffective outcomes (19). There are three levels of care as shown in figure 1.

Today, many facilities are directly damaged by the conflict, while others are closed due to insecurity (19). At PC, 22% of facilities are closed and one third of open facilities reported unavailability of essential drugs (26). The general workforce density ratio in the health sector is 76/10,000 population. This is

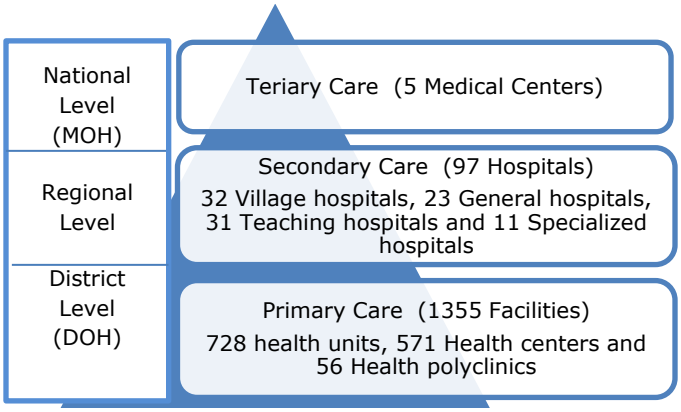

Figure 1: Health care levels in Libya, source: (19)

above the World Health Organization (WHO) recommendation for achieving the Sustainable Developmental Goals (SDGs); 45 per 10,000 populations. The total number of PC staff is 29,875 and the density per 10,000 populations is 46. The general average staff number ,per each PC facility, is 88 (19).

In regard to the private sector, a recent assessment reported 4,662 private facilities in Libya, a 70% expansion over a decade. This assessment included 537 outpatient clinics, 235 inpatient clinics, 371 dental clinics, 3089 pharmacies, 411 laboratories, and 19 diagnostic centres (49).

The health sector funding usually decreased during the conflict and is often used for reconstructions and supplies (28). In addition to this, there is a loss of transparency and a growing corruption (47). Libya does not have an itemized MH budget or tracking means to measure spending on MH (19).

The availability of essential MH drugs reached only 14% in hospitals. At PC, only 4 facilities provide MH services and drugs availability is estimated at 1% (19). Affordability is a big barrier to access MH drugs (46). The current availability of MH guidelines in PC is 1% (19). In terms of MH, human resources are inadequate at all levels of care and the percentage of health workers at PC who are trained in MH are 2% (19). The Libyan Board of General Practice included a MH module for PC physicians in the postgraduate curriculum (52,53). Even though, the Psychiatry Board establishment decree is recently issued by the Libyan Board of Medical Specialties (LBMS), the MH post-graduate training is still under the Internal Medicine Board (53). An MH diploma was established in 2013 with the support of the WHO, but later suspended as a result of the conflict (19). Libya does not have an itemized MH budget or tracking means to measure spending on MH (19).

Many national organizations started working in Libya since the enactment of the Association Act in 1971 and this has expanded after launching the Act 19 on 2004

(19). After the conflict many national agencies and international were engaged in MH field (48). A MHPSS working group was established, to improve coordination and maximize resources. This working group was affected by the conflict and relocation of international partners to Tunisia (48).

A mapping assessment in 2017 reported 190 MHPSS implementing actors who had conducted 314 activities targeting different locations and beneficiaries in the country. Most of the activities (38%) were delivered in community centres, followed by clinics (21%), schools (18%), hospitals (9%), home-visits (4%) and IDP camps and shelters (2%) (see Figure 2 for the MHPSS pyramid (48: p.31)). The main proportion was in Tripoli, while the South and East of the country were comparatively underserved (48).

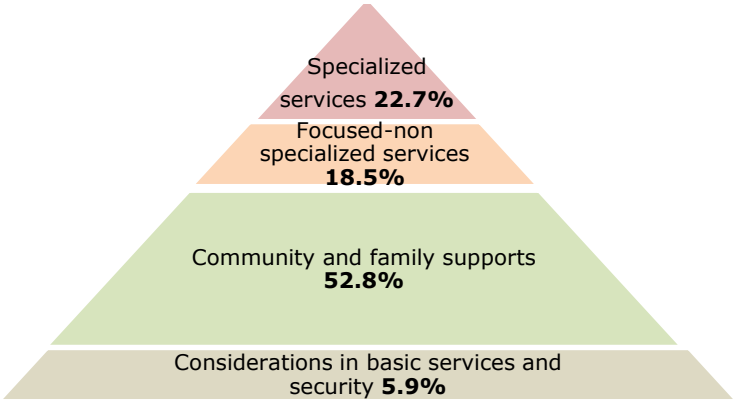

Figure 2: MHPSS interventions pyramid (48: p.31).

In the private sector, 2 clinics provided MH inpatient services, one in Tripoli and one in Benghazi, and 10 others provided outpatient services (92). Although, Libya has issued the MH Act in 1975, it was neither implemented nor reviewed (19). Health system reform efforts in Libya have started in 2012 (18,24). In 2004, the Libyan government decree to reorganize Primary Health Care (PHC) that emphasized 11 main areas: Health Promotion and Awareness, Food Safety and Health Nutrition, Safe Water, Basic Sanitation and Health Environment, Maternal and Child health, Vaccination, Prevention of Communicable and Non-Communicable Diseases, First Aid and Treatment of Common Diseases and Injuries, Provision of Essential Drugs, Mental Health, Occupational Health and Social Services and Health Care for the Elderly (51). Health system reform efforts in Libya have started in 2012 (18,24). Recently a National Centre for Health System Reform (NCHSR) was established in Libya and it reports directly to the Prime Ministry Office (PMO) (50). Health policies is a major part of this reform (82).

3.0 Problem statement, Justification and Objectives

3.1 Problem Statement

In conflicts, MH is a major concern and a huge burden for its physical, social and economic impact at individual, family and country level (13,54). The prevalence of depression and Post Traumatic Stress Disorder (PTSD) in Libya is high and is estimated to reach 30-40 % of the population, especially in hot spots of the conflict (55). WHO post-conflict estimations show that for every five people, one is affected by a mental condition and one in ten people is moderately or severely affected by a mental disease. This includes PTSD, anxiety, depression disorders and psychosis (12). Health providers in Libya similarly reported increased numbers of psychosomatic illnesses, stress, anxiety, PTSD, sleep disturbance, irritation, urine incontinence in children and nightmares (20). The majority of cases, that resulted from the conflict, is categorized by the WHO as ''Other Significant Mental Health Complaints'' (8). The latter is generally treated through counselling and psychosocial support. Such services can be provided by non-specialists and might be managed at PC or even community level (15,18,56,57). Nurses and trained lay staff have the capacity to address these MH needs if they are qualified and empowered through appropriate policies (58). The integration of MH into PC has a distinct value added in post-conflict contexts such as the Libyan context (56). Moreover, the HRP emphasized that integrating MH and psychosocial support (MHPSS) at PC and community level is a priority (26). Even though, MH emphasized in the HRP, that coordination among MH providers is a clear policy making challenge (26,30).

The MH burden is increasingly recognized by the Libyan MOH as a priority. However, current policies do not address the needs (19,26,51). The Libyan context is complicated and policy making is influenced by many factors. Multiple policy gaps need to be addressed to improve access, coverage and quality of MH services (10,59). In the country only 2 psychiatry hospitals deliver inpatient MH services and 6 general hospitals provide outpatient services (19). These hospitals need refurbishment (45), while quality levels are questioned by the public (60). The availability of essential MH drugs reaches only 14% in hospitals. At PC level, only 4 facilities provide MH services and drugs availability is estimated at 1% (19).

The current policies might lack the evidence and reflections of previous policies developed decades ago. The use of evidence and reflections is crucial to develop consistent, effective and efficient policies (15,46,61,62). A policy review and analysis helps to understand the factors that influence policy making in terms of context, process, content and actors (63). This understanding is necessary to improve access, effective coverage and quality of MH services by developing the right policies (2,15,32). It is also essential to achieve sustainable implementation and to scale up these policies all over the country in the current context (64,65). The scarcity of literature and research papers at national, subnational and local levels is a huge barrier to develop national effective policies as the investment in research is very limited in the country (39).

3.2 Justification

Mental and physical issues overlap and mental patients usually have comorbidities and complain of physical disabilities (56). In addition, mental conditions have socio-

economic impacts on individuals and communities, which span from divorce to discrimination, unemployment and high costs of care (13,17,18). Mental conditions can lead to suicidal attempts, if it is not addressed (4).

After nine years of experimentations with health policy reform in Libya, there is an urgent need to conduct a policy review and analysis, especially with the recent global shift from institutional health care to community health care (15,67). This policy shift is necessary to improve demand, access and quality of MH services, and to address MH needs (56). Integration of MH care into PC, saves financial resources and is technically feasible as proved in other (17,56,68). Such integration is therefore at the core of any future reform (40,46,47). Otherwise, challenges of poor governance, inadequate resources and lack of ownership and leadership will persist (56).

A review of national policies and an analysis of the context, actors, process and content would help policy makers to develop more effective policies (15,63). Further, global guidance is useful and other countries' experiences could help. Nonetheless, copying policies and models of care from other countries without the necessary adaptation is proved to fail (15,56). Policy making, planning and programming are usually fragmented in conflict contexts similar to the Libyan setting (47). Multiple players and different agendas are expected, especially in a fragile and fragmented context (48). In addition, there are often parallel and uncoordinated interventions by many international actors (28). The process and content of policy making are usually influenced by many internal and external factors in similar settings, such as political instability and economic crisis (15). Extraction of lessons learned from similar post-conflict and fragile contexts, would support the evidence needed, to improve policies that ensure effective coverage and quality MH care (17). Whilst opening the door for further in-depth stakeholder analysis and policy research on MH in Libya.

3.3 Overall Objective

To conduct a policy analysis of MH integration into PC in Libya to share recommendations with policy makers in order to improve the policies and address the gaps.

3.4 Specific Objectives

1. To describe and analyse the policy context of MH integration into PC in Libya.
2. To identify the actors involved in the policies of MH integration into PC in Libya.
3. To describe and analyse the policy process and content of MH integration into PC in Libya.
4. To extract lessons learned from conflict and fragile state settings and other relevant LMIC experiences.
5. To make recommendations and to share them with policy makers in order to improve policies of MH integration into PC.

4.0 Methodology

4.1 Literature Review

4.1.1 Search strategy

This paper used literature review as the main method to search for all national policy documents, grey literature of international partners, multilateral and NGO organizations, and research papers concerning policies of MH integration into PC in fragile state and conflict settings. Online databases such as PubMed, NCBI, BMJ and Cochrane were used to identify, Arabic and English, peer reviewed papers. Search engines such as Google and Google scholar were used as well as the library of Vrije University of Amsterdam. The ''snowballing'' technique was used. Official websites of the MOH of Libya and the WHO were also consulted. The study included policy documents over the past ten years. However, using snowballing and the MOH website led to some documents that were published before that date. Some documents were collected using emails and it was cited after approval of the senders. The keywords and Boolean operator terms used are mentioned in Table 3.

Table 3. Research keywords.

OR	Mental Health	AND	Integration	AND	Libya
	MHPSS		Implementation		EMRO
	Primary care		Policy		MENA
	Primary health care		Action plan		LMIC
	General practice		Strategy		Conflict
	Community				Fragile

4.1.2 Inclusion and exclusion criteria

Retrieved literature was selected after reading the title and abstract, or after scanning the literature first. In regard to general literature; the literature was included, if the following criteria were met:

- literature published between 2000-2020, some literature that was published before 2000 was included because of information relevancy.
- Literature in Arabic and English.

Literature was excluded when:

- Not available on full text.
- Literature in languages other than Arabic and English.

In regard to Libyan policy documents; the document was included if:

- Document published between 2010-2020, some documents that were published before 2010 were included because of document relevancy.
- Documents written in Arabic and English.
- Approved and non-approved, finalized and non-finalized documents.

Policy document was excluded when irrelevant to integration of MH into PC.

4.2 Complementary Interviews

The principle investigator identified 8 Key Informants (KIs) for complementary in-depth online interviews (see Annex 4) to explore different perspectives and enrich the data retrieved from the literature review. These KIs were identified based on a conducted preliminary literature review. They include experts from the Primary Health Care Institute (PHCI), National Centre of Disease Control (NCDC), Health Information Centre (HIC), WHO country office and regional office, and other national and international experts. These complementary interviews contributed to the triangulation and comprehensiveness of this study and reduced information bias. In addition, KIs were asked to suggest any further relevant policy documents of MH integration into PC in Libya to enhance the literature research products. A waiver for this study (see Annex 3) was granted by the Research Ethics Committee at KIT (see Annex 1) and Libyan National Committee for Biosafety and Bioethics (see Annex 2). The waiver was accompanied by a topic guide that was used to interview the KIs and was structured according to the conceptual framework mentioned below using the same aspects and sub-issues in the same order. Coding, coding framework and voice recording were used, in addition, note taking during interviews. Hand-writing and voice records were compared to make transcripts accurate and consistent as much as possible. Transcripts were coded and formatted according to the four aspects of the analysis framework. All information was anonymously derived, processed, stored and published in this study. Policy documents that were shared by KIs and used in this study, were referenced using the name of the organization to keep anonymity.

4.3 Conceptual Framework

The review and analysis process followed the health policy analysis model of Walt and Gilson (see figure 3), which was chosen because of the comprehensive approach it provides and the multidimensional analysis for the complexity of policy domain.

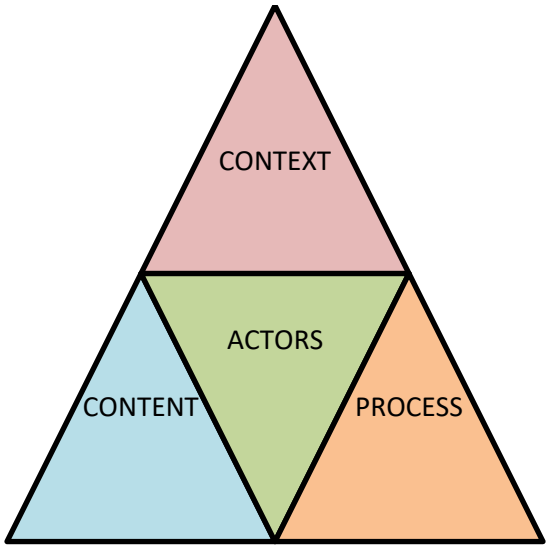

Figure 3: The Walt and Gilson policy model, 1994 (63)

A search was conducted using frameworks used in the identified literatures, in addition, to google scholar, which resulted in three identified frameworks. Walt and Gilson's model was chosen over other two frameworks: i) a frame work for analysing public policies that was developed by the National Collaboration Centre for Health Public Policy in Canada (2) and ii) a policy assessment tool that was developed by the WHO (WHO-AIMS) (69). The first one focused on the policy effect and only the implementation part of the policy process and ignored the other aspects, such as context and actors. The second model focused only on policy content, while context, actors and process were overlooked. Context, actors and process aspects are very relevant in the Libya case.

The Walt and Gilson model was chosen because it provides a broad analysis, that covers the whole four aspects, which was necessary in the Libyan case, where different internal and external factors are playing changing roles in policy making in a complicated context. In addition, it is a simple structure that suits the purpose and scope of this study. The use of this model supported systematic and structured analysis of the policy and strengthened extraction of valuable results.

As mentioned above, the framework used 4 main aspects for policy analysis; context, actors, process and content (63). This study analysed policy documents and KIs interviews, following the same sequence and the same sub-issues: Context (Political, Economic, Cultural, Conflict, Urban/Rural, Vulnerable Groups, health system, International), Actors (National, Subnational, Local Providers, Private Sector, Individuals, The Public, National NGOs and International Actors), Process (Priority setting, Costing, Decision Making, Implementation, Monitoring and Evaluation) and Content (Values, Objectives and Interventions). Study findings will be presented in this study starting by findings from the literature review for each aspect of the framework, and be complemented by interviews' findings.

4.4 Triangulation

To achieve maximum reliability, the study used both national and international resources of information, with variable focus, and triangulation was done by checking information retrieved from the literature review against KIs interviews. In addition, an inductive approach was used in this exploratory study, in both the literature review and the complementary interviews in order to enrich the study.

5.0 Study Findings/Results

5.1 Policy Documents Identified

In general, MH has been undervalued in Libyan policies in comparison to other health services such as, maternal and child health, and PC was ignored in comparison to other levels of care. Even though there was only one specific MH policy in Libya, MH was included in many other health policies. This inclusion was limited and focused only on some aspects of MH as explained later. The literature review revealed 22 policy documents and in addition, four others were shared by the KIs. All identified national MH and PHC related policies are listed in Table 4 which briefly summarizes 26 policy documents. The table illustrates the name of the policy document, finalization date, approval status and policy level. In addition, there is a brief policy description. Laws, regulations and decrees represented 13 documents (51,70–80) while the other 13 were policies, strategies or action plans (18,44,68,81–90). With regards to approval status, 18 documents were approved (44,51,68,70–78,80,83,84,86,88) and eight others were not approved (18,79,81,82,85,87,89,90). Ten policies were approved at PMO and eight at MOH level. Only two regional documents were identified (68,84), in addition, to 24 national policy papers. The study identified five national PC documents (44,71,74,79,83) and one regional PC document (84). One national and one regional policy specific to MH (18,68), while the majority were about health in general or other categories such as school health and Non Communicable Diseases (NCDs) (85,87).

Table 4. Policy document identified.

N.	Name of Policy Document	Finalization Date/Approval Status	Level of Policy	Policy Description
1	Health Law 106 (70)	1973/Approved	National/PMO	Outlines general goals, rules and organization of health sector. Guided the concept of basic rights and needs including health
2	Implementation Report of Law 106 (73)	1975/Approved	National/PMO	Outlines operational procedures of the health Law 106.
3	Municipalities Organizational Decree by the Prime Ministry Office (74)	1989/Approved	National/PMO	Outlines PHC organization at municipality level
4	National Strategy Health for All and by All (44)	1995/Approved	National/PMO	Outlines the national health strategy in terms of principles, priorities, services and levels of care
5	Primary Health Care Reorganization Decree by the Prime Ministry Office (51)	2004/Approved	National/PMO	Outlines strategic goals, services, facilities, components and governance of PHC in Libya
6	Health Care Planning Authority Establishment Decree (75)	2004/Approved	National/PMO	Outlines tasks, functions and financial arrangements of the Health Care Planning Authority
7	Health Insurance Law (76)	2010/Approved	National /The Parliament	Outlines the organization of the national social health insurance in terms of structure, benefit package, inclusion list, exclusion list, beneficiaries, providers and monitoring
8	The Arabic Strategic Plan to Develop Primary Health Care and Family Medicine (84)	2010/Approved	Arabic regional level/ Ministries of health levels	Outlines the strategic goals of PHC and family medicine in the Arabic region
9	Psychological Support Centre Establishment Decree (72)	2011/Approved	National/PMO	Outlines the strategic directions of psychological support to war victims and those in need

10	Decree Reorganizing the National Program of Mental Health and Psychosocial Support (91)	2012/Approved	National/MOH	Outlines strategic directions of the national MHPSS programme
11	Proposal for the Mental Health Policy Framework in Libya (18)	2012/ Not Approved	National/MOH	Outlines a proposed MH policy with a focus on primary care and community-based services
12	National NCD Strategy (85)	2012/Not Approved	National/NCDC	Outlines the national strategic directions in NCD care including primary and secondary prevention
13	Regional Strategy on Mental Health and Substance Abuse (68)	2012/Approved	EMRO regional level/ministries of health level	Outlines the regional burden of MH disorders, the cost-effectiveness of interventions, the strategic objectives of the region and the monitoring and evaluation plan
14	Ministry of Health Organizational Structure Decree by the Prime Ministry Office (77)	2013/Approved	National/PMO	Outlines the functions of the MOH, different directorates and offices in the organizational structure of the ministry and their tasks
15	National Health Strategy 2015-2030 (86)	2013/Approved	National/PMO	Outlines the strategic health vision of Libya 2015-2030 and provides recommended policies and interventions to improve health sector performance
16	National Strategy for School Health (87)	2013/Not Approved	National/PMO	Outlines strategic directions and aspects of school health in Libya including health services, nutrition and community participation
17	Ministry of Health Internal Organization Decree (78)	2014/Approved	National/MOH	Outlines the internal structure of different directorates, departments and units of the ministry
18	Health Information System Strategy (88)	2018/Approved	National/ MOH	Outlines the vision, mission, strategic objectives and implementation plan for a health information system in Libya
19	Essential Package of Health Services (EPHS) (79)	2018/Not Approved	National/MOH	Outlines the main service domains, levels of care, resources needed and management components
20	Primary Health Care Institute Establishment Decree by the Presidency Council (71)	2018/Approved	National/The Presidency Council	Outlines the administrative and financial autonomy of the PHCI and describes its mandate and functions
21	The National Medicine List (80)	2018/Approved	National/MOH	Outlines all drugs items that are allowed for import and utilization in the public health sector in Libya
22	Strategic Action Plan for Adolescent and Youth Health (89)	2018/Not Approved	National/NCD	Outlines the strategic objectives, actions, activities, beneficiaries, performance indicators and stakeholders of adolescent and youth health
23	Strategic Directions of Community Health Workers in Libya (90)	2018/Not Approved	National/MOH	Outlines approach, role, services, capacities, partnerships and objectives of community health workers in Libya
24	Libyan Strategy for Prevention of Mother to Child Transmission of HIV (81)	2018/Not Approved	National/MOH	Outlines strategic objectives, approach and key actions in a PMTCT strategy
25	National Health Policy 2020-2030 (82)	2019/Not Approved	National/MOH	Outlines vision, mission, general principles and systematic guidance for a national health policy
26	Medium Term Primary Health Care Strategy 2020-2022 (83)	2019/Approved	National/MOH	Outlines the scope of PHC in Libya systematically and the needed interventions to strengthen all pillars in order to improve access, coverage, efficiency and quality of PHC

5.2.0 Policy Documents Analysis

5.2.1 The Context

The context of the policies documents is summarized in Table 5.

In terms of political context, a centralized top-down approach characterized the majority of documents which in turn reflected a centrally planned policies, while only six included decentralization (18,51,74,79,82,83) This centralization emphasized the role of the government in all documents, which referenced mainly the PMO and the MOH. Rapid turnover of governments over the past ten years was identified as a key feature leading to a number of policies being approved by different governments including the General People's Committee (76), the Libyan Transitional Government (72,91), the Libyan Interim Government (77,78) and the Libyan National Accord Government (71,80,83). Public voice and community participation were only mentioned in 5 policies (18,83,85,87,90).

In respect of economic context, policy documents reported a scarcity of resources and budget fragmentation (82,83).

Regarding the cultural context, two policy documents stigmatized MH patients by treating the patient as a danger than needs to be detained (70,73). Others reflected a misperception of MH and health in general, over focusing on curative aspects whilst ignoring promotion, prevention, protection and rehabilitation (70,73,76,80). Besides, only two policies included promotion, prevention and rehabilitation MH services (18,68).

Conflict was reflected in six documents (72,79,82,83,88,91) out of 12 developed after the resumption of hostilities in 2014.

Urban/rural diversities were identified in two policy documents (83,86) and vulnerable groups specifically mentioned in two other documents (18,82).

The health system references were found in four policies (18,82,83,86). One policy document mentioned the out-migration of national health workforce to other countries (86).

International context including global initiatives such as health for all and Alma-Ata declaration, and cooperation with international organizations were identified in 12 national policies (18,44,51,79,81–83,85–88,90).

Table 5. Context of policy documents.

N.	Context category	Description of the factor
1	Political	Role of government is dominant and involved all parts of policy making. Centrally planned policies. Political division. Frequent turnover of governments and policy makers. The public's voice is almost absent.
2	Economic	Financial resources scarcity. Fragmented budget.
2	Cultural	Stigmatization and misperception of MH
3	Conflict	Destruction of facilities IDPs, returnees and migrants. Humanitarian and emergency settings.
4	International	Global and regional policies and initiatives. International cooperation.

5.2.2 The Actors

All actors who were identified in all policy documents are reported in Table 6.

At national level, the PMO and the MOH were the main actors in MH policy making. Many actors who work for the MOH were mentioned in policy documents, for instance,

the PHC Directorate, the Human Resources Directorate, the Pharmaceuticals Directorate, the HIC, the NCDC, the Medical Supply Organization (MSO) and the PHCI (18,71,77,78,80,82,83,85,88). Other sectors were included such as the Ministry of Interior (MOI) and the Ministry of Justice (MOJ) (70,73), the Ministry of Planning (MOP), the Environment General Authority (EGA) (51,86), the Ministry of Education (MOE) (87,89), the Ministry of Social Affairs (MOSA) (72), the Ministry of Culture and Civil Society (MOCC), the Warriors Affairs Authority (WAA) (91), the Ministry of Finance (MOF) (72,76,83,86), the Ministry of Local Government (MOLG) (89), the Ministry of Youth (MOY) (89), the General Information Authority (GIA), the Bureau of Statistics and Census (BSC) and the Civil Registry Authority (CRA) (88). Although, all these actors were identified, there was no clear multi-sectoral plan in policy documents that shows roles of different actors and communication mechanisms.

The subnational level was identified in all documents except for eight policies and it was mainly DOH and municipalities (44,70,73,76–78,85,87).

The local provider level was included in every policy document, but as implementers not as actors in priority setting or decision making, except for two policies (18,91). The main included providers were hospitals.

The private sector was mentioned as an actor in three documents (82,84,86). The role of the private sector was limited to policy implementation.

At individual level, psychiatrists were the main actors in MH policies (70,72,73,85,91) while two policies included psychologists in decision making (18,72) and one policy included MH nurses and social workers (18).

The public was mentioned in all policies as beneficiaries, but no policy identified them as a participant in policy making except for one policy that included civil society representation at decision making level (72).

National NGOs were identified only in four policy documents (18,68,84,89).

International actors were not included in only five policy documents (51,70,73,74,87). Otherwise all policies included them.

Table 6. Actors in policy documents.

N.	Name of Policy Document	Issue Date	stakeholders	Role	Local provider	Other sectors	Community
1	Health Law 106 (70)	1973	**National** PMO and all ministries	Consultation and approval	Absent	Present	Absent
2	Implementation Report of Law 106 (73)	1975	**National** PMO and all ministries	Consultation and approval	Absent	Present	Absent
3	Municipalities Organizational Decree by the Prime Ministry Office (74)	1989	**National** PMO and all ministries	Consultation and approval	Absent	Present	Absent
4	National Strategy Health for All and by All (44)	1996	**National** National People's Conference and all ministries	Consultation and approval	Absent	Present	Absent
5	Primary Health Care Reorganization Decree by the Prime Ministry Office (51)	2004	**National** PMO and all ministries	Consultation and approval	Absent	Present	Absent

6	Health Care Planning Authority Establishment Decree (75)	2004	**National** PMO and all ministries	Consultation and approval	Absent	Present	Absent
7	Health Insurance Law (76)	2010	**National** General People's Congress	Discussion and approval	Absent	Absent	Present
8	The Arabic Strategic Plan to Develop Primary Health Care and Family Medicine (84)	2010	**National** MOH **International** Ministries of Health in the Arab region, the Arab League and the Arab health Ministers Board	Development, finalization and approval	Absent	Absent	Absent
9	Psychological Support Centre Establishment Decree (72)	2011	**National** MOH, MOSA, Social Solidarity Fund, MOF, Martyrs' Authority and Civil Society **International** WHO	Development, implementation and monitoring	Absent	Present	Present
10	Decree Reorganizing the National Program of Mental Health and Psychosocial Support (91)	2012	**National** MOH, NCDC, Universities, Hospitals, WAA and National Physical Rehabilitation Program	Development and coordination	Present	Present	Absent
11	Proposal for the Mental Health Policy Framework in Libya (18)	2012	**National** MOH/NCDC/Tripoli and Benghazi Mental Hospitals. **International** National Institute for Health and Welfare (Finland) and WHO.	Consultation, development and finalization	Present	Absent	Absent
12	National NCD Strategy (85)	2012	**National** **NCDC** departments	Development, finalization and approval	Absent	Absent	Absent
13	Regional Strategy on Mental Health and Substance Abuse (68)	2012	**International** EMRO	Development, finalization and approval	Absent	Absent	Absent
14	Ministry of Health Organizational Structure Decree by the Prime Ministry Office (77)	2013	**National** PMO and ministries	Consultation and approval	Absent	Present	Absent
15	National Health Strategy 2015-2030 (86)	2013	**National** Departments of MOH and national experts	Consultation, development and finalization	Absent	Present	Absent
16	National Strategy for School Health (87)	2013	**National** National experts and Schools	Development and implementation	Absent	Present	Absent
17	Ministry of Health Internal Organization Decree (78)	2014	**National** Departments of PHC directorate at MOH	Consultation, Development and finalization	Absent	Absent	Absent
18	Health Information System Strategy (88)	2017	**National** Directorates of MOH, NCDC, GIA, BSC, CRA and the International Libyan University.	Consultation, Development and finalization	Absent	Present	Absent

			International EU, WHO, UNICEF, IOM, and GIZ				
19	Essential Package of Health Services (EPHS) (79)	2018	**National** MOH, MSO and local providers **International** EU	Consultation, development and finalization	Present	None	Absent
20	Primary Health Care Institute Establishment Decree by the Presidency Council (71)	2018	**National** PM and national Ministries	Consultation and approval	Absent	Present	Absent
21	The National Medicine List (80)	2018	**National** pharmaceuticals Directorate at MOH **International** WHO	Consultation, Development and finalization	Absent	Absent	Absent
22	Strategic Action Plan for Adolescent and Youth Health (89)	2018	**National** MOLG, MOY, MOSA, MOCC, and University of Tripoli	Consultation, development and finalization	Absent	Present	Absent
23	Strategic Directions of Community Health Workers in Libya (90)	2018	**National** Faculty of Public Health, National Economic and Development Board, National Immunization Programme, Libyan Association of Midwifery, Human Resources for Health Development Centre, and national experts **International** WHO, UNICEF, UNFPA, IOM, GIZ, IMC, IRC	Consultation, development and approval	Present	Absent	Absent
24	Libyan Strategy for Prevention of Mother to Child Transmission of HIV (81)	2018	**National** NCDC and local providers **International** WHO and Global Fund	Consultation and development	Present	Absent	Absent
25	National Health Policy 2020-2030 (82)	2019	**National** MOH and NCHSR **International** WHO	Consultation, development and finalization	Present	Present	Absent
26	Medium Term Primary Health Care Strategy 2020-2022 (83)	2019	**National** MOH, MOF, MOP, DOH and municipalities, **International** Pragma, WHO, UNICEF, UNFPA, IOM, IMC and IRC	Consultation, development and finalization	Present	Present	Absent

5.2.3 The Process

The policy process is summarized in Table 7.

The priority setting was centralized at MOH level in all documents. Only eight policies based their priorities on a situation analysis and needs assessment (18,68,81–83,85,86,88). All other policies relied mainly on experts' contributions.

Costing was missing in all identified policy documents.

The decision making was concentrated at ministerial level in the majority of policy documents (70–73,75–80,83–88,91). In other policies it was at DOH level in four policy documents (51,83,84,86), at municipality level in two document (74,82) and at local providers level in nine documents (18,44,51,70,73,81,87,89,90).

The policy implementation was the responsibility of MOH in eight policy documents (68,70,75,77,79,82,84,86), municipalities in two documents (74,90), local providers such as hospitals in three documents (44,73,81) and the DOH in four documents (44,51,83,84). In addition, beneficiaries were included in the implementation in four MH policies (70,73,76,87).

Priority setting, decision making and implementation parts included international actors in regional documents (68,84) and recent national policy documents (18,72,79,81–83,86,88,90).

The monitoring and evaluation was only clear in only five policies (44,51,83,87,88), while other policies did not specify any monitoring and evaluation task.

Table 7. Process of policy documents.

N.	Name of Policy Document	Issue Date	Process	Stakeholders involved	Monitoring and Evaluation
1	Health Law 106 (70)	1973	Developed by the MOH and discussed at the ministries board then approved by the PMO	All ministries	PMO
2	Implementation Report of Law 106 (73)	1975	Developed by the legal affairs office at MOH and approved by MOH	None	MOH
3	Municipalities Organizational Decree by the Prime Ministry Office (74)	1989	Developed by the MOH and submitted to the PMO for approval	All ministries	Municipalities
4	National Strategy Health for All and by All (44)	1996	Developed by the MOH and submitted to the PMO for approval	All ministries	Multi-sectoral committee at national level
5	Primary Health Care Reorganization Decree by the Prime Ministry Office (51)	2004	Developed by the General Health Secretariat and submitted to PMO for approval	All national ministries	Multi-sectoral committees at local level
6	Health Care Planning Authority Establishment Decree (75)	2004	Developed and approved by the PMO	All national ministries	PMO
7	Health Insurance Law (76)	2010	Developed by local municipalities and proposal submitted to the national parliament for approval	Parliament members	PMO
8	The Arabic Strategic Plan to Develop Primary Health Care and Family Medicine (84)	2010	Developed by a regional committee of experts and submitted by the general secretariat of the Arab league to be approved by member states	All Arab countries/Ministries of Health	National Ministries of Health
9	Psychological Support Centre Establishment Decree (72)	2011	Developed by the MOSA and approved by the PMO	MOH, MOF, Martyrs Authority, Social Solidarity Fund, WHO	Social Solidarity Fund
10	Decree Reorganizing the National Program of Mental Health and Psychosocial Support (91)	2012	Developed by the NCDC and Approved by MOH	MOH, NCDC, Hospitals, WAA, National Physical Rehabilitation Program	MOH

11	Proposal for the Mental Health Policy Framework in Libya (18)	2012	Developed by Finnish experts to be approved by MOH	MOH, NCDC, Directors of Tripoli and Benghazi mental hospitals, Finnish experts and WHO experts	MOH
12	National NCD Strategy (85)	2012	Developed by the national centre of disease control	NCDC departments	MOH
13	Regional Strategy on Mental Health and Substance Abuse (68)	2012	Developed by WHO regional office (EMRO)	Regional experts of MH	MOH in member states
14	Ministry of Health Organizational Structure Decree by the Prime Ministry Office (77)	2013	Developed by the MOH and submitted to the PMO for approval	All national ministries	Administration Control Authority
15	National Health Strategy 2015-2030 (86)	2013	Developed by the National Planning Council and submitted to the General National Conference to approve	MOH departments	Parliament
16	National Strategy for School Health (87)	2013	Developed by national experts committee formed by the national economic and social development board in partnership with MOE and MOH and submitted to PMO for approval	National Economic and Social Development Centre/MOE/MOH /MOSA/National experts	MOE
17	Ministry of Health Internal Organization Decree (78)	2014	Developed by the MOH and submitted to the PMO for approval	All national ministries	Administration Control Authority
18	Health Information System Strategy (88)	2017	Developed by the HIC and submitted to the MOH for approval	Directorates of the MOH/MOP/BSC/Public and government service/GIA	MOH
19	Essential Package of Health Services (EPHS) (79)	2018	Developed by the PHC directorate and international experts, and submitted to MOH for approval	Departments of the MOH, national experts and international stakeholders	MOH and municipalities
20	Primary Health Care Institute Establishment Decree by the Presidency Council (71)	2018	Developed by the NCHSR and submitted to the Presidency Council for approval	MOH and its departments	MOH
21	The National Medicine List (80)	2018	Developed by the Directorate of Pharmaceuticals and Medical Equipment at the MOH and submitted to the MOH for approval	WHO/ National experts	Food and Drug Control Centre
22	Strategic Action Plan for Adolescent and Youth Health (89)	2018	Developed by NCDC waiting for submission to MOH for approval	MOH, MOE, MOSA, MOY, Civil Society	None
23	Strategic Directions of Community Health Workers in Libya (90)	2018	Developed by the PHC directorate waiting for submission to the MOH for approval	MOH directorates, institutions and WHO	MOH/Municipalities
24	Libyan Strategy for Prevention of Mother to Child Transmission of HIV (81)	2018	Developed by NCDC waiting for submission to the MOH for approval	WHO	MOH
25	National Health Policy 2020-2030 (82)	2019	Developed by WHO experts to be approved by MOH	MOH, NCDC, NCHSR, HIC, MSO and WHO	MOH
26	Medium Term Primary Health Care Strategy 2020-2022 (83)	2019	Developed by the PHC directorate and Pragma experts, and submitted to MOH for approval	Departments of MOH, stakeholders from other sectors, international health partners	MOH and municipalities

5.2.4 The Content

The review of the policy contents is summarized in Table 8.

In terms of values, many documents shared some common policy values. For instance, the evidence-based value was reported in seven policies (18,51,68,70,72,79,86). The right to health was also identified in the content of six policies (18,44,51,70,82,86). Universality and equity were mentioned in nine policy documents (18,44,51,70,76,82,83,86,91) while four other policies advocated to combat stigma (18,68,81,87). Four policies focused on decentralization (51,74,77,82) and four others focused on financial protection and risk sharing (44,70,76,82). Furthermore, cost-effectiveness was raised as an important value in four policies (68,79,83,86). Some policies emphasized the value of accountability as well as monitoring and evaluation (82,83,85,88).

In regard to objectives, provision of services was the main objective in the majority of MH policies (18,44,51,70,72,76,83,84,86,87,91). Early detection of MH issues was an identified objective in fewer policies (18,72,89). Few policies included the objective of strengthening leadership of MH (18,68,82). Capacity building of human resources was a basic objective in policy content (18,44,75,82–84,90). Others identified the improvement of the health information system (44,51,82,84,86,88) and the mobilization of financial resources (18,44,68,86,91) as objectives. Other policies targeted the enhancement of medical supplies (44,51,82,86), legislation and regulatory updates (75,86) and investment in research (85,86). Quality assurance was reported as an objective in four policy documents (18,83–86). The study identified support and engagement with the private sector as objective in three policies (82,84,86). Few policies targeted the raising of public awareness in regard to MH (18,85,89,90). An interesting objective was protection of the society from MH patients (70,73).

In terms of interventions, three policies mentioned MH interventions as a MH programme (74,86,91), while other four policies mentioned it as MH services (18,72,76,85,88). In other policies MH was included in another health category such as family medicine (76,77,84,87) and NCDs (79). In addition, some policies combined MH with social support as one service (72,85,89). Integration of MH into PC was found in four policy documents as a recommended intervention (18,51,68,79). The majority of policies emphasized the importance of the three levels of care and a functional referral system to avail needed MH services (18,68,82,84). The health system approach was identified in the interventions of six policies (18,68,79,82,83,86), while the importance of a multi-sectoral approach was highlighted in six policies (18,51,68,70,72,87,91).

Table 8. Content of policy documents.

N.	Name of Policy Document	Issue Date	Content	Distributional Impact
1	Health Law 106 (70)	1973	Values: right to health, equity, universality, evidence-based and sustainable development Objectives: improve health status of the population Interventions: preventive and curative	The Law provides the power to the MOH to regulate, manage and lead all health related issues. In addition, it emphasizes the right to health and provision of services free of charge to all citizens

			services. Detention of MH patients	
2	Implementation Report of Law 106 (73)	1975	The operational procedures related to MH services, mainly the hospital-based care. That includes detention, discharge and referral	It gives the power to the committee of mental diseases supervision to manage all operational procedures of mental care
3	Municipalities Organizational Decree by the Prime Ministry Office (74)	1989	Values: Decentralization Objectives: Provision of services Interventions: MH program	The decree gives the municipalities the power to manage and supervise all health related domains at municipality level
4	National Strategy Health for All and by All (44)	1996	Values: equity, universality, evidence-based, social acceptance, feasibility and affordability Objectives: Capacity building of human resources for health, strengthening of health information system, financial resources mobilization and improvement of medical supplies	The strategy prioritizes health and advocates for resource mobilization. This might be challenged with other sectors interests
5	Primary Health Care Reorganization Decree by the Prime Ministry Office (51)	2004	Values: equity, universality, social acceptance, economic and social development, evidence-based and multi-sectoral approach. Objectives: provision of services. Interventions: MH integration into PHC	It enhances the role of PC and extend its scope. Also, ensures the right of citizens to use the PC services freely
6	Health Care Planning Authority Establishment Decree (75)	2004	Values: right to health. Objectives: improve health status, capacity building of human resources for health, update legislations and strengthening of medical supply chain	The decree prioritizes health and advocates for resource mobilization. This might be confronted with other sectors interests
7	Health Insurance Law (76)	2010	Values: financial protection and risk sharing. Objectives: Establishment of social health insurance. Interventions: To develop multiple national insurance funds and develop purchaser provider contracts.	It protects the right of employees to be insured by employers and it ensures that the state will cover those with no or low income and other vulnerable groups such as orphans. On the other hand, it punishes employers in case they do not insure their employees.
8	The Arabic Strategic Plan to Develop Primary Health Care and Family Medicine (84)	2010	Values: community participation. Objectives: early detection, raising awareness and strengthen health information system. Interventions: develop guidelines and referral system.	The strategy shows the main role of family medicine and family doctors in PC and health services in general. Hospitals might be affected as the strategy advocates for reallocation of resources to PC.
9	Psychological Support Centre Establishment Decree (72)	2011	Value: right to health Objectives: provision of services, capacity building of human resources for health and raising awareness. Interventions: develop national practical plan and time frame.	The decree gives the Social Solidarity Fund the authority to provide psychosocial services. This might overlap with MOH authorities and duplicate functions
10	Decree Reorganizing the National Program of Mental Health and Psychosocial Support (91)	2012	Values: equity and universality Objectives: Provision of services. Interventions: develop policies and plans of MHPSS	The decree gives authority to the program committee to develop policies. This might overlap with other departments at MOH such as planning and PC
11	Proposal for the Mental Health Policy Framework in Libya (18)	2012	Values: Right to health, Integration, efficiency, equity and multi-sectoral approach. Objectives: establishment of community-based MH centres, strengthening PC services	This policy proposal directs financial and human resources toward MH which might be confronted by other medical specialties. Also, it advocates for community-based

			of MH and support inter-sectoral collaboration. Interventions: to develop a model of integrated MH care, capacity building of multidisciplinary team of MH, support MH departments in general hospitals and strengthen MH services of adolescent, elderlies and migrants.	and PC services of MH which might be resisted by psychiatrists at mental hospitals.
12	National NCD Strategy (85)	2012	Values: right to health Objectives: provision of services, raising awareness, enhance monitoring and evaluation, invest in research and community mobilization. Interventions: develop plan, mobilize resources, establish clinics and training of staff.	The strategy emphasizes the burden of NCD and advocates for stronger support. This might negatively influence the financing of vertical programs of communicable diseases
13	Regional Strategy on Mental Health and Substance Abuse (68)	2012	Values: integration, equity, accessibility, cost-effectiveness and evidence-based. Objectives: strengthening leadership, integration of MH into PC, improve referral, support vulnerable groups and inter-sectoral coordination.	The strategy emphasizes the importance on MH for the general population and the needs of mental patients. But this might affects other health needs in priority settings.
14	Ministry of Health Organizational Structure Decree by the Prime Ministry Office (77)	2013	Values: right to health. Objective: improve health status and support health facilities. Interventions: develop policies and plans.	The decree shows the important role of PC directorate at the MOH, however, Because of the expansion in the organogram, many overlapping and duplications were detected among different directorates.
15	National Health Strategy 2015-2030 (86)	2013	Values: no discrimination, competency, quality and transparency. Objectives: provision of health services, strengthening health information system, capacity building of human resources, improve supply chain, update legislations and organization of private sector.	The strategy advocates for more resources and focus on health sector as crucial element for sustainable development. This can negatively affect other sectors and their share of the investment.
16	National Strategy for School Health (87)	2013	Values: right to health. Objectives: provision of services, raising awareness and improve health status. Interventions: develop health folder, conduct surveys, training of staff and conduct campaigns.	The strategy raises the health rights of school students and their special needs, in addition to, other sectors role. Other age groups might be affected by such approach.
17	Ministry of Health Internal Organization Decree (78)	2014	Values: right to health, equity and universality. Objectives: improve health status, support health facilities and develop policies and plans.	The decree gives more detailed description of the functions of PC directorate at MOH. Once again, there was overlapping with other departments including NCDC and DOH
18	Health Information System Strategy (88)	2017	Values: Evidence-based, quality assurance and sustainable development. Objectives: improve planning and policy making, strengthening of health information system and improve surveillance. Interventions: develop plan, provide tools and engagement of health facilities.	The strategy emphasizes the critical role of information pillar of the health system and multi-sector cooperation needed. Other health system pillars might be affected negatively in resource allocation.
19	Essential Package of Health Services (EPHS) (79)	2018	Values: right to health, equity, universality, efficiency and evidence-based. Objectives: provision of services, improve quality and mobilization of resources. Interventions: develop plan, provide tools and engage stakeholders.	The package ensures basic services and facilitates managers job. However, it excludes other services which might affects people in need of these services.
20	Primary Health Care Institute Establishment Decree by the Presidency	2018	Values: right to health, equity, universality, quality assurance, evidence-based and sustainable development. Objectives: improve health status, provision of services and strengthening of PHC.	The decree gives more autonomy to PC and the chance to allocate extra resources. However, Hospitals' share might be affected negatively.

	Council (71)		Interventions: develop plan, develop standards and support health facilities.	
21	The National Medicine List (80)	2018	Value: quality assurance and evidence-based. Objectives: provision of services. Intervention: develop plan and standards.	The list includes the essential drug items which supports the job of supply managers at national and district level. But, it interferes with interests of many suppliers in the market.
22	Strategic Action Plan for Adolescent and Youth Health (89)	2018	Values: Right to health, equity and sustainable development. Objectives: provision of services. Interventions: capacity building and raise awareness.	The strategy focuses on adolescents and their health rights and needs. And it uses a multi-sector approach.
23	Strategic Directions of Community Health Workers in Libya (90)	2018	Values: right to health, equity, accessibility, team work and community participation. Objectives: provision of services and capacity building. Intervention: develop standards, training of staff and supervision.	The document introduces new community-based approach to improve access to services. Over-referral to health centres might overburden them.
24	Libyan Strategy for Prevention of Mother to Child Transmission of HIV (81)	2018	Values: Stigma reduction, equity, evidence-based and effectiveness. Objectives: provision of services, decrease morbidity and reduce mortality. Interventions: testing services, consultation services, raising awareness and training staff.	The policy emphasizes the rights and needs of mothers and children. This policy might overlooked other groups such as elderlies and adolescents.
25	National Health Policy 2020-2030 (82)	2019	Values: equity, reform, multi-disciplinary approach, financial protection and efficiency. Objectives: Introduce health system reform, improve effectiveness and accountability, strengthening PC, capacity building of health workforce and improve access to essential drugs.	This policy advocates for reform and long term strategies which might be confronted by emergency allocations and treatment abroad interests.
26	Medium Term Primary Health Care Strategy 2020-2022 (83)	2019	Value: equity, universality, effectiveness, efficiency and evidence-based. Objectives: improve access and quality, support PHC workforce, and enhance services. Interventions: develop plan, provide tools and support health facilities.	The strategy advocates for PC strengthening and further investment. That might affects other levels of care and vertical programs.

5.3.0 Interview Analysis

5.3.1 The context

In the political context, all KIs reported a centralized political context and the rapid turnover of policy makers which in turn contributed to instability and weak leadership. This turnover affected even subnational and middle management decision makers. One KI reported that the director general at one institute was changed 11 times in 15 years. Three KIs mentioned that top policy makers were concerned about day-to-day policies rather than strategic policies. They linked this to the rapid turnover of governments and emergency context in Libya. Although, it is hard to measure political will, the majority of KIs agreed that there is political will in MH policies, while others mentioned the lack of political will as the main barrier to financial and human resources to MH. This barrier is enhanced by the current political division according to KIs.

When KIs where asked about the economic context, the majority reported that when it comes to policies, Libya is considered as a middle income country which makes it hard to mobilize international financial resources. However, on the other hand, six KIs

reported that national resources are inaccessible. Even the limited amount of mobilized funding was directed towards emergency interventions rather than MH policies.
Under cultural context section of the interviews, stigma was reported in almost all interviews as a significant cultural factor at both health professionals and community levels, which led to some policies that stigmatized MH. One KI said that MH had been a stigma before the revolution on 2011, but it became worse in post-conflict policies. Other cultural context factors, such as perception of MH and its mixing with jinn and magic needs to be considered in policy making as reported by KIs. Two KIs described a ''distorted concept of MH'' at policy making level that led to an underestimation of MH. A few KIs reported that some policy makers deny the need for MH and undervalue public health and PC because of this misconception.
When probing for the conflict context question in MH policies, multiple reactions described it in different ways: political, social and ideological. The last type was mentioned as an unseen conflict that affects policies and resulted from different interests and schools of thought. It can also be due to personal interests or the growing corruption in a fragile context as mentioned by two KIs. Instability and fragmentation, caused by the conflict, affected significantly MH policies, according to KIs. Uncertainty and unpredictability of the conflict and newly emerging diseases were reported as significant factors that impacted recent policies. According to KIs, the insecurity led to the centralization of policies of psychotropic drug management and reduced access to these medications. An interesting finding suggested by, one KI, was to ignore the current emergency context and develop the best technical policies, so when the time comes they will be implemented in a more stable environment.
The urban/rural divide was mentioned by the majority of KIs; in terms of infrastructure, availability of human resources and the perception of MH. One KI mentioned that vulnerable groups such as IDPs, returnees and migrants were only mentioned in international organizations' reports, but not in national policies.
The health system itself was reported as being highly medicalized, hospital focused and supply oriented, which was reflected in policies according to KIs. The majority of KIs reported that the health system approach was not used in most policies. Two KIs said that the weakness of the health system was a barrier to develop policies that could manage emergencies and at the same time maintain routine daily work. The political and economic factors have adversely impacted the availability of human resources in all MH policies as raised by all KIs. Even though numbers of health staff might be adequate in general, their distribution and performance are a cause of deep concern.
The international community was described as a critical contextual factor. Fragmented international support with different objectives and delivery mechanisms affected MH policies as reported by seven KIs. Also, frequent turnover of international partners was identified in MH policies according to three KIs.

5.3.2 The Actors

Multiple actors were identified during KIs interviews. Two KIs preferred the term actors over stakeholders, due to the lack of coordination and leadership as they reported. Five KIs commented on the overlapping of job descriptions and the conflicting roles of actors.

The main national actor was the MOH, which in itself is composed of several actors: The National Committee of Mental Health, the NCDC, the PHCI, the LBMS, the HIC and other departments and advisory committees at ministry level. Other actors relevant to MH policies included, the MOP, the MOF, the MOSA, the MOJ, the MOY, the MOE, the Ministry of Economy, the Ministry of Housing, the Ministry of Information, the Ministry of Transportation, the Ministry of Labour and Social Security Fund, as well as the Presidency Council, the SDGs National Committee, the NCHSR, the CRA and legislative bodies such as the Parliament.

At subnational level of the topic guide, the DOH was the main actor in policies, while few KIs mentioned the municipalities.

Local providers such as general hospitals, tertiary hospitals and national NGOs were identified actors.

All KIs emphasized the private sector role in MH in Libya. Even though, most KIs identified this as positive expansion and linked even to reduction of MH stigma, few KIs raised their concerns about unregulated private sector growth. KIs raised alarm of the financial burden that affects poor families, due to uncontrolled prices. Also, few KIs raised the concern of how far the private sectors should be engaged in order to ensure a balance public and private services.

When probing to individual actors, KIs said that a multidisciplinary team was missed in most MH policies. This team includes psychiatrists, psychologists, social workers, general practitioners, nurses and managers at PC facilities. A few KIs separated doctors into two groups; those who were educated and built their career in Libya and those who had done that abroad. Surgeons were identified as important actors in MH policies, in view of their power and influence over policy makers. As an example, surgeons played an important role in the establishment of MH departments in general hospitals.

The public, communities and end-users were mentioned by KIs as having a role in policy making, especially recently as a result of freedom enjoyed in the post revolution period and availability of new tools, such as social media.

National NGOs were mentioned by two KIs as missed actors in MH policies.

International actors, included donors, advisory organizations and implementing partners, such as European Union (EU), WHO, UNICEF and UNFPA. Interestingly, one KI mentioned actors behind the scenes who would influence MH policies without appearing in policy documents, such as medical industries, political parties and armed groups.

5.3.3 The Process

The priority setting was identified as a critical part of the process and it was described as centralized, due to the limited capacity of the health system to focus on more than one priority at the same time, as reported by two KIs. The inclusion of local actors, during the priority setting, was identified as a real challenge, because of the large number of municipalities and DOH in the absence of governorates or health regions. The engagement of different sectors was mentioned by the majority of KIs as an important step, during the priority setting, in order to achieve the principle of ‘‘MH in all policies’’.

The lack of a scientific base and needs assessment, during the priority setting, was reported by the majority of KIs. Two KIs added that in the best case scenarios, MH policies' decisions are based on a clinical point of view that ignores the public health aspect. Variable opinions were identified, regarding the source of evidence in the policy making process. Four KIs raised the importance of surveys and psychiatric epidemiological studies, while two others pointed out to routine data collected at facility level for a sustainable and efficient process. Three KIs mentioned the importance of resource allocation immediately after priority setting to support decision making and policy implementation.

When it comes to decision making, many KIs pointed out the centralized nature of decisions, which they described as an old-fashioned. Three KIs mentioned the inertia as a factor contributing to delay with regards to policy endorsement sometimes lagging for years. Three KIs reported that endorsement might need approval by other ministries and PMO as well. Another KI identified legislative barriers such as the lack of MH in job descriptions and staff patterns of PC, in addition, to the need to have a psychiatry consultant, in order to establish a MH department or clinic in a general hospital.

All KIs raised implementation as the most difficult part of the policy making process. pilot approaches to implementation as three of them considered it opportunity for learning and advocacy, and to facilitate inclusion of different actors. While two other KIs identified it as a source of inequity and contributor to centralized approaches. Supportive supervision was another missed issue related to policy implementation mentioned by five KIs.

Three KIs said costing was missing in most policies, which should precede implementation.

Six KIs emphasized that monitoring and evaluation has to be integrated in implementation of any policy and they raised concern over the fact that MH policies were rarely if ever tested or even monitored.

Generally speaking, the involvement of international actors, during the policy process, was mentioned as an important, but challenging step with communication and coordination difficulties. Divergent reflections, in regard to international organizations, in the policy process was detected. Five KIs appreciated the meetings, workshops and consultations organized by international organizations during the policy making process. On the other hand, two KIs criticized the shortcomings of this process, which revolved around the same actors and same regions every time. The remote management approach of most international organizations, limited the process of policy making and contributed to the delay, according to six KIs.

Finally, expanding consultative dialogue and gathering inputs at different levels was seen as a critical missed factor in the MH policy process as mentioned by KIs.

In general, seven of the KIs identified a top-down approach in the policy making process in Libya. They confirmed a recent change toward a bottom-up approach. One KI emphasized the inclusiveness regardless of the process direction. Also, the policy process was identified mainly as individual efforts, rather than institutional work and being reactive more than proactive. The issue of starting from scratch after each leadership turnover and not building new policies upon lessons learned from previous ones was detected by many KIs as a critical shortcoming.

5.3.4 The Content

In general terms, all KIs raised the issue of absence of clarity and comprehensiveness in policy content. Generic policies with undefined vision were described.

With regard to values in policy content, equity, efficiency, effectiveness, integration and quality were identified policy values by the KIs.

In terms of objectives, three KIs noted that some objectives were not adapted to the Libyan context or were outdated. Other KIs said that most objectives were about improving services, capacity building of human resources and provision of essential supplies. Few KIs were surprised when the researcher shared that two policy documents included objectives of protecting the society from MH patients and treat those patients as dangerous cases requiring detention in mental hospitals.

When KIs were questioned about the MH policy interventions, they said that most interventions were constrained by national legislations according to four KIs and they were neither practical nor implementable interventions. Most interventions are hospital-based and oriented to curative services with neglect of PC and public health as mentioned by five KIs. The majority of KIs emphasized the lack of promotion, protection and rehabilitation in MH interventions, as well as the absence of occupational therapy in the MH policies' content. According to six KIs, MH was usually a vertically designed policy that lacks integration and connection between different levels of care. Two KIs identified the risks of integration as well, including neglect of MH due to competing emergencies. Recently, interventions of policies started to focus on Universal Health Coverage (UHC) and PHC, but without specifying how MH will be mainstreamed as key part of UHC, as reported by three KIs.

Overall, the majority of KIs appreciated the technical content of most policies, especially the content of those policies that were developed in partnership with WHO and international organizations. Nevertheless, some aspects were missed such as continuous professional development and incentives to enrolment in a MH career as recognized by most KIs. They said that the focus was on short term training instead of systematic long term interventions. KIs also pointed out that MH policies missed the combination of PC and community-based interventions that Libya needs. Finally, KIs raised the fact that the MH was overlooked in other sectors' policies as well, for instance, the curricula of primary and secondary schools.

5.4 Lessons learned from Other Countries' Policies

Regarding the policy context, in Iraq, literature shows how dictatorship and conflict resulted in a remarkably increased burden of MH. The lack of financial resources allocation and insecurity context leads to failure of policies of MH integration into PC, especially as the health workforce was depleted by waves of out-migration. However, national and international political will exists within the momentum of change during crises (47). As in the Libyan case, national crises can generate funds and mobilize domestic resources for MH as well as external donors (17). The literature reported that the absence of MH strategy confronts this political momentum and wastes these mobilized financial resources (47). Context oriented interventions were reported in Yemen as psychologists were prescribing MH drugs in rural regions, while psychiatrists were limited to urban regions (65). Crisis is a great window of opportunity to start

reform, develop better policies and introduce new legislation (17). Policies of MH integration into primary care can be advocated successfully and implemented sustainably, when local beliefs and societal values are included in these policies (15). The MH perception is influenced by culture and mixed with magic and jinn in Arab culture (65). The collapse of the previous regime in Iraq brought the chance to strengthen the concept of community (17). The health system has a significant role. Studies reported that the enrolment of MH patients, access to MH drugs and quality of care, are affected by payment mechanisms and the scope of practice for health workers in Canada (40).

In regard to policy actors, the concept of the multidisciplinary MH team was enhanced in Iraq after the collapse of previous regime (17). In Bosnia Herzegovina and Kosovo, psychiatrists resisted the MH shift from institutional to community-based care, especially those who are decision makers (15). The exclusion of MH professionals at health reform platforms might lead to neglected MH during policy making (47). MH professionals are few among low and middle income countries (LMIC), but it was proved how they play a major role and lead others in such contexts (17). National NGOs in Yemen participated significantly in society sensitization, in regard to MH and human rights (65). International actors can play an important role in planning, financing, implementation and monitoring of MH policies. They clearly contribute to the initiation of MH policies and capacity building, however they confront national ownership on the long run (15,47). Coordination and leadership are keys to maximize resources and achieve goals in the existence of multiple national and international actors. In Kosovo and Somalia, governance and coordination of MH witnessed a significant development after the war (17).

In regard to policy process, the inclusion of local MH actors facilitated sustainability of MH policies due to the existence of ownership (15).

In terms of the policy content, in Yemen, the MH national program was started by a hospital-based approach and curative services orientation, however, international actors' recommendations facilitated a shift toward MH integration into PC (65). Interventions that emphasize MH in the EPHS were implemented in Afghanistan during the crisis, and they trained more than 1000 health staff on essential MH care. While in Burundi, building the capacity of the supply chain and ensuring availability of essential MH drugs were implemented interventions in the emergency context of the country. Integration of the MH at community level and access improvement, was successful after the Tsunami crises in Indonesia. Despite the burden, caused by displacement of Iraqis to Jordan during the war, it created the opportunity to introduce MH services at the community level in the host country (17). Introduction of new insurance schemes, privatization and decentralization of MH services, could reduce access dramatically when national capacities are not ready to run such financing and governance systems (15). The Building Back Better report of the WHO showed how short term humanitarian interventions were used as bases to build more sustainable ones (17). In spite of the post-conflict complex context, addressing MH needs in times of crisis is a public health priority and can contribute to peace and development as reported in Iraq (47).

6.0 Discussion

6.1 Context

Looking at the political context, centralized policies were clear findings in almost all MH policy documents where government played a fundamental role. This finding mentioned in sections concerning actors and process as well, because MH policy context influences policy actors and process. Centralization had a negative impact on policies especially when accompanied by rapid turnover of governments. Changing policy makers at the top of the hierarchy, led to changing whole policies, because lower levels were not included. Even though, this finding is unlikely to be limited to Libya, it was not explicitly mentioned in the literature. This centralization limited the inclusion of actors that might explain the variable reflections from KIs regarding the availability of political will, as some of them might have been involved in policy making, while others might not have been involved. Centralized political context limited the public voice and community participation in policy making. However, four recent policies mentioned community participation. The latter change might be the result of the momentum brought about by freedom and change atmosphere as mentioned in the background chapter and confirmed by the KIs interviews' results. The same momentum was mentioned in Iraq; however, this momentum might be lost if it was not associated with a strategic policy (47). Rapid turnover of policy makers led to short term policies, which focused on emergency management rather than development-oriented policies. This focus might explain the delayed endorsement of policies and unsuccessful implementation, identified in the policy process section. The unstable context might have caused policy makers to ignore long-term policy priorities as they knew that their role would be limited to a few months, before next reshuffle. The findings of the political context of policy documents were confirmed by KIs contributions. There was no enough literature with regards to bridging this gap between emergency and developmental MH policies. This study developed some recommendations that might support addressing the gap.

In the economic context, the scarcity of financial resources and budget fragmentation were identified in policy documents. The crisis was reflected in the content of all MH policies, where much focus was placed on resource mobilization due to limited allocations. The out-migration of the workforce mentioned in one policy document can be considered a consequence of the economic crisis. Lessons learned supported the same finding. In Iraq, for instance, the lack of financial resources was a barrier to the implementation of policies of MH integration into PC, and was accompanied by insecurity and out-migration of health staff (47). The economic context influenced policy content as resource mobilization and staff training represented a much focus in the objectives. The results of the economic context in policy documents were supported by KIs interviews.

Regarding the cultural context, from the results of this study, stigma is deeply rooted in the Libyan culture and even policy makers were influenced by it. This cultural factor resulted in stigmatizing the MH in some policy documents, which treated MH patients as a danger to society requiring detention in hospitals. The latter finding was not identified in any other country. The linkage between MH and jinn and magic was mentioned by KIs and reflected in lessons learned from other countries such as Yemen. As the context is changing, there is greater awareness of the impact of stigma amongst

policy-makers as reflected in policy documents and KIs contributions. This recent realization can be due to the conflict. Even though the conflict itself aggravates the stigma, as reported by KIs, the introduction of international organizations might have sensitized Libyan health actors to stigma and supported stigma reduction in MH policy content. The MH perception was not limited to stigma, but the lack of inclusion of MH in health policies, particularly in public health and PC perspectives of MH. The latter perspectives emphasize MH promotion, prevention, protection and rehabilitation services.

Even though many policies were developed after the ongoing conflict, most of them did not adequately reflect the post-conflict context in which they were being developed. The KIs referred to this gap in the policy documents. This omission could be due to the complexity of developing contextualized policies, or the fact that exclusion, of many important actors, by centralized policies, reduces access to evidence and information during the policy making. The latter explanation is supported by KIs who reported that fragmentation influenced MH policies and resulted in an incomplete analysis due to poor communication. Also, some international organizations used a ''copy-paste'' approach when facilitating policy drafting or tried to impose international model as the Bosnian experience has shown (15). Although post-conflict context is definitely complex for any policymaking, it has proven to be a great opportunity to develop and implement successful MH policies (17).

Only four policy documents reported on the urban/rural divide and specific needs of vulnerable groups such as IDPs, returnees and migrants and only two KIs mentioned these vulnerable groups.

The health system was missing in many policy documents and this gap was supported by KIs contributions. However, the health system pillars, such as financing, supply and human resources, were reflected in policy content. Lessons learned from Canada, showed how important the health system is in MH policy making, for instance, provider payment mechanisms and its implications on access and quality of MH care.

International initiatives clearly impacted Libyan policies as reflected in policy documents and KIs' interviews. Fragmented international support and rapid turnover of international actors were identified as critical issues.

6.2 Actors

At national level, it was expected that the MOH would be the main actor in policy making, due to the centralized political context discussed above in the section addressing policy context. However, multiple actors and sectors identified in recent policies and KIs interviews, might reflect better understanding of multidiscipline and multi-sectoral approaches to MH in Libya. In fact, this recent expansion of in the number of actors might be due to fragmentation. After 2011, the number of actors at MOH level rapidly grew together with other health actors and actors in other sectors due to poor governance and fragmentation typical of emergency contexts, that was explained in the back ground chapter. At the ministry level, many departments were identified in MH policy documents and KIs interviews, which shows fragmentation at the top level.

Other sectors included, were the MOI and the MOJ, due to the old misperception at policy makers level of what MH exactly is at policy makers level. Lately many other

ministries were engaged in policy documents. Nonetheless, this engagement might also have been the result of improved perceptions of MH and influence of international organizations as reported by some KIs. In addition, considering the fragmented setting of Libya where it is difficult to implement change, the involvement of multiple actors might be seen as advantageous with regards to implementation. The latter interpretation was a key lesson learned from Bosnia (15). However, division of labour and communication mechanisms amongst policy actors were identified critical gaps in policy documents and lessons learned from other countries, such as Kosovo and Somalia (17).

However, at subnational level, municipalities were rarely included in policy documents. This result was supported by KIs interviews in policy process section of the topic guide which reported the growing number of municipalities and DOH as a barrier to decentralized policy. It was stated in the background chapter that the current number of municipalities is 113.

At local provider level, the role of providers was limited to implementation, due to the highly centralized policymaking process, except for a few policies that included providers as decision-makers, as discussed also under the section of this chapter dealing with process. The DOH and hospitals were the main identified providers in the latter inclusion.

With regards to the private sector, private providers contribute significantly to MH care as identified in policy documents and confirmed by KIs interviews. However, KIs reported a risk of financial hardship and quality concerns in the lack of regulatory capacities in the fragile Libyan context. This concern has also been illustrated in Bosnia where the introduction of privatization dramatically reduced the access to MH care (15).

At individual level, psychiatrists were the main actor, while psychologists and particularly, MH nurses and social workers were omitted in MH policy documents. This characteristic was also reported in KIs interviews and identified as a key lesson learned in Bosnia, where the policymaking process was controlled by psychiatrists (15). These different levels of involvement, might be due to the fact that doctors have a higher social status. In addition, it might be to the result of legislation as mentioned by KIs. These legislations include staff pattern, job descriptions and drug prescription. The interaction between these actors affected the process of policy making. For instance, the example KIs referred to different schools of thought, among medical doctors, who were educated locally or abroad. Although, deep analysis of actors is beyond the scope of this study, it was obvious that surgeons are more powerful than other specialties, which might be due to the cultural perception of surgeons as a high status profession.

As a result of a highly centralized approach, the public were always identified as passive beneficiaries and there was no public consultation process before the approval of any policy. Only one policy document identified a civil society representative as a decision maker in the policy document. This gap was complemented by KIs feedback conforming the growing role of the public due to a political momentum brought about by 2011 revolution allowing freedom of expression, particularly through social media.

In as far as international actors, representation in policy documents was clearly expanded after 2011. This expansion was because of the emergency context and the increased political role of the international community, after the collapse of the

previous regime. Similar dynamic was reported in the Iraq'. Representation included donors, advisory organizations and Implementing. These agencies have different, financing, administration and logistic systems and different mandates and interests. The latter created a fragmented international support that was mentioned in the context section.

National NGOs were identified as actors in only four policy documents and only two KIs reported NGOs as relevant actors in MH policies. The expansionist role of national NGOs was identified in Yemen in the lessons learned section (65).

It was interesting that some KIs preferred the term 'actors' over 'stakeholders', which was linked to weak leadership and lack of communication and coordination as well as unclear vision as reflected in KIs interviews. KIs feedback in this respect supports findings from an analysis of policy documents reflecting multiple fragmented actors and telling of how policy actors influenced the policymaking process and ultimately policy content.

6.3 Process

With regards to the priority setting, policy contents reflect the monopoly of few actors, specific opinions and agendas and the lack of evidence base. Situation analyses and needs assessment, were identified only in few policy documents. These findings were confirmed by KIs, who added that almost all national policy initiatives were the result of individual agendas. The latter statement can be explained by the political history of Libya marked, as it has been by a prolonged dictatorship was and de facto led for too long by a few empowered individuals. These individuals used their power to purse in the absence of institutional memory and participatory approaches. This influence is supported by KIs, linking the reactive style of the policy process and the lack of self-reflections to the rapid turnover of actors on the one hand and emergency context on the other.

Decision making was mainly centralized at ministry level as reflected in several policy documents, which featured a limited role of DOH and municipalities in decision making. KIs feedback further corroborated this view. Usually weak peripheral capacity is justified on ground of a prevailing centralized approach. However, corruption was stated concern as mentioned by KIs during the interviews and reported in the background chapter of this paper.

Interestingly, the KIs commented on the importance of inclusiveness, not only in a vertical sense (top-down versus bottom-up), but also in a horizontal sense, thus including relevant decision-makers from other departments and sectors.

With regard to the implementation, the MOH tried to control this process adopting the same centralised approach. Recent policy documents showed a more prominent role for the DOH, municipalities, national NGOs and local communities in policy implementation. This expanded role was mentioned in the context and actors' sections. However, such most of these policies were not implemented. KIs also raised the issue of limited or no implementation and justified it in view of the lack of resources. This justification was also a common feature in the Iraq experience, which in turn shows how important it is to have feasible priorities and long term commitment to implement a policy. Implementation research with regards to MH was a gap in the literature, especially in post-conflict settings.

Other process barriers were identified in policy documents such as legislations that directly challenge implementation. Legislative barriers were identified in the policy content section and point out to a need for an update and alignment of legislations as a core objective. Besides, it was also reported by KIs. Debate and divergence of views amongst KIs with regards to the use of pilot approaches in implementation, shows how flexible and context-specific the implementation should be. In Yemen, lessons learned point out to the need for context-specificity in the design of interventions in order to ensure success. The use of a psychologists to prescribe MH drugs in rural areas is a telling example in this respect.

Monitoring and evaluation was a neglected in most of the policy documents and this neglect was confirmed by the KIs interviews. This neglect can be a by-product of the lack of transparency and an underinvestment in systems for feedback during Libya's dictatorship rule. Another reason for neglect can be attributed to the rapid turnover of policymakers after 2011, which prevented any form of evaluation. However, recent policy documents have in fact emphasized monitoring, evaluation and accountability. This recent emphasis might be due to involvement of local providers and end-users in policy making. These last actors are naturally concerned about outcomes and impact at the point of deliver. This study identified that quality of MH care is missing in health indicators and a few articles mentioned it.

According to the policy documents results, the policy making process after 2011 was greatly influenced by international actors at all levels from priority setting, to decision making and implementation. The same finding was identified in the KIs interviews where a clear reference was made to collapsed national capacities and emergency settings. This interpretation is supported by lessons learned from Iraq, Afghanistan, Yemen, Somalia and Bosnia (17). The same opportunities and threats deriving from international organizations were identified in other country experiences. These international organizations facilitate advocacy and initiation, but confront ownership and sustainability of the policy process as reported in Bosnia (15). Both national and international KIs agreed that the only way out of this dilemma is a strong national leadership, in addition to wide national consultation campaigns, to communicate MH policies as widely as possible to create ownership. This last statement was supported by lessons learned from the above-mentioned countries, which emphasized leadership and inclusion.

Another interesting finding was added by KIs who that successful implementation could in turn facilitate inclusion of more actors in the policy making process.

6.4 Content

Clearly, most policies focused on content, as it is the case in other countries as mentioned in the background chapter.

In terms of values, several values were included in the MH policy documents. However, combating stigma was rarely mentioned, due to misconceptions around MH and lack of awareness at both public and policy making levels. Likewise, the KIs raised the issue of the absence of this value. Recent policies advocated for values such as decentralization and community engagement. This can be linked to the discussion in context, actors and process sections where decentralization was interpreted by the current momentum of change.

In terms of objectives, it was unfortunate to find that objectives included protecting society from MH patients and dealing with them as a danger to themselves and communities. The same misconception surrounds MH what resulted in the addition of this objective. Interviews with KIs reported their surprised reaction regarding this objective. This finding shows that integration of MH into PC needs the right entry point to address both; the misconceptions and stigma.

In general, policy documents started by focusing on service provision and mobilization of financial resources as objectives. However, service delivery objectives focused on curative services. The latter was identified by KIs and found in other countries experiences such as in Yemen. The post-conflict setting might offer a chance to expand MH services as it occurred in Afghanistan, where the scope of the EPHS was expanded to include MH. Policy documents moved towards more systematic approaches by including capacity building of human resources, strengthening the information system and the supply chains. However, capacity building was usually limited to short term training, without conducting needs assessment and taking place in the absence of any long term training strategies. The crisis can be a good opportunity to accelerate and expand capacity building activities as witnessed in other countries including Afghanistan, Iraq and Jordan. With regard to the information system strengthening in policy documents, it used to be input oriented without any outcome or impact measurements, but this has improved in recent policies. Supply chain support objectives lacks efficiency and are prone conflicts of interests which manifest themselves through preferences for particular specifications and brands, and expensive tertiary care supplies. Other countries' experiences showed how MH drugs availability could be improved even in an emergency context such as that of Burundi (17).

Lately, policy documents started to pay more attention to new objectives such as quality assurance, the engagement of the private sector, and investment in research and community mobilization. This late change of policy objectives was identified in the KIs interviews. These new objectives can be the result of a new context marked by freedom of expression, which increased the size of participation in formulation of objectives, in addition to the influence of international organizations such as the WHO. More recent policies focused on strengthening monitoring, evaluation and accountability in their objectives. Even though this particular aspect was discussed in the process section, it was identified in some other policy documents as an objective within the policy content. Including it as an objective, could be due to desire to pre-empt opportunities for corruption and increased public pressure to see tangible results as mentioned by KIs whose reflections supported policy documents' findings.

At the level of interventions, policy documents were either focused on vertical MH programmes or marked by limited inclusion of MH under other health services such as school health and NCDs. A marked ''vertical approach'' was mainly found in policy documents where psychiatrists had a bigger role, while an integrated approach was identified in policy documents, where international organizations had a bigger role. Both different roles in service delivery design of psychiatrists on the one hand and international organizations on the other, were also identified during the KIs interviews. This might be explained by a specific clinical orientation of psychiatrists and their concerns with financial resources. On the other hand, International organizations

usually advocate for integration and efficiency as shown in Yemen, Iraq and Afghanistan, where PC and community-based interventions were established after the conflict and significantly supported by international organizations (17). This shows how policy actors can influence the policy content and lead to development of different interventions.

The majority of policy documents, especially recent ones, reflected a multi-sectoral approach in their content and the principle of ''MH in all policies''. However, they did not emphasize MH in other sectors. This finding was confirmed by KIs who raised this concern noting that it is important to include the MH in primary and secondary schools' curricula in order to change the MH perceptions and raise awareness. This example mentioned by KIs brings the necessity to look at others sectors policies' content to the fore. There were few articles with regards to MH in education policies, but not other sectors.

Few policy documents included a focus on MH interventions at PC level and only one document included community-based interventions. Feedback from KIs interviews corroborated this finding and interestingly pointed out to the need for a combined approach including PC and a community-based models. KIs also brought up the importance of creativity and thinking 'out of the box' to introduce new models of care, that would suit a post-conflict setting, such as a mixed model of care. In Iraq, the collapse of the previous regime was an opportunity, to establish community-based MH interventions. The same occurred in Jordan when hosting Iraqi refugees. In both cases, community MH was established. Moreover, in Yemen, psychologists were allowed to prescribe MH drugs in rural areas (17). The mixed Libyan model might provide rich added knowledge to post-conflict MH policies.

Overall, the content of policy documents was promising and included all levels of care and multi-sectoral interventions in most policy documents. While, some KIs appreciated the technical content of MH policies, others raised concerns about clarity and criticized the policies for being very generic. The divergence opinions can be due to different roles KIs played in policy making. This criticism by KIs confirms the need to review the policy processes and actors and address any gaps.

6.5 Limitations

The study scope excluded informal interactions between the actors and other power sources, such as political parties or armed groups.

It was also limited in view of a lack of end-users' perspectives, as this study relied on a review of policy documents and KIs interviews, which did not include any end-users. While there is a richness of literature with regards to MH integration into PC globally, research investment in Libya is meagre and scientific publication is sparse in all fields, including MH.

National policies are usually not fully documented, due to a weak institutional capacity and rapid turnover of governments, as well as an absence of effective archives.

Although cross-checked with Google and websites of the MOH and international partners, some grey literature might have been missed in this study.

A regular and frequent turnover of national and international staff, made it challenging to reach many significant KIs, who left the country and changed their contact information.

Most of the national and international written reports emphasize advantages rather than challenges and disadvantages, due to reasons related to political gains or funding opportunities. The majority of these reports focus on rapid assessment, instead of deep analysis of MH and PC.

7.0 Conclusion and recommendations

7.1 Conclusion

The Libyan political context is very centralized. The government played a major role in policy making. A rapid turnover of policy makers at national and international level, clearly impacted MH policies and resulted in multiple actors and delayed process. In addition to, short-term emergency oriented policies at the expense of more strategic long-term developmental policies.

The country is in economic crisis of scarce resources and fragmented budget which is a critical barrier to implementation.

Although stigma surrounding MH is considerable challenge in Libya, combating stigma was barely mentioned in MH policies. Misunderstandings around MH and underestimation of its value is an obvious barrier to include MH in policies and resource allocation. These misunderstandings led to the neglect of public health and PC. National and international NGOs have an important role to sensitize both policy makers and the general population with regards to stigma and to improve perception of MH.

The ongoing conflict was not emphasized in policy documents. This omission spanned over a number of different dimensions such as, political division, displacement and migration. This considered being the result of fragmentation, poor communication and the need to align to international standards of policy making and policy drafting. However, the current post-conflict context could also be considered as opportunity to develop effective policies of MH integration into PC.

Inequalities between urban/rural communities, vulnerable groups such as IDPs, returnees and migrants are also apparent in MH policies. While vulnerable groups have more MH needs, they actually have less access to MH care. Most policies focused on urban settings and overlooked rural settings and the needs of vulnerable groups.

The health system was rarely referenced in MH policies, even though it was reflected in policy content. The lessons learned showed how important it is to consider a health system approach in policy making including all pillars of governance, finance, human resources, service delivery, information and supplies. The international initiatives were reflected in MH policies, however, a fragmented international support considered as a critical issue.

The main actor at national level is the MOH, while at subnational level the DOH and municipalities play a more prominent role in recent policies. Local providers, mainly hospitals, were identified as actors in policy implementation. The role for national NGOs, municipalities and the general population in MH policies is expected to increase, as a result of the momentum of freedom and new movement toward decentralization.

Multiple sectors were identified and a multi-sectoral approach was mentioned in most policy documents However, this multi-sectoral aspect needs better communication among different actors, to maximize resources and develop coordinated policies that support MH integration into PC.

A multidisciplinary MH team was clearly defined, however usually psychiatrists play a prominent role, while other MH team members are often disempowered and further disenfranchised by supportive legislation. Legislation and/or regulations on staff patterns, job descriptions and ability to prescribe.

The private sector is a rapidly growing actor in the health market, including in MH, but it is not well engaged in MH policies. Even when it is included, the role of the private

sector is limited to the implementation. Current public sector deterioration and weak regulatory capacity of the government, in a fragile context, facilitated an expansion of the private sector, which might cause financial hardship, especially in low income people and it raises quality concerns as well.

International actors are expanding their role and they significantly participate in MH policies, and they can be a great support if they were led by strong national leadership to use their positive efforts in initiation and advocacy, and to mitigate their negative impact on sustainability and ownership.

In Libya, policymaking process has been dominated by the MOH, especially with regards to priority setting and decision making. Even at the MOH level, only few individuals lead the process, due to lack of institutional capacities and participation of other employees at the ministry. Many factors influence this trend towards centralization, including: the political history of the country, current limited resources, instability and corruption. The lack of evidence was a big gap in priority setting and decision making.

Implementation is the most difficult part of the policy process and the knowing-doing gap is persistent, especially in a context marked by complexity and volatility such as the current one. Resource allocation is necessary for implementation. However, it is costing is often overlooked after policy development. Nonetheless, feasible policies can facilitate implementation even in low resource setting.

Although, the engagement of actors at national and subnational level is improving, fragmentation is a challenge that affects inclusivity in all policy making processes in Libya. Furthermore, the remote management from Tunisia-based international organizations is a significant barrier to effective communication and coordination. This barrier clearly impacts policymaking processes, because of the current significant role of international organizations in Libya.

Inclusion, self-reflection and widespread consultation are essential, but also missing elements in MH policies. Costing, monitoring and evaluation of policies are identifiable gaps. Policymaking is an iterative process in which different parts influence and influenced by each other. However, in Libya, the frequent turnover of leadership led to processes restarting anew every time.

Generally speaking, policies of MH integration into PC in Libya, are limited and generic in terms of policy content and stigma is not explicitly addressed in any of them. Recent policies advocate decentralization and community participation. However, in reality MH policies are still centralized. Decentralization is a complicated and risky process in the Libyan fragile context, but highly contextualized MH policies are in fact needed.

In terms of intervention, most policies focus on hospital care and curative services, while promotion, prevention and rehabilitation of MH services are overlooked. The public health perspective, which is essential to develop effective MH policies, is also completely neglected.

Only a few policies followed a systematic approach to address MH, while most policies focused on short-term training and brand supplies. Community-based interventions and continuous professional development were identified gaps.

Other sectors' policy content, is relevant to integrate MH into PC, for instance the inclusion of MH in primary and secondary schools' curricula. This early education in curricula might work better than media campaigns and advocacy later on.

Many lessons learned from post-conflict countries that have developed MH care can be used in Libya, but these experiences need to be adapted to the Libyan context and led by local leaders when it comes to policy making.
Overall, MH policies in Libya showed gaps in all aspects including context, actors, process and content. All aspects influence and are influenced by each other. They are almost equal in terms of order and importance.

7.2 Recommendations

Prime Ministry Office

- To decentralize the policy making context and shift the ministry role to focus on leadership and regulatory function. While middle and low management levels should be engaged in policy making, using institutional approach.
- To empower the municipalities, DOH and the people with regard to MH policy making in order to mitigate the negative impact of the rapid political turnover.
- To strengthen MH leadership and accountability through the establishment of MH units or focal points at MOH level and DOH level, and to empower them with autonomy, supportive and needed resources.

Ministry of Health

- To update and contextualize MH policies, according to the current context, true needs and available resources and to develop long term developmental policies, that can be bridged with the current emergency policies and contribute to more stability and sustainable development. And to align these policies with health system reform policies and other sectors' policies such as schools' curricula.
- To conduct expanded and continuous communication and consultation campaigns to combat stigma to sensitize both policy makers and communities to MH, PC and public health, and to include everyone in policy making in order to create national and local ownership.
- To use a systematic approach and holistic interventions in MH policies including the update of legislations in order to address administrative and financial barriers to MH integration into PC. To develop the right combination of PC and community-based model of MH, that fits with local context diversities, and to establish a referral system that ensures continuity, comprehensiveness, coordination and quality of promotion, prevention, curativeness and rehabilitation of MH care to all including vulnerable groups achieving MH wellbeing and UHC.
- To leverage the remote and fragmented international actors' support to assist the MH integration into PC. This includes financing, experiences, advocacy and capacity building, and to mitigate their negative influence on ownership and sustainability.

District of Health

- To enhance the multidisciplinary MH team at primary care level and build up their capacity according to needs assessment and using a continuous professional development approach, and empower them with the needed legislations.

- To build public private partnerships in MH and to engage private providers in the process of needs assessment and policy making. This partnership has to be associated with raising the capacity of regulatory bodies and finding the right mix of public-private partnership to prevent financial hardship and improve quality.

Universities and Researchers

- To invest in researches of MH integration into PC with a focus on policies, health system and implementation in order to generate evidence that address the knowing-doing gap and supports self-reflection, monitoring and evaluation of the policies.

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Annexes

Annex 1: *Approval of Research Ethics Committee at KIT.*

KIT Royal Tropical Institute

RESEARCH ETHICS COMMITTEE

Contact: Meta Willems (secretary REC)
Telephone +31 (0)20 568 8514
m.willems@kit.nl

To:
Ghassan Sulaiman Khalifa Karem (MPH/ICHD Student)
By E-mail: Ghassan Karem
<karemghassan1@gmail.com>

Amsterdam, 25 June 2020

Subject Decision Research Ethics Committee regarding a waiver for the study: "Policy Analysis of Mental Health Integration in the Primary Care in Libya (S-125)"

Dear Ghassan Sulaiman Khalifa Karem,

The Research Ethics of the Royal Tropical Institute (REC) has reviewed your application for a waiver for the study "Policy Analysis of Mental Health Integration in the Primary Care in Libya (S-125)" which was submitted on March 13 and resubmitted on June 24, 2020.

Your proposal involves, in an addition to a literature review, online interviews with eight key stakeholders to explore different perspectives and enrich the data from the literature. These key stakeholders include experts from the Primary Health Care Institute, the National Center of Disease Control, the Health Information Center, the WHO country office and other national and international experts who will only be interviewed in their professional capacity. The proposal has been exempted from full ethical review based on the following considerations:

a. the participants will be involved in their professional capacity only; the issues to be covered in the topic list cover information related to the duties of the respondents and information in the public domain; questions related to any personal questions are not included;
b. the participants will be asked informed consent before the data collection with the assistance of a research assistant in the country, to make sure participation is voluntary and participants are informed that they can decide to decline or withdraw from the interview at any moment without any effect on reputation, or other consequences;
c. participating in this study does not foresee any physical, psychological and/or socio-economical risk or discomfort;
d. all information will be derived, processed, stored and published anonymously.

The Committee grants this waiver provided that you inform the KIT GDPR project officer about your research for GDPR monitoring purposes.

The Netherlands
Fax +31 (0)20 568 8444

ABN AMRO 40 50 05 970
ABN AMRO USD 62 62 48 183

The Committee requests you to inform the REC once substantive changes to the protocol are made, important changes to the research team take place or researchers are added to the research team.

Moreover, the Committee requests you to send the final report of the research containing a summary of the study's findings and conclusions to the Committee, for research monitoring purposes.

Please note that in case the final report is not submitted to the REC, or GDPR measurements are not taken care of sufficiently, this may have consequences for review of your next research proposal.

Wishing you success with the research,

Pam Baatsen
Chair of the KIT REC

Annex 2: Approval of Libyan National Committee for Biosafety and Bioethics.

State of Libya
Ministry of Higher Education & Scientific Research
Libyan National Committee for Biosafety & Bioethics

دولة ليبيا
وزارة التعليم العالي والبحث العلمي
اللجنة الوطنية للسلامة الحيوية والأخلاقيات البيولوجية

الرقم الإشاري: ٤٥/ع س/136
التاريخ: 2020/7/9

السيد المحترم/ غسان كريم

تحية طيبة,

إشارة إلى طلبكم الحصول على الموافقة الأخلاقية للمشروع البحثي تحت عنوان :

A POLICY ANALYSIS OF MENTAL HEALTH INTEGRATION IN PRIMARY CARE IN LIBYA

تفيدكم اللجنة بالموافقة على طلبكم مع ضرورة التقيد بالملاحظات التالية والتي هي جزء من الموافقة :

- الحصول على الموافقة المستنيرة للمشاركين (المرضى) قبل الشروع في البحث/الدراسة,
- المحافظة على خصوصية المشاركين وسرية المعلومات,

الالتزام الكامل بارشادات السلامة الحيوية والضوابط الأخلاقية: يمكن الرجوع إلى ضوابط منظمة الصحة العالمية إلى حين صدور الارشادات والضوابط في ليبيا قريبا .

نتمنى لكم التوفيق في مهمتكم, والسلام عليكم .

د. عبدالعزيز محمد البوني
رئيس اللجنة

رئيس اللجنة

صورة للملف الدوري العام

البريد الإلكتروني : info@lncbb.org.ly هاتف: 0217290727 , 0217266274 , 0217116082

Annex 3: The waiver and topic guide.

A waiver request for literature review complemented by key informant's interviews

From Ghassan Sulaiman Khalifa Karem
Amsterdam, 12/06/2020

To: Chair Research Ethics Committee, KIT
Dear Concern,
This letter is to request a waiver of ethical clearance for a study on (Policy Analysis of Mental Health Integration in The Primary Care in Libya) which takes place in Tripoli, Libya.
The study is implemented by [Ghassan Karem] as a thesis research of master course (ICHD course) at KIT with the purpose to analyse the policy related to integration of mental health in the primary care in Libya. This research paper will focus on grey literature using policy documents, implementing partners reports and research papers that include mental health integration in primary care in fragile and conflict settings. The study results will be used to inform decision makers and support them with the needed evidence to improve policies.
The principle investigator will identify 8 key experts for a complementary in-depth online interviews to explore different perspectives and enrich the data that will retrieved from the literature review. These key experts are identified based on a preliminary literature to be conducted. They include experts from the Primary Health Care Institute, National Center of Disease Control, Health Information Center, Mental Health focal point of WHO country office, and other national and international experts
I would like to kindly request the Research Ethical Committee at KIT to a waiver of ethical clearance for the interviews of this study for the following reasons:

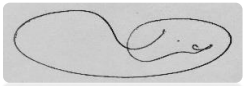
1. The questions will only ask about professional opinions, experiences, and reflections on the topic using the guide that developed in an open and flexible way to collect rich information from key experts. The topic guide does not ask any personal questions and all participants have the right to skip any question that has no relevance according to their opinion.
2. The participation is completely voluntary and all participants can withdraw at any point during the process without any consequences that might affect them or their reputation, for instance, sharing their inputs with the Ministry of Health or their current directors which might affect their jobs and carrier. Therefore, all information to be collected will be coded and anonymously shared.
3. All information will be collected, processed and disseminated anonymously. Participants' names will be replaced by codes and only the researcher has the access to the name of each code. Results of interviews will be transformed into general

findings and shared within the text without showing who said what during the interviews.

4. All participants will be asked informed consent before the interview, to make sure voluntary and informed participation is taking place. The researcher will read the informed consent loudly for each participant at the beginning of each interview and give them chance to ask for any clarification.
5. The interview guide was developed by principle investigator using mental health policy assessment tools as WHO-AIMS, in addition to, feedback from Advisors and colleagues at KIT.
6. Participating in this study does not have any physical, psychological or socio-economical risks or effects on participants. The participants do not have to travel or pay any cost, and they have the choice to choose their location and the time of the interview. The informed consent includes confidentiality, withdrawal flexibility and other relevant aspects.
7. The study is scientifically sound, justified and described in a clear detailed protocol and conducted in accordance with the basic ethical principles of the Declaration of Helsinki.

The interview guide can be found in Annex 1 to this letter and the informed consent form can be found in Annex 2.
We hope to have informed you sufficiently on the objective and content of this study to make a decision on our request.

Yours sincerely,
Ghassan Karem



Checked and approved by academic advisor
Mahdi Abdelwahab
On 23 June 2020

Annex 1: Key Informant Interview Guide

Introduction: I am a student of public health master course at KIT and this research is about Policy Analysis of Mental Health Integration in The Primary Care in Libya. I am interviewing a group of key experts to enrich this study and use that to inform policy makers in order to improve the policy and address the gaps. While we will use the themes from the interviews, the interviews themselves will be strictly confidential.

Your knowledge would be very valuable and it will be used for the purpose of the study and the interview will only take 60-75 minutes.

Topic	Sub-issues
Policies related to mental health integration in primary care	What are the Last updated relevant policies? Are they implemented? If not, why in your opinion?
	How do you describe the content of these policies?
	How do you describe the policy making process and what factors influencing it?
Stakeholders related to those policies	Who are the national and international stakeholders who influence the policies in terms of content and process?
	What are their positions and how they influence the policy?
Context	How does the context influence the policies in terms of content, process and stakeholders?
	How does context affects the implementation and sustainability of policies?
The way forward	What other factors that influence the policy in Libya?
	How we can improve the policies and contribute to implementation and sustainability?
	What outcomes would you like to see in the future?
Validation and Triangulation	I will share with you some findings of the literature reviews I have conducted so far and please I need your interpretation and comments on each one of them

Close: Thank you very much for your time. Your knowledge and insights will be very helpful to us. I expect the study to be completed over the next 3 -4 months and primary results will be shared with you before making it publically available to get your feedback. Thank you again.

Annex 2: Informed Consent Form

Form A: Key informants Interview

Part I: Information Sheet

I am Ghassan Karem, studding at KIT and I am doing a research to analyze the policies of mental health integration in the primary health care in Libya. I am going to give you information and invite you to be part of this research. Please stop me as we go through the information and I will explain them for your clarity.

Purpose of Research: Mental health needs in Libya are increasing due to the previous and current conflicts, and increasingly understood by decision makers. However, they might lack the needed evidence that could lead to more effective policies and address the needs. I believe that your experience will help this research to achieve the objective of this study by sharing your rich information in regard to the topic.

Voluntary participation and Right to Refuse or Withdraw: This research will involve you as well as other key experts because your participation can contribute to enriching this research and address many gaps that were uncovered by the literature review, in addition to, supporting the validity of results and research quality. Your participation is entirely voluntary and it is your choice to participate or no. If you choose not to participate that will not affect you or your reputation. If you choose to participate you can stop your participation at any time of the interview and you can escape any question if you find it irrelevant. We will use online meeting and you can choose to sit at a comfortable place and use the device you want and I will take notes. No one else, except the interviewer and will be present unless you like someone else to be there at your side. The discussion will be tape-recorded if you permit, but at withdrawal all information will be destroyed immediately.

Risks and Benefits: I am asking you to share your personal reflection on policy making which is not about evaluation of your colleagues' performance or your performance. You do not have to answer any question in the review if you feel the question(s) is too personal or if talking about it makes you uncomfortable. You do not have to give me any reason for not responding to any question. There will be no direct benefits to you, however, results of research will be disseminated and you can use it as well as your colleagues.

Confidentiality: The information that we collected from research will be kept private and safe, and it will have a number instead of your name. Only the researcher will know the number and it will not be shared with or given to anyone else. The tapes will be destroyed after one year, except in withdrawal situation; it will be destroyed immediately.

Sharing Results: The knowledge that I get from this research will be shared with you and other key informants before it is made widely available to public. After the study is completed

Who to contact: If you wish to ask questions later, you can contact (name, address, phone number, e-mail). This proposal was approved by the Libyan National

Committee for Biosafety and Bioethics (NCBB) at the Ministry of High education and Scientific Research, which is a committee whose task is to make sure that research participants are protected from harm. If you wish to find about the NCBB, contact (name, address, phone number, e-mail). It has also reviewed by the ERB of Royal Tropical Institute (KIT) in Amsterdam, The Netherlands, which is supporting the study. If you wish to find about KIT, contact (name, address, phone number, e-mail).

Part II: Certificate of Consent

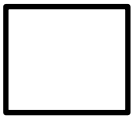
I have been invited to participate in research about "Policy Analysis of Mental Health Integration Policies in Primary Care in Libya". I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction, I consent voluntary to participate in this study.

Name of participant: …… Signature of participants: …… Date: ……

If illiterate,

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Name of witness: ……..... Signature of participants…….

Date……. Thumb print of participants 

Statement by the research/person taking consent: I have accurately read out the information sheet to the invited participant, and to the best of my ability made sure that the participant understands all above mentioned information. I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent and the consent has been given freely and voluntarily. A copy from the consent form has been provided to the participants.

Name of Researcher: ……

Signature of Researcher: ……Date: ……

Annex 4: List of Interviewees.

Code	Organization	Field of experience
F1	World Health Organization, Libya office	Expert of mental health
M1	Ministry of Health	Expert of primary care
F2	World Health Organization, Libya office	Expert of primary care
F3	European Union	Expert of Libyan policies
M2	Ministry of Health	Expert of health system
M3	National Expert	Expert of health policies
M4	University of Tripoli	Expert of public health
M5	World Health Organization, EMRO	Expert of mental health

Annex 5: Consents of Interviewees.

Part II: Certificate of Consent

I have been invited to participate in research about "Policy Analysis of Mental Health Integration Policies in Primary Care in Libya". I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction, I consent voluntary to participate in this study.

Name of participant: Ibrahim Jabeal. Signature of participants:

Date: 07-07-2020

If illiterate,

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Name of witness: ..... Signature of participants.....

Date..... Thumb print of participants

Statement by the research/person taking consent: I have accurately read out the information sheet to the invited participant, and to the best of my ability made sure that the participant understands all above mentioned information. I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent and the consent has been given freely and voluntarily. A copy from the consent form has been provided to the participants.

Name of Researcher: Ghassan Karem Signature of Researcher:

Date: 07-07-2020

Biosafety and Bioethics (NCBB) at the Ministry of High education and Scientific Research, which is a committee whose task is to make sure that research participants are protected from harm. If you wish to find about the NCBB, contact (name, address, phone number, e-mail). It has also reviewed by the ERB of Royal Tropical Institute (KIT) in Amsterdam, The Netherlands, which is supporting the study. If you wish to find about KIT, contact (name, address, phone number, e-mail).

Part II: Certificate of Consent

I have been invited to participate in research about "Policy Analysis of Mental Health Integration Policies in Primary Care in Libya". I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction, I consent voluntary to participate in this study.

Name of participant: Sara Zarti. Signature of participants:

Date: 30-06-2020

If illiterate,

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Name of witness: ..... Signature of participants.....

Date..... Thumb print of participants

Statement by the research/person taking consent: I have accurately read out the information sheet to the invited participant, and to the best of my ability made sure that the participant understands all above mentioned information. I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent and the consent has been given freely and voluntarily. A copy from the consent form has been provided to the participants.

Name of Researcher: Ghassan Karem Signature of Researcher:

Date: 30-06-2020

study. If you wish to find about KIT, contact (name, address, phone number, e-mail).

Part II: Certificate of Consent

I have been invited to participate in research about "Policy Analysis of Mental Health Integration Policies in Primary Care in Libya". I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction, I consent voluntary to participate in this study.

Name of participant: Mohamed Ibrahim Daganee. Signature of participants:

Date: 05-07-2020

If illiterate,

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Name of witness: ..... Signature of participants.....

Date..... Thumb print of participants

Statement by the research/person taking consent: I have accurately read out the information sheet to the invited participant, and to the best of my ability made sure that the participant understands all above mentioned information. I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent and the consent has been given freely and voluntarily. A copy from the consent form has been provided to the participants.

Name of Researcher: Ghassan Karem Signature of Researcher:

Date: 05-07-2020

study. If you wish to find about KIT, contact (name, address, phone number, e-mail).

Part II: Certificate of Consent

I have been invited to participate in research about "Policy Analysis of Mental Health Integration Policies in Primary Care in Libya". I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction, I consent voluntary to participate in this study.

Name of participant: Hesham Ben Masud. Signature of participants:

Date: 30-06-2020

If illiterate,

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Name of witness: ..... Signature of participants.....

Date..... Thumb print of participants

Statement by the research/person taking consent: I have accurately read out the information sheet to the invited participant, and to the best of my ability made sure that the participant understands all above mentioned information. I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent and the consent has been given freely and voluntarily. A copy from the consent form has been provided to the participants.

Name of Researcher: Ghassan Karem Signature of Researcher:

Date: 30-06-2020

study. If you wish to find about KIT, contact (name, address, phone number, e-mail).

Part II: Certificate of Consent

I have been invited to participate in research about "Policy Analysis of Mental Health Integration Policies in Primary Care in Libya". I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction, I consent voluntary to participate in this study.

Name of participant: Aqila Noori. Signature of participants:

Date: 02-07-2020

If illiterate,

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Name of witness: ..... Signature of participants.....

Date..... Thumb print of participants

Statement by the research/person taking consent: I have accurately read out the information sheet to the invited participant, and to the best of my ability made sure that the participant understands all above mentioned information. I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent and the consent has been given freely and voluntarily. A copy from the consent form has been provided to the participants.

Name of Researcher: Ghassan Karem Signature of Researcher:

Date: 02-07-2020

study. If you wish to find about KIT, contact (name, address, phone number, e-mail).

Part II: Certificate of Consent

I have been invited to participate in research about "Policy Analysis of Mental Health Integration Policies in Primary Care in Libya". I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction, I consent voluntary to participate in this study.

Name of participant: Adel El Taguri. Signature of participants:

Date: 05-07-2020

If illiterate,

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Name of witness: ..... Signature of participants.....

Date..... Thumb print of participants

Statement by the research/person taking consent: I have accurately read out the information sheet to the invited participant, and to the best of my ability made sure that the participant understands all above mentioned information. I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent and the consent has been given freely and voluntarily. A copy from the consent form has been provided to the participants.

Name of Researcher: Ghassan Karem Signature of Researcher:

Date: 05-07-2020

study. If you wish to find about KIT, contact (name, address, phone number, e-mail).

Part II: Certificate of Consent

I have been invited to participate in research about "Policy Analysis of Mental Health Integration Policies in Primary Care in Libya". I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction, I consent voluntary to participate in this study.

Name of participant: Edda Costarelli. Signature of participants:

Date: 12-07-2020

If illiterate,

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Name of witness: ..... Signature of participants.....

Date..... Thumb print of participants

Statement by the research/person taking consent: I have accurately read out the information sheet to the invited participant, and to the best of my ability made sure that the participant understands all above mentioned information. I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent and the consent has been given freely and voluntarily. A copy from the consent form has been provided to the participants.

Name of Researcher: Ghassan Karem Signature of Researcher:

Date: 12-07-2020

study. If you wish to find about KIT, contact (name, address, phone number, e-mail).

Part II: Certificate of Consent

I have been invited to participate in research about "Policy Analysis of Mental Health Integration Policies in Primary Care in Libya". I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction, I consent voluntary to participate in this study.

Name of participant: Khalid Saeed. Signature of participants: Khalid saeed, RA/MNH, WHO/EMRO Date: 09-07-2020

If illiterate,

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Name of witness: ..... Signature of participants.....

Date..... Thumb print of participants

Statement by the research/person taking consent: I have accurately read out the information sheet to the invited participant, and to the best of my ability made sure that the participant understands all above mentioned information. I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent and the consent has been given freely and voluntarily. A copy from the consent form has been provided to the participants.

Name of Researcher: Ghassan Karem Signature of Researcher:

Date: 09-07-2020