Implementing and scaling up mental health care in Ethiopia: sharing experiences and lessons learned

Dr Charlotte Hanlon & Professor Atalay Alem

CENTRE FOR GLOBAL MENTAL HEALTH

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Who are we?
Why are we here?

- Department of Psychiatry, Addis Ababa University
  - WHO Collaborating Centre in mental health research and capacity-building
- Working closely with Ethiopian Ministry of Health
  - Technical working group, Strategy development, Primary Care Guidelines
- PI/co-investigators on research projects to implement and evaluate mental health care
  - PRIME, Emerald, AFFIRM and ASSET


Ethiopia

- 100 million population
- Around 43% < 15 yrs
- 80 ethnic groups
- 200 dialects
- 81% living in rural areas
- Human Development Index: 173rd (of 176)
- Life Expectancy: 62 yrs (m) and 65 yrs (f)

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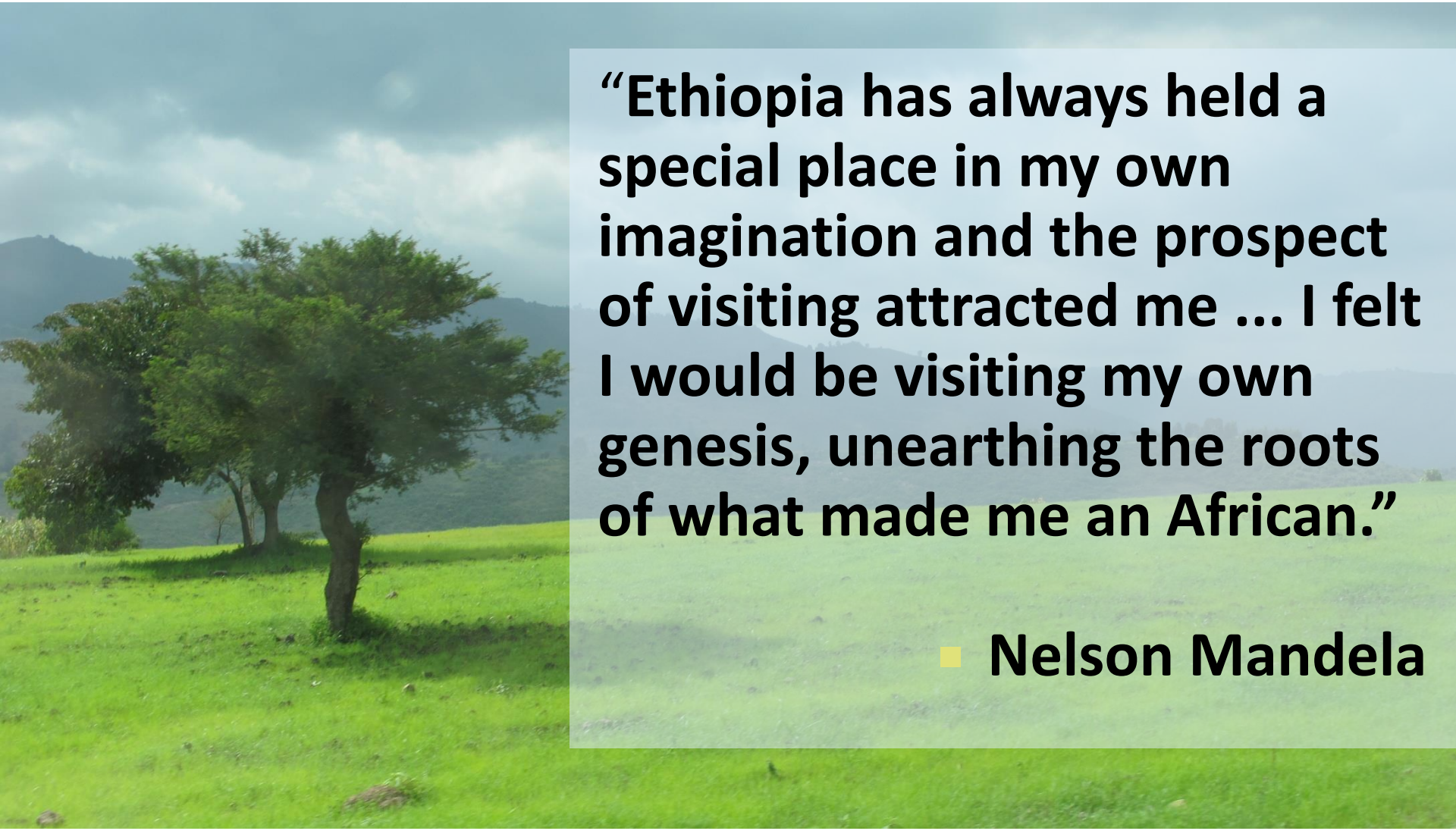
Ethiopia



“Ethiopia has always held a special place in my own imagination and the prospect of visiting attracted me ... I felt I would be visiting my own genesis, unearthing the roots of what made me an African.”

- **Nelson Mandela**

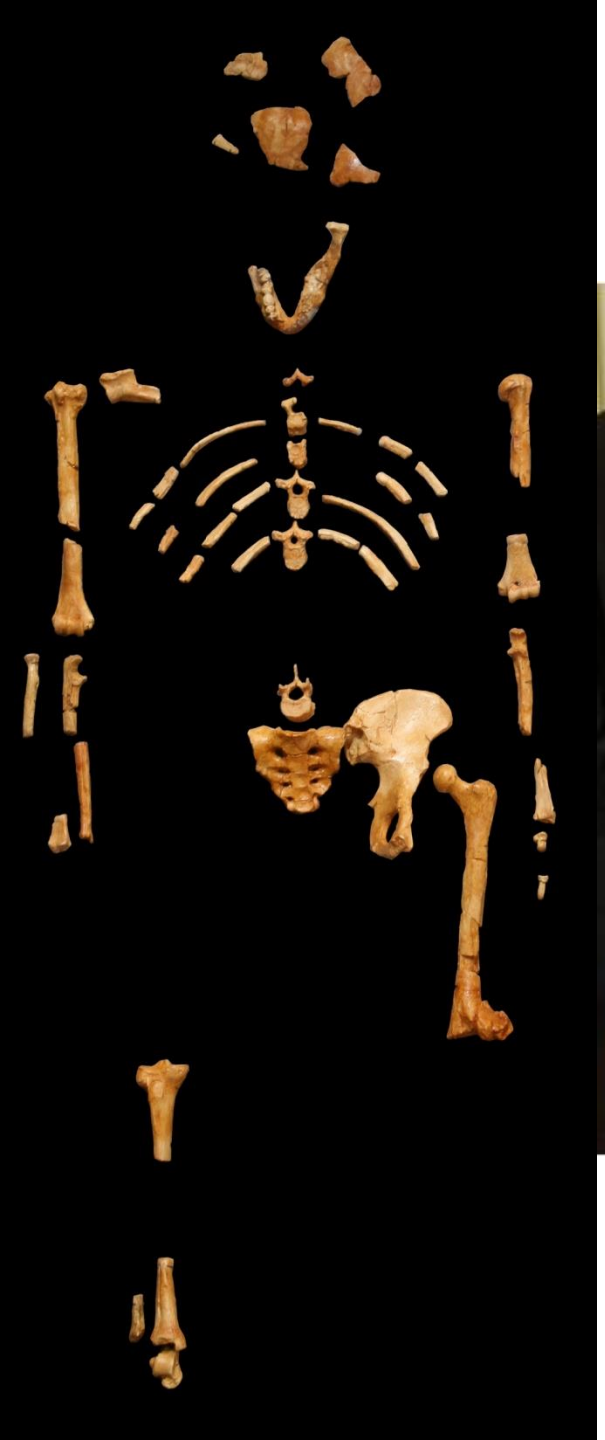


Photo: Jonathan Ernst/Reuters

https://en.wikipedia.org/wiki/Lucy_(Australopithecus)

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The Ethiopia epidemiological studies

- >68,000 screened (house-to-house)
- >2000 diagnostic interview
- 919 people with psychosis followed up for 10 years
- Findings: same prevalence; poor functioning, high mortality
- Important advocacy impact

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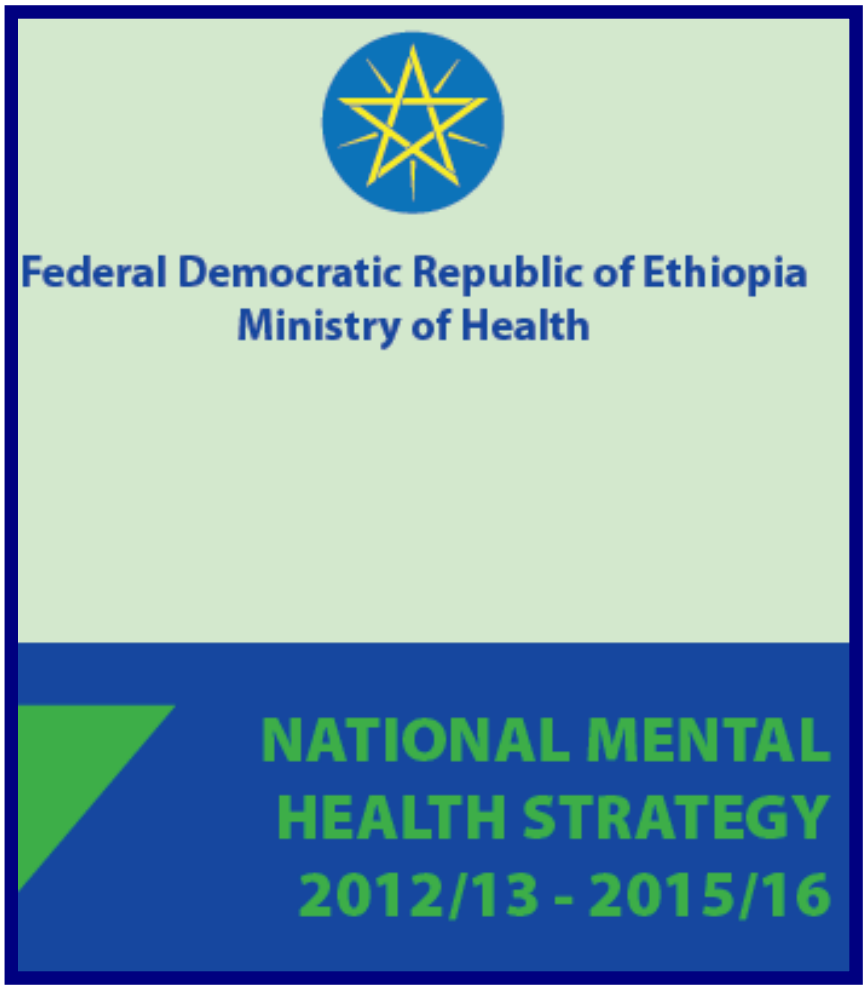
Ethiopia scale-up



- Implementing National Mental Health Strategy
- Demonstration sites: PRIME, AFFIRM & Emerald
- WHO pilot of mhGAP
- Transformation of primary care (PACK/ASSET)

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PRIME

(Programme for Improving Mental health carE)

AIM: To generate **high quality evidence** on the **implementation** and **scaling up** of **treatment programmes** for **priority mental disorders** in primary & maternal health care contexts in low resource settings

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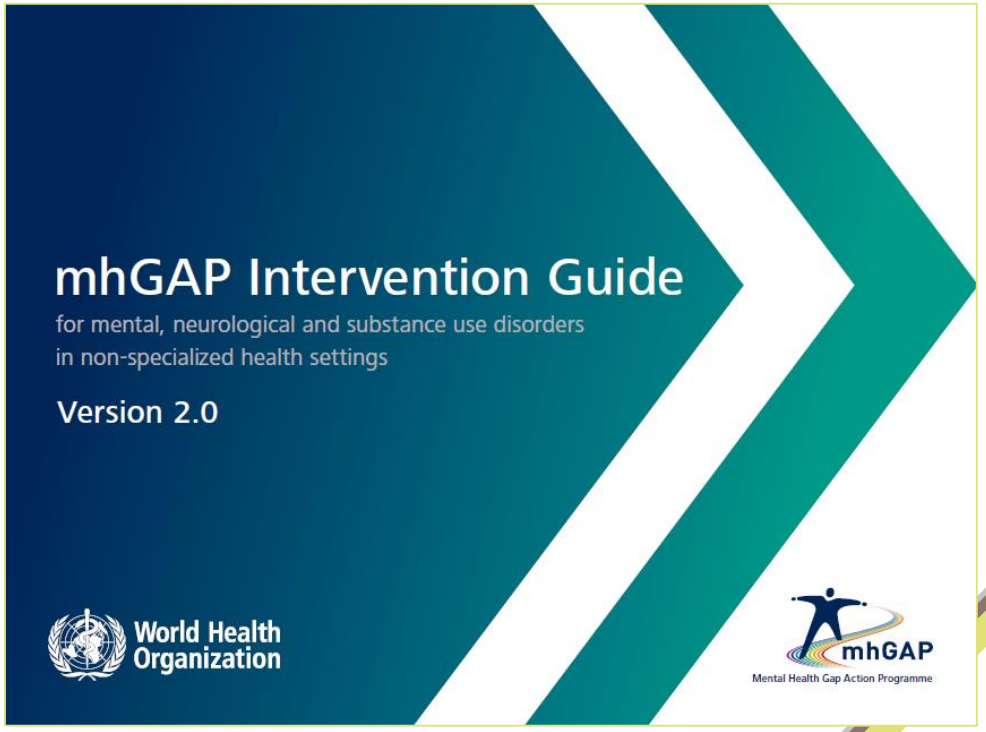
Approach

- Research to understand "how" to implement
- Priority MNS conditions
- Task-sharing
- District as the unit for integrated planning
- Focus on disadvantaged groups



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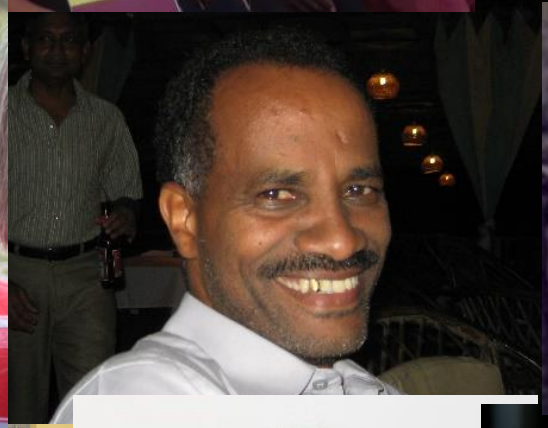

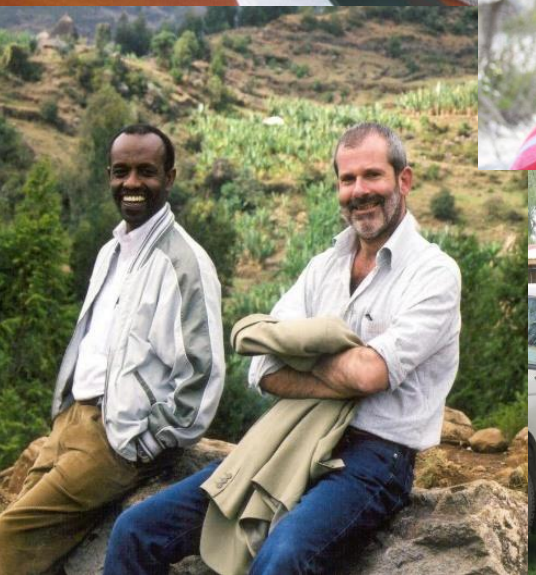



Sodo District, Ethiopia

- 160,000 people
- 90% rural
- No doctors
- No mental health specialists

Sodo district

Health service context		Indicators
Health providers	Hospitals	0
	Health centres (PHC)	8
	Health posts	58
Health professionals	Doctors	0
	Health officers	4
	Nurses	7-10/health centre
Mental health	Psychiatrist/nurse	0
	Psychologist	0
	Social worker	0
	Occupational therapy	0
	NGO for mental health	0

Participatory planning

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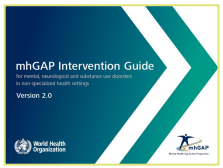
District mental healthcare plan

PRIME	Awareness	Detection	Treatment	Recovery	Enabling
Healthcare Organisation	Engage & mobilise		Medication supplies	Multi-sectoral links	Programme management
Specialist mental healthcare			Complex cases	Case reviews	Supportive supervision
Primary care facilities	Increase awareness & decrease stigma	Detect & assess		Continuing care	Build capacity
Community		Case detection	Basic psychosocial support	Promote inclusion & recovery	

WHAT DID (AND DID NOT) WORK?

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Successes

- Improved access & coverage
- More affordable
- Highly acceptable
- No safety concerns
- Few quality concerns
- Benefits of treatment

Challenges

- Detection of depression & alcohol problems
- Psychosocial care
- Staff turnover & sustainability
- Non-response
- Pre-service

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SUCCESSES

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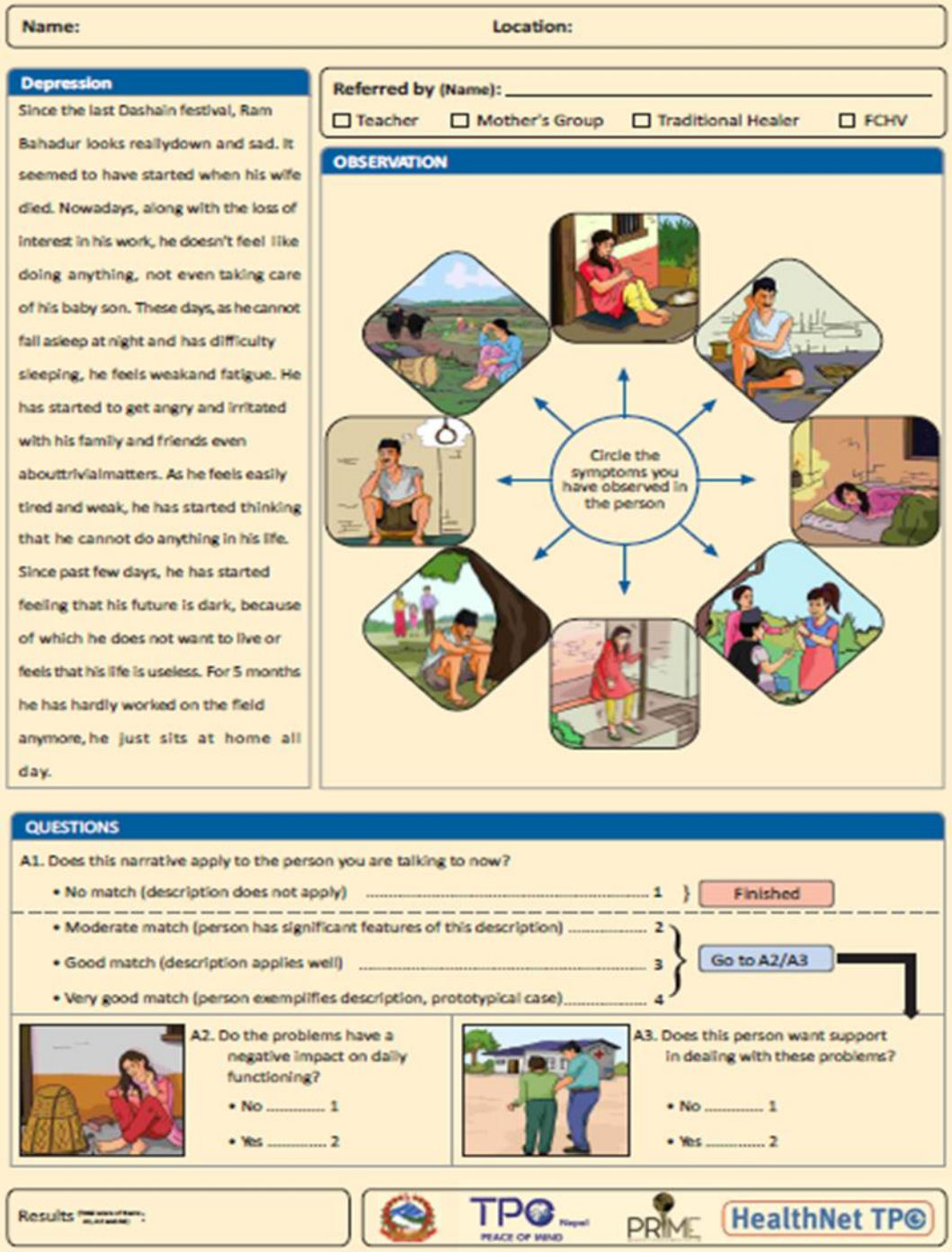
District/community engagement

Community health worker training



Community Informant Detection Tool

- Priority disorders
- Case descriptions adapted from mhGAP
- 3 questions
- No psychiatric labels

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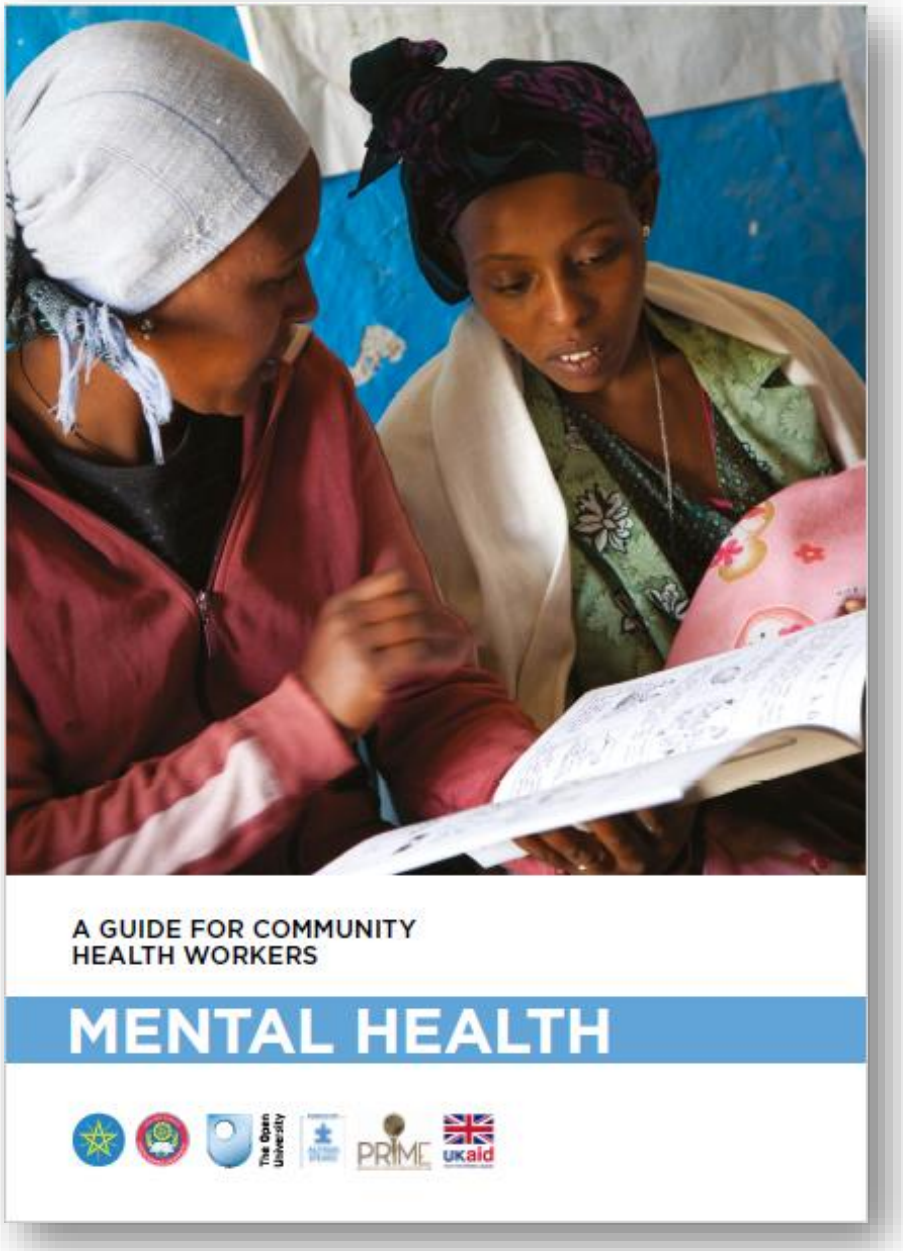
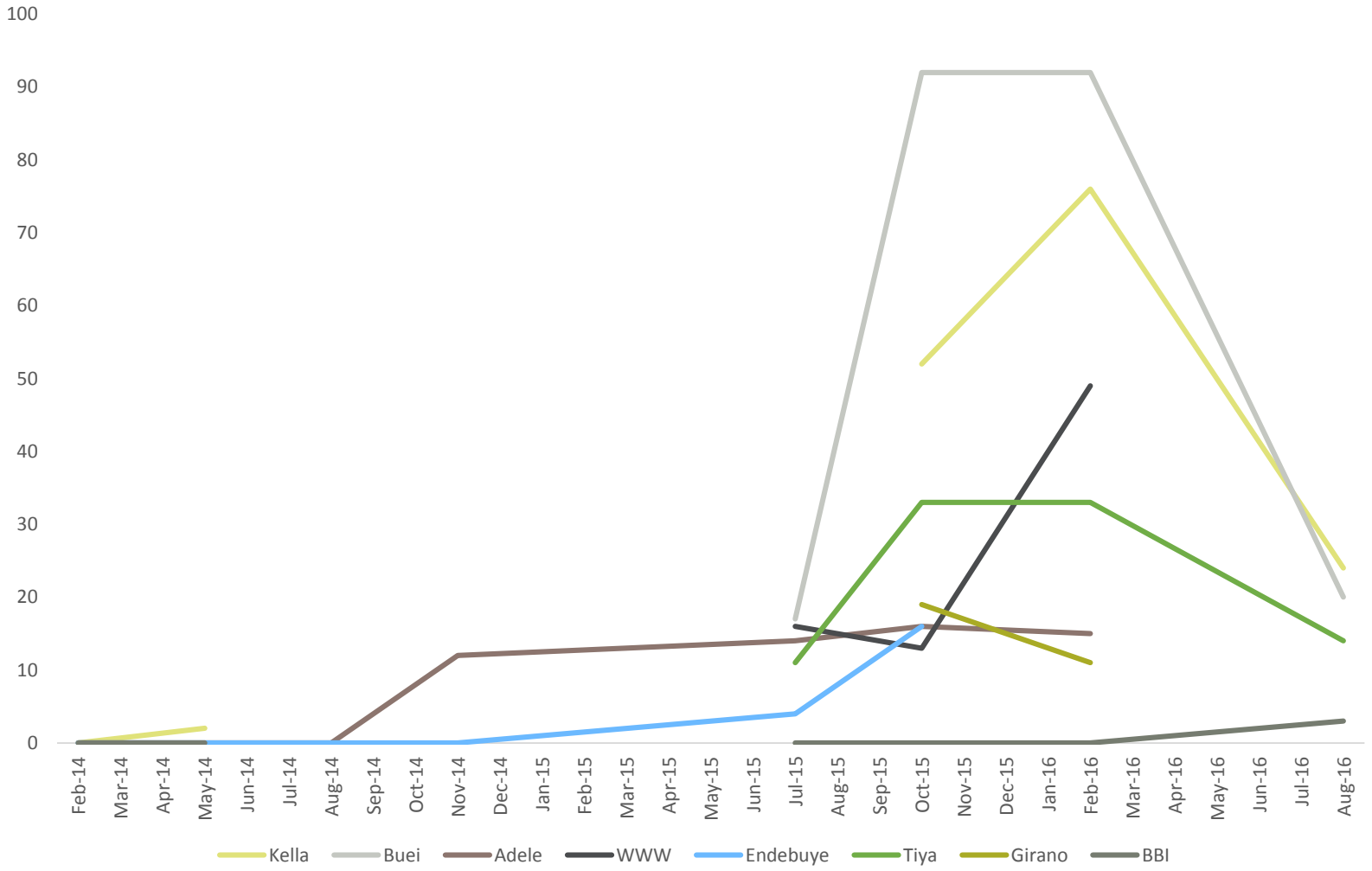
Mental health pocket guide for community health workers



People attending with psychosis



Community case-finding

'In our sub-district, the communities have seen the effect of the drug because there was one person who has mental health problem. After he began treatment, he recovered totally from the disease. Because of this, ***the community is searching for other people who have similar mental health problems*** *in other kebeles and sending them to health facilities. They are asking us to teach the community in holy water areas.'*

HEW FGD 1

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High contact coverage for psychosis and epilepsy

- 300 people with psychosis engaged in care
- 61 people with probable non-engaged
- 6 already specialist care
- 2 refused

81% coverage

- 95% of PHC worker diagnoses of psychosis were correct
- No dangerous prescribing

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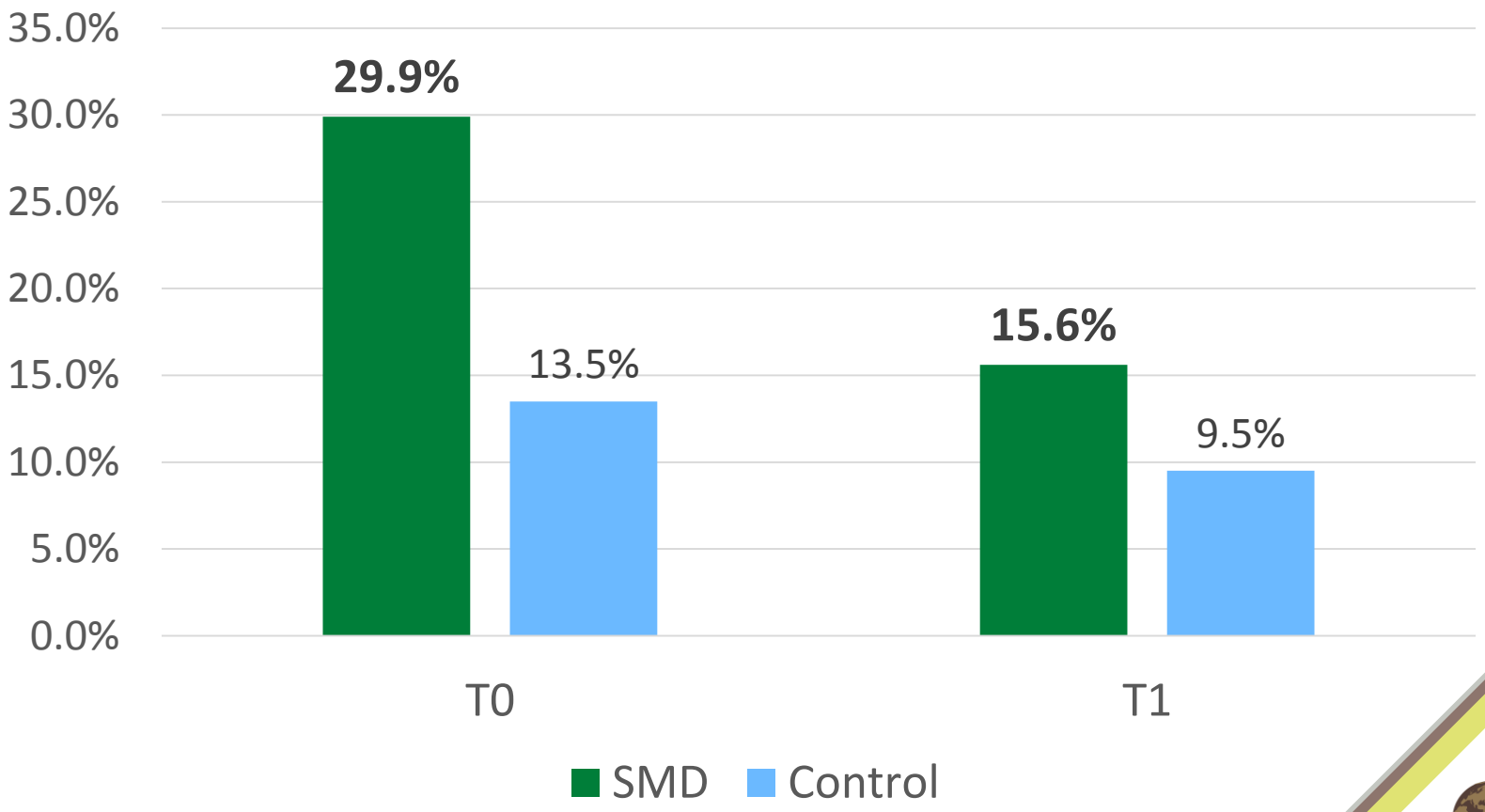
High impact (1 yr): food insecurity



PhD student: Kebede Tirfessa

Tirfessa et al. Epidemiology and Psychiatric Sciences, 2017

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High clinical and social impact (1 yr)

- Reduced symptom severity
- Increased functioning
- Reduced discrimination

Restraint reduced from 25% to 11%

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Witnessing recovery

'Previously those people who are mentally ill were discriminated from the community and faced many problems and remained in homes. But currently due to the treatment, they recovered from the disease and they are now leading their life and joined the community in different social occasions. By seeing their changes, currently the community also have good attitude for them and they took lessons that mentally ill people can recover from their disease.'

HEW FGD 1

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Service satisfaction was high

'I was very happy because I have got the treatment, I can get out and come back by myself just like other people do. I feel healthier when I took the medication unless the problem commences. I can go to the market or other places by myself.'

- Dep ID10

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Community support

‘*There was a person who was living on a street and he has improved very well because the community supports us a lot… if you can see him now, you can appreciate his change, he has an amazing improvement …he is talking like a normal person. Previously, he was walking naked and he was just wandering around the street…now, he even greets me when he saw me around, he is in a very good condition. He was living in a church, now he asked people to pay a house rent for him and he is taking care of himself. The community members have helped us a lot…’*

HEW FGD02 P4

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CHALLENGES
(& POSSIBLE SOLUTIONS)

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Challenge with ongoing care for psychosis and epilepsy

- Only 30% of people with psychosis received ‘minimum adequate treatment’
- High mortality (11/300 psychosis)
- Pattern of engaging and disengaging
- Key problems
  - Affordability of medicine
  - Stigma of chronic illness

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Lesson learned: increasing engagement

- Lay persons – reminder visits
- Making medication free

→83.6% minimally adequate treatment

AFFIRM
AFrica Focus on Intervention Research for Mental Health

What didn't work so well? Depression/alcohol

- **Depression:** expect at least 3% = 2640
- 100 people from 8 health centres

- **Alcohol:** hazardous use 22.6%
- 50 people from 8 health centres

Missed opportunity –integration is essential for these conditions

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Possible solution: Horizontally integrated care

NHS
National Institute for Health Research

ASSET
HeAlth System StrEngThening in Sub Saharan Africa

Stressed or distressed patient

Give urgent attention to the stressed or distressed patient with:
- Suicidal thoughts or behaviour ↩62.

Assess the stressed or distressed patient: if known with depression, give routine care ↩100.

Assess	Note
Symptoms	Manage symptoms on symptom pages. If patient has multiple physical complaints consider depression ↩99.
Stressors	• Help identify psychosocial stressors. Ask about family or relationship problems, financial difficulty, bereavement, chronic ill-health. Ask about loneliness in older person. • If patient is terminally sick and survival is predicted to be short, also give palliative care ↩120.
Trauma/abuse	Has the patient ever had a bad experience that is causing nightmares, flashbacks, avoidance of people/situations, jumpiness or a feeling of detachment? If yes ↩66. If patient being abused ↩66.
Anxiety	• If excessive worry causes impaired function/distress for at least 6 months with ≥ 3 of: muscle tension, restless, irritable, difficulty sleeping, poor concentration, tired: **generalised anxiety** likely ↩100. • If anxiety impairs function and is induced by a particular situation/object (phobia) or has no obvious cause with repeated sudden fear with physical symptoms (panic) ↩100.
Depression	In the past month, has patient felt depressed, sad, hopeless or irritable or worrying a lot, had multiple physical complaints, felt little interest or pleasure in doing things? If yes to any ↩99.
Substance abuse	In the past year, has patient: 1) drunk ≥ 4 drinks[1]/session, 2) used khat or illegal drugs or 3) misused prescription or over-the-counter medications? If yes to any ↩103.
Women's health	• If recent delivery, give postnatal care ↩116. • If woman > 40 years, ask about menopausal symptoms: hot flushes, night sweats, vaginal dryness, mood changes, difficulty sleeping and sexual problems ↩119.
Medication	Review medication: prednisolone, efavirenz, metoprolol, metoclopramide, theophylline and estrogen containing oral contraceptives can cause mood changes. Consider changing medication or alternative contraceptive and antihypertensive. If persistent symptoms on efavirenz for > 6 weeks, change ART ↩79.

Advise the stressed or distressed patient

- Encourage patient to question negative thinking and be realistic if s/he often predicts the worst, generalises, exaggerates problem, inappropriately takes the blame, takes things personally.
- Help the patient to choose strategies to get help and cope:

Get enough sleep
If patient has difficulty sleeping ↩67.

Encourage patient to take time to relax:

Spend time with supportive friends or family.

Do a relaxing breathing exercise each day.

Encourage patient to do activities s/he enjoyed previously.

Get active
Advise regular exercise.

Access support
Encourage patient to connect with friends, family, spiritual leaders and community groups like Edir, Mahber, Senbete.

- Do relaxing breathing in a quiet place for 10 minutes everyday: sit comfortably, breathing slow, steady breaths through nose. Time breathing with counting: 1, 2, 3 in; 1, 2, 3 pause; 1, 2, 3 out.
- Support problem solving: List main problems and identify an important but solvable problem. Support the patient to identify steps to solving the problem. Agree on specific steps that the patient will try in the next week. At follow-up, review, trouble-shoot and set new goals.
- Refer to available counsellor, psychiatric nurse/psychologist or social worker.
- Deal with bereavement issues if patient or family member has a life-limiting illness or if patient is recently bereaved:
  - Acknowledge grief reactions: denial, disbelief, confusion, shock, sadness, bargaining, yearning, anger, humiliation, despair, guilt and acceptance.
  - Allow patient/family to share sorrow and talk of memories, the meaning of the patient's life or religious beliefs. Suggest connecting with a spiritual counsellor as appropriate.
- For tips on how to communicate effectively ↩124.

Offer to review the patient in 1 month. If no better, refer to available counsellor, psychiatric nurse/psychologist or social worker.

[1]One drink is 1 shot (25mL) of spirits (whiskey, vodka, areke, gin), or 1 small glass (125mL) of wine/tej or 1 can/bottle (330mL) of beer/tela.

‘It was really good, they have welcomed me well, and they in fact treated me like family and advised me as such.’

Psy-SU ID12

'When I go on follow-ups they just dispense the medication. There is no one to give counselling on how I am doing with the medication. I wish they asked me questions or if I could ask them questions. People who ask will have solutions.’

Psy-SU ID07

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What we missed

- High unmet need for child developmental disorders
- Marginalisation of families
- Need for community level intervention

- → WHO Caregiver Skills Training programme

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Sustainability

Training → Trainers: Psychiatric nurses & clinical officers within district

Supervision → Integrate within all supervision
Monthly psychiatric nurse

Service provision → M&E; review meetings, refresher training; medication

Uptake of care → Community-based insurance
Service user empowerment

Political commitment

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Taking it to scale

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Financing

- Analysis for Ethiopia:
  - Leverage from other health programmes
  - Including mental health in community insurance
  - Make the case to external donors
  - ‘Sin tax’ to contribute

- Other possibilities
  - Research-implementation funds to kick-start

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Summary

- Task-shared mental health care can work
- Something can be done even with low resources
- Quick wins are important
- It needs time to embed
- It needs ongoing support (not ‘hit and run’)
- Monitoring and ongoing learning are crucial

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Partners in PRIME

- **Ethiopia** AAU, MoH
- **India** Sangath, PHFI, MP State MoH
- **Nepal** Healthnet TPO, MoH
- **South Africa** UKZN, HSRC, DoH

Photo: 1st PRIME Meeting, Cape Town, June 2011. Photo: Amit Makan

- **Uganda** Makerere University, MoH
- Alan Flisher Centre for Public Mental Health (UCT, SA)
- World Health Organisation
- Centre for Global Mental Health (KCL/LSHTM)
- Basic Needs; Perinatal Mental Health Project

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www.prime.uct.ac.za

University of Cape Town

Alan J. Flisher Centre for Public Mental Health

Centre for Global Mental Health (LSHTM, KCL & KHP)

UKaid from the British people

World Health Organization

BasicNeeds BasicRights

TPO Nepal

UNIVERSITEIT STELLENBOSCH UNIVERSITY

UNIVERSITY OF KWAZULU-NATAL

HSRC Human Sciences Research Council

Perinatal Mental Health Project

Sangath

South African Department of Health

Nepal Ministry of Health

Uganda Ministry of Health

Ethiopia Ministry of Health

Madhya Pradesh Department of Public Health & Family Welfare

Makerere University

University of Addis Ababa

Public Health Foundation of India

PRIME is a Research Programme Consortium (RPC) led by the Centre for Public Mental Health at the University of Cape Town (South Africa), and funded by the UK government's Department for International Development (DFID). The project aim is to develop world-class research evidence on the implementation, and scaling up of treatment programmes for priority mental disorders in primary and maternal health care contexts in low resource settings. Partners and collaborators in the consortium include Addis Ababa University and Ministry of Health (Ethiopia), Sangath, Public Health Foundation of India and Madhya Pradesh State Ministry of Health (India), Health Net TPO and Ministry of Health (Nepal), University of Kwazulu-Natal, Human Sciences Research Council, Perinatal Mental Health Project and Department of Health (South Africa), Makerere University and Ministry of Health (Uganda), BasicNeeds, Centre for Global Mental Health (London School of Hygiene & Tropical Medicine and Kings Health Partners, UK) and the World Health Organisation (WHO).

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