

Primary Mental Health Care Services in Ethiopia: Experiences, Opportunities and Challenges from East African Country

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Profile of Ethiopia

Ethiopia a country located in the horn of Africa, is one of the ancient independent nation in the world and has rich in diversity and cultures. The country covers 1.1 km² [1]. It has population of 101,497,038 million peoples of which 50,524,765 (49.8%) are males and 50,982,273 (50.2%) are females [1]. The country has over 80 different ethnic groups and it is the second most populous nation the east Africa next to Nigeria [1]. Total life expectancy (both sexes) for Ethiopia is 56.2 years. This is below the average life expectancy at birth of the global population which is about 71 years. Male life expectancy at birth is 53.6 years and female life expectancy at birth is 58.8 years [1].

The structure of health service delivery in Ethiopia and implication for integration of mental health

Ethiopia has been implementing Health Sector Development Programme (HSDP) since 1997. The first phase of HSDP was completed in 2002 and the second phase was completed in June 2005. This necessitated the development of the third phase of HSDP, which covers a period of five year (July 2005 to June 2010) [2]. Currently the country launched phase five HSDP having four tier structures [3].

There is a new, four-tier structure to the health service, not only providing the infrastructure for the delivery of health care (which the project will strengthen through the provision of medical equipment), but also for the continuing education of health teams at various levels.

Tier 1: The primary health care unit: A health center will provide for 25,000 people and is fed by five health posts, each responsible for 5,000 people. Every health center is to be staffed by a health officer, a clinical nurse, a community nurse, an environmental sanitarian and a laboratory technician.

Tier 2: The district hospital: To be fed by ten health centers covering a population of 250,000. Staffed by four GPs and a health officer, together with clinical and community nurses, a pharmacist and a laboratory technician. It will carry out routine curative and referral care and oversee the community health work of the population. There will be only limited cold surgery as the emphasis will be on life saving surgery with appropriate training provided for GPs.

Tier 3: The regional hospital: Staffed by six or more specialists and serving a population of one million, it will be responsible for the referral work from district hospitals and will be the focus of training and development.

Tier 4: Specialist hospitals: These comprise of regional hospitals with specialist units serving 5 million people.

The new health care structure for the country assumes a much stronger role for the health centers, assumes decentralization of care and services, and seeks to meet the needs of the poorer rural population as well as reducing the burden on the central hospitals.

This health care structure is found to be very suitable for easy success and achievements of integrating mental health in primary health care.

Mental Health Services in Ethiopia

It is estimated that about 25 million Ethiopians suffer some form of mental disorder, while less than 10 per cent receive any form of treatment, and less than 1 per cent receive specialist care [4].

Psychiatrists are an extremely scarce resource in Ethiopia; in population of over 101 million, there are only 63 psychiatrists, yielding a ratio of 0.65 psychiatrists to 1 million people. Most of the psychiatrists are concentrated in the large cities and consequently treatment gap exists as a high proportion of Ethiopians live in rural areas (more than 80 percent of the populations of the country live in rural areas) and therefore have no access to mental health services. As far back as the 1970s, the World Health Organization (WHO) recommended that psychiatry be firmly rooted in primary care in order to effectively reduce the treatment gap for mental health disorders [5]. Community model of mental health care in Ethiopia impediments to mental health care services in our communities include the uneven distribution of mental health resources, problems of accessing services in remote locations, affordability, and social acceptability in relation to ignorance and belief systems. Families often have to make out-of-pocket payments for these services due to non-availability of social support systems. Specifically, on the National Health Insurance Scheme (NHIS), there is limited coverage for mental health care.

The resultant effect of all these impediments is the rising number of people with mental health disorders living on the streets, a major social problem requiring urgent attention. Integrating mental health services into primary care is the most viable way of ensuring that people receive the mental health care they need. People can access mental health services close to their homes, thus keeping families together and maintaining their daily activities, and also avoid indirect costs associated with seeking specialist care in distant locations. In addition, intervening at primary care level helps to minimize stigma and discrimination [5].

Community model of mental health care in Ethiopia

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In order to overcome problems of low coverage of mental health service in Ethiopia ministry of health is practicing community based mental health services including integration of mental health service at primary health care (PHC) level. There are several advantages to treating common mental health problems in primary care and other priority health care programs. First, integrated treatment programs in which medical providers are supported to treat common mental health problems offer a chance to treat 'the whole patient', an approach that is more patient-centered and often more effective than an approach in which mental health, acute and chronic physical health, reproductive health, and chronic pain problems are each addressed in a different 'silo' without effective communication between providers. Second, integrated care programs that can address patients' mental health needs in the context of general or other specialized health care settings are often more attractive to patients and family members who are concerned about the stigma that is still associated with mental and substance abuse disorders and the treatment settings that specialize on caring for individuals with severe mental disorders [6].

Integrating mental health service in primary health care (Mental Health Gap Action Program (mhGAP) for people suffering from mental, neurological, and substance use disorders) in Ethiopia: Mental Health Gap Action Program (mhGAP) for people suffering from mental, neurological, and substance use disorders was started to be implemented before one year and six month in different regions of Ethiopia at primary health care levels. The purpose of mhGAP is implementation and Scaling up care for mental, neurological, and substance use disorders in primary health care facilities (non-specialized health-care settings) by non-specialized professionals (working at first- and second-level facilities) and 360 primary health care professionals selected from different health care facilities were trained on selected mhGAP priority disorders. These trained professionals receive periodic supervisions and training on site of work from well experienced psychiatry professionals. In additions they have mentoring programs including e-mentoring system where they consult psychiatry professionals by using phones, emails and other electronic communications systems.

Mental health care at non specialized centers (health centers, district and regional hospitals): In 1985 the ministry of health of Ethiopia, Amanuel mental specialized hospital training department and world health organizations (WHO) decided to train psychiatry nurses as the best alternative to provide mental health services at non-specialized health centers including at primary health care levels in the country. The training program was started in 1987. General nurses from district hospitals and health centers were recruited. The training took one year and was designed to enables them to identify and treat common mental disorders. Around 446 psychiatry nurses were trained in this program and working at different regions of the country. These trained professionals receive periodic supervisions and refreshment training on site of work from well experienced psychiatry professionals.

Support and Supervisions

Support and supervision aims to assist trainees to deliver improved mental health care (clinical supervision) and provide support in the work environment related to mental health care implementation (administrative and programmatic supervision). Support and supervision is considered as one part of the training and was planned to given periodically at least twice a year by well experienced psychiatry professionals. In additions they have group supervision and refreshment training outside the work environment as well as consultation by telephones. Follow up support and supervision put in place for success and sustainability of the care.

Challenges

- Inconsistence support for the training.
- Problem of understanding of the service by regional and local leaders.
- Giving little attention for mental health by the stake holders.
- Shortage of budget for supportive supervision and mentoring.
- Interrupted supply of drugs.
- Staff turnover.
- Inadequate sensitization and follow-up of the mhGAP scale up.
- Delayed supportive supervisions.
- Inadequate demand for the services.

Conclusion

- Creating awareness for the necessary stake holders is vital.
- There is a need to train attrition to trained health workers and sustainability of skills through training and support is vital.
- Effective monitoring and evaluation is necessary for sustainability of services.
- Integration of mental health into primary care is necessary and practicable though with challenges.
- A collaborative effort and the use of existing community-based structures are necessary for effective mental health service delivery at the grassroots.
- Increasing number of PHC staff trained in mental health care and Continuous supply of psychotropic medication is vital for effectiveness of integration.
- Continuous support and training for trained professionals is necessary for sustainability of the program.
- Future researches in scale up concentrating on impact and outcomes of interventions are implicated for understanding the success of interventions.

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