

# Integrating Mental Health into Primary Health Care

Amanuel Specialized Mental Hospital,  
Federal Ministry of Health of Ethiopia

April 2009

# **PROJECT PROPOSAL FOR ETHIOPIA**

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### **A. BACKGROUND INFORMATION**

#### **1. Background Country Information**

Ethiopia is situated in the horn of Africa between 3 and 5 degrees north latitude and 33 and 48 degrees east longitude. The total area of the country is about 1.1 million sq. km. The total projected population of the country for July 2007 was 77.1 million. 56% of the population is aged below 20 years while 35% is between 20 and 60 years of age.

The topographic features range from high land (The highest peak, being 4,550 meters above sea level) to low land (The lowest level being the Affar Depression at 110 meters below sea level). The climatic condition of the country varies with the topography, ranging from 47<sup>0</sup>C (116.6<sup>0</sup>F) to 10<sup>0</sup>C (50<sup>0</sup>F).

The Federal Democratic Republic of Ethiopia is administratively divided in to nine Regional States and two City Administrations. These are further divided in to 611 Woredas (districts) and 15,000 local administrations called Kebele. Majority (82%) of the population lives in rural areas and on farming. The country has diversified geographical and socio-cultural features, with more than 80 ethnic groups, cultures and languages.

There are about 16 million house holds with an average household size of 4.7 persons. The national working languages are is Amharic and English while Oromiffa, Somali and Tigrigna are the other main languages. Christianity and Islam are the major religions.

Despite being the oldest sub-Saharan State, Ethiopia's history has been laden with continuous natural disasters and frequent civil strife which was marked during the 1980s and 1990s. This situation has led to the stagnation of economic development, making the country one of the poorest in the world's poorest continent. The economy is dependent on agriculture, which in turn relies on natural rain, making harvests unpredictable. Because of these factors, the country, while owning huge idle arable land amounting to 12% of the total land area (Food and Agriculture Organization 2001), remains dependent on donation to feed its people. The economy is dependent on agriculture, which in turn relies on natural rain, making harvests unpredictable. Because of these factors, the country, while owning huge idle arable land amounting to 12% of the total land area (Food and Agriculture Organization 2001), remains dependent on donation to feed its people. According to the report of the World Bank in 2005, the country's per capita GDP of US\$160 is less than a quarter of the Sub-Saharan Africa's (SSA) average.

In spite of the late positive changes in the health care coverage, public health care is accessible only to 77% of the population while the proportion of fully immunized children is 50% (Ministry of Health of Ethiopia 2005/2006). There is a heavy burden of disease with a growing prevalence of potentially preventable communicable diseases.

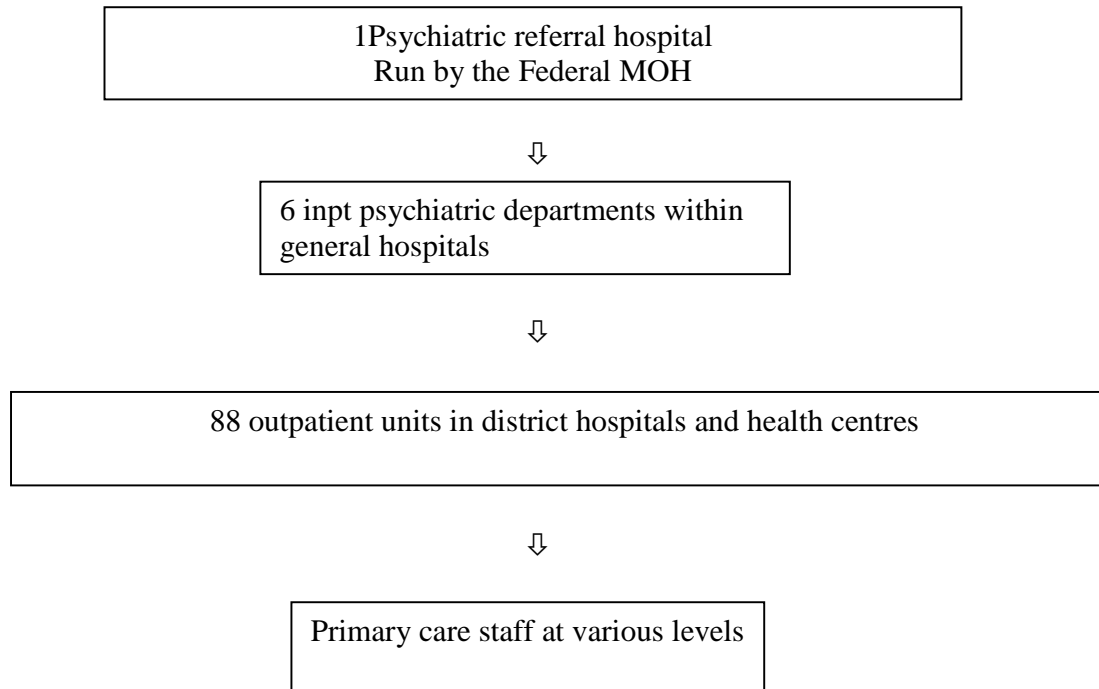
Life expectancy at birth is 52 yrs. Adult literacy in Ethiopia is estimated at 42% and only 34% of adult women can read and write the proportion of health budget to GDP is 3.4% and 1.7% of the health budget is devoted to mental health. Studies have shown that about 15% of the adult population in the country was suffering from mental disorders. The prevalence rate in children varied from 3.5%-17%. The health care system of the country has 4 tiers. The highest tier is composed of tertiary (referral) hospitals. These are under the control of the National Ministry of Health, The Universities (Teaching Hospitals) or the regional health bureaus. Next to the tertiary hospitals are the regional hospitals that act as the referral centres for the lowest two tiers. The district hospitals constitute the third level down the system of care. These involve the vast majority of the country's hospitals. The lowest level of the tier is the primary care level, consisting of health centres with 5 satellite health posts.

Ethiopia had endorsed PHC strategy since 1970's to realize equitable access to health services but the achievement had been very limited. Currently the country is implementing a 20 year health sector development plan divided in to 3-5 year rolling plans called Health Sector Development Plan (HSDP). During the Health Sector Development Plan (HSDP I) a four-tier system for health service delivery was introduced. This is characterized by a Primary Health Care Unit (PHCU), comprising one Health Center (HC) and five satellites Health Posts (HP), then the District Hospital (DH), Zonal Hospital (ZH) and Specialized Hospital (SH). A PHCU has been planned to serve 25,000 people, while a DH and a ZH are each expected to serve 250,000 and 1,000,000 people respectively<sup>1</sup>

Reviews of the 1st HSDP (1997/98- 2001/02) indicated the challenges in achieving universal coverage of PHC. In response to this the government has introduced an innovative program called Health Extension Program (HEP), during the 2nd HSDP (2002/03-.2004/05). The HEP is an innovative community based program with the aim of creating healthy environment and healthful living by making available community (Kebele) based essential health services at the grass roots level. By so doing it is envisaged to improve equitable access by focusing on sustained preventive health actions and increased health awareness.

The program is implemented by deploying at each village (Kebele) of two salaried female Health Extension Workers (HEW) who are trained for a year at Technical and Vocational Training and Education Centers. The HEP makes the bottom level of Essential Health Services Package (EHSP) of the country and is primarily preventive and promotive service, while basic curative care starts at the health centre level.

The Federal Ministry of Health has been undergoing a sector-wide reform, called business process reengineering. As a result of this reform, a state owned pharmaceutical fund and supply agency is established. This agency is organized in a way that it supplies door-to-door essential medications to each public health facilities. Hence, if we increase the number of mental health professionals in each level of care, supply of essential psychotropic drugs is not expected to be a problem. Currently, mental health services are provided mainly by mental health specialists and to a small extent by primary health care staff. The following is the network for the country's mental health services:



In Ethiopia, a *National Mental Health Institute* is being established at the federal level to improve the mental health situation; the institute will provide oversight for training, service planning, delivery and monitoring. The National Mental Health Institute will be established by the year 2009 and until then Amanuel hospital will carry out its duties and responsibilities. At the regional level, the responsibility for mental health services will sit with the disease prevention and control department. The responsibility for mental health services will then be delegated to Mental Health team leaders in each of the regional health bureaus. This responsibility will include policy review and modification, research, monitoring and evaluation, as well as a key coordination, liaison and advocacy role

with other stakeholders and institutions, including non-government service providers. Psychiatrists will provide clinical supervision & mentoring to specialist mental health workers as well as offering input into policy development.

Therefore, this project is designed to further strengthen the positive changes that are happening in the country. It is wise to take maximum advantage of the favorable political and policy environment that mental health is enjoying at this moment.

## **2. Background to the current project proposal**

Ethiopia formally included mental health care in its general health care plan (the Health Sector Development Program III) for the first time in 2005. The plan envisages achieving 80 % mainstreaming of mental health care by the end of 2010. This proposed plan aims to enable the country achieve the target of the national health care plan for mental health care.

<b>Table 3: WHICH ARE THE THREE MAIN STRENGTHS OF THE COUNTRY MENTAL HEALTH SYSTEM?</b>
1. The Ministry of Health has accepted mental health care as an integral part of its duties and has decided to establish a national institute of mental health by the year 2009. The institute is expected to promote mental health services across the country.
2. Local training of psychiatrists has started. Regional Universities have started training of psychiatric nurses. Masters level postgraduate training is planned to start shortly for midlevel health professionals (i.e. health officers and psychiatric nurses).
3. Health care is hugely subsidized and the poor can have access to free treatment

<b>Table 4: WHICH ARE THE THREE MAIN WEAKNESSES OF THE COUNTRY MENTAL HEALTH SYSTEM?</b>
1. Lack of mental health care in the primary care system
2. Erratic supply of psychotropic drugs
3. Low level of mental health knowledge and skills - among the general health care workers

## **B. DESCRIPTION OF THE PROJECT**

**Table 5: BRIEF DESCRIPTION OF THE PROJECT**

This project is designed to bring a maximum impact in mental health in Ethiopia as the mental health system has enjoyed positive changes in the last one year. The ministry of health has recently prepared a clinical guideline and training module in mental health for primary health workers in Ethiopia. Furthermore, it is planned to enhance the production of mental health workers through the starting of bachelor level training programs for psychiatric nurses at 4 regional universities (2 has already started training). A Masters program for midlevel health professionals is also planned to be started at the central level. This puts mental health in a better position as retention of trained staff will not be difficult as it was in the past

From an organizational point of view, an autonomous national mental health institute is in the process of being established under the Ministry of Health.

This project will be used as an evidence to determine the types of mental health services to be availed at the different levels of the health care. During the project's life time a referral system will be established linking the primary care with the various levels of mental health units. The higher levels of mental health care will provide mentorship and supportive supervision to their lower level catchments. This will be sustained in the future as the entire project will be an integral part of the health system reform. The mental health information system will be an integral part of the overall HMIS, which has been redesigned to have a paper-based as well as electronic data collection analysis system.

**Table 6: DESCRIPTION OF THE WEAKNESSES IN THE MENTAL HEALTH SYSTEM THAT THE PROJECT TACKLES**

1. Primary care staffs rarely deliver mental health interventions, leading to unnecessary burden on the few mental health workers
2. There are very few mental health workers who provide mental health care at secondary and tertiary level.
3. Undergraduate and post-degree mental health training is poor for all the mental health staff

**Table 7: GENERAL OBJECTIVES OF THE PROJECT**

1. To enhance the capacity of primary care staff in recognizing and treating mental disorders; to join the primary care team to mental health staff in a more structured way
2. To update the knowledge and skill of the PHC staff
3. To mainstream mental health service

**Table 8: STEPS TOWARDS IMPLEMENTATION OF THE PROJECT**

	SPECIFIC OBJECTIVE	ACTIONS	ACTORS	TIME	RESULTS	INDICATORS
Step 1	Increase the capacity of primary health care staff to diagnose and treat mental disorders	Training of primary health care, nurses and health officers on mental health through face to face training using the national training module. <b>(10 days training for each staff per year - Total 30 days training for each staff over 3 yrs.: 1 fresh training &amp; 2 refreshers training for each staff plus on-going supervision) in Amhara Region</b>	National Institute of mental health of the FMOH, Amanuel hospital, Addis Ababa, Jima, Gondar and Mekele universities, , primary health care staff, consumer associations, NGOS	2009-2012	700 primary care staffs (100 doctors, 200 nurses, 200 health officers & 400 health extension workers) trained on mental health	No. of doctors, nurses & trained (WHO-AIMS items 3.1.2., 3.2.3), No. of days of training , No. of Woredas covered, number of patients treated in primary care centres, psychotropic drugs consumed, referrals between primary care and specialist services
Step 2	To create a body to monitor the progress and develop mechanisms to deal with potential problems of integration	Establishing a liaison body between the Head of the primary care staff & the Mental Health coordinator in the regional health bureau that will discuss the	Regional Health Bureau, mental health coordinator in the RHB,FMOH, WHO	2009-2012	5 Liaison body established & 40 interactions meeting held	Liaison body established & no. of meetings held

		problem of integration every two months				
Step 3	Mid-term evaluation of project in one of the regions	Set up team to evaluate progress in one of the regions using identified indicators. Hold workshop to discuss results and adapt project for further implementation	Amhara Regional Health Bureau mental health coordinator in RHB , FMoH, WHO	2011	Mid-term evaluation completed and lessons learnt summarized for implementation in other provinces	Mid-term evaluation team established, indicators administered, and workshop held
Step 4	Create awareness in and enhance the identifying capacity of PHC physicians, nurses and health extension Workers	Training of primary health care physicians, nurses and health workers on mental health through face to face training and the development of a training module. <b>(10 days training for each staff per year - Total 30 days training for each staff over 3 yrs.: 1 fresh training &amp; 2 refreshers training for each staff plus on-going supervision)</b> in Oromia and SNNP Regions.	Department of mental health MoH, teaching hospitals, professional organizations, primary health care doctors, NGOS	2011-2012	1800 primary care staffs (200 doctors, 400 health officers, 400 nurses & 800 health extension workers) trained on mental health	No. of doctors, health officers, nurses & trained (WHO-AIMS items 3.1.2., 3.2.3), No of days of training , No. of sub districts covered, number of patients treated in primary care centres, psychotropic drugs consumed, referrals between primary care and specialist services
Step 5	Final evaluation	Evaluate progress of the project using identified indicators. Hold workshop to discuss results	Oromia and SNNP regional health bureaus mental health coordinators of the RHBs, FMoH, WHO	2012	Evaluation completed and workshop held	Evaluation report

<b>Table 9: DIFFICULTIES AND SOLUTIONS</b>	
<b>EXPECTED DIFFICULTIES</b>	<b>POSSIBLE SOLUTIONS TOWARDS THE EXPECTED DIFFICULTIES</b>
Lack of motivation of primary health staff to take on a new workload on top of their existing duties	Awareness training to health care workers regarding the proper definition of health. Demystify mental disorders by training health workers on the tractability of the common disabling mental problems. Negotiate with the MOH to include a new duty of identifying and referring/ and/or/ initiating treatment of common mental disorders in the job description of mid level health workers
Resistance from the staff of the autonomous regional health bureaus to assign staff and facilities to mental health services and training	Coordinated intervention and proposal from the Ministry of Health and the heads of Regional Health Bureaus
Shortage of trainers and monitors at the regional level	Coordinate foreign collaboration. Organise and implement an incentive mechanism to motivate senior professionals at the central level
Shortage of psychotropic drugs	Organize a memorandum of understanding between MOH and local pharmaceuticals to maintain a steady supply of selected psychotropic drugs and ensure that adequate budget is allocated by the regional health bureaus to psychotropic drugs

## **C. IMPACT OF THE PROJECT**

<b>Table 10: WHAT WILL BE THE IMPACT OF THE PROJECT</b> (e.g. in terms of accessibility of mental health facilities, availability of medicines or interventions, improved follow up, more respect for human rights, implementation of new interventions, etc)
1. Increased accessibility of services for patients at regional levels
2. Increased satisfaction of patients, families and communities from the improved level of wellbeing of treated cases.
3. Increase of referral to mental health services of patients with severe mental disorders
4. Improved follow up for severe mental disorders after the discharge from general hospital wards

## **D. RESOURCES**

<b>Table 11: NEEDED RESOURCES FOR THE WHOLE PROJECT</b> (sign to which class the project belongs)	
<b>Small</b> (<50,000 USD) (e.g., development of a mental health plan)	
<b>Medium</b> (50.000-500,000 USD) (e.g. organizing a series of trainings for primary health care professionals)	<b>XXXXX</b>
<b>Large</b> (>500,000) (e.g. implementing a network of outpatient facilities in the country)	

<b>Table 12: DESCRIPTION OF THE NEEDED RESOURCES</b>		
	<b>DESCRIPTION</b>	<b>AMOUNT IN \$</b>
MENTAL HEALTH STAFF		
BUILDINGS		
EQUIPMENT	Materials for primary care information system (to be entirely covered by the government)	50,000

TRAINING	Trainers, travels, training materials	250,000
MEDICINES	Expected increase in consumption of psychotropic drugs (to be entirely covered by the government)	100,000
OTHERS (specify)		
Total		

**TABLE 13: POSSIBLE SOURCES OF FUNDING** (these sources are presumed and not necessarily already found now).

FUNDER	
Government – Federal Ministry of Health/Regional Health Bureau	200.000
NGOs	200,000
Professional Associations	
Others (specify)	
Total	<b>400,000</b>