mhGAP in Ethiopia:
PROOF OF CONCEPT
2013

FMOH

World Health Organization

European Commission

Fondation d'Harcourt

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WHO wishes to thank Professor Jose Luis Ayuso Mateos (Universidad Autónoma de Madrid, Spain) for his review of this document.

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Graphic Design: Alessandro Mannocchi, Rome

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1. EXECUTIVE SUMMARY

1.1 Background

The Federal Ministry of Health in Ethiopia has recently issued a Mental Health Strategy that aims to develop mental health services that are "decentralized and integrated at the primary health care level". This is in line with the WHO Mental Health Gap Action Programme (mhGAP), which aims to scale up care for people suffering from mental, neurological and substance use (MNS) disorders.

The implementation of mhGAP is fully aligned with the WHO Global Mental Health Action Plan 2013 – 2020, and the Brazzaville Declaration on Non-communicable Diseases Prevention and Control in the WHO African Region.

1.2 Objective

The Proof of Concept phase of the mhGAP programme in Ethiopia seeks to establish the feasibility and develop the mechanisms of mhGAP in the country.

1.3 Approach

The project was devised to use existing infrastructure, involving all levels of formal health care, from the primary to the tertiary level. Task shifting was the main strategy.

1.4 Results

The Proof of Concept phase enabled the development of a system to implement mhGAP. The system has functioned and has enabled non-mental health workers to address the basic needs of people suffering from MNS disorders. In the four pilot sites of implementation, 2730 people have so far (by November 2013) benefited from the project.

1.5 Lessons learnt and recommendations

The Proof of Concept phase has been a valuable learning process that should be taken into consideration during the scale-up phase of mhGAP in Ethiopia.

Key recommendations are:

- Train non-mental health professionals to deliver care for people suffering from mental, neurological and substance use disorders according to the training package of the mhGAP Intervention Guide (mhGAP-IG);
- Actively engage mental health professionals in training, supportive supervision and mentorship;
- Increase the involvement of Regional Health Bureaus (RHBs);
- Develop a data quality framework on relevant indicators;
- Ensure that essential psychotropic drugs are continuously available at health facility level.

Decentralization is a gradual process that enables the Regional Health Bureaus to be more autonomous. During the Proof of Concept phase, this process has been made possible by the leadership of the Ethiopian Federal Ministry of Health (FMoH) and Amanuel Mental Specialized Hospital, in close collaboration with the World Health Organization (WHO).


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1.6 Next steps

A scale-up process will take place, starting in January 2014. The lessons learned and recommendations from the Proof of Concept phase should be actively integrated with the scale-up phase.

PSYCHOEDUCATION FOR DEPRESSION
TESTIMONY OF HANNA, AGED 40, MEKELLE, TIGRAY REGION

"I have always been happy and healthy in my life. Until something terrible happened to me: my only child died. After that dramatic episode, my life hasn't been the same.

I kept thinking about him, and couldn't sleep at night. I felt so sad and I would be so nervous and my heart would beat very fast.

This made me so worried I thought something bad was going to happen to me as well.

When I visited the clinic the nurse asked me many questions and she finally explained to me that all my symptoms were due to what they call depression.

She explained that many mothers who lose a child experience it and listened to me. She told me that I do not need medications. With time, I have felt much better and my sleep has become regular again."

2. OBJECTIVE

WHO has been active in mental health in Ethiopia for many years. Currently, the main focus is to promote the integration of mental health into primary health care.

The WHO global Mental Health Gap Action Programme (mhGAP) is reflected in Ethiopia in the project "Scaling up services for mental, neurological and substance use (MNS) disorders within WHO Mental Health Gap Action Programme (mhGAP)". This is a three-year demonstration project co-funded by the Fondation d'Harcourt and the European Commission. The demonstration phase comes to an end in December 2013.

The demonstration phase is summarized as follows:

Duration of the project	**October 2010 – December 2013**
Location	Selected sites in Ethiopia
Objective	To integrate provision of care and services for people with mental, neurological and substance use (MNS) disorders into the primary health care system, which will ensure a substantial increase in the number of people who have access to and seek care
Implementing partners	Federal Ministry of Health of Ethiopia, Regional Health Bureaus, WHO
Target group(s)	Health planners/programme managers at national, state and local levels and health-care providers, including non-specialists and specialists in the selected districts of Ethiopia
Final beneficiaries	People with MNS disorders and their families in the selected districts in Ethiopia

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3. APPROACH

The project has followed the WHO mhGAP guidelines for the implementation of mhGAP in terms of training and supervision. The mhGAP Intervention Guide was contextualized to Ethiopia and training materials developed accordingly.

The task shifting approach proved successful in training and retraining health workers following the mhGAP training formula (see box below).

MHGAP TRAINING "FORMULA"

The mhGAP Base Course represents the first contact of primary health care (PHC) workers with mhGAP. It consists of a five-day training and is taught over five days sequentially. Afterwards, participants are expected to be able to identify and manage persons with MNS disorders, under appropriate supervision.

The same PHC workers are re-trained (on average after about six months of supervision) on the mhGAP Standard Course. The Standard Course is an expansion of the mhGAP Base Course; it revisits all of the material taught in the Base Course and adds the remainder of the material that is in the mhGAP-IG.

Compared with the Base Course, the Standard Course has more focus on building skills through role-play and other participatory techniques. This method is meant to reinforce the knowledge gained in the Base Course through re-training and to introduce new knowledge in a dynamic way.

4. RESULTS

The demonstration phase has focused on 19 clinics in four regions (Amhara, Tigray, Oromia and Southern Nations, Nationalities and People (SNNPR)). The following table captures the number of health workers that received training in the frame of mhGAP.

Number of mental health professionals and primary Health Care workers trained in the frame of mhGAP		
Professional	**Type of training**	**Number**
Non-specialized health workers	mhGAP Training package (Base, Standard)	156
Mental Health Professionals	mhGAP Training of Trainers and Supervisors (ToTS)	76
TOTAL	All	232

The geographical location of trained human resources is mapped in the picture below:

Number of cases detected and treated or referred during the last six months (March–August 2013) under mhGAP by region and by diagnosis

REGION	Depression	Psychosis	Epilepsy	Others[1]	TOTAL
Tigray	38	19	26	8	91
Amhara	4	19	121	9	153
Oromia	39	8	159	84	290
SNNPR	8	4	43	4	59
All	89	50	348	105	592

Percentage of cases detected and treated or referred during the last six months (March–August 2013) under mhGAP by diagnosis

	Depression	Psychosis	Epilepsy	Others[1]
All regions	15%	8.6%	58.9%	17.5%

Proportion of cases by gender

	Male	Female
All regions	52.6%	47.4%

Proportion of cases by age

	<18	>18
All regions	15.7%	84.3%

The demonstration phase of mhGAP in Ethiopia has also contributed to the development of the National Mental Health Strategy 2012/13 – 2015/16. mhGAP is fully aligned with the strategy, which contains a relevant component on decentralization of mental health services.

1 The entry OTHERS includes: Alcohol disorders, Other Significant or Medically Unexplained Complaints and any other mental conditions that the health workers have been able to detect, manage and/or refer.

5. LESSONS LEARNT AND RECOMMENDATIONS

Mental health professionals in Ethiopia are few (fewer than 50 psychiatrists in a country with a population well above 80 million); this scenario makes task shifting the most appropriate approach to address mental health needs at a population level.

Training and supervising non-mental health professionals has proved to be effective in delivering a basic package of services for people with MNS disorders.

Under the leadership and guidance of the Federal Ministry of Health and the Amanuel Mental Specialized Hospital, the decentralization process has been promoted with a gradual involvement of regional health bureaus and specialists in the regions to engage them on administrative and technical levels.

Data is being collected through mhGAP supervision forms that have been produced for the implementation of mhGAP in Ethiopia.

Currently, efforts are being directed towards the integration of mhGAP into the Health Management Information System.

The availability of psychotropic medications varies from region to region and from facility to facility. As a result of the project, most clinics now have continuous availability of medications, though some still have difficulties in making all medications available. Negotiations with the Pharmaceuticals Fund and Supply Agency to bridge the gap are helpful and ongoing in some of the regions.

YONAS, AGED 33, MEKELLE, TIGRAY REGION

Management of epilepsy can be challenging, especially in settings with limited capacity to manage the condition.

Yonas was born in a rural area in Tigray, Northern Ethiopia. He started suffering from epilepsy several years ago. When he finally met a health worker who diagnosed him with epilepsy, he was prescribed pharmacological treatment. The tablets he was given made him free from epileptic fits. Since he was feeling better, he decided to discontinue the medication.

After approximately two years, Yonas developed the same problem again. When he presented with abnormal body movements and loss of consciousness, he was visited by a health worker in Mekelle who was familiar with the mhGAP approach to epilepsy. The worker explained to Yonas what type of disease epilepsy is, and he was put on medication again and advised not to discontinue it unless after careful consultation with a competent health worker. The mhGAP Guidelines suggest that people should only discontinue medicine if they have had no seizures within the past two years, but his previous care provider did not know this. Yonas is now free from epileptic fits and lives a normal life.

6. Next steps

The Proof of Concept phase has been a success and the lessons learnt from it provide the foundations for the scale-up of care to people across Ethiopia. Mental health provision in the country has gained momentum, as is proven not only by the implementation of mhGAP but also by the commitment of the Federal Ministry of Health, which has recently issued the Mental Health Strategy. The scale-up phase will be in full harmony with this strategy.

The first phase of the scale-up phase is planned for 3 years and the details are summarized in the table below:

Scale-up Plan – Phase 1				
Year	N. of clinics	Coverage	N. of health workers to be trained	N of training .workshops
Year 1 (2014)	100	3%	200	27
Year 2 (2015)	200	6%	400	54
Year 3 (2016)	333	11%	666	89
TOTAL	633	20%	1,266	170

The lessons learnt and recommendations from the Proof of Concept phase should be integrated within the scale-up process.

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