Essential medicines for MNS disorders in SSA: insufficient demand as a barrier to access

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Main issues to consider

- What are the drivers of demand for MNS medications in SSA?
- How does demand affect access to (availability of) MNS medications in SSA?

The context of MNS care in SSA

Human resources are scarce…

- Example: Psychiatrists
  - Less than 1 per 100,000 population
  - Compare: >10 per 100,000 population in Europe

The reality is worse...

- In many countries the ratio is 1 psychiatrist to more than 1,000,000 population
- Countries such as Malawi, Liberia, Sierra Leone have one single psychiatrist each

- Much worse ratios for other mental health professionals such as psychologists, social workers, etc.

Material resources for MNS services are sparse...

- For example: approximately 2.4 beds per 100,000 population in SSA
  - Compare: 79 in Europe per 100,000 population

Access to service is limited

- Not just because of scarcity of resources but also because of mal-distribution:
  - Most specialist facilities are located in a few cities
    - But >60% of the population live in rural areas in many countries
- Also, not just that psychiatric beds are few
  - 80% of psychiatric beds are in mental hospitals rather than in the community

The resulting standards of care…

Treatment gap

- **Serious cases of mental disorders receiving any treatment during the prior 12 months***
  - **South Africa : 26%**
  - **Nigeria : 21%**
    - **Among treated cases, only 10% received minimally adequate treatment**

- **Epilepsy**
  - **In many countries, only 5-10% of cases receive any treatment**

*Adapted from Wang et al. Lancet 2007

Delay in receiving treatment

- Among the few who receive treatment
  - Only about 6% do so in the first year of illness onset
  - It takes an average of 6 years for most persons to receive treatment

Continuity of care is poor…

- Systems are attuned to providing care for communicable diseases and less able to deliver effective care for chronic (non-communicable) diseases
  - There are 80 annual outpatient visits per 100,000 population in AFRO countries
    - Compare: global median of 384
  - The median number of visits in 12 months among cases receiving treatment in Nigeria was 1.7

Barriers to help-seeking …1

- Poor knowledge and stigma
  - Evidence comes from a representative community sample of 2040 adults
  - Knowledge is poor in the public:
    - > 40% of Nigerians believe mental illness is due to supernatural causes
      - Possession by evil spirits
      - Punishment by God
    - 30% believe in religio-magical (rather than medical) treatment

Barriers to help-seeking …2

- Attitude to mental disorders in the community
  - Stigma is rife (irrespective of education):
    - 78% of Nigerians would be upset working with someone with mental illness
    - 83% would be ashamed if people knew they had a relative with mental illness

Most of those who receive treatment do so in primary or general health care settings

12-month proportional treatment in the various health sectors

	Mental health specialty % s.e	General medical % s.e	Human Services % s.e	CAM % s.e
Nigeria	8.3 3.6	66.6 10.0	30.9 10.1	1.1 1.1
South Africa	16.3 2.2	66.4 2.5	24 1.9	23.8 2.1

Inefficient use of scarce resources…

- Proportion of cases treated in the *specialist* mental health sector:
  - Nigeria
    - Serious 0%
    - Moderate 0%
    - Mild 9.5%
  - South Africa
    - Serious 16.2%
    - Moderate 4.2%
    - Mild 15.5%

But has the primary care providers' training prepared them to recognize and treat MNS conditions?

Training physicians….

- Doctors training often consists of
  - 2 to 4 weeks of clerkship in psychiatry
    - Exclusively spent in mental hospitals
- Most have no training in the treatment of common mental disorders such as depression, anxiety, etc.

Non-physician primary care providers…

- The Nigerian example
  - Community Health Officers
    - 15 hours during a 2-year training
    - Most would not see a clinical case during the time

Continuing education uncommon…

- Only in a minority of countries have more than half of the providers received in-service training in mental health in 5 year:
  - For primary health care doctors: 23% of the countries
  - For primary health care nurses: 24%

Knowledge about prescribing….

- Guidelines or manuals about management and treatment are commonly unavailable
  - Such manuals are present in only 25% of SSA
- When available, they are often misleading in their recommendations:
  - For example, for the condition “Anxiety with loss of apetite”, the only non-psychotic mental disorders included in the 2010 edition of the Standing Orders for Community Health Workers in Nigeria, the treatment recommendations are:
    - Multivitamin 1 tablet three times daily for 7 days
    - Diazepam 5mg nocte for 5 days

Attitude of PHC workers often a barrier to detection and treatment

- One indicative finding::
  - In a study of 207 PHC workers by Abiodun
    (Drug and Alcohol Dependence, 1991 (28): 177 – 182)

    - 75.4% regarded the health aspects of alcohol and drug abuse as “of low grade” importance
    - 20% recommended “punishment” as the desired intervention

When care is sought..

- Detection is often poor
  - Primary care study
    - Detection is poor: only about 50% of those with psychological problems identified by their doctors
      - Among children, detection is even poorer
    - A detection rate of 13.8% for common mental disorders by community health workers has been reported
  - Treatment is often inappropriate or inadequate
    - Antidepressants are hardly used for depressed patients, and when used are often in sub-optimal dosage

Gureje et al. 1995

Commonly prescribed psychiatric treatments: cases recognised by treating ***physicians*** as suffering from a psychological disorder

	Current Depression	Anxiety Disorders	Somatoform Disorders	All recognized cases
	Estimated %	Estimated %	Estimated %	Estimated %
Any type of drug	41.2	53.8	36.4	50.9
treatment	35.3	53.8	18.2	39.3
Sedatives	0.0	0.0	0.0	0.9
Antidepressants	0.0	0.0	0.0	0.0
Antipsychotics	17.6	30.8	27.3	18.8
Vit./tonic/analgesics	5.9	0.0	9.1	0.9
Other drugs				

Overall procurement of MNS medications is low….

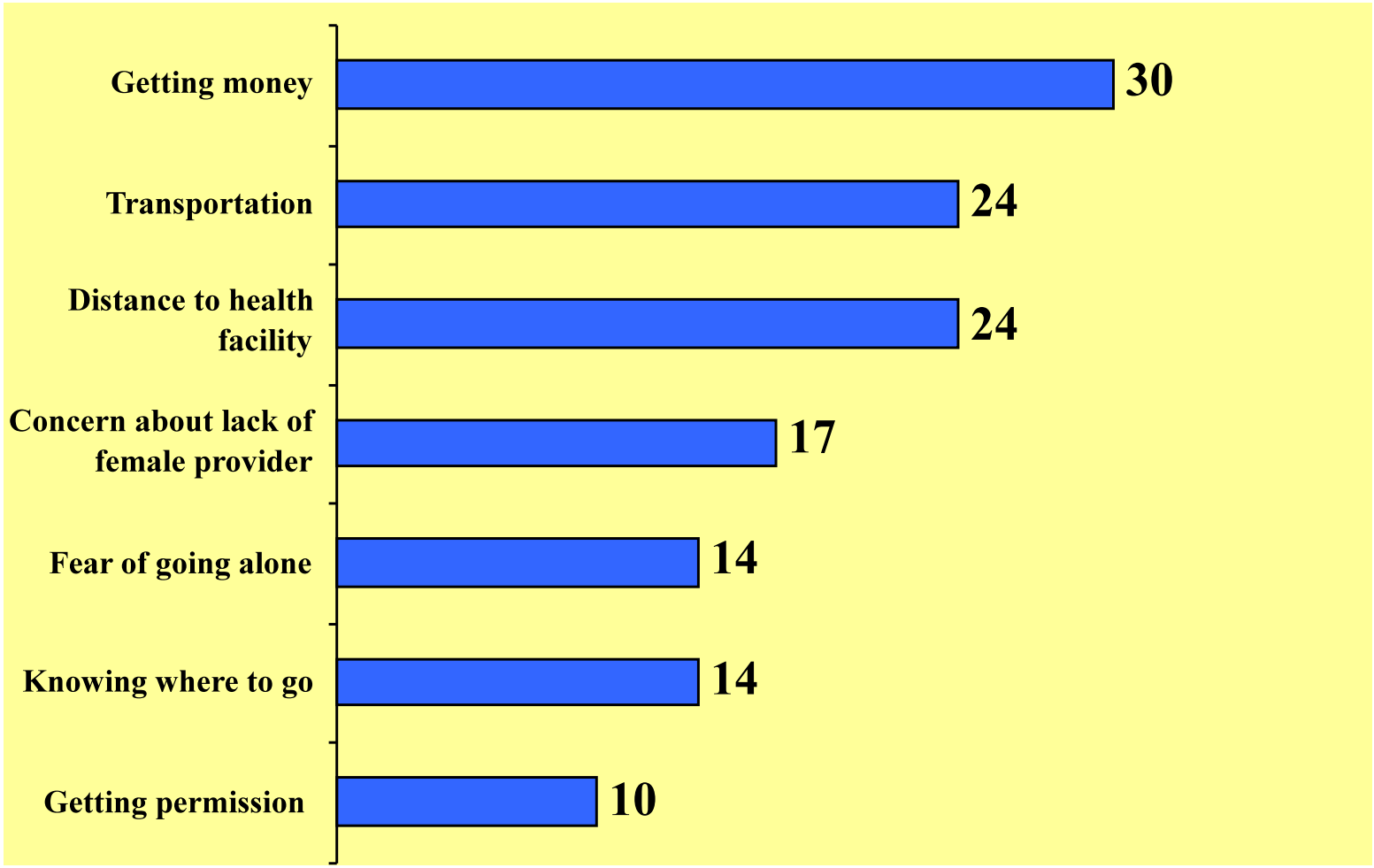
- SSA countries spend a median of $2,300 per 100,000 population on medications
  - Compared with the global median of $680,800.

Barriers to care…poverty

- Poverty and cost of care
  - No universal health insurance coverage
    - Payment is out-of-pocket
    - 70% live under the poverty line

"*Out-of-pocket payment is the most regressive way to pay for health, and the way that most exposes people to catastrophic financial risk" WHO*

Money as a barrier to seeking care



Demographic and Health Survey,

Cost and affordability..

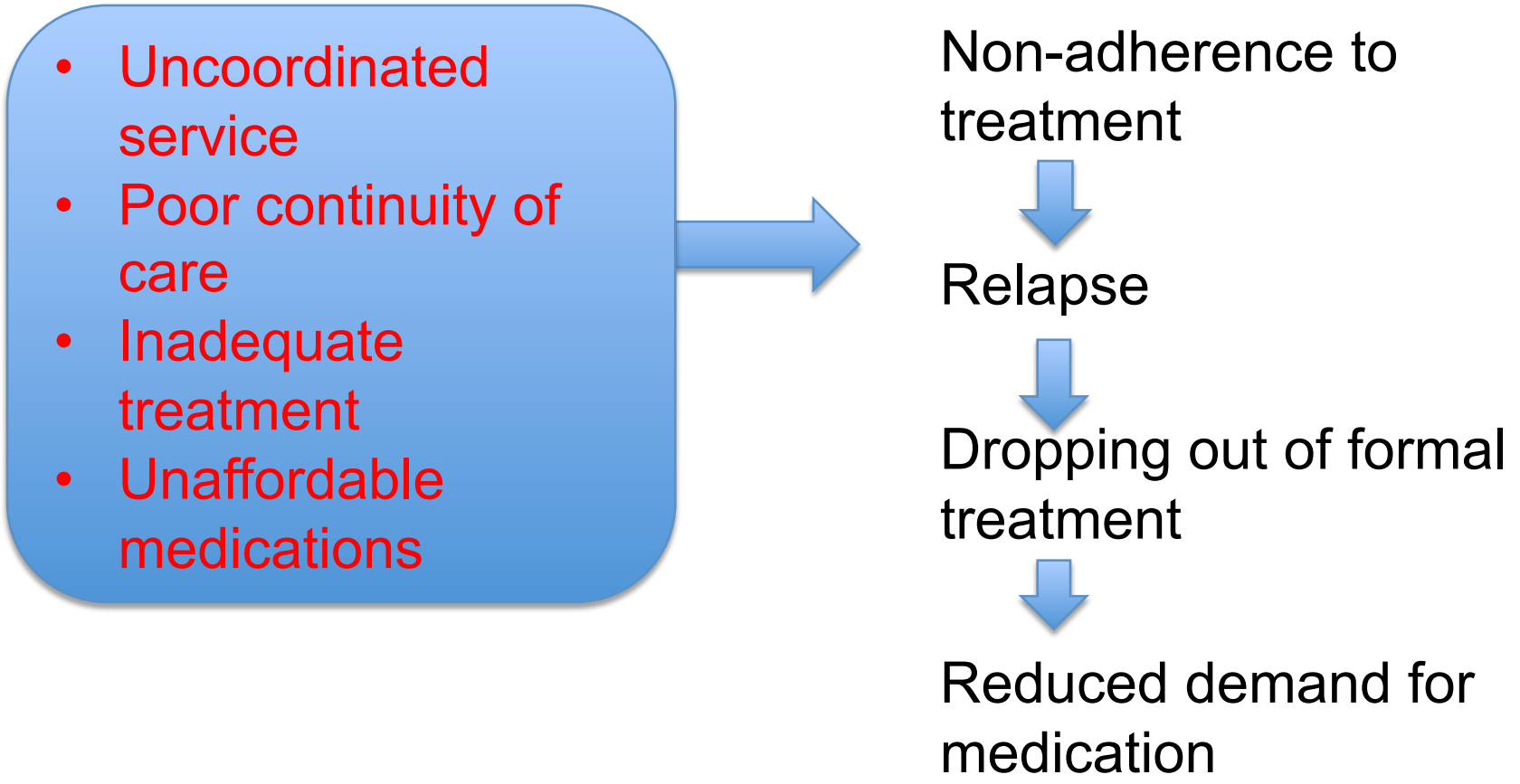
- 1 month of:
  - Haloperidol: 10mg daily 500 naira
  - Risperidone: 4mg daily 6,000 naira
  - Carbamazepine: 400 mg daily 10,000 naira

- Minimum wage in public service: 9,000 naira/ month
  - Many people in informal labor or private employment do not earn up to that!

Medications often disappear from the shelves …

Medications are commonly obtained from for-profit outlets

- When sale is poor, as a result of poor demand, the incentive to procure and store the medications is not there in those outlets
  - Results: even in tertiary hospitals, it is not uncommon for medications to make only fleeting appearance and disappear because sale is poor
  - Most affected: newer MNS medications with relatively high cost


• Uncoordinated service
• Poor continuity of care
• Inadequate treatment
• Unaffordable medications
Non-adherence to treatment
Relapse
Dropping out of formal treatment
Reduced demand for medication

The mental health system…

- Characterized by few specialists, inefficient coordination
  - Primary care providers
    - Lack the support and supervision they need
    - Give poor attention to mental health in the context of many competing priorities
    - Lack the confidence to use MNS medications and become less and less familiar with their use over time

So, what may help?

- We have been conducting a service scale-up programme using mhGAP in a state in Nigeria since 2010
  - Engagement with policy makers
  - Training of primary care providers from selected PHCs to use the mhGAP-Intervention Guide
    - 198 trained till date
  - Public enlightenment efforts
    - Facility-based information on MH by providers
    - Media interviews

What have we noticed?

- A dramatic increase in help-seeking for MNS disorders
  - Some patients who have been confined to healers' facilities sought care
    - Especially for epilepsy
- Increased provider competence
  - Increased detection of MNS disorders
  - Acceptable levels of fidelity with mhGAP-IG

Specifically, for medication…

- Increased prescription of MNS medications
  - High on the list (first-line drugs):
    - Phenobarbitone for epilepsy
    - Amitryptiline for depression
- Increased procurement
  - From none, number of PHCs stocking MNS medications went up to 11 after 12 months
  - Director of Pharmaceutical Services in the state included a specific request for MNS medications in the budget for 2014

The lessons learnt…

- Some effective ways to improve access through increased demand are to:
  - Remove the “filters” to recognition and treatment of MNS disorder
    - Improve help-seeking, through public education
    - Enhance detection and treatment: through education of providers to improve skill and reduce negative attitude
    - Reform the health system: so the few specialists provide continuous supervision and support for first-line providers and streamline referral pathway to achieve efficiency
  - Engage with policy makers to improve procurement
  - Deal with “ability to pay” (e.g. through insurance)

Thank you for listening!