Mental Health Interventions in a Rural Community in South-West, Nigeria

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DISCLOSURE

- NO CONFLICT OF INTEREST DECLARED

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Lagos University Teaching Hospital (LUTH) main gate

Ground floor→ ward E1 (psychiatric ward, LUTH)

Introduction

- Estimated 450 million people worldwide suffer mental illness (WHO report 2001).
- 14% of global disease burden due to mental disorders.
- Unipolar Depression 3rd leading cause of global burden of disease by 2030. (WHO 2004 update on global burden of disease).

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Introduction

- Mental health treatment gap exists. (Kohn et al 2004).
  - Between 76-85% in LAMICs
  - Between 35-50% in high income countries. (Demyttenaera et al 2004).
- Poor Budgetary allocation, stigma, scarce resources, inequitable distribution of available resources (Saxena et al 2007).
- Paradigm shift: integration and collaboration

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Introduction

MENTAL HEALTH IN NIGERIA

- Population ≈ 160 million, LAMIC
- Only 8% of severe cases of mental illness receive treatment in the preceding 12 months. (Gureje and Lasebikan 2006).
- Out of pocket mode of payment.
- Traditional / Spiritual care patronised.
- Adopted as 9th component of PHC but not fully integrated (Odejide and Morakinyo 2003).
  - Short-term local efforts
  - Nil national/regional network
- Recent pilot study on mHGAP-IG adaptation in Nigeria (Abdulmalik et al 2013)

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- Resources for mental health:
  - 44 mental health outpatient facilities, located mostly in urban centres; 8 are stand-alone mental health hospitals.
  - 4,000 mental health beds, mostly in the stand-alone hospitals.
  - Psychiatrists 0.06 per 100,000 population
  - Psychologists- 0.02 per 100,000 population
  - Psychiatric Nurses – 0.19 per 100,000 population
  - Non-specialised doctors – 0.09 per 100,000 population (WHO Mental Health Atlas 2011).

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AIM

To report on efforts at integrating mental health services into primary care within an existing community-based health facility

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Setting

- Location – Pakoto Community, Ifo LGA of Ogun State, South-West Nigeria.
- Focal Points
  - Institute of Child Health and Primary Care (ICH & PC)
  - Ori-Oke (Prayer Mountain)

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ICH & PC

- Model Primary Health Care Centre (Out-station of LUTH).
- Commissioned in 1987
- Covers communities under Ilepa/Coker Ward, Ifo LGA
- Core staff
  - Community Health Officers (CHO)
  - Community Health Extension Workers (CHEW)
  - Health Technicians (e.g. pharmacy technicians)
- Community-based staff
  - Volunteer Health Workers (VHW)
  - Traditional Birth Attendants (TBA)

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ICH & PC

ICH & PC

ICH & PC

- Existing Services
  - Treatment of minor ailments using standing orders
  - Immunization / Family planning
  - ANC / Deliveries
  - Dental Health
  - Eye Care
  - CHO Training
  - Monitoring VHA / TBA in the catchment area

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Ori-Oke (Prayer Mountain)

- Non-denominational prayer centre.
- Residential facility for the mentally ill receiving “Faith Healing”.
- Users mainly from neighbouring communities in South-West, Nigeria
- Details of collaboration in a paper by Oshodi and Ogbolu to be presented in poster.

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Mode of Entry

- Preliminary meetings/discussions with stakeholders
- Courtesy calls to major community leaders
- Aim
  - Understand socioeconomic milieu
  - Evaluate available resources
  - Form formidable collaboration
  - Full community participation

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Stakeholders

- Management of ICH &PC
- Primary Health Care (PHC) workers (including pharmacy staff)
- Volunteer Health Workers (VHWs) & Traditional Birth Attendants (TBAs)
- Community/Ward development committees representatives
- Representatives from "Ori Oke"

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Training

- Module designed by Dept. of Psychiatry LUTH
- CHEWs/Nurses → 1 hour, twice weekly x 8weeks to identify, treat & refer when necessary
- VHWs/TBAs → one-off workshop to identify possible cases in the community & then refer to PHC

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Service Delivery Strategies

- PHC→
  - Routine daily clinic by PHC workers
  - Weekly mental health on Tuesdays by visiting psychiatrist + a PHC worker
  - Regular mental health talks at ANC + GOPC
- "Ori Oke"→
  - Weekly outreach clinic by visiting psychiatrist + a PHC worker
- Pharmacy→
  - psychotropics sourced from LUTH pharmacy
  - Psychotropic medications from an NGO (indigent patients)
- Referral→
  - Existing 2-way referral system

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Outreach at “Ori Oke”

Photo taken with permission

Outcome/Observations

- 15 PHC workers received training
- Services well utilized and on-going
  - 177 new patients in first 24 months (fig 1)
  - Follow up visits (fig 2)
  - 2-way referral utilized
- Increasing service utilization due to→
  - Acceptance & support by PHC workers & host community
  - Ease of access
- Limits of prior training orientation (use of standing orders) on performance

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Table 1: Demographic and clinical data

Description	n	Percentage (%)
Gender (n = 177)		
Male	94	53.1
Female	83	46.9
Marital Status (n = 177)		
Married	55	31.1
Single	122	68.9
Employment status (n = 177)		
Employed	51	28.8
Unemployment	126	71.2
Presentation (n = 177)		
Psychotic	169	95.5
Non psychotic	8	4.5
Antipsychotic prescription (n=169)		
Typical	152	89.9
Atypical	17	10.1

Fig 1: New Patients seen within first 24 months (n = 177)

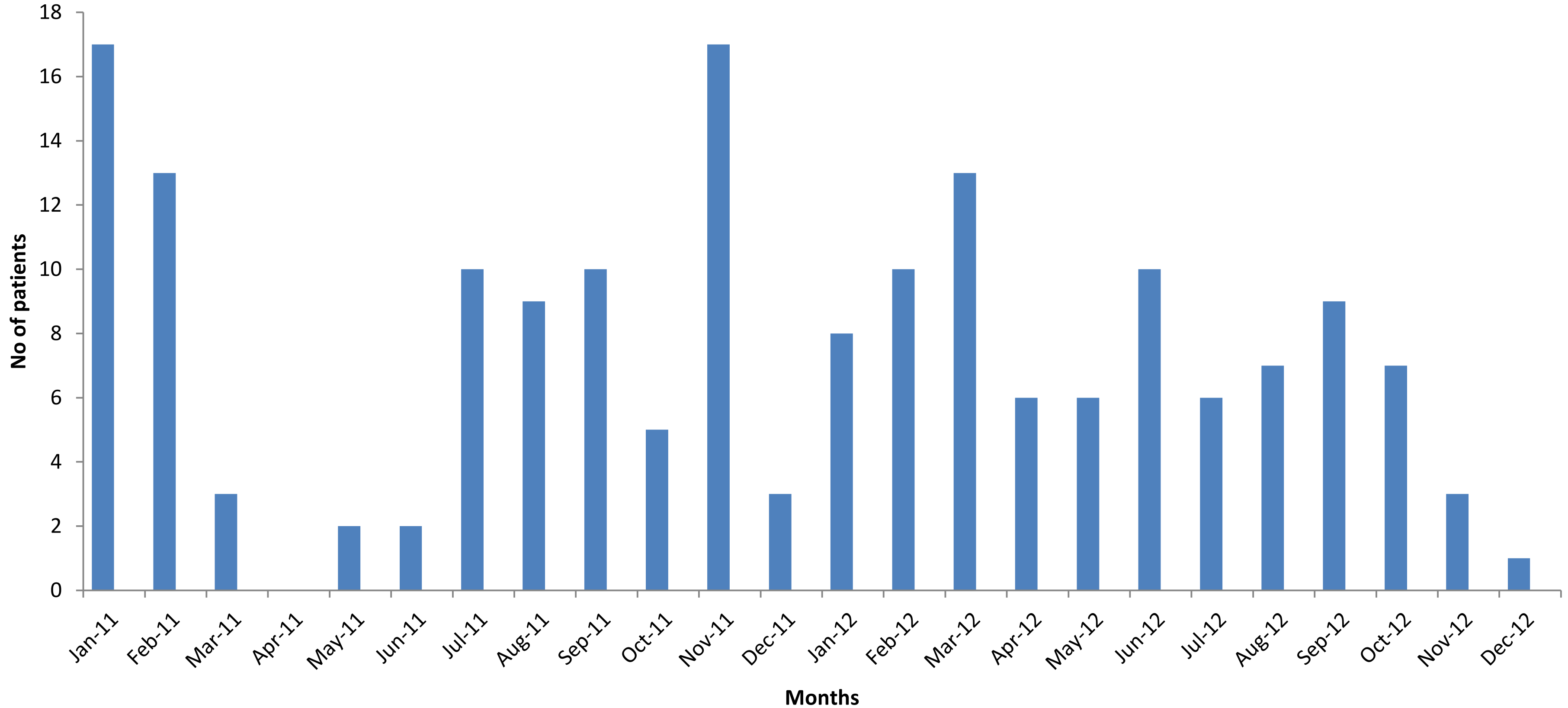
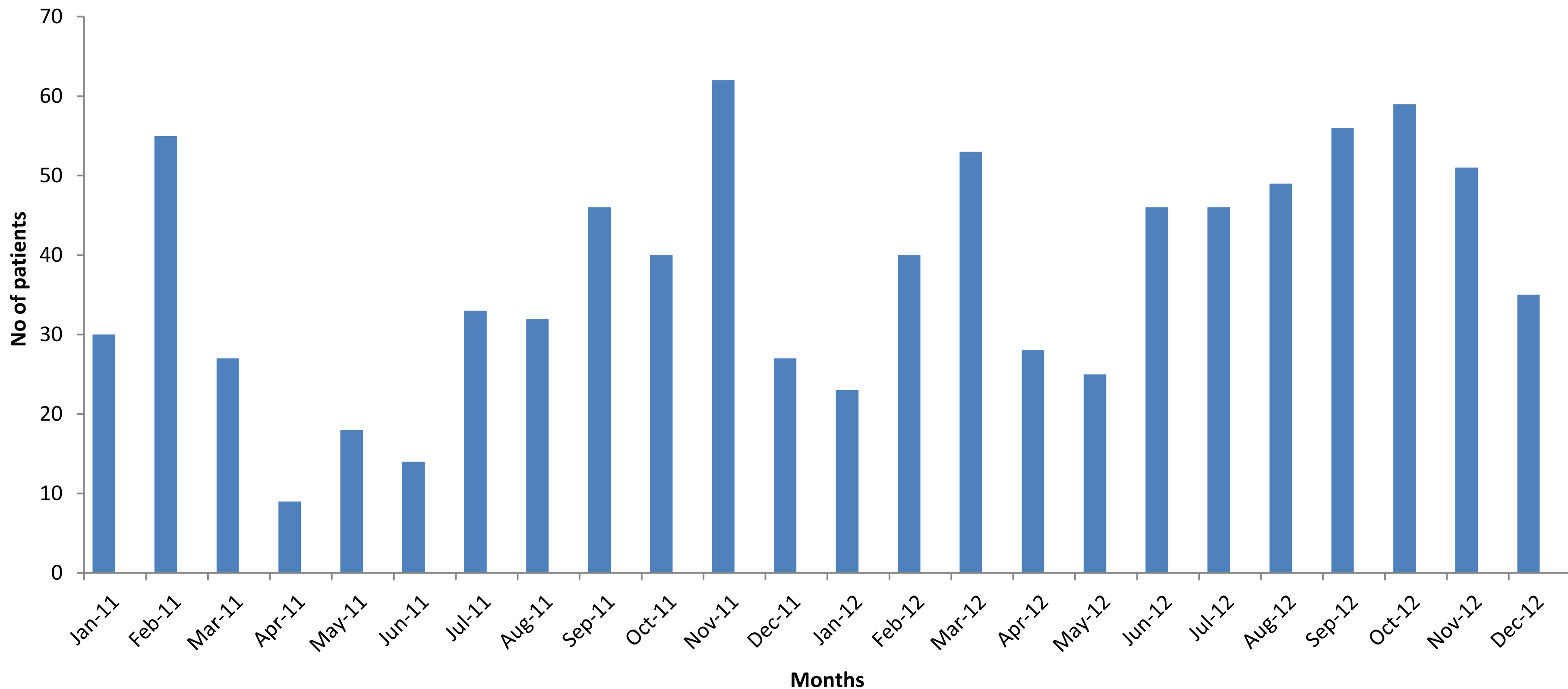


Fig 2: Follow-up visits within the first 24 months



LIMITATIONS

- Funds
- Training
- Personnel
- Prevailing sociocultural beliefs

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Next Steps

- Follow-up training of PHC workers
- Continuous Monitoring and evaluation
- To explore support from institutional heads to improve quality of service

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RECOMMENDATIONS

- Effective MH policy, plans, strategies and necessary legislation
- Mental health units at local and national levels
- Funding for community-based services
- Curriculum review & effective training
- Cohesive & well-coordinated nationwide network

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CONCLUSION

- Integration of mental health into primary care is necessary and practicable though with some challenges
- A collaborative effort and the use of existing community- based structures are necessary for effective mental health service delivery at the grassroots.

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My little Princess

THANK YOU!

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