Decentralisation & integration of mental health care in PHC

Lessons from Rwanda
Part II

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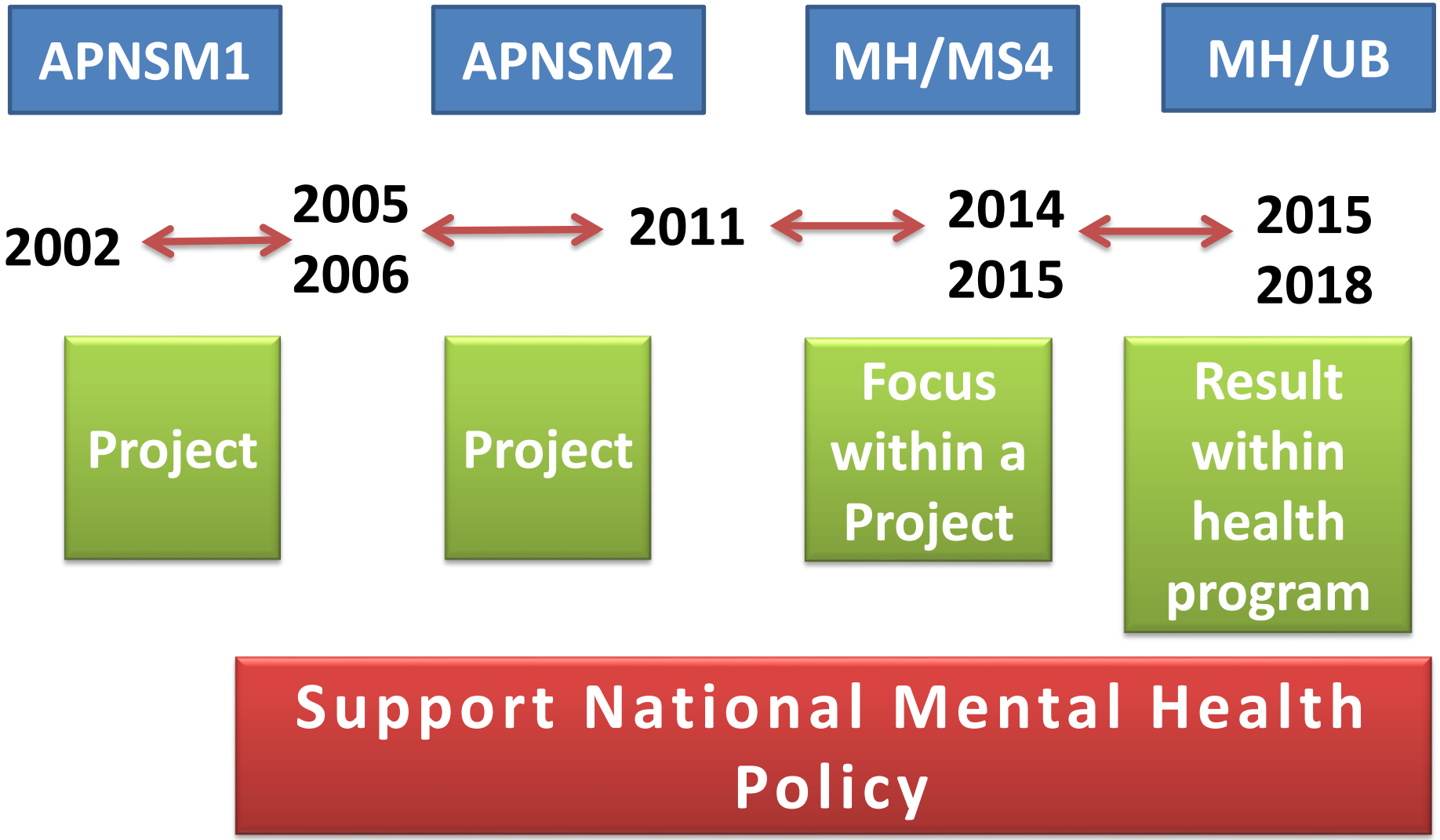
MH in Rwanda

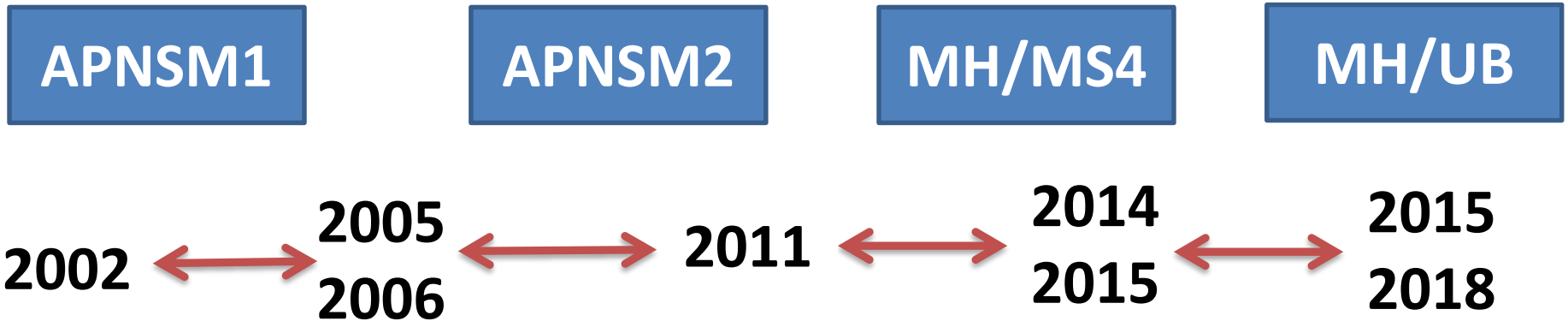
MH Intervention within Belgium Cooperation Program

MH intervention

Avant 1994	1994 ~ 2000	À partir de 2000
• Prises en charge traditionnelles et religieuses	• Interventions centrées principalement sur les psycho traumatismes	• **Soins de SM intégrés** dans le système de santé cib **les problèmes pri de SM**
• Hôpital psychiatrique	• Projets/ONG +++	• **Appuis institutionnels**
	• Option: Interventions d'urgence et ponctuelles	• Options: ***décentralisation, intégration des Soins de SM, soins ambulatoires, approche communautaire***
Isolement	**Prises en charge ponctuelles**	**Prise en charge globale, renforcement du système de santé**

Appui via BTC


APNSM1
APNSM2
MH/MS4
MH/UB
2002
2005
2006
2011
2014
2015
2015
2018
Project
Project
Focus within a Project
Result within health program
Support National Mental Health Policy


APNSM1
APNSM2
MH/MS4
MH/UB
2002
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Psychological support in the framework of the Gaçaça process,
Training of the first general nurses frome DHs
Decentralization and integration of MHcare in general care
Strengthening the integration of MH care
Setting up Specialization
Quality
Strengthening mental health care provision
Drug abuse issues
- strengthening the health system
- ambulatory & community MH care

- Decentralization and Integration of Mental Health Care in General Care
  - via
- Supporting Mental Health Division
- Strengthening Reference Settings in MH

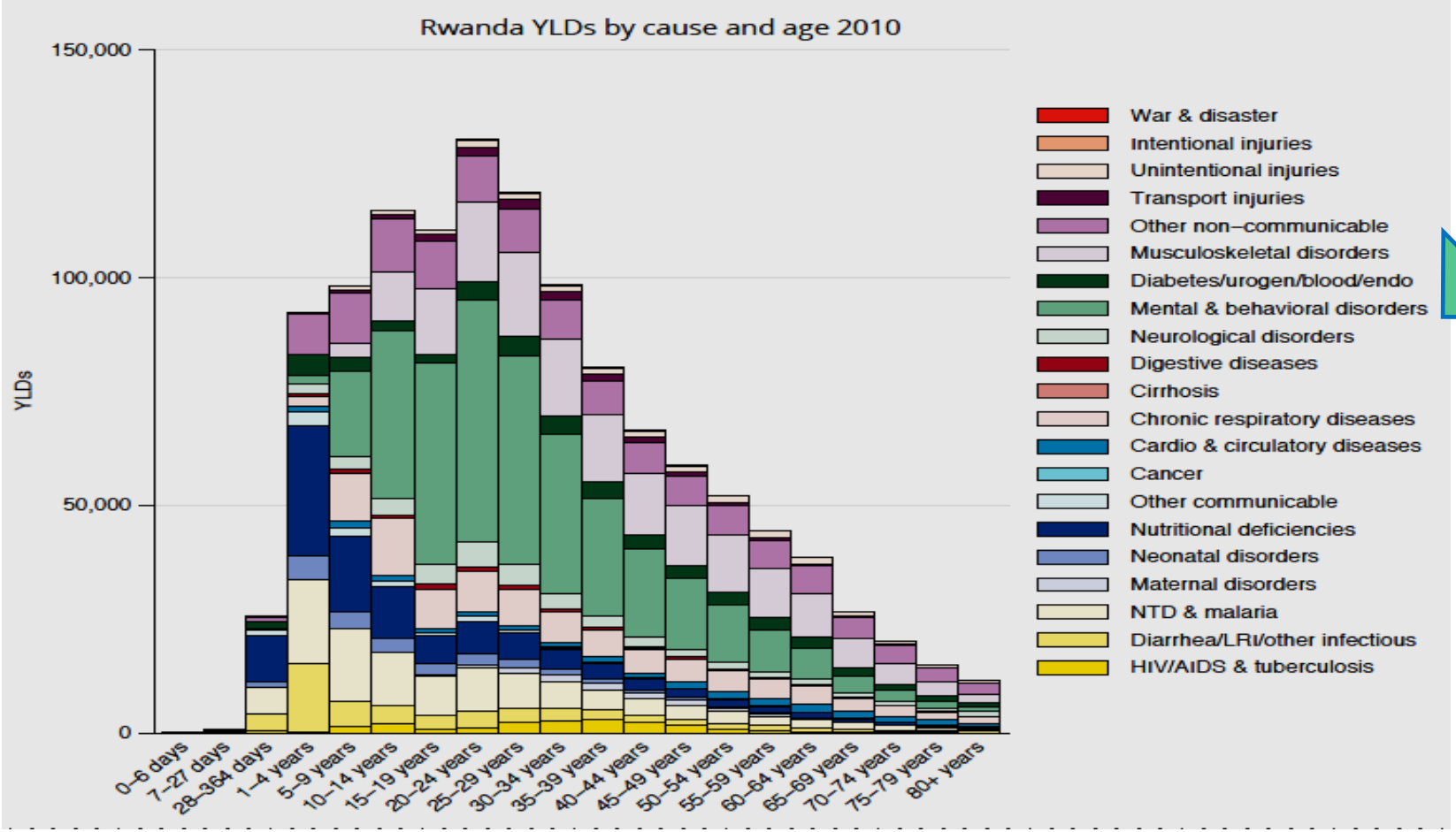
MH in Rwanda

MENTAL HEALTH CONTEXT

Rwanda faces an exceptionally large burden of mental disorders

Major depression and anxiety disorders lead the top five causes of years lived with disability (YLDs) 2010

The top five leading causes of YLDs in Rwanda are major depressive disorder, anxiety disorders, iron-deficiency anemia, low back pain, and chronic obstructive pulmonary disease. (Global Burden of Disease Study 2010 http://www.healthdata.org/sites/default/files/files/country_profiles/GBD/ihme_gbd_country_report_rwanda.pdf)



The size of the colored portion in each bar represents the number of YLDs attributable to each cause. The height of each bar shows which age groups had the most YLDs in 2010.

- **Post-Traumatic Stress Disorder (PTSD):**

- 26.1% of general adult population (N. Munyandamutsa &al. 2009)

- Significant rate of co-morbidities

  Major depression: 68.4%
  Alcohol dependence: 10% Headaches: 72%

- US: 5% of men and 10-12% of women have suffered or are suffering from PTSD and for several years[1]

- Populations that experienced extreme situations between 1997 and 1999: prevalence of PTSD
  - 17.8% (Gaza)[2]
  - 37.4% (Algeria)[4]
  - The Balkans, which was also exposed to a genocidal civil war, prevalence of PTSD of 23.5% was found among the civilian population in Kosovo[3]

- **Major depressive disorders** prevalence: **15.5%** of adult population (Bolton & al. 2000) Study emphasized that depressive symptoms were strongly associated with functional impairment in performing most daily tasks

  (N. Munyandamutsa &al. **22.7%** 2009)

- **Epilepsy** prevalence: 5% of general population (Ministry of Health 2005)

- **Drug use** (Gishoma, 2012)
  More than half of the youth in the sample have used substance/drug (52.4%),
  7.46 % are dependent on alcohol, 4.88 % on tobacco and 2.54 on Cannabis.
  The age of onset is as low as 11 years

Most of mental disorders are related to the genocide in 1994 because of the magnitude of the destruction and loss

Nearly one million of people were killed during 100 days (one-seventh of the country's population).

Approximately 1.264.000 orphans (30% of children's population)

Destruction of the socio-economic system including the health system

Integrating mental health care into health system

KEY POLICY ACTIONS & STRATEGIES

Governance and leadership

- **Health Sector Policy** *(*2005): *mental health identified as a* ***priority area for intervention.*** *This policy called for the integration of mental health services in all national health system*

- **Officially-approved Mental Health Policy,** (introduced in 1995 and reviewed in 2011):
  - Initiated a process of decentralisation
  - Shift of services and resources from mental hospitals to community mental health facilities; integration of mental health services into primary care**.**

Key strategies

- Inclusion of mental health as part of the healthcare package at DHs & HCs;
- Establishing mental health units in all district hospitals;
- Introduction of psychiatric nurse practitioners in district hospitals to provide community mental health care: task shifting;
- Training general health professionals: at least 1 GN and 1GP/DH, at least 2 GN/HC, at least 1 CHW/village to provide community

- Establishing a cascade supervision and mentorship system
- Avail of Psychotropic medicines in primary care;
- Integrating mental health care and psychotropic medicine into the community-based health insurance scheme to improve accessibility and reinforce equity
- Launching a specialisation programme in psychiatry to improve quality of care
- Arising awareness on MH & drug use issues
- Integrating mental health indicators into monitoring and evaluation systems.
- Developing Mental Health Law

Decentralisation & Integration of mental health care into health system

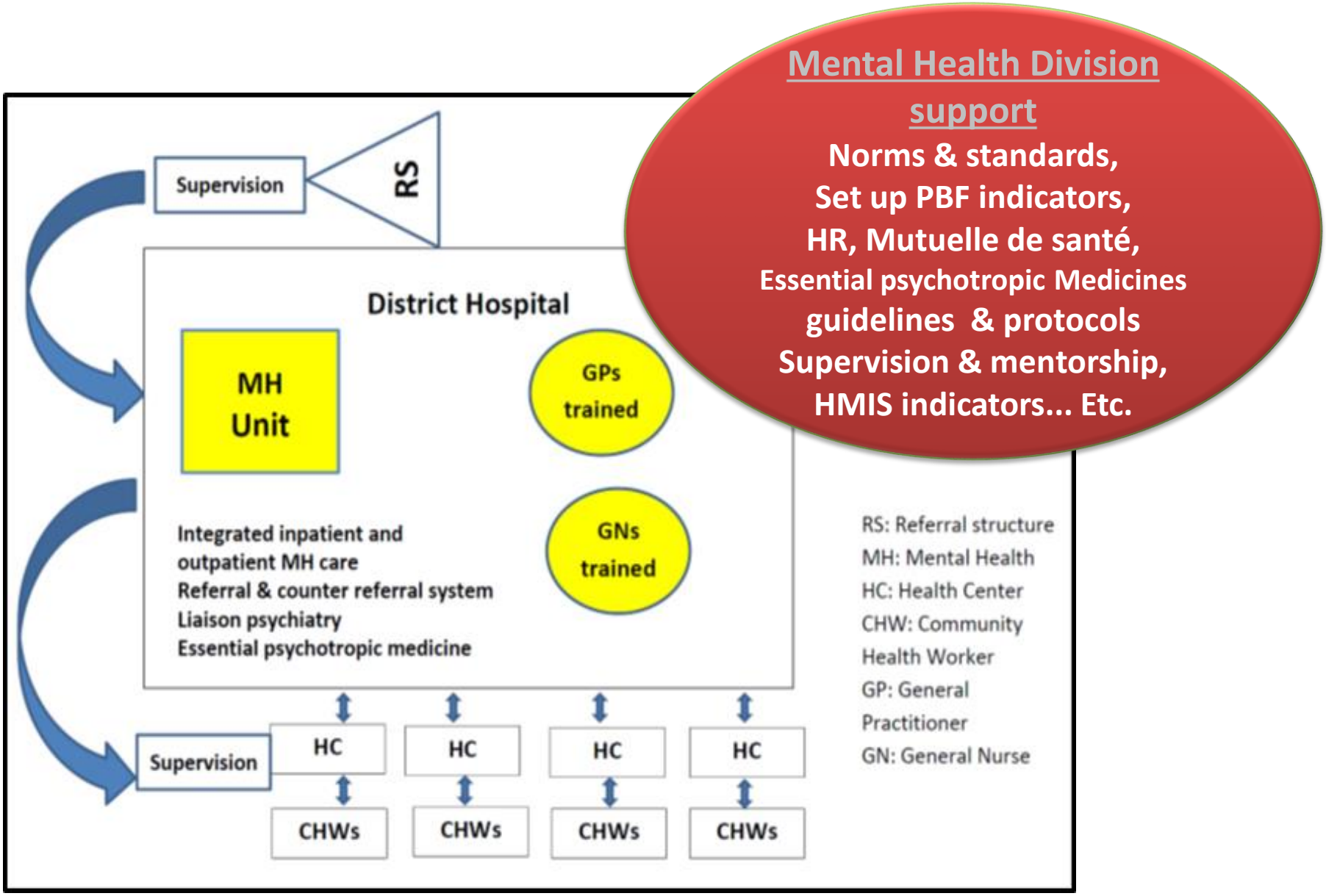
KEY PROGRESS & IMPLEMENTATION

Key Progress in the integration of MH care

1 - Mental health services are effectively decentralised & MH

- DH & PH (43), through Mental Health Unit, delivers a comprehensive mental health care package
- Staff: 2 mental health nurses +/- 1 psychologist
- MH units are mentored and supervised by teams from national level. In turn, psychiatric nurses from DH mental health units supervise HCs.
- Protocols and guidelines: established

Mental health care set up in District Hospital



2 - Major steps taken to integrate MH care in HCs to allow MH treatment accessible in primary care

- HCs: at least one General Nurse trained in MH
- More than 15000 CHWs trained in MH to fight against stigma, early detection of mental health problems and to orient families and patients throughout the MH care system.
- Huge number of volunteers (non health professionals) trained each year, countrywide, in the commemoration context

3 – MH care integrated in CBHI scheme and Psychotropic drugs available and integrated in the national LEM

4 -Mental health system monitored using HMIS indicators

8 - Training of health professional increased and improved:

- How to deal with common MH disorders: GPs, General Nurses from DHs, Genera l Nurses from HCs
- Interpretation of EEG

9 - Training psychiatrists started in Rwanda at UR: First 3 psychiatrists graduated and 11 students enrolled in the program

10 - Efforts to educate public about mental health and drug use issues: Wide sensitisation program is carried out by RBC/MH

psychiatrist	0	10
neurologist	0	4(Ndera1, CHUK1, CHUB2)
Psychiatric nurse	0	500
clinical psychologists	0	>2000
G.Nurse trained in HCs	0	500
CHWs trained	0	15000
Hospital providing MH care	1 (Ndera)	45
Psychotropic drug on LME	0	22 including anti epileptic drugs

Reinforcing accessibility and equity

- Decentralization of mental health care has increased geographic accessibility and reduced transfers to mental health reference structures

Year	2008	2009	2012	2013	2015 HMIS	2016 HMIS
Number of MH Units	23	(27/32)	43	43	43	43
Outpatient New cases	-	-	28 461	26 757	33 241	26 060
Total consultation visits (new and old cases)	**19 000**	**31 520**	**129 387**	**135 413**	**184 240**	**201 902**
Inpatient MH care	-	2 240	1 518	1 158	3 152	3 236
Transfers	-	640	-	639	817	779

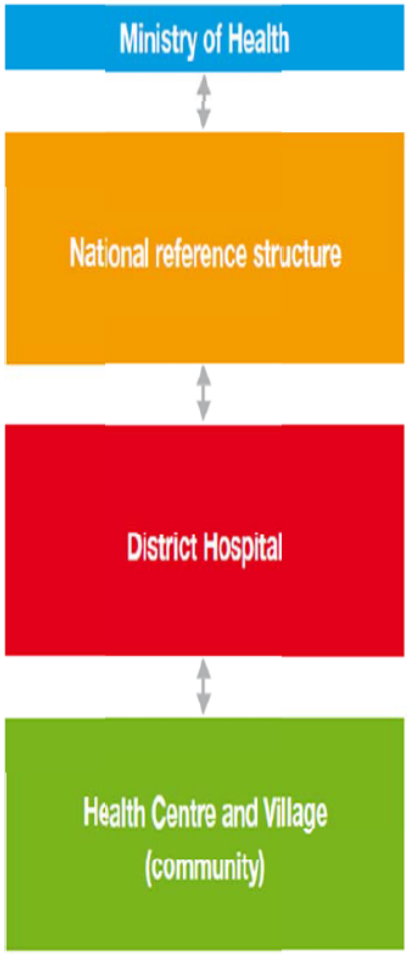
Number of mental health consultation visits in Health Centers: 2015, 2016

	2015		2016	
Disorders	**Visits**	**%**	**Visits**	**%**
Epilepsy	39251	0.65	54272	0.66
Other Psychological problems	20402	0.34	28084	0.34
Suicide attempted or successful	402	0.01	413	0.00
GT	**60055**	**1.00**	**82769**	**1.00**

Total mental health consultation visits in all health facilities: 2015, 2016

Year	Ndera	RH	PH	DH	HC	Total
Visits 2016	57760	27594	6849	80283	82769	**255255**
	0.23	0.11	0.03	0.31	0.32	1.00
Visits 2015		30394	7664	82580	60055	**180693**
	0.00	0.17	0.04	0.46	0.33	1.00

Human resources at all levels of health system



Mental Health Division: in charge of implementation of the national mental health policy	3units: Psychiatric Care Unit, Community MH Unit & Fight against Drug Abuse Unit
- Mentorship & weekly formative supervision - Third cycle psychiatry specialisation - Responsible for supervision of MH units in DHs	- 2 National reference structures including 1 unit dedicated to drug abuse and alcohol treatment - 7 psychiatrists (in 2018 there will be 15 up from zero psychiatrists in 2000). 6 GPS, 76 Psychiatric nurses, 8 psychologists
- 43 MH Units providing MH care in DHs - Outpatient & inpatient MH care & referral - Formative supervision - Protocols & Guidelines - Specific essential psychotropic medicine list - Responsible for supervision of health centers	- 64 psychiatric nurses, 41 psychologists - 158 GP and 216 nurses trained to deal with common mental disorders - Per DH, at least one GP gets hands-on training.
- HC: GNs trained to deal with common mental disorders, Specific essential psychotropic medicine list, and referral - CHWs: Fighting against stigma, earlier detection, orientation patients and their families in the health care system - Volunteers from civil society: providing psychological support during genocide commemoration periods	- 766 GNs trained in HC, Objective: 2 per HC - More than 15000 CHWs trained, at least one per village - Many volunteers trained each year: NGOs, RRC, RNP, AERG,

11 – Launching a Program on prevention against drug abuse

12 - Promoting human rights and regulation of MH practice: Mental Health Law in process to be adopted

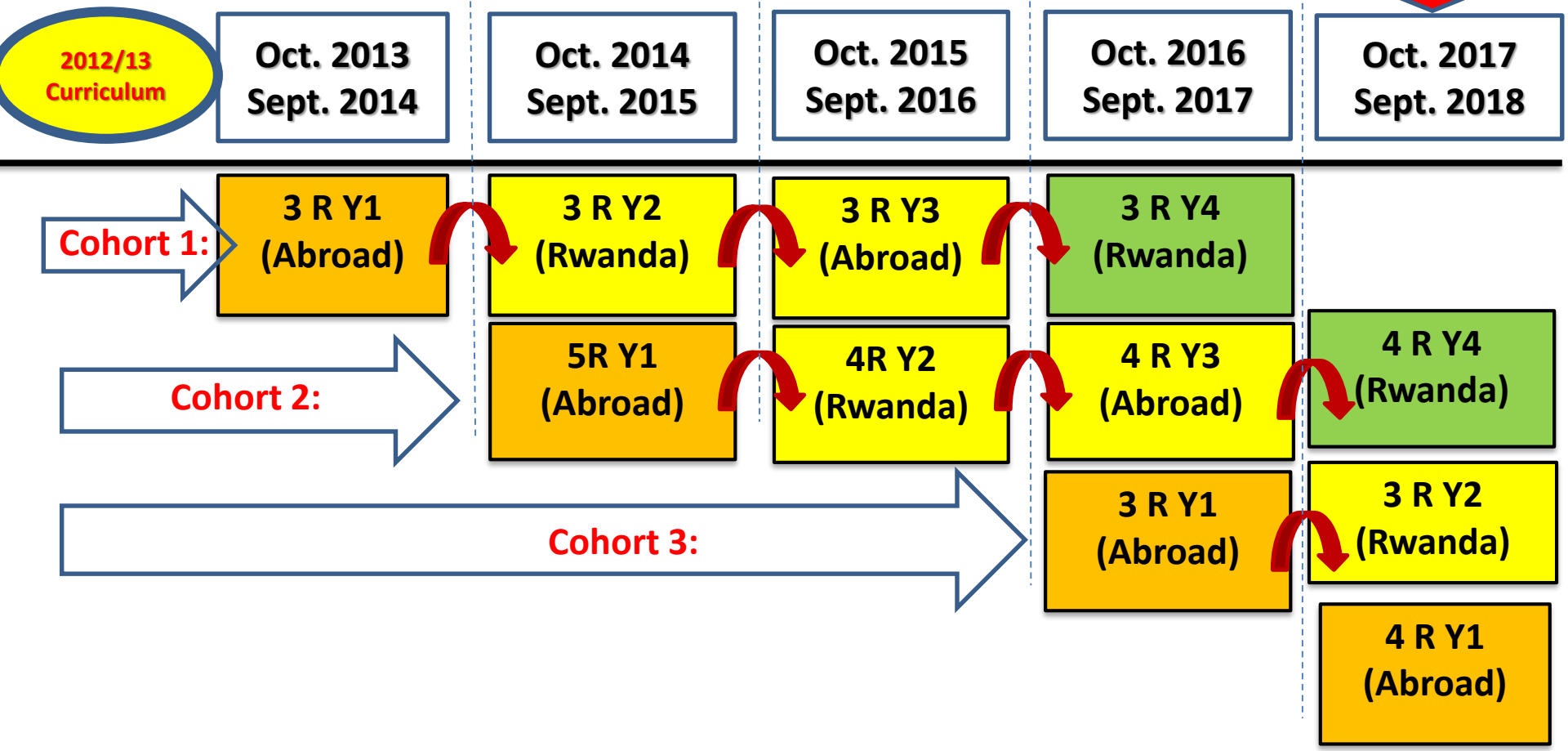
13 – Intersectoral collaboration: Links with other governmental and nongovernmental institutions increased

- Support trauma victims during genocide commemorations
- Program against drug abuse
- Integration MH component in care provided to people living with HIV/Aids
- Others

Reinforcing quality of care and providing specialized mental health care

- MMed Psychiatry: Orientation: “General Psychiatry”
- Cascade supervision system
- Continuous training (CPD Program)
- 2,427 Rwandans have received degrees in clinical psychology
- 345 psychiatric nurses trained by 2013

MMed PSY progress implementation



KEY LESSONS LEARNT

PARTAGÉ AVEC L'ÉQUIPE DE:
"REDUCED PREMATURE MORTALITY IN RWANDA: LESSONS FROM SUCCESS
BMJ 2013;346:F65 DOI: 10.1136/BMJ.F65 (PUBLISHED 18 JANUARY 2013)

Key lessons learnt

National leadership & Governance

- High level political commitment to equity and to service delivery

- Mental health identified as a priority area for intervention within the Health Sector Policy

  National mental health policy and a clear plan for action

- Establishment of a mental health division within the Ministry of health;

***Country ownership*—**Health system spending managed by or in partnership with national and local government

Health systems approach— disease specific or other "vertical" programes to build and strengthen platforms for integrated service delivery

- Inclusion of mental health as part of the basic health package
- Integrating mental health care into the community-based health insurance scheme,
- Training non specialists & task shifting

Community based care — For example, using community health workers to increase the effectiveness and efficiency of care delivery,

Training non specialists & task shifting make really difference

Cross-sector collaboration— Strengthening health systems with partnerships across sectors and ministries

MAIN CHALLENGES & PERSPECTIVES

Challenges

- Low awareness in general population including educated
- Insufficiency of funds allocated to mental health
- Insufficiency of qualified MH professional
- Drug abuse issues
- Lack of community services (rehabilitation)
- New features of PTSD: (In very young born after genocide)

Perspectives

- Compléter l'offre de soins de santé mentale en ambulatoire en introduisant des modalités de prise en charge encore inexistantes ou à l'état embryonnaire: urgences psychiatriques, soins de jour, soins pour enfants et adolescents; soins pour toxicomanes

- Lancer les Services de Santé Mentale au niveau des nouveaux Hôpitaux de référence et des Hôpitaux Provinciaux

Niveau périphérique:

- Aller plus loin dans l'intégration dans les soins généraux particulièrement concernant la prise en charge de l'épilepsie

- Renforcer la SM au niveau des CS et de la communauté

Autres

- Mise en place de la loi sur la SM (draft existe)
- Renforcer la coordination intersectorielle et programme santé
  - Problèmes spécifiques: consommation de drogues, trauma, HIV/SIDA
  - cibler les milieux spécifiques: milieu scolaire, milieu pénitentiaire, milieux de jeunes

Thank you