CLINTON HEALTH ACCESS INITIATIVE

Why mental health medicines don't reach patients: lessons from five African countries

November 2026



Photo: Olivier Mugwiza

About this report

Over the past year, CHAI worked closely with the governments of Ethiopia, Nigeria, Rwanda, South Africa, and Ghana to identify why mental health medicines so often fail to reach the people who need them. This report shares what CHAI found, what governments have already done in response, and where further action is needed. This work was funded by Wellcome and carried out in partnership with MedAccess.

Executive summary

Safe, effective medicines for anxiety, depression, bipolar disorder, and schizophrenia have existed for decades, and many are affordable. Haloperidol, one of the most widely used antipsychotics, illustrates the point: a year of treatment costs between US$3 and US$14 per patient.[1] Yet in low-income countries, fewer than one in ten people living with psychosis receive care.[2] A one-year pathfinding program across Ethiopia, Nigeria, Rwanda, and South Africa, joined by Ghana in mid-2026, found the obstacles to access lie in how medicines are priced, bought, supplied, and prescribed, and that these problems reinforce one another. Small mental health medicine budgets lead to small, irregular orders that draw few supplier bids, keeping prices high and stock unreliable. As a result, clinicians prescribe less, and the low use that follows is recorded as low demand and used to inform the next budget. Each finding below describes a point where this cycle can be broken and where governments have already begun to act.

Prices for the same medicine vary severalfold, between countries and over time. Governments usually purchase medicines through tenders, in which suppliers compete to win a contract, but prices can differ widely. Risperidone, an antipsychotic used to treat schizophrenia and bipolar disorder, cost 10 times more per patient-year in one Nigerian facility than in South Africa's 2026 national tender. The program identified two main reasons. First, prices fall where suppliers compete. In South Africa's tenders, the price of aripiprazole fell 76 percent once two new suppliers started competing for the government's business. Many medicines currently have too few suppliers to generate robust competition: in Ethiopia, 35 percent of mental health medicines have only one registered supplier. Second, small order quantities can deter suppliers. In Rwanda, purchases of the antidepressant fluoxetine fell from 1.7 million to 100,000 tablets, and the price per tablet rose eightfold, as small orders failed to meet some suppliers' minimum order quantities or deliver economies of scale. In Ghana, the program found some tenders received no supplier responses at all, leaving the government unable to purchase those medicines.

Medicines are often forecast, funded, and procured based on past use, not need. Governments typically estimate how much medicine to buy and set budgets based on how much was used the year before. But past use understates need because stockouts and insufficient treatment coverage keep consumption low, leaving budgets and orders small year after year. Some requests are only partly funded. In Ghana, the Mental Health Authority (MHA) received on average 22 percent of the funding it requested for psychotropic medicines between 2018 and 2025, and facilities reported receiving only 20 to 30 percent of the quantities they requested. South Africa has up-to-date consumption data, with suppliers reporting deliveries monthly, but mental health forecasts are built on past use, and the data needed to estimate need has gaps. In Ethiopia, facilities collected

[1] Based on 5 mg tablets at a 10 mg daily dose across Ethiopia, Nigeria, Rwanda, and South Africa.
[2] Mental health atlas 2024. Geneva: World Health Organization; 2025.

less than half of the forecast quantity for 36 of 43 tracked medicines, even though 30 were in stock at national warehouses, reflecting limited stock visibility across the supply chain and constrained facility budgets.

Few people access long-acting injectables (LAIs), especially second-generation ones. Most antipsychotic medicines are taken as daily tablets. LAIs, given every two or four weeks, can help people stay on treatment and reduce relapses and hospital stays, yet few people in low- and middle-income countries can access them. The two types of LAIs face different problems. Older (first-generation) LAIs can be a cheaper option but are not always included in supply catalogs and treatment guidelines. Newer (second-generation) LAIs tend to have fewer of the adverse side effects that can drive people off treatment. But second-generation LAIs are priced far above the US$1.50 to US$5 per injection at which they would be cost-effective. Across countries, the program found public purchase records for a second-generation LAI only in Nigeria, where procurement data from six of the country's 10 Federal Neuropsychiatric Hospitals showed four public facilities buying paliperidone palmitate. People with lived experience who advised the program saw promise in LAIs for adherence and autonomy, provided they are offered as one treatment option with informed consent. CHAI and MedAccess aim to bring second-generation LAI prices down to cost-effective levels, which would make them a realistic option for public health systems in low- and middle-income countries.

Medicines on essential medicines lists often cannot be ordered or prescribed. Governments use essential medicines lists to set priorities for which medicines to buy. But to reach a patient, a medicine must also be registered with the regulator, added to the supply or procurement agency's catalog so facilities can order it, included in treatment guidelines so health workers may prescribe it, and covered by insurance. Each step is managed by a different institution, and a gap at any one can stop the medicine from reaching people. In Nigeria, the essential medicines list, drug formulary, insurance coverage, and clinical guidelines do not align. In Ethiopia, there is misalignment between the essential medicines list, procurement list, and treatment guidelines for second-generation LAIs. In Rwanda, treatment guidelines do not allow nurses trained to treat psychosis to initiate patients on antipsychotics. Registered products therefore cannot be consistently procured, reimbursed, or used for treatment.

Governments are already acting on these findings. Each government tested the program's findings against its own data, and the same patterns appeared to varying degrees in all five countries. Ethiopia, Nigeria, and Rwanda are building the findings into national strategies to improve medicine access. In Ethiopia, the Ethiopian Pharmaceutical Supply Service (EPSS) directed all branches nationwide to keep psychotropic medicines in uninterrupted supply, and a Ministry of Health-led stock monitoring group was established to review medicine stock status monthly from facilities and EPSS warehouses through a dedicated WhatsApp platform. At the 11 facilities reporting to that group, availability of medicines rose from 54 percent in May 2026 to 76 percent in September 2026. Rwanda launched a stock-visibility portal, and Ghana's Ministry of Health requested quantification of psychotropics to inform next year's budget.

Because the problems behind these findings are linked, further progress depends on planning budgets around need, aligning the lists that decide which medicines can be bought and prescribed, and pooling demand so that suppliers compete, with funders backing government plans until budgets and orders grow. With support from Wellcome, CHAI and MedAccess are working together to shape the market, and CHAI will continue to work alongside governments on the specific challenges each country has identified.

Why the gap in mental health persists

Nearly one billion people, one in eight worldwide, live with a mental health condition.[3] Psychotropic medicines have been widely used for decades. Antipsychotic medicines cut the risk of schizophrenia relapse by roughly half to two-thirds compared with placebo.[4] Despite the existence of affordable, proven medicines for mental health conditions, mental health receives less than 1.5 percent of total health expenditure in many low- and middle-income countries.[5]

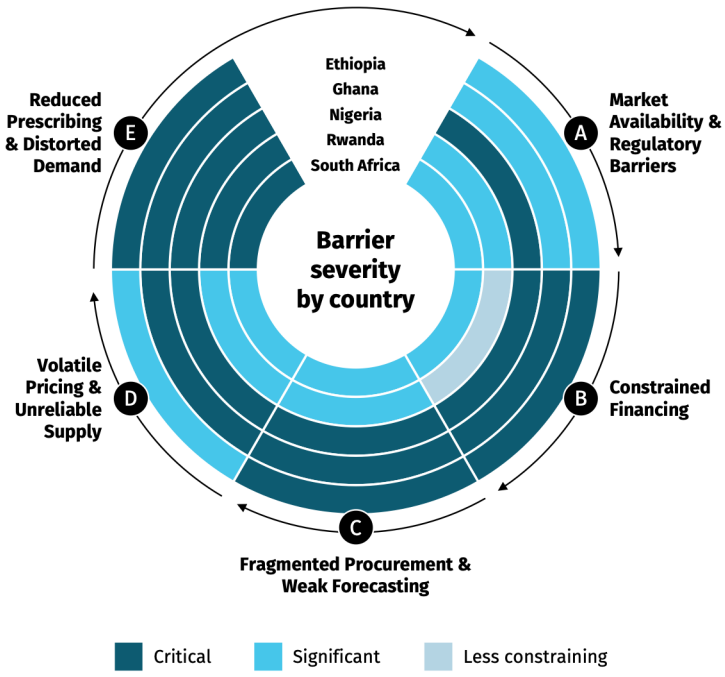
Across the findings below, CHAI identified five cross-cutting barriers that keep medicines from reaching people (Figure 1). In every program country, CHAI found these barriers reinforced one another. Mental health receives a small share of health budgets, leaving medicine orders small and irregular. Limited and inconsistent orders attract few suppliers, leaving prices high and supply unreliable. When medicines are out of stock, clinicians prescribe less and patients stop treatment. The resulting low use is recorded as low demand, which informs the next budget.

The barriers in this cycle limit access to psychotropic medicines in each country, at different levels of severity (Figure 1). Reduced prescribing and distorted demand is the only barrier rated critical in all five countries, as a lack of prescribers, scope-of-practice rules at lower levels of care, and stigma hold back use even where medicines are available and in stock. Financing, procurement, and pricing are critical in three countries.

Figure 1: Interrelated cross-cutting barriers and their severity by country, as rated by CHAI and validated by governments. Each finding below touches one or more barriers, as noted under its heading.

Interrelated cross-cutting access barriers to medicine access

- **A Market Availability & Regulatory Barriers**
  Well-established medicines do not yet exist, or face regulatory challenges in entering markets
- **B Constrained Financing**
  ...products are deprioritized, and limited, variable budgets are under- or mis-allocated against need...
- **C Fragmented Procurement & Weak Forecasting**
  ...resulting in unpredictable purchasing across uncoordinated buyers with systematically underforecasted demand...
- **D Volatile Pricing & Unreliable Supply**
  ...causing increased supplier risk and higher, more volatile prices, limited availability, or disengagement...
- **E Reduced Prescribing & Distorted Demand**
  ...eroding clinician confidence and patient trust, decreasing utilization, and further mis-signaling needs...



[3] World mental health report: transforming mental health for all. Geneva: World Health Organization; 2022.
[4] Leucht S, Tardy M, Komossa K, Heres S, Kissling W, Salanti G, et al. Antipsychotic drugs versus placebo for relapse prevention in schizophrenia: a systematic review and meta-analysis. Lancet. 2012;379(9831):2063–71.
[5] Mental health atlas 2024. Geneva: World Health Organization; 2025.

Key findings and recommendations

Prices for the same medicine vary severalfold, between countries and over time

Prices for the same product vary widely between countries, with much of the variation reflecting small volumes, emergency purchases, and limited buyer visibility. Risperidone, an antipsychotic used to treat schizophrenia and bipolar disorder, cost 10 times more per patient-year in one Nigerian facility than in South Africa's 2026 national tender. CHAI found that supplier competition is a major driver of what governments pay, and that small orders deter competition.

Prices fall where suppliers compete, because incumbents must cut prices to retain share when new suppliers enter a tender, while a sole supplier faces no such pressure. In South Africa's public tenders, the price of aripiprazole fell 76 percent per tablet between the 2021 and 2023 rounds as two new suppliers displaced the incumbent. Over the same period, the price of amisulpride, supplied by a single company, rose 10 percent. A price adjustment to that 2023 contract in March 2026 added a further 11 percent, roughly in line with inflation. When a new supplier won the 2026 tender two months later, the price fell 17 percent from the adjusted level, back to around where it stood in 2021. For many medicines, the supplier base is too narrow for competition to take hold. In Ethiopia, more than a third of mental health medicines have only one registered supplier.

Small orders are commercially unattractive to suppliers, because the fixed costs of a production run, shipping, and preparing a bid are spread over few units, and larger orders are available elsewhere in the global market. Suppliers set minimum order quantities for this reason, and tenders that fall below them can go unanswered. Rwanda Medical Supply reported in May 2026 that 20 of the 68 mental health line items it manages were in total stockout and being re-tendered. In at least some cases, this was due to tenders failing because order volumes fell below suppliers' minimum order quantities. When volumes shrink, unit prices rise. Rwanda Medical Supply's fluoxetine purchases fell from about 1.7 million to about 100,000 tablets between 2022 and 2025, and the average price rose roughly eightfold, from about 1.5 to 12.6 US cents per tablet. In Ghana, some tenders drew no bids, as small and irregular orders, foreign exchange volatility, registration and assurance requirements, and delayed procurement processes created an unattractive market for suppliers. Because of this, governments end up paying more for the same medicines, and some go unpurchased altogether.

BARRIERS

D

- *Volatile Pricing & Unreliable Supply*

RECOMMENDATIONS

Make prices visible, improve tender terms, and pool demand across facilities or across countries. Shared price, volume, and supplier data would let a procurement officer in Kigali or Abuja judge an offer against what Pretoria paid. Pooled orders lift volumes above suppliers' production minimums and give suppliers greater commercial incentive to register and bid. Predictable schedules and reliable payment reduce the cost and risk of supplying these markets, which can lower prices and create steady supply.

EARLY PROGRESS

Manufacturer engagement: CHAI and MedAccess began engaging manufacturers in July 2026 and have signed three nondisclosure agreements to explore how medicines can be supplied in program countries at sustainable prices.

Medicines are often forecast, funded, and procured based on past use, not need

In every program country, forecasts rely on historical consumption, and budgets, where they exist, are informed by past spending. Where mental health resources are scarce and prescribers are limited, investment is cyclically constrained by reduced prescribing, low purchase volumes, and stockouts. As a result, each year's plan understates true demand, and the shortfall is carried into the next year. Gaps in stock and patient data make the shortfall hard to see and correct.

Requests built on suppressed consumption already significantly understate need, and in some countries even these are only partly funded. In Ethiopia, forecasts are based on historical consumption, which stockouts and stockout-driven prescribing patterns have suppressed, so order quantities remain low. In Ghana, the MHA received on average 22 percent of the psychotropic funding it requested between 2018 and 2025, and facilities reported receiving only 20 to 30 percent of the quantities requested. In South Africa, suppliers report deliveries monthly, so consumption data is current, but it reflects the patients currently reached rather than total need, and mental health forecasts are built on it. Comprehensive patient-level data is not available in the public sector, and the most recent national prevalence estimates are from the 2002–2003 South African Stress and Health study, the country's first national mental health survey.

Without visibility of stock and patients, planners cannot see where medicines are needed, and without coordinated purchasing, orders remain small and fragmented across facilities. In Ethiopia, 30 of 43 tracked medicines were in stock at national warehouses, yet for 36 of the 43, facilities collected less than half of what they had forecast, reflecting weak stock visibility between EPSS and health facilities and constrained facility budgets. In Nigeria, the national logistics system that tracks HIV, tuberculosis, malaria, and essential medicines does not cover mental health, so there is no national data on psychotropic stock or consumption. Rwanda has no health information system indicator for patients on or in need of medicines, so there is no routine measure of need to plan against. As a result, shortfalls stay hidden, and each year's budget repeats the last.

BARRIERS

B C E

- *Constrained Financing*
- *Fragmented Procurement & Weak Forecasting*
- *Reduced Prescribing & Distorted Demand*

RECOMMENDATIONS

Base forecasts and budgets on estimated need as well as past use, and track stock and patients so that supply follows need.

EARLY PROGRESS

Ethiopia: Following government-led workshops with CHAI in early 2026, Ethiopian facilities left with action plans to revise their medicine lists and improve quantification, and experts were deployed to provide site-level quantification support. EPSS directed all its branches nationwide to closely monitor psychotropic medicine supply and maintain it without interruption, and a Ministry of Health-led group now reviews monthly stock data from facilities and EPSS warehouses. At the 11 high-volume facilities reporting to the group, availability of a 33-item list of mental health medicines rose from 54 percent in May to 76 percent in September 2026.

Few people access LAIs, especially second-generation ones

Most antipsychotic medicines are taken as tablets every day. LAIs are formulations of the same or similar medicines, given as an injection that releases the medicine slowly over two or four weeks, so a patient needs a dose only once or twice a month. They can improve adherence and reduce relapse and hospital use, yet few patients in the program countries can access them.

The public sector rarely buys second-generation LAIs, and where it does, it pays many times the price at which they would be cost-effective. In Nigeria, four public facilities paid around US$3,500 per patient-year for paliperidone palmitate, according to procurement data from six of the country's 10 Federal Neuropsychiatric Hospitals. These were the only public purchase records for a second-generation LAI the program found. Second-generation LAIs would be cost-effective at roughly US$1.50 to US$5 per injection, and current prices are one to two orders of magnitude higher. In Ethiopia, paliperidone palmitate would be cost-effective at about US$1.59 per injection, against the roughly US$289 per injection paid by Nigerian facilities. The risperidone depot is on Ethiopia's 2024 essential medicines list but not on the EPSS procurement list, largely because of its cost.

Comparing LAIs with tablets means weighing the full cost of treatment and the health gained across first- and second-generation tablets and LAIs. Medicine prices alone can mislead, because medicines are only a small share of the total cost of treatment; health worker time and the management of side effects make up most of the rest. Each injection must be given by a health worker every two to four weeks, while better adherence can mean fewer relapses and hospital stays. For maintenance treatment, the program's cost-effectiveness model found that haloperidol decanoate, a first-generation LAI, cost about US$64 per patient per year in Ethiopia against US$115 with oral risperidone, and US$88 in Rwanda against US$171 with oral olanzapine, with similar health outcomes on trial evidence. LAIs of both generations may have a larger role, but the market for them in sub-Saharan Africa is small and immature, particularly for second-generation products, and older depots are not always included in supply catalogs or treatment guidelines.

BARRIERS

A D

- *Market Availability & Regulatory Barriers*
- *Volatile Pricing & Unreliable Supply*

RECOMMENDATIONS

Secure supply of older injectables and agree on prices for newer ones that match their value. Older depots need to be included in treatment guidelines and, where missing, in essential medicines lists and supply catalogs. Tablets of the same medicines must remain available too, because LAIs add to the oral options rather than replacing them.

EARLY PROGRESS

Ethiopia and Rwanda: In September 2026, Ethiopia and Rwanda validated the program's cost-effectiveness findings. Rwanda will use a cost-effectiveness tool built by the program to introduce LAIs. In Ethiopia, validation workshop participants recommended refining the tool to compare LAIs more fully, so it can inform future revisions of the essential medicines list and treatment guidelines.

People with lived experience see promise in LAIs, with safeguards. Members of the program's Lived Experience Council, a group of individuals living with mental health conditions across program countries who advised the program throughout, shared that older medicines with severe side effects can drive people off treatment. The Council saw promise in LAIs for adherence and autonomy, while noting that a depot cannot be withdrawn if side effects appear, so monitoring must be in place before it is given. The Council viewed injectables as one treatment option, offered with informed consent and choice.

For LAIs, and for mental health medicines more widely, cost-effectiveness analysis that accounts for the full cost of treatment and the health gained is not yet routinely used in public-sector procurement decisions. Built into procurement, it can show governments which options deliver the most health for a given budget, and the prices at which newer products become cost-effective.

Medicines on essential medicines lists often cannot be ordered or prescribed

Governments use essential medicines lists to prioritize the medicines that best meet their populations' health needs based on efficacy, safety, and cost, and to guide procurement, supply, and reimbursement. To reach a person, a listed medicine must clear several steps, each owned by a different institution (Figure 2). A medicine must be registered with the regulator, added to the supply agency's procurement catalog, included in treatment guidelines that authorize health workers to prescribe it, and covered by insurance or reimbursement lists. Misalignment at any step can stop a medicine from being ordered or prescribed, and the resulting low use is recorded as weak demand that shapes future planning.

First, because each list is managed by a different institution, a medicine added to the essential medicines list is not automatically added to the procurement catalog (step 3), formulary, or reimbursement list (step 5). In Nigeria, misalignment was found across the essential medicines list, the National Drug Formulary, national health insurance coverage, and clinical guidelines (steps 1, 4, and 5), meaning that even registered products cannot be consistently forecast, procured, or reimbursed. In South Africa, some registered medicines and formulations are not yet included in national formularies or tenders, or can be prescribed only at certain levels of care (steps 3 and 4).

BARRIERS

A E

- *Market Availability & Regulatory Barriers*
- *Reduced Prescribing & Distorted Demand*

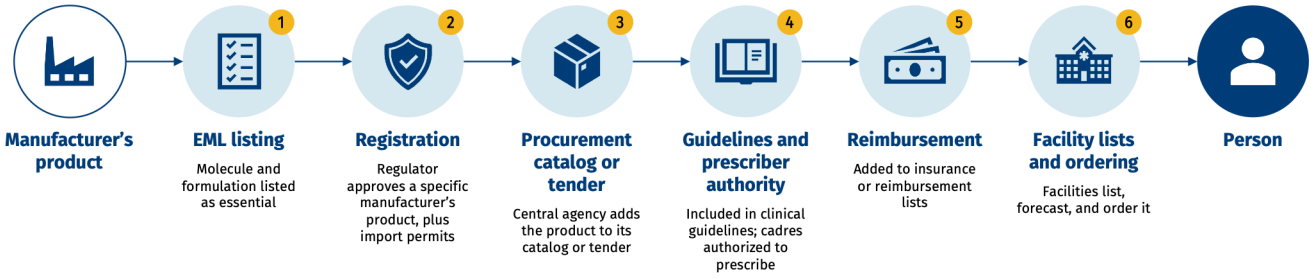
RECOMMENDATIONS

Align procurement catalogs, treatment guidelines, prescribing rights, and reimbursement lists with the national essential medicines list to close gaps.

EARLY PROGRESS

Ethiopia: Ethiopia's Ministry of Health finalized its first national standard treatment guidelines for mental health in December 2025, introducing newer-generation medicines. The guidelines are ready for rollout and give health workers a national standard for prescribing, a first step toward aligning the lists that govern medicine access.

Figure 2: Typical steps a medicine must clear to reach individuals in the public sector



Second, prescribing rights (step 4) are usually limited to doctors or specialists, who are too few to reach most patients. Nurses and other primary care workers, who are the first point of contact for most health system users, often cannot initiate or manage treatment, so patients must wait for, or travel to, a specialist. Rwanda has trained primary care nurses to treat mental health conditions under the World Health Organization (WHO) Mental Health Gap Action Programme, yet the 2022 national treatment guidelines do not authorize nurses to start patients on antipsychotics, and the guidelines do not include LAIs. Health centers must refer patients to hospitals before follow-up can resume, even when patients are stable, in a country with only 14 psychiatrists for more than 13 million people. In South Africa, medicine scheduling and scope-of-practice rules constrain prescribing and access to medicines in primary care. Nigeria has no standalone mental health treatment guidelines, so there is no agreed standard for what to prescribe at each level of care. The outcome is that medicines governments have chosen as essential often fail to reach the people they were listed for.

Governments are already acting on these findings

The findings above show where mental health medicines get stuck. Over the past year, governments in all five countries tested these findings against their own data, validated them, and began to act.

In Ethiopia, Nigeria, Rwanda, and Ghana, the institution responsible for mental health policy convened a validation workshop, with CHAI in a supporting role. South Africa validated the findings through consultations and a July 2026 convening with its National Department of Health. Participants included Ministries of Health, WHO, Africa Centres for Disease Control and Prevention (Africa CDC), regulators, supply agencies, insurers, hospitals and health facilities, and people with lived experience. Together, participants reviewed the evidence and agreed on immediate priorities to unblock obstacles to medicine access.

Governments have begun to act on the findings, with CHAI supporting. On stock availability, following government-led workshops with CHAI, Ethiopia's EPSS issued a directive to all branches nationwide to ensure uninterrupted supply of psychotropic medicines to health facilities, and a Ministry of Health-led working group was established to review monthly stock status from facilities and EPSS warehouses through WhatsApp, enabling medicines to move from warehouses to facilities. Rwanda launched a stock-visibility portal. In Ghana, the Ministry of Health asked the MHA for the psychotropic allocations needed for next year's budget, and the MHA delivered the estimate within two weeks, with CHAI supporting the quantification. On LAIs, Ethiopia and Rwanda validated the program's cost-effectiveness findings, and Rwanda will use the program's tool to introduce LAIs. On aligning medicine lists and guidelines, Ethiopia's Ministry of Health finalized its first national standard treatment guidelines for mental health in December 2025, introducing newer-generation medicines, and the guidelines are ready for rollout. Action on prices is at an earlier stage. In Ethiopia, EPSS has developed medicine markup and subsidy guidelines with CHAI, which await leadership endorsement, and CHAI and MedAccess are working on prices more broadly through discussions with manufacturers.

These steps are being built into national plans. Ethiopia is revising its 2026–2030 national strategy, Nigeria has developed the supply chain section of its first national strategic plan for 2027–2031 with CHAI support, and Rwanda has an endorsed route to include medicine access in its next plan. In South Africa, the next opportunities are the 2029–2030 budget bids, the 2029 tender, and the post-2030 national mental health strategy. Once medicine access is written into national plans, it has a basis for funding in future government budgets.

What comes next

The medicines in this report already exist, and many are affordable. Getting them to patients depends on how they are financed, bought, supplied, and prescribed, and the past year has shown how quickly governments can move once the obstacles are visible. Based on the program's work to date, CHAI sees three areas where governments can lead:

- Planning and budgeting for need as well as past use, so that orders reflect how many people need treatment.
- Aligning essential medicines lists, procurement catalogs, treatment guidelines, and prescribing rules, so that medicines chosen as essential can be ordered and prescribed.
- Sharing price and supplier data and pooling demand, working with regional bodies such as Africa CDC, so that suppliers compete for larger, predictable orders.

Funders can support this leadership by backing government plans until budgets reflect need and larger, steadier orders bring prices down.

CHAI will carry this work forward through the Mental Health Access Initiative, a three-year program funded by Wellcome, continuing the work described above in the five pathfinding countries and adding support in a sixth country. Each country's barrier ratings set its starting point, and CHAI will work with each government to co-create a plan that targets its most critical barriers. Across countries, the work aims to make demand visible, align and leverage the policies and protocols that govern medicine use, help supply respond, secure financing, and turn availability into use. Success means a person in need can access support, be prescribed the medicine that works for them, chosen with their informed consent, and find it in stock the following month, and the month after that, at a price that is sustainable.