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Challenges & opportunities for implementing integrated mental health care: A district level situation analysis from 5 low and middle-income countries

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SUMMARY

Little is known about how to tailor implementation of mental health services in low- and middle-income countries (LMICs) to the diverse settings encountered within and between countries.

In this study, we compared the baseline context, challenges and opportunities in districts in five LMICs (Ethiopia, India, Nepal, South Africa and Uganda) participating in the PRogramme for Improving Mental health carE (PRIME). We applied a situation analysis tool that made use of information that is largely available in the public domain.

- We found that the study districts faced substantial contextual and health system challenges for delivering mental health care within the primary care system
- Some challenges were common to all LMIC sites but others were site-specific.
- Health system opportunities were also apparent in each of the sites.
- The information gained is being used to develop feasible, acceptable and sustainable district-level plans for delivery of mental health care which are individualised to each of these LMIC settings.

Prior to implementation and scale-up of mental health care in LMIC, a systematic situation analysis can provide vital information on how to tailor generic international recommendations to the challenges & opportunities found in a particular country setting.

PRIME's goals are to:

(1) Develop **evidence** on the implementation & scaling-up of mental health treatment in primary & maternal health care, in low resource settings

(2) Enhance the **uptake** of its research evidence amongst key policy partners and relevant stakeholders

programme for improving mental health care
Evidence on scaling-up mental health services for development

District characteristics and health care resources

	Ethiopia	India	Nepal	South Africa	Uganda
District Name	Sodo (Gurage Zone)	Sehore (Madhya Pradesh)	Chitwan	Dr Kenneth Kaunda (North West Province)	Kamuli
District Population	161,952	1,311,008	575,058	632,790	740,700
% Rural	90%	81%	73%	14%	97%
Literacy	22%	71%	70%	88%	63%
Hospitals	0	2	2	4 (+1 mental hospital)	2
Primary Care Clinics	8	15	4	28	41
Doctors Available	No	Yes	No[1]	Yes	Yes
Psychological therapies	None	Yes (Generic Counselling)	Private hospital[2]	Yes[3]	None
Psychiatrists	0	1 (public)	2 (public), 3 (private) in district capital	2 full time psychiatrists in psychiatric hospital[4]	0
Clinical Psychologists	0	1 (public), 2 (NGOs)	0	12[5]	0
Counsellors	0	1 (public), 1 (NGO)	0(public), 7 (private)	139[6]	0
Psychiatric medication (reliable supply of)	No	No	No	Yes	No
District mental health plan or implementation of national MH plan	No	No, but there is a mental health programme	No	Yes	No
Budget for mental health (% of district health budget)	No	No	No	No	Yes (not ring-fenced)
Information systems for recording MNS disorders	2 categories: 'mental or behavioural disorder' & 'epilepsy'	Not in HMIS. Categories of 'mild, moderate and severe' disorders	7 mental health conditions included in HMIS	No specific disorders recorded	7 mental health conditions included in HMIS
Models of care for chronic disorders in PHC (Adherence Support; Outreach for loss to follow up)	Yes for HIV&TB Yes for HIV	Yes for HIV & TB Yes for HIV	No No	Yes for HIV & TB Yes for HIV, TB & SMD	Yes for HIV & TB Yes for HIV
Disability payments	No	Yes, for SMD	Yes, for SMD	Yes, for SMD & epilepsy	No
Community based PHC workers (paid; health volunteers)	Yes (1/2500) Yes	Yes[7] Yes[9]	No Yes (1/1000)	Yes[8] No	No Yes, identify & refer
Link between PHC and traditional/religious leaders	None	None	None	None	None
NGOs, FBOs & CBOs working with persons with MNS disorders	None	Only substance use	Only substance use	Yes[10]	None

1 In Nepal, doctors and psychotropic medications are only available at the highest level of primary care, which is not locally accessible for the majority of the population and differs from the definition of PHC in other country settings

2 Psychological therapies in Nepal included group therapy and motivational interviewing

3 A range of therapies offered, CBT commonly used at specialist facility

4 Psychiatrists also provide district outreach services part-time

5 1 at PHC, 3 in district hospitals, 5 in specialist facility and 3 psychology interns

6 Lay health worker counsellors for pre-post HIV testing, behaviour change & adherence counselling

7 Accredited social health activists (1 per 1000), DOTS providers

8 n=1577, includes DOTS providers, adherance supporters, health educators

9 For HIV Care: outreach workers for people dropping out of care and peer educators

10 Provide limited social support & advocacy work for persons with SMD & intellectual disabilities

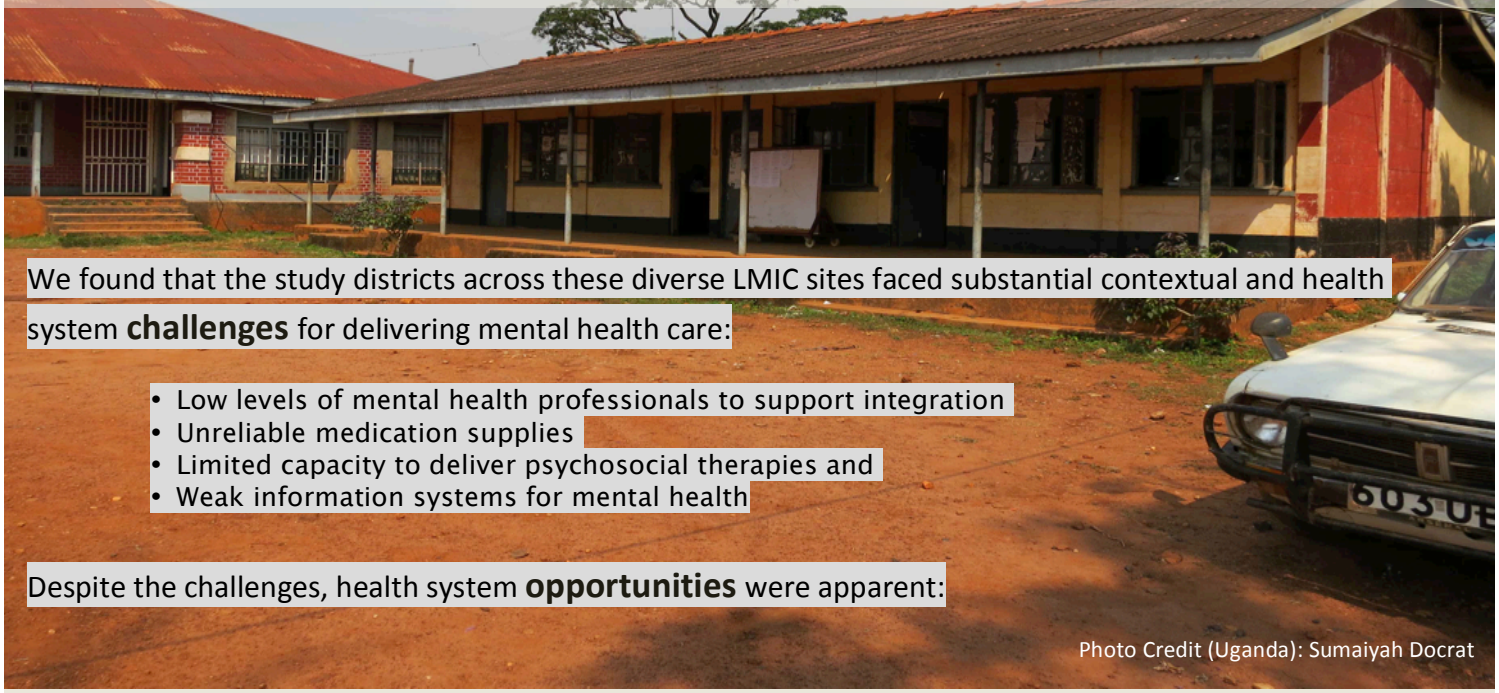
ACRONYMS

CBO Community Based Organisation
FBO Faith Based Organisation
HMIS Health & Management Information Systems
NGO Non Governmental Organisation
MNS Mental, Neurological & Substance Use Disorder
PHC Primary Health Care
SMD Severe Mental Disorder

Methodology

A situation analysis tool was developed to assess the readiness of each of the LMIC districts to implement integration of mental health into primary care. The tool was designed to identify contextual and systems challenges and opportunities. The situation analysis tool made use of information that is largely available in the public domain.

Health system challenges and opportunities



We found that the study districts across these diverse LMIC sites faced substantial contextual and health system **challenges** for delivering mental health care:

- Low levels of mental health professionals to support integration
- Unreliable medication supplies
- Limited capacity to deliver psychosocial therapies and
- Weak information systems for mental health

Despite the challenges, health system **opportunities** were apparent:

Photo Credit (Uganda): Sumaiyah Docrat

Potential to apply existing models of care: In each district there was potential to apply existing models of care for tuberculosis and HIV or non-communicable disorders, which have established mechanisms for detection of drop-out from care, outreach and adherence support.

Good network of community-based workers: The extensive networks of community-based health workers and volunteers in most districts provide further opportunities to expand mental health care.

Photo Credit (India): Vikram Patel

Policy recommendations

Start with a country situation analysis: A country-specific situation analysis is an important and useful first step in order to develop a feasible, acceptable and sustainable plan for integrating mental health care into primary care.

Strengthen health systems factors: Critical health systems level factors for supporting integration of mental health care into primary care were weak or absent across LMIC sites. These factors need to be strengthened for successful implementation.

Developing service models for delivering mental health care: Models of care for other chronic disorders (communicable and non-communicable) provide a useful starting point for developing service models for delivery of mental health care.

Engaging the community: The limited activity of community-based organisations across the country sites, indicates the need to mobilise the community to support people with mental illness.

Reference

Policy brief based on published research by Charlotte Hanlon, Nagendra Luitel, Tasneem Kathree, Vaibhav Murhar, Sanjay Shrivasta, Girmay Medhin, Joshua Ssebunya, Abebaw Fekadu, Rahul Shidhaye, Inge Petersen, Mark Jordans, Fred Kigozi, Graham Thornicroft, Vikram Patel, Mark Tomlinson, Crick Lund, Erica Breuer, Mary De Silva, Martin Prince (2014). PLoS Medicine. Challenges and Opportunities for Implementing Integrated Mental Health Care: A District Level Situation Analysis from Five Low- and Middle-Income Countries.

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About PRIME

PRIME is a Research Programme Consortium (RPC) led by the Centre for Public Mental Health at the University of Cape Town (South Africa), and funded by the UK government's Department for International Development (UKAID). The programme aims to develop world-class research evidence on the implementation, and scaling-up of treatment programmes for priority mental disorders in primary and maternal health care contexts, in low resource settings.

Partners and collaborators include the World Health Organization (WHO), the Centre for Global Mental Health (incorporating London School of Hygiene & Tropical Medicine and King's Health Partners, UK), Ministries of Health and research institutions in Ethiopia (Addis Ababa University), India (Public Health Foundation of India), Nepal (TPO Nepal), South Africa (University of Kwazulu-Natal & Human Sciences Research Council) and Uganda (Makerere University & Butabika Hospital); and international NGOs such as BasicNeeds, Healthnet TPO and Sangath.

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