Strengthening mental health systems in low- and middle-income countries: recommendations from the Emerald programme

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Background

There is a large treatment gap for mental, neurological or substance use (MNS) disorders. The ‘Emerging mental health systems in low- and middle-income countries (LMICs)’ (Emerald) research programme attempted to identify strategies to work towards reducing this gap through the strengthening of mental health systems.

Aims

To provide a set of proposed recommendations for mental health system strengthening in LMICs.

Method

The Emerald programme was implemented in six LMICs in Africa and Asia (Ethiopia, India, Nepal, Nigeria, South Africa and Uganda) over a 5-year period (2012–2017), and aimed to improve mental health outcomes in the six countries by building capacity and generating evidence to enhance health system strengthening.

Results

The proposed recommendations align closely with the World Health Organization’s key health system strengthening ‘building blocks’ of governance, financing, human resource development, service provision and information systems; knowledge transfer is included as an additional cross-cutting component. Specific recommendations are made in the paper for each of these building blocks based on the body of data that were collected and analysed during Emerald.

Conclusions

These recommendations are relevant not only to the six countries in which their evidential basis was generated, but to other LMICs as well; they may also be generalisable to other non-communicable diseases beyond MNS disorders.

Declaration of interest

None.

Keywords

Global mental health; health systems; health system strengthening; healthcare delivery.

Results

A summary of our recommendations is provided in Appendix 1. In addition, some practical pointers are listed in Appendix 2.

Governance

Poor governance was identified as an important barrier to effective integration of mental healthcare within primary healthcare settings. To address this, the Emerald programme identified the following key governance strategies (see Petersen et al, Abdulmalik et al, Hanlon et al, Marais & Petersen, Mugisha et al, and Upadhaya et al for further details): strengthening capacity of managers at subnational levels and/or policymakers at the national level to develop and implement integrated plans; strengthening key aspects of the essential health system building blocks to promote...
responsiveness, efficiency and effectiveness; developing workable mechanisms for intersectoral collaboration, as well as community and patient engagement; and developing innovative approaches to improve mental health literacy and achieve stigma reduction. A recurring challenge for good governance is adequate financing, which can be addressed via evidence-based advocacy and budgetary re-prioritisation.

Mental health financing

The Emerald programme showed that as part of effective planning, countries can benefit from undertaking an assessment of the human and financial resources needed to scale-up a package of evidence-based care and prevention strategies for priority MNS disorders. Emerald developed, tested and applied a new module for the OneHealth tool (see http://www.avenirhealth.org/software-onehealth.php), to estimate the costs and health impact of mental health service scale-up in the six Emerald countries. The findings were that costs of scale-up of key mental health services are modest in absolute terms (under US$ 0.50 per head of population for psychosis, depression and epilepsy in Ethiopia, Nepal and Uganda), but with substantial anticipated improvements in health. However, these costs are still considerably in excess of current allocations because of low prioritisation to mental health.

Across the six diverse Emerald LMICs, a relatively consistent picture emerged – that there is limited financial risk protection for households affected by MNS disorders. Emerald’s findings indicated that households living with an MNS disorder constitute a key vulnerable population, who have a high risk of chronic poverty and intergenerational poverty transmission, and who therefore require development assistance. Development efforts can target the ‘upstream’ determinants of mental health: violence, poverty, inadequate housing, unemployment, lack of basic amenities, poor education, experience of trauma and stigma; which can significantly reduce the risk of MNS disorders among those not yet affected and increase the ability to cope with financial hardships as a result of MNS disorders among those already affected. This could be implemented in the form of financial assistance such as disability grants or cash transfers for people living with an MNS disorder. It is also essential to improve access to mental healthcare, preferably delivered through primary care and community-based healthcare platforms, for example by including mental healthcare within universal health coverage plans.

In order to improve access to services and move towards universal health coverage for people with MNS disorders, greater financial protection needs to be given to individuals and households with MNS disorders, preferably through explicit inclusion of MNS disorders in ongoing national insurance schemes or programmes (see the paper by Chisholm et al in this thematic series). Universal or social health insurance models offer the most promising avenues to tackle the low priority given to mental health.

Service provision

Although great strides have been made in the development of policy and legislative frameworks that support integrated care, the Emerald programme found that the implementation of these mental health policies and plans remains a challenge, requiring technical support, such as manuals, standard operating procedures, ‘Train the Trainer’ technical support, and monitoring and evaluation using continuous quality improvement to embed integration.

The Emerald programme also found that the integration of mental health into primary healthcare (PHC) requires more than just technical (continued) training and structured supervision of healthcare providers in the required clinical skills (for example through the Mental Health Gap Action Programme (mhGAP)). This training needs to be accompanied by systems strengthening of all the basic building blocks of the PHC system to support integrated mental healthcare. This includes systems interventions to support integrated person-centred collaborative continuing care of chronic and multimorbidity conditions at an organisational level. It also refers to the need for workforce preparedness interventions that include relational leadership skills, clinical communication skills and emotional coping skills (see paper in this thematic series by Petersen et al). A clinical communication skills training module that promotes a person-centred approach was developed as part of Emerald and introduced into the national scale-up efforts in South Africa to support integrated mental healthcare into primary care services. It has also been adapted for use in Ethiopia as part of training activities.
of the adaptation of integrated chronic care guidelines called the Practical Approach to Care Kit (PACK).11

Systems strengthening interventions to support integrated mental healthcare varied across the six Emerald countries depending on country needs but were found to improve patients’ experience of overall chronic care across the countries. Furthermore, Emerald found that strengthening of the community platform is also important to promote intersectoral collaboration, mental health literacy, reduce stigma and empower patients and caregivers for support and self-care.

**Mental health information systems**

In order to guide the process of scaling up of mental healthcare, a revised health management information system (HMIS) that includes mental health indicators is needed in LMICs.32,33 Through a broad-based consensus building process that included a cross-country Delphi study and consultative workshops,34 Emerald developed a set of indicators that can be used within the routine mental health information systems in LMICs to monitor the provision of mental health services in PHC (see Jordans et al’s paper11 in this thematic series for the list of indicators and the evaluation of use of the indicators). With a limited set of indicators, Emerald aimed to assess ‘effective coverage’ including financial coverage, both of which are needed for the assessment of implementable universal health coverage.

The set of indicators, after a brief training of health workers, were introduced in practice. Emerald assessed its performance and perceived utility, finding mostly high and increasing levels of completeness and accuracy of data completion, even though some indicators fell behind in perceived utility. The results showed that it is feasible, useful and acceptable to use the indicators for routine monitoring of mental healthcare within existing HMIS in LMICs (see papers by Jordans et al11 and Ahuja et al12 in this thematic series for further details). We therefore propose these indicators to be considered for incorporation into existing health information systems, and adopted within the WHO mhGAP implementation strategy.

**Knowledge transfer**

This has been included here as a cross-cutting component, which – although not one of the WHO’s ‘building blocks’ for health system strengthening – we consider to be an important requirement within health system research. It is imperative that research evidence is communicated effectively and efficiently to a wide range of stakeholders, including those who may apply this information in practice to improve treatment and care. Knowledge transfer from research into policies and patient care could be accelerated by involving patients and carers. For effective communication of research results, there is a need for multiple dissemination strategies. This may include meetings with stakeholders such as advocacy meetings or community groups, websites, social media, leaflets, newsletters, policy briefs, research papers, conferences, annual reports, videos and press conferences and releases. The paper by Ayuso-Mateos et al13 in this thematic series goes into further details on this, as well as the impact that the knowledge transfer efforts within Emerald had on mental health service delivery and policy planning within the six Emerald countries.

**Discussion**

The Emerald programme created a rich body of evidence to inform proposed strategies for strengthening mental health systems in LMICs. This evidence was collected in six LMICs in Africa and Asia, but has applicability beyond those countries to other LMICs and potentially to underresourced areas in HICs,3 as well as to non-communicable diseases other than MNS disorders. Indeed, some of the tools developed during Emerald have already been successfully used in Zimbabwe (see Hendler et al and Kidia et al16,37), and we would encourage other countries to follow suit. The evidence collected during Emerald has resulted in a set of recommendations, which we hope will be useful in informing models of best practice not just in the six Emerald countries but also in other LMICs and possibly other HICs worldwide on how to enhance health systems so that services for people with MNS disorders are improved.
Summary of recommendations

(a) Governance: poor governance needs to be addressed as a key barrier to the effective integration of mental healthcare.

(b) Mental health financing: the mental health module of the OneHealth tool is useful to estimate the human and financial resources needed to scale-up a package of evidence-based care and prevention strategies for priority mental, neurological or substance use (MNS) disorders. Emerald’s findings show that it is essential to improve access to services and move towards universal health coverage for people with MNS disorders; for this, greater financial protection needs to be given to individuals and households living with MNS disorders, preferably through explicit inclusion of MNS disorders in ongoing national insurance schemes or programmes, in particular social health insurance models and targeted poverty alleviation programmes.

(c) Human resources: there needs to be capacity-building of mental health patients, caregivers, service planners/managers and researchers in low- and middle-income countries (LMICs) in mental health system strengthening. Training activities and collaborations should be carefully planned, implemented and evaluated, that emphasise appropriateness, reciprocity, sustainability and equality in partnerships; governments and/or donors need to make resources available for this.

(d) Service provision: the scale-up of integrated mental healthcare into primary healthcare (PHC) in LMICs is far more complex than adding packages of care to existing PHC services. Leveraging existing health system processes that are synergistic with chronic care are important, as well as initiatives to strengthen some of the basic building blocks of the healthcare system to create a more enabling platform for integrated mental healthcare. Furthermore, community strengthening is important to promote empowering of patients and caregivers for support and self-care; and the implementation of mental health policies and plans requires technical support.

(e) Mental health information systems: Emerald developed and evaluated a set of indicators (measuring treatment need, utilisation, quality and costs) that can be used within routine mental health information systems in LMICs to monitor the effective coverage of mental health services in PHC. These indicators should be incorporated into existing health information systems, and adopted within the WHO Mental Health Gap Action Programme implementation strategy.

(f) Knowledge transfer: research evidence should be communicated effectively and efficiently to a wide range of stakeholders, including those who may apply this information in practice to improve treatment and care, using a wide array of platforms suitable for the target audience.

Appendix 2

Practical pointers for mental health system strengthening in low- and middle-income countries

(a) Moving towards universal health coverage for people with MNS disorders requires consideration of the resources needed to scale-up services and also consideration of the fair and sustainable mechanisms for providing enhanced financial protection to affected households.

(b) Ensure that there is a strong focus on capacity-building of patients, policymakers, planners and researchers to support mental health system strengthening.

(c) Any country that is envisioning the integration of mental health into primary healthcare should review the requirements and processes across the health system building blocks. This paper provides guidance around this process.

(d) Ensure that routine health information systems include mental health indicators so that mental healthcare needs and services can be routinely monitored.

References

2 Thornicroft G, Semrau M. Health system strengthening for mental health in low- and middle-income countries: introduction to the Emerald programme. BJPsych Open 2019; this issue.