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
### District characteristics and health care resources

<table>
<thead>
<tr>
<th>District Name</th>
<th>Ethiopia</th>
<th>India</th>
<th>Nepal</th>
<th>South Africa</th>
<th>Uganda</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Name</td>
<td>Sodo (Gurage Zone)</td>
<td>Sehore (Madhya Pradesh)</td>
<td>Chitwan</td>
<td>Dr Kenneth Kaunda (North West Province)</td>
<td>Kamuli</td>
</tr>
<tr>
<td>District Population</td>
<td>161,952</td>
<td>1,311,008</td>
<td>575,058</td>
<td>632,790</td>
<td>740,700</td>
</tr>
<tr>
<td>% Rural</td>
<td>90%</td>
<td>81%</td>
<td>73%</td>
<td>14%</td>
<td>97%</td>
</tr>
<tr>
<td>Literacy</td>
<td>22%</td>
<td>71%</td>
<td>70%</td>
<td>88%</td>
<td>63%</td>
</tr>
<tr>
<td>Hospitals</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>4 (+1 mental hospital)</td>
<td>2</td>
</tr>
<tr>
<td>Primary Care Clinics</td>
<td>8</td>
<td>15</td>
<td>4</td>
<td>28</td>
<td>41</td>
</tr>
<tr>
<td>Doctors Available</td>
<td>No</td>
<td>Yes</td>
<td>No¹</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychological therapies</td>
<td>None</td>
<td>Yes (Generic Counselling)</td>
<td>Private hospital²</td>
<td>Yes³</td>
<td>None</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>0</td>
<td>1 (public)</td>
<td>2 (public), 3 (private) in district capital</td>
<td>2 full time psychiatrists in psychiatric hospital⁴</td>
<td>0</td>
</tr>
<tr>
<td>Clinical Psychologists</td>
<td>0</td>
<td>1 (public), 2 (NGOs)</td>
<td>0</td>
<td>12⁵</td>
<td>0</td>
</tr>
<tr>
<td>Counsellors</td>
<td>0</td>
<td>1 (public), 1 (NGO)</td>
<td>0 (public), 7 (private)</td>
<td>139⁶</td>
<td>0</td>
</tr>
<tr>
<td>Psychiatric medication (reliable supply of)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>District mental health plan or implementation of national MH plan</td>
<td>No</td>
<td>No, but there is a mental health programme</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Budget for mental health (% of district health budget)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes (not ring-fenced)</td>
</tr>
<tr>
<td>Information systems for recording MNS disorders</td>
<td>2 categories: ‘mental or behavioural disorder’ &amp; ‘epilepsy’</td>
<td>Not in HMIS. Categories of ‘mild, moderate and severe’ disorders</td>
<td>7 mental health conditions included in HMIS</td>
<td>No specific disorders recorded</td>
<td>7 mental health conditions included in HMIS</td>
</tr>
<tr>
<td>Models of care for chronic disorders in PHC (Adherence Support; Outreach for loss to follow up)</td>
<td>Yes for HIV &amp; TB</td>
<td>Yes for HIV &amp; TB</td>
<td>No</td>
<td>Yes for HIV &amp; TB</td>
<td>Yes for HIV &amp; TB</td>
</tr>
<tr>
<td>Community based PHC workers (paid; health volunteers)</td>
<td>Yes (1/2500)</td>
<td>Yes¹</td>
<td>No</td>
<td>Yes⁴</td>
<td>No</td>
</tr>
<tr>
<td>Link between PHC and traditional/religious leaders</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>NGOs, FBOs &amp; CBOs working with persons with MNS disorders</td>
<td>None</td>
<td>Only substance use</td>
<td>Only substance use</td>
<td>Yes⁵</td>
<td>None</td>
</tr>
</tbody>
</table>

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:

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.
**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**


---

**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.

---

**PRogramme for Improving Mental health care (PRIME)**

Alan J Flisher Centre for Public Mental Health
Department of Psychiatry & Mental Health
University of Cape Town
46 Sawkins Road, Rondebosch, South Africa 7700

Web: [www.prime.uct.ac.za](http://www.prime.uct.ac.za)

---

This document is an output from a project funded by UK Aid from the Department for International Development (DFID) for the benefit of developing countries. However, the views expressed and information contained in it are not necessarily those of or endorsed by DFID, which can accept no responsibility for such views or information or for any reliance placed on them.