INQUIRY: The Journal of Health Care Organization, Provision, and Financing
Volume 58: 1–12

DOI: 10.1177/00469580211028579
journals.sagepub.com/home/inq
SAGE

Health System Governance for the Integration of Mental Health Services into Primary Health Care in the Sub-Saharan Africa and South Asia Region: A Systematic Review

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Abstract

Governance has been highlighted as an important building block underpinning the process of mental health integration into primary healthcare. This qualitative systematic review aims to identify the governance issues faced by countries in the Sub-Saharan Africa and South Asia Region in the implementation of integrated primary mental healthcare. PRISMA guideline was used to conduct a systematic search of relevant studies from 4 online databases that were filtered according to inclusion and exclusion criteria. Using the Critical Appraisal Skills Program (CASP) Qualitative Checklist, a quality appraisal of the selected articles was performed. By drawing upon institutional theory, data was extracted based on a pre-constructed matrix. The CERQual approach synthesized evidence and rank confidence level as low, moderate or high for 5 key findings. From 567 references identified, a total of 8 studies were included. Respondents were policymakers or implementers involved in integrated primary mental healthcare from the national, state, and district level. Overall, the main governance issues identified were a lack of leadership and mental health prioritization; inadequate financing and human resource capacity; and negative mental health perceptions/attitudes. The implication of the findings is that such issues must be addressed for long-term health system performance. This can also improve policymaking for better integration of primary mental health services into the health systems of countries in the Sub-Saharan and South Asia region.

Keywords

health system, governance, mental health, mental health services, integration, integrated primary mental healthcare, Africa, South Asia, qualitative systematic review

What do we already know about this topic?

There are empirical studies on health system governance of mental health care at the primary healthcare level in the Sub-Saharan Africa and South Asia region, however, there have not been a review looking into the common governance issues shared by countries involved.

How does your research contribute to the field?

Synthesis of findings from empirical studies of health system governance for integrated primary mental healthcare contributes to identification of common governance issues to guide policymaking decisions.

What are your research's implications toward theory, practice, or policy?

Learning points from other countries on common health system governance issues for integrated primary mental healthcare can assist policymakers to make effective decisions for governance.

Background

Globally, there has been an epidemiological transition from communicable to non-communicable diseases, including mental disorders, due to lifestyle changes and improved control of infectious diseases. In addition, the serious magnitude of the mortality and morbidity of mental disorders has been emphasized by numerous global burden of disease studies and projections.[1-3] However, despite the mental disease burdens associated with adverse effects, both socially and economically, mental disorders have still been poorly prioritized by international and national policymakers as well as funders.[4] In this regard, the World Health Organization (WHO) has made attempts to increase the awareness of mental health, from the beginning of the 21st century to its most recent Comprehensive Mental Health Action Plan 2013 to 2020. This action plan includes 4 main objectives, with the first focusing on the importance of effective governance for mental health.[5,6]

The concept of governance, which has become the subject of many discussions in the fields of social sciences and public health, has been defined as the use of economic, political, and administrative authority to manage affairs that include the mechanisms and processes through which the rights, obligations, and differences of the citizens are met and mediated.[7] It also covers the whole range of institutions and relationships involved in governing and decision-making.[8]

In regard to health systems, the WHO has defined health system governance as "ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability."[9] Good health system governance has also been conceptualized as an imperative requirement for the optimal function of all other health system components. It is important to note that the WHO's definition is based on political ideology, that is, the health system can be influenced by transparent rules and governed by effective oversight. However, the "governance" building block must be considered over all other building blocks in order to strengthen the performance of health systems as a whole.[9]

In general, health system governance takes the perspective of a comprehensive view of a health system such as a national health system.[10] However, this concept has also been applied to smaller segments or "subsystems" by focusing on a particular health issue (eg, mental health), population (eg, maternal and child health), service type (eg, hospitals) or a specific level of a health system such as the district level.[11,12] With reference to integrated primary mental health care, governance has been highlighted by the WHO as an important building block underpinning the process of mental health integration into primary healthcare.[14]

The concept of integrated healthcare has been discussed by numerous researchers. Although several consensuses have surfaced, the most recent and clearest model is the Rainbow Model, which encompasses several different classifications of integration within a health system.[13] More specifically, the perspective that this particular article takes is systemic integration, which examines the alignment of rules and policies within a health system, based on the political environment and community involvement. In this regard, the present review focuses on the health system governance factors that facilitate the integration of mental healthcare into primary healthcare.

It has been strongly suggested that primary mental healthcare improves access to service, while still being affordable and cost-effective. This is especially important in countries located in the poorer world regions such as in the Sub-Saharan Africa and South Asia.[14] Previous research has also shown that people with mental disorders who are treated in primary healthcare have good outcomes, especially when linked to a network of services at a secondary level in the community.[15] Overall, the goals of integrated primary mental healthcare include: providing mental health service at the primary healthcare level in order to complement tertiary- and secondary-level mental health services; strengthening prevention strategies for mental disorders; and ensuring that primary healthcare workers are able to apply their professional skills to improve mental health outcomes in primary healthcare.[16]

In order to realize these goals, it is important for policymakers to not only understand the wide array of governance issues at various levels, but also to incorporate good governance into policy formulation and implementation. However, poor governance has been one of the key barriers to effectively implementing integrated primary mental health services.[17] Meanwhile, there has been a paucity of evidence, particularly in the area of governance for integrated primary mental healthcare. Therefore, this systematic review synthesizes the findings of empirical studies on the governance of integrated primary mental healthcare in the Sub-Saharan Africa and South Asia region to answer the question of what governance issues are faced by countries in the implementation of integrated primary mental healthcare.

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Received 30 September 2020; revised 29 May 2021; revised manuscript accepted 7 June 2021

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Methods

A systematic qualitative synthesis was conducted to obtain a comprehensive overview of existing studies on the governance of integrated primary mental healthcare. This type of review summarizes the studies published in a specific area of research and focuses on specific research questions in a systematic and repeatable manner.[18,19] Although such an approach has been traditionally used to examine the effectiveness of healthcare interventions, different methods have been developed to address a broader range of issues (eg, policy development, appropriateness, feasibility, and meaningfulness) related to healthcare programmes.[20]

This review was executed by 3 public health researchers, with various expertise in health service management, health policies and health planning. In addition, all of the authors participated in face-to-face meetings and online discussions during the data collection, review, and writing stages. Overall, this review involved 5 steps:

Step 1: Create a theoretical framework guide.
Step 2: Conduct a systematic search and select the potential articles.
Step 3: Perform a critical appraisal of the selected articles.
Step 4: Conduct data extraction and analyse the selected articles.
Step 5: Assess confidence in findings.

Step 1: Create a Theoretical Framework Guide

There are several well-known theories on the concept of governance that commonly focus on the relationship between principals and agents in an institution such as the principal-agent theory, the stewardship theory and the stakeholder theory.[21] However, with the emphasis of the present review on health system governance, the focus should expand beyond the relationship between authorities and actors, and incorporate the interactions between an institution and the environment by drawing upon institutional theory.[22] In other words, institutional theory can help explain how organizations strive to meet the environment's expected characteristics in order to receive legitimacy from society and the broader environment.[23]

The term "institution" has been defined as regular social interactions/practices that require agreed upon and predictable rules/ways of doing things.[24] Organizations within an institution attempt to conform to easily recognisable and acceptable standards, which helps foster their legitimacy. As for institutional theory, it describes how both deliberate and accidental choices influence organizations to mirror the norms, values, and ideologies of the organizational field. By conforming to isomorphic pressures in the environment, legitimacy can be achieved together with structures and processes which has been shown to be more impactful.[25] In general, organizations adapt their internal characteristics in order to conform to the expectations of key stakeholders (eg, the state, the providers or the public), while institutional theorists emphasize the social and cultural aspects of organizational environments, rather than the tasks and technical elements.

According to institutional theory, there are 3 isomorphic pressures: coercive pressure, mimetic pressure and normative pressure.[25] Although these pressures are analytically distinct, they may not be as easy to empirically distinguish. The details of each are as follows:

1. **Coercive pressure:** Formal or informal pressure exerted on an organization by powerful entities, such as the state, and by cultural expectations of conforming to rules/laws and adopting the favored structures/systems.
2. **Normative pressure:** The effect of professional standards and the influence of professional communities on organizational characteristics.
3. **Mimetic pressure:** The pressure to copy/mimic other organizations' activities, systems/structures in order to appear in line with their counterparts and receive a positive evaluation from the environment and the public.

For this review, these 3 categories was used to organize the data extraction, synthesis and analysis in identifying the systemic governance issues for integrated primary mental healthcare.

Step 2: Conduct a Systematic Search and Select the Potential Articles

Adhering to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) reporting guideline, a systematic review of qualitative studies was conducted.[26] Four electronic databases were searched (ie, PubMed, Cochrane Library, CINAHL, and Scopus) by using Boolean operators to combine the keywords using the following search terms: "governance OR leadership OR accountability OR stewardship AND mental health AND primary mental healthcare AND integration AND Africa AND South Asia."

These terms were searched in abstracts, titles, and article contents. In addition, online archives of specific peer-reviewed journals (ie, the International Journal of Mental Health Systems and the International Journal of Mental Health) were searched by using the term "mental health systems governance." It is important to note that only the articles that discussed governance at the health system level were included. Moreover, the searches did not include websites of entities engaged in the area of health governance (eg, the World Bank, the WHO, etc.) or grey/unpublished papers, since the aim was to learn from actual experiences of other countries.

Several inclusion and exclusion criteria were also used to select the articles for synthesis. Overall, the studies were

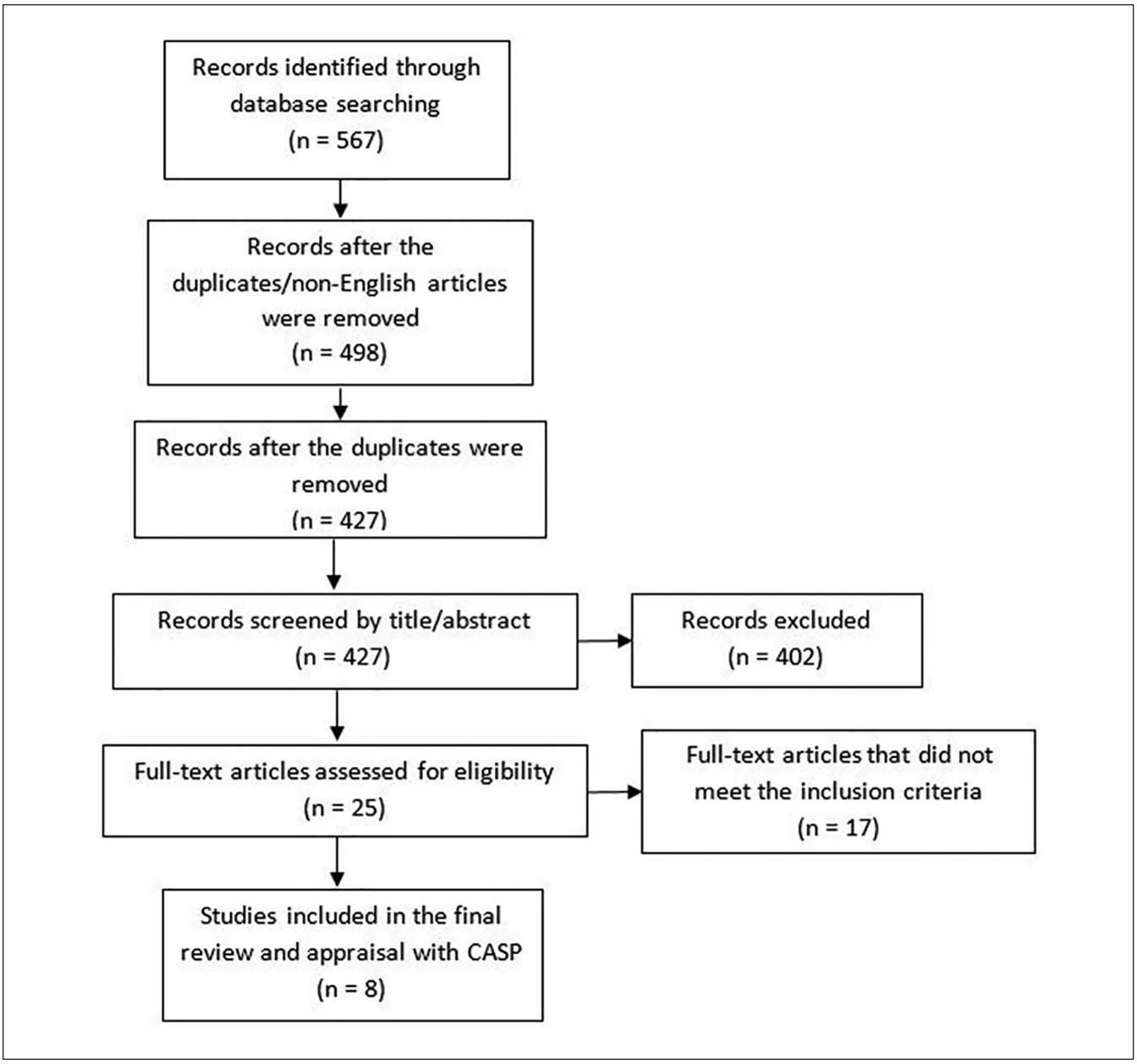

Figure 1. PRISMA flow diagram of the search results.

limited to those published in English between 2000 and 2018. The inclusion criteria were as follows: (1) original or empirical research with clear aims, methodologies, results, and discussions; (2) studies on the governance of integrated primary mental healthcare in the Sub-Saharan and South Asia region; (3) studies on the overall integrated primary mental healthcare, with identified governance aspects; and (4) studies on the governance of district-level primary mental healthcare provision. As for the exclusion criteria, they were as follows: (1) publications prior to 2000; (2) non-empirical articles (eg, reviews, editorials, commentaries, news, etc.); (3) studies on clinical governance, compared to a health system or broad governance perspective; and (4) studies on the integration of mental healthcare, without discussing any governance aspects.

Duplicates were removed after the references for all of the studies were entered into the Mendeley library. In order to ensure comprehensiveness, especially at the point when the analysis started approximately 3 months after the initial exploration of the articles, an additional search was conducted to capture any newly published studies.

Figure 1 presents a PRISMA flow diagram of the search results. The initial search produced a total of 567 articles. However, after the duplicates were removed, 427 articles

remained. A subsequent review of the titles and abstracts reduced this number to 25. The full texts of these 25 articles were then thoroughly read, after which 8 articles were selected according to the inclusion and exclusion criteria. The details regarding these 8 selected articles are summarized in Table 1.

Step 3: Perform a Critical Appraisal of the Selected Articles

Since all of the remaining 8 articles were qualitative in nature, they were critically appraised (during the full-text screening stage) by using the Critical Appraisal Skills Program (CASP) Qualitative Checklist (https://www.casp-uk.net/casp-tools-checklists/). This checklist was used for quality assessment because previous research found that the level of agreement between the appraisers was reasonable when evaluating qualitative articles.[27] In the present review, the studies were appraised according to their descriptions (ie, aim, participants, methods and outcomes), methods (ie, appropriate to the aim, selection of the participants, valid/reliable data collection methods and adequate description of the analysis) and presentation of the findings. This also included questions about the appropriateness and reliability of the analysis. Overall, the articles were categorized as follows: "high quality" (a score between 8 and 10); "medium quality" (a score between 5 and 7); and "low quality" (a score of 4 or less).[28] This appraisal also helped the researchers assess the risk of bias in individual studies and across studies.

Step 4: Conduct Data Extraction and Analyse the Selected Articles

Data extraction was conducted by researchers, which was entered into Microsoft Excel and tabulated into Matrix A (presented as Table 1), which includes the governance framework applied, the level of analysis, the methods used and data sources, the aspects of governance and governance issues. An initial version of this matrix was developed, based on the theoretical framework and the 3 isomorphic pressures of institutional theory (explained earlier), in combination with an assessment of the governance of the different health systems.[25,29] The matrix was then tested by the 3 reviewers by using 3 independently reviewed publications to ensure that each member had a common understanding of the review categories. Based on the team's feedback, the matrix was further refined. Subsequently, the refined matrix was used to review the 8 full-text publications. Each publication was then independently reviewed by each reviewer and the findings were compared. Finally, discussions were conducted to resolve any differences in interpretations between the reviewers by using a deductive approach, which has been previously used in different situations.[30]

Step 5: Assess Confidence in Findings

The CERQual (Confidence in the Evidence from Reviews of Qualitative Research) approach were used to assess confidence in review findings (Table 2).[31] This method helps in assessing and describing how much confidence to place for each key finding from systematic reviews of qualitative evidence. Four components are included in the CERQual approach: (1) methodological limitations for each study, (2) coherence in fitness of data, (3) adequacy of data, and (4) relevance.[32] In assessing the methodological limitations, each individual study was evaluated using the modified CASP tool as described in step 4. Variation across studies in terms of conflicting or convincing explanations contributed to the coherence to see whether data from individual studies fit to the review findings. Adequacy was assessed by the number of studies and thickness of data in each individual study. The applicability of the review findings to the context (population, setting, and perspective) of the review question functions in assessing relevance. Based on an overall assessment of methodological limitations, coherence, adequacy and relevance, the confidence in the evidence for each key finding was assessed as high, moderate, low, or very low.

Results

Descriptions of the Included Studies

Examining other countries' issues regarding health system governance as well as the challenges encountered during mental health integration is necessary for guiding policymakers and planners in making effective decisions. Thus, several health system governance studies have been conducted that shared key learning experiences and addressed such integration into primary healthcare.[33,34] For example, previous research showed that the application of governance frameworks can help determine how the principles of good governance might be operationalized at different system levels.[29] In this regard, the principles of good governance most referred to are the following 9 principles introduced by the United Nations Development Program (UNDP): accountability, strategic vision, rule of law, transparency, participation, effectiveness and efficiency, responsiveness, consensus orientation, and equity.[7,42]

As stated earlier, the present review identified 8 empirical studies, all of which were qualitative in nature (see Table 1). Methodologically, among the 8 studies, 3 used a combination of in-depth interviews and document analyses of government policies,[13,37] 4 only conducted in-depth interviews with key-informants[33-36] and 1 only conducted document analyses.[37] The studies also included countries in different income groups and used various frameworks to assess the governance of each country. However, the most commonly used frameworks were those by Siddiqi et al[38] and Mikkelsen-Lopez et al.[39] Furthermore, the findings on

Table 1. Characteristics and Quality Appraisal of Reviewed Articles.

N.	Author, country	Assessment framework applied	Level of analysis	Methods used and data sources	Aspects of governance	Governance issues	CASP quality assessment
1	Abdulmalik et al,[12] Nigeria	Health system governance frameworks by Siddiqi et al[38]	National, state and district level	Interviews with key stakeholders Document analysis of relevant policies	1) Strategic vision and legislation 2) Effectiveness and Responsiveness 3) Participation and collaboration 4) Ethics and equity 5) Intelligence and information system	Coercive pressure: low priority for mental health, insufficient data to guide planning, poor funding, Normative pressure: inadequate professional numbers, lack of training, lack of awareness and negative attitudes among providers Mimetic pressure: pervasive discrimination and stigma in the community	High
2	Hanlon et al,[34] Ethiopia	Health system governance framework by Siddiqi et al[35,38]	National, regional and district level	Interviews with key stakeholders	1) Rule of law: legal framework, regulation 2) Strategic vision: policy, planning and coordination, leadership. 3) Participation and consensus: participatory decision-making, service user and caregiver participation 4) Responsiveness and integration of care: prioritization and meeting mental health needs, integration at facility, integration in community. 5) Effectiveness and efficiency: financing, human resources, infrastructure, and equipment 6) Equity and inclusiveness: access, stigma 7) Ethics: quality assurance, safeguards for ethical research 8) Intelligence and information: monitoring and evaluation, accountability, and transparency	Coercive pressure: no mental health legislation yet, but good political support for formulation, committed, but limited budget for scale-up, limited routinely collected mental health indicators Normative pressure: lack of human resource capacity and training, negative attitudes by providers Mimetic pressure: poor community participation, issue of widespread stigma at the community level, issue of poverty	High
3	Marais and Petersen,[35] South Africa	Combination of health system governance frameworks by Siddiqi et al[38] and Mikkelsen-Lopez et al[39]	National, provincial and district level	Interviews with key stakeholders	1) Rule of law 2) Strategic direction 3) Responsiveness and integration 4) Effectiveness and efficiency 5) Participation and collaboration 6) Equity and inclusiveness 7) Ethics and oversight 8) Intelligence and information	Coercive pressure: poor planning, lack of priority and coordination, lack of funding Normative pressure: lack of human resource capacity and training, negative attitudes by providers Mimetic pressure: issue of widespread stigma at the community level	Medium
4	Petersen et al,[40] Ethiopia, India, Nepal, Nigeria, South Africa, Uganda	Combination of health system governance frameworks by Siddiqi et al[38] and Mikkelsen-Lopez et al[39]	National, provincial and district level	Interviews with key stakeholders	1) Rule of law and strategic direction 2) Effectiveness and responsiveness: human resources 3) Effectiveness and responsiveness: financing, medicines and protocols, infrastructure, information systems 4) Participation and collaboration 5) Equity and ethics 6) Information, accountability and transparency	Coercive pressure: issues in developing and implementing mental health laws and legislations, lack of institutional accountability, lack of funding Normative pressure: lack of human resource capacity and training, negative attitudes by providers Mimetic pressure: common issue of widespread stigma at the community level, emergent in all 6 countries	High
5	Upadhaya et al,[41] Nepal	Health system governance framework by Siddiqi et al[38]	National and district level	Interviews with key stakeholders Document analysis of relevant policies	1) Strategic vision and rule of law 2) Transparency and accountability: monitoring of mental health services and policies 3) Responsiveness 4) Participation, coordination and collaboration: involvement in policy and planning, involvement in service delivery 5) Effectiveness and efficiency: human resources capacity, budget allocation utilization, supply of psychotropic drugs 6) Equity and inclusiveness: access to services 7) Ethics 8) Mental health information system	Coercive pressure: poor implementation of existing mental health policies and plans, absence of mental health unit and act, integration into PHC was ignored, poor access to services Normative pressure: lack of professional training, lack of awareness and stigma among providers Mimetic pressure: issues of poverty and stigma associated with mental disorders within the community	High
6	Janse van Rensburg et al,[42] South Africa	Framework for assessing power in collaborative processes	District level	Interviews with key stakeholders	1) Mental health stewardship: financing, prioritization, strategic leadership, information and monitoring system, resistance 2) Participants: participants and formal authority, participants and resources, participants, and discursive legitimacy 3) Process design: formal authority, resources, and discursive legitimacy 4) Content: formal authority, resources, and discursive legitimacy	Coercive pressure: lack of strategic leadership, lack of funding and prioritization of mental health, resistance to current governance due to strict bureaucracy, tension between state and non-state actors Normative pressure: lack of consensus of what constitutes mental disorders and how to treat them Mimetic pressure: patient's dependency on hospitals, issues of insurance coverage, cultural differences	High
7	van Ginneken et al,[43] India	No framework used; Themes inductively identified from interviews matched with typology of health system policies	District level	Interviews with key stakeholders Document analysis of relevant policies	1) Governance arrangement: leadership, accountability and transparency, international influence, participatory and inclusive decision-making 2) Financing arrangement: hurdles in the early years, hurdles in the last decade 3) Delivery arrangements: organization of services at PHC level, health workforce (PHC workers and specialists)	Coercive pressure: inadequate leadership, poor accountability mechanism, poor funding Normative pressure: poorly motivated and trained health workforce Mimetic pressure: non-existent engagement of users, disregard for users' social and cultural contexts	Medium
8	Mugisha et al,[46] Uganda	Health system governance framework by Siddiqi et al[35,38]	National and district level	Interviews with key stakeholders	1) Strategic directions: mental health policies 2) Rule of law 3) Responsiveness and integration 4) Effectiveness and efficiency: human resources, financing 5) Medicines and technologies 6) Participation and collaboration 7) Equity and inclusiveness 8) Ethics and oversight 9) Intelligence and information 10) Accountability and transparency	Coercive pressure: national mental health policy still in draft form, outdated law, lack of priority and funding, weak implementation of monitoring and evaluation Normative pressure: lack of human resource capacity and training, negative attitudes by providers, poor infrastructure Mimetic pressure: poor community participation, presence of stigma	Medium

Table 2. CERQual Evidence Profile and Summary of Qualitative Findings (SoQF) Table.

Key findings	Studies supporting key findings	Component 1: methodological limitations	Component 2: coherence	Component 3: adequacy of data	Component 4: relevance	Overall CERQual rating for confidence assessment	Explanation of CERQual rate
Lack of clear leadership for mental health at the top level with divergence of direction between the national level and local leadership (ie, state and district)	Abdulmalik et al,[12] Hanlon et al,[34] Marais and Petersen,[35] Petersen et al,[40] Upadhaya et al,[41] Janse van Rensburg et al,[42] van Ginneken et al,[43] Mugisha et al[46]	Minor methodological limitations.	No or very minor concerns about coherence.	No or very minor concerns about adequacy of data.	Minor concerns about the relevance.	High confidence	Minor concerns regarding methodological limitations, relevance, coherence and adequacy.
Greater priorities are given to communicable diseases and diseases with high mortality heightened by low political will as a result of poor community demand and lack of data on mental disorders.	Abdulmalik et al,[12] Van Rensburg et al,[36] Siddiqi et al,[38] Petersen et al,[40] van Ginneken et al[43]	Minor methodological limitations.	Moderate concerns about coherence	No or very minor concerns about adequacy of data.	Minor concerns about the relevance.	Moderate confidence	Some concerns about the fit between the data from 3 primary studies that mention priority given by government for mental health integration and the review finding.
Mental health budget was not specifically available or only provided as part of lump-sum for district health activities with various issues on problematic historical budgeting process, inability to access funds and inequal distribution.	Abdulmalik et al,[12] Hanlon et al,[34] Marais and Petersen,[35] Petersen et al,[40] Upadhaya et al,[41] Janse van Rensburg et al,[42] van Ginneken et al,[43] Mugisha et al[46]	Minor methodological limitations.	Minor concerns about coherence.	Minor concerns about adequacy of data.	Minor concerns about the relevance.	High confidence	Minor concerns regarding methodological limitations, relevance, coherence and adequacy.
Shortage and poor distribution of trained primary care staff for mental health, with high staff turnover, poor supervision, confusion on roles and responsibilities with lack of accredited, high standard training programs.	Abdulmalik et al,[12] Hanlon et al,[34] Marais and Petersen,[35] Petersen et al,[40] Upadhaya et al,[41] Janse van Rensburg et al,[42] van Ginneken et al,[43] Mugisha et al[46]	Minor methodological limitations.	Minor concerns about coherence.	Minor concerns about adequacy of data.	Minor concerns about the relevance.	High confidence	Minor concerns regarding methodological limitations, relevance, coherence and adequacy.
Prevalent negative attitudes toward mental health both from the community and primary healthcare works due to lack of awareness and cultural acceptability of available treatments for mental disorders affected by low involvement of service users in planning. Clear policy frameworks to address stigma were also not apparent.	Abdulmalik et al,[12] Lewin et al,[31,32] Van Rensburg et al,[36] van Rensburg and Fourie,[37] Siddiqi et al[38]	Minor methodological limitations.	Minor concerns about coherence	Minor concerns about adequacy of data.	Moderate about the relevance.	Low confidence	Minor concerns regarding methodological limitations, and coherence. Moderate concern regarding adequacy of data as 2 studies were silent on this issue. Moderate concern regarding relevance as studies covers only a subgroup of the population and there may be differences in the focus of perspective.

governance issues were mapped according to the 3 types of isomorphic pressures mentioned earlier. For instance, issues pertaining to government laws, legislations, structural, and operational issues were categorized under coercive pressure; issues in relation to workforce capacity, training, and work culture were categorized under normative pressure; and issues in regard to public opinion and community cultural influences were categorized under mimetic pressure.

Health System Contexts of the Countries

The countries included in this study shared similar characteristics in terms of health service provision in the public sector. In this regard, each country experienced an expansion of primary healthcare services and significant public healthcare reforms during the past decade. Each country also included a primary healthcare structure that was responsible for ensuring that mental health services were integrated into the broader health system and delivered to the wider population.

Another common characteristic among the countries was the flow of policy formulation, proposals, and implementation. For example, policies pertaining to mental health were formulated and proposed at the federal/national level in the Ministry of Health, while policy implementation commonly involved state/provincial coordinators and planners engaged in primary healthcare and mental health. Subsequently, ground-level implementation was supervised by district-level managers of primary and mental healthcare services.

Governance Issues Related to Leadership and Direction

Leadership is closely related to governance in terms of strategic vision, accountability, responsiveness, and participation. Thus, good governance may not thrive in the presence of poor leadership.[9] In this regard, issues of leadership were found in more than half of the reviewed articles, including a lack of commitment in building strong relationships, a lack of professional advocacy for mental health and a lack of transparency in decision-making.[35,39] More specifically, Nepal had an absence of leadership at the Ministry of Health level, whereas Ethiopia and South Africa included strong mental health leadership at the highest level, with weaker leadership at the lower levels of their respective health systems.[34,41,42] In addition, there were unhealthy conflicts between the central and provincial leadership, which was attributed to their political struggle for power. For instance, the leadership at the central level failed to provide sufficient direction for successful governance. This resulted in the further mismanagement of the limited funds assigned to mental health.

Issues of leadership continuity also emerged, due to the decline of motivated and capable mental health professionals (eg, psychiatrists) involved in the planning and implementation of mental health programmes at all levels (ie, central/federal, state/provinces and district/regions).[34,43] Meanwhile, the approach of assigning mental health professionals to lead service planning and coordination was limited by the small number of specialists and their lack of leadership training and experience. In 1 study, a leadership "buy-in" was introduced to ensure a consensus in strategic direction. This is generally achieved when the needs of the population are recognized and grounded in trust.[44]

Finally, issues related to leadership and direction were highlighted by the majority of the countries studied. For instance, some countries experienced a deficiency of clear leadership at the top level, while other countries experienced a discrepancy between the national direction for mental health and local leadership at the lower levels of their health systems (eg, provinces, states or districts). Such situations have negatively impacted the governance of health systems and the smooth integration of mental health.

Governance Issues Related to the Prioritization of Mental Health

The prioritization of mental health is also linked to strategic vision, responsiveness, and participation. Thus, the governance of integrated primary mental healthcare can be affected by low prioritization of mental health, since it affects how policymakers promote certain agendas.[45] Many studies have emphasized that mental health has not been prioritized at the central level because greater priorities are given to communicable diseases (eg, HIV and tuberculosis), which are more in line with current global health priorities[12,34,35,42,43,46] Although non-communicable diseases are gradually increasing in political priority, there are concerns that such diseases will be prioritized over mental health.[34]

Low prioritization was also described as a result of low political will, which stems from low community demand and is commonly associated with stigma, negative attitudes and a peculiar public view that separates mental health from general physical health.[34,35,46] In addition, a lack of data on the prevalence of mental disorders was identified as a barrier to prioritising mental health.[41] The lack of mental health prioritization in some countries has also been attributed to prioritising diseases that have a stronger link to mortality, as opposed to "hidden" diseases such as mental disorders.[12,35,46]

In sum, mental health has frequently been overshadowed by communicable and other non-communicable diseases in most countries. This has not only affected how far leaders will promote mental health agendas, but it has also decreased the demand from the community and the prioritization of mental health.

Governance Issues Related to Financing and Resource Allocation

Financing is a critical factor for ensuring that mental health plans and policies are translated into action (via the allocation of resources), while governance acts as the oversight and control for the financial mechanism to align with the objectives of the institution.[47] In addition, with adequate financing, the delivery of mental health services, the development of a trained workforce and good infrastructure can be acquired.[48]

Financing and allocation issues for mental health at the primary healthcare level were found in all 8 studies. For example, in Nepal, mental health services were not available at primary healthcare centers in most of its districts. Moreover, the budget allocated for mental health was mostly directed toward 1 particular mental hospital in Kathmandu.[41] As for the other studies of low-income countries, such as Ethiopia and Uganda, the budget allocated for mental health was provided as part of a lump-sum distribution, based on district-level priorities of health activities and programmes.[34,46] In particular, although mental health received a limited budget in Ethiopia, due to the low priority of district actors, the government recently dedicated additional funds toward improving integrated primary mental healthcare activities. Regarding lower middle-income countries, such as Nigeria and India, financial allocation for mental health, at both the state and district levels, were available.[12,43] However, the issues were more related to the inability to access funds, due to various administrative and political challenges.

In regard to South Africa (an upper middle-income country), 1 study reported inadequate funding, with problematic budgeting processes in which the allocation of funds was based on historical budgets and disparities in the distributions among the provinces.[35] Other studies stated the need for appropriate cross-subsidization and private-public partnerships in order to deliver mental health services, upgrade health facilities and optimize the limited resources in the public sector.[37,42]

Overall, financing and resource allocation issues were strongly emphasized by all the countries involved. More specifically, the countries experienced inadequate funding for integrated primary mental healthcare and related problems in implementing such services in the public sector, especially at the ground level.

Governance Issues Related to Human Resource Capacity and Training

Professional capacity affects organizational characteristics, and this is linked to the principles of good governance (ie, responsiveness, effectiveness, and efficiency). In this regard, several studies described that the shortage of trained primary care staff for the community significantly affected the integration of mental health into primary healthcare.[12,34,35,41,43,46] This was also closely related to high staff turnover of primary care workers at the district and facility levels.[34,35,41] In addition, since there was some confusion regarding who was responsible for providing community-based services, more role clarification between groups of providers was necessary. Other highlighted issues included: poor distribution of the workforce and a high attrition rate to the private sector or outside of the country.[43]

Finally, several studies mentioned that the lack of mental health training among health professionals was a barrier to good governance.[34,35,41,43,46] Moreover, in certain countries, there was not only poor supervision, and support for newly trained primary care workers, but there were also training programmes that lacked accreditation, maintained low standards, and included inadequate delivery times.[41,46]

Governance Issues Related to the Perceptions and Attitudes Toward Mental Health

In general, organizations attempt to copy/mimic other activities, systems, and structures to appear like their counterparts and receive a positive evaluation from the public. How the perceptions and attitudes toward mental health relate to this is their effect on an organization's accountability and level of conformity to public demands.[25] Negative attitudes toward mental health (eg, stigma and discrimination) have been described as a barrier to good governance in many countries.[12,34,35,41,46] The lack of awareness on how debilitating untreated mental disorders can become and the cultural acceptability of available treatments for mental disorders were additional barriers to accessing effective care.

Furthermore, negative attitudes toward mental disorders were prevalent among primary healthcare workers, which was due to inadequate training and a lack of engagement.[34,35,46] In this regard, the statements included: psychiatric patients should require hospital treatment; mental health issues should not be 1 of the responsibilities of primary healthcare providers; and available policy frameworks should clearly address how to deal with stigma at all levels.[34,35]

Discussion

This systematic literature review showed that empirical studies on the governance of integrated primary mental healthcare are still limited. Nevertheless, after mapping the influencing governance factors (based on institutional theory), similar issues were found among the countries studied.[25,49] Overall, the main governance issues identified were a lack of leadership and mental health prioritization and; inadequate financing and human resource capacity; and negative mental health perceptions/attitudes.

First, a lack of prioritization of mental health at the country level is strongly linked to issues in leadership and strategic direction, which, in turn, has an impact on health system

governance. However, there has been a growing global push to remove mental health from the side-lines and make it 1 of the main issues in the international development agenda.[50] As highlighted in the WHO's Mental Health Action Plan 2013 to 2020, several evidence-based interventions have been effective in promoting, protecting and restoring mental health, beyond institutionalization.[6] These interventions may also provide substantial health and economic returns when appropriately implemented. With this in mind, country leaders should provide better direction for the integration of mental health into primary healthcare via strong policies and correct implementation.

Second, the challenges in financing and human resource capacity have a bearing on the governance of integrated primary mental healthcare. In fact, a sustainable mental health system can only be realized with adequate financing.[51] It is also the mechanism whereby plans and policies are translated into action through the allocation of resources. Thus, in order to ensure that the governance of mental health systems is not compromized, it is crucial that sufficient funding for mental health is included as an important national agenda. Related to financing is the distribution of human resource capacity and training at the ground level. In this regard, effective delivery of mental healthcare in primary care settings should be supported via community-based approaches that assist non-specialists/general health professionals, with training and supervision from mental health specialists.[52]

Third, the prevalent negative attitudes and perceptions toward mental health problems, be it from the primary healthcare workforce or from the community, have negatively impacted the governance of mental health systems and created barriers to accessing care.[32-34] Some countries do not have clear policy frameworks that address stigma at all levels. However, there has been a global, multisectoral effort regarding mental health promotion and prevention, with the aim of reducing discrimination, stigmatization and human rights violations.[6,14] It is hoped that proper advocacy and implementation at the country level will bring about positive changes.

This review also demonstrated that it is important to have an overall perspective of mental health system development. In this regard, several landmark publications have been published on mental health, the most notable being the WHO's 2001 World Health Report, with the message "new understanding, new hope."[5] Subsequently, the WHO published the Mental Health Gap Action Program and its intervention guide,[10,16] the Grand Challenges for Global Mental Health[52] and the Comprehensive Mental Health Action Plan 2013-2020, which includes a health systems approach to addressing the global burden of mental health disorders.[6] Meanwhile, ongoing work is focused on the disease burden of mental health disorders and the effectiveness of local interventions.

Finally, the studies on mental health system development and strengthening are still limited. Thus, it is important for countries, especially those undergoing the epidemiological transition toward non-communicable diseases and chronic conditions (eg, mental health disorders), to continue focusing on such development. With this in mind, the international "Emerging Mental Health Systems in Low-and-middle-income countries" (EMERALD) research project, which lasted from 2012 to 2017, was developed to improve mental health outcomes by enhancing health system performance.[54] The context of this international development project was reflected in the findings of this review, whereby 7 out of the 8 articles were within the aforementioned time frame, including 6 countries that participated in this project.

Conclusion

This systematic review examined the findings of empirical studies on the governance of integrated primary mental healthcare in the Sub-Saharan and South Asia region. By drawing on institutional theory, several important and interrelated governance issues were revealed, including: a lack of leadership and mental health prioritization; inadequate financing and human resource capacity; and negative mental health perceptions/attitudes. Overall, this review provided a consensus on the critical mental health system governance factors that need to be addressed at the national level. It can also serve as a reference point for other countries to improve their mental health integration into primary healthcare.

Disclaimer

No portion has been presented elsewhere.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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