At the time of writing, the UN General Assembly is meeting in New York, NY for its September 2023 meeting, and at the top of the agenda is a two-day Sustainable Development Goals (SDGs) Summit. “Now is the time for a global plan to rescue the Sustainable Development Goals (SDGs) which are woefully off-track halfway towards their 2030 deadline,” UN Secretary-General António Guterres said on Monday in New York.(1)

In 2015, 193 countries pledged to reduce premature noncommunicable diseases (NCD)-related mortality and risk factors by 2030 in efforts to meet targets for SDG 3.4, which encourages countries to reduce by one third premature mortality from NCD through prevention and treatment and promote mental health and well-being.(2) Globally, NCD are the leading cause of morbidity and mortality with an estimated 41 million deaths (74% of all global deaths) annually.(3) Yearly, 17 million people die from NCD before the age of 70 years and low-and-middle income countries (LMICs) account for 86% of these premature deaths.(3) Also, LMICs accounted for 77% of all global NCD deaths in 2022.(3) Despite the high burden of NCD-related morbidity and mortality in LMICs, recent evidence reveals that no country in this geopolitical zone has made significant progress towards meeting SDG 3.4 target by 2030.(4)

SDG 3.4, and closely related SDG 3.5, mention mental health and substance use disorders (SUD) specifically among the NCD. Mental health and SUD contribute significantly to the burden of diseases globally; approximately 300 million people are affected with at least one form of mental disorder.(5) An estimated global prevalence of 2.2% of the population has at least one form of SUD.(6) People with mental disorders frequently also experience SUD. (7) Mental health and SUD combined cause over 11 million deaths and more than 225 million disability-adjusted life-years (DALYs) each year.(8) These are likely underestimates, particularly for LMIC where detection rates are low,(9) and mental health services are inadequate.(9) One of the reasons these are specifically called out among NCD is that mental health is inextricably linked with other SDG domains including early child development, education and life-long learning, employment and working conditions, minimum income for healthy living, healthy and sustainable housing and communities, and a social determinants approach to prevention.(10) To achieve the 2030 SDG, not just the ones related to NCD, mental health and the factors most immediately affecting it must be a priority.

Implementation research on NCD programs in different regions and settings could promote cost-effective and efficient ways to scale-up life-saving health system strategies to reduce NCD-related morbidity and mortality.(11) There are well-supported, evidence-based NCD prevention and treatment interventions, and there has been an attendant growth in NCD implementation studies, yet there is limited published literature on large-scale, system and country-level NCD implementation research, especially in LMICs.(11) Mental health and SUD-focused interventions are no exception; few have been established at a regional or national scale due to issues such as lack of context-specific understanding of target populations or adequate resources to implement at scale.(12)
We would argue that mixed-methods, stakeholder-engaged theoretically informed implementation research is specifically suited to move progress toward the mental health and SUD SDG forward by addressing two major concerns: (1) the inequalities that characterize mental healthcare in all countries but especially LMICs and (2) the lack of systems-level prioritization needed to improve access to and quality of mental healthcare.

The theoretical models and methodological innovations of implementation science are well-suited to address inequalities and lack of prioritization around mental health and SUD in LMICs in several ways. The focus on context that is inherent in implementation research facilitates a critical baseline understanding on what the gaps in service provision for mental health and SUD and more broadly public health in general are in a specific context (i.e., country). This allows governments and other funders and policy makers to prioritize interventions designed for and/or adapted to the local system rather than tools or guidelines or other interventions that have worked elsewhere. Further, by engaging stakeholders and using qualitative as well as quantitative methods to characterize the system from the perspective of those most affected, implementation research can help identify and address systemic inequalities, such as those between urban/rural populations, as well as structural inequalities based on socio-economic status and other deeply embedded population characteristics.

This commentary provides an example of one lower-middle-income country, the United Republic of Tanzania, to concretely illustrate the challenges in achieving the 2030 SDG around NCD and specifically mental health and SUD and how implementation science might help move progress forward towards the goals. In Tanzania, a recent situational analysis revealed neurosis, epilepsy, psychosis, and SUD contributed 17% of all cases of NCD at primary health care (PHC) facilities. Despite the scope of the problem, there are significant and critical gaps in the provision of mental health care in Tanzania, including insufficient numbers of providers, inadequate funding, and poor levels of health system preparedness. The 2020 WHO Mental Health Access showed that government’s total expenditure on mental health was just 4% of total government health expenditure. Access to mental health services is extremely limited, and available predominantly at secondary and tertiary care facilities (regional and zonal level facilities that cover several administrative regions). Furthermore, the current burden of mental health and SUD is likely underestimated due to several factors, including stigma as a barrier to seeking care and health management information systems vary significantly depending on the level of care at PHC facilities. Most facilities still utilize paper-based health management systems for preparation of monthly, quarterly, and annual reports, with archeaic case definitions for various mental health and SUD; conditions are classified as either psychosis, neurosis, epilepsy, or substance misuse. At the regional, zonal, and national referral levels, however, diagnostics follow international classifications guidelines such as the International Classification of Diseases (ICD) or the Diagnostic and Statistical Manual for Mental Disorders (DSM). As a result, these data are lost in translation between the local and regional facilities and the higher-level facilities and national policy makers. An efficient national data system and repository would facilitate the reliable and timely reporting of the statistics.

Reflecting on two of the main challenges in mental health and SUD that can be addressed by implementation science, there are significant inequalities around mental health in communities and health systems in Tanzania. While there are generally very few resources available for mental health in Tanzania, those that do exist are only available in urban and semi-urban areas. This not only disadvantages those in rural areas who also tend to have fewer resources and less capacity to travel to areas where mental health and SUD care is available, but it makes the system even more fragmented. In addition to the lack of service availability, there is increased stigma around mental health among rural populations, which means that people are less likely to seek services. The reasons for mental health stigma can vary by region but causes include lack of education and awareness as well as spiritual and faith-based beliefs. Implementation science can begin to address these disparities for rural populations on multiple levels; meaningful and rigorous stakeholder-engaged data collection can help build an understanding of the challenges faced by rural populations. This work would include community-based participatory approaches to identify and adapt strategies to address context-specific challenges. For example, training community health workers (CHW) to deliver some of the services has been shown to help expand service coverage for screening, treatment, follow up, linkage to care, and long-term management of mental health and SUD. Working with local community leaders and care providers could help implementation of a mental health intervention by CHW for rural populations that can’t access care otherwise. In addition, CHW from the community itself are also uniquely positioned to address stigma-related challenges around socially held beliefs about mental health.

Implementation science can also help address the issues about prioritization for mental health and SUD in Tanzania by leveraging recent political will to address challenges and make progress toward SDG and universal coverage. Last year, Tanzania held its first-ever national mental health dialogue during which government ministers and parliamentary representatives highlighted multiple challenges and identified pathways to advance efforts toward equitable access to mental, neurological and SUD care. These included focus on implementation of the Framework to Implement the Comprehensive Mental Health Action Plan in the WHO African Region, mental well-being for children and adolescents, and reform of policies and legislation promoting mental well-being such as strengthening the health workforce and other system-level
Implementation methods should work with multilevel stakeholders, including those with lived experience of mental health and SUD. These methods should also identify where resources would be most effective as well as recognize appropriate interventions that would be feasible, acceptable, and cost-effective for the gaps that exist in the Tanzanian system nationally and regionally.

In short, implementation science is uniquely suited to address the gap between evidence-based interventions that are known to improve mental health and SUD care delivery and outcomes for populations in low resource settings with its critical focus on context and its synthesis of multiple methodological and theoretical traditions. Rigorous implementation research would help target specific gaps in infrastructure, such as within data systems, and would also identify and incorporate feedback from the stakeholders most affected by challenges at all levels of the system. Advances in implementation research incorporating lessons from behavioral economics and cost analysis could also provide the type and scale of data that could make mental health and SUD, and NCD more broadly, a priority for policy makers and funders that would have a clear return on investment. Finally, implementation science also provides structure to bring together expertise across disciplines and stakeholder groups to co-create knowledge and together identify practices to address gaps in care delivery and outcomes that are critical if we hope to achieve the SDG by 2030.

REFERENCES
