Motivation and methods of external organisations investing in mental health in low-income and middle-income countries: a qualitative study

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Summary

Mental disorders (including substance use disorders, dementia, and self-harm) account for a substantial burden of disease and economic costs in low-income and middle-income countries (LMICs), yet they attract little funding. External resources are urgently needed but evidence on investments is scarce. This Health Policy paper uses 35 elite interviews and documentary analyses to examine how and why external organisations have invested in mental health in LMICs over the past three decades, and how this investment has changed over time. Four levels are examined: organisations, source countries, recipient countries, and global landscape. Organisations have invested in numerous internal and external activities. Among the various factors shaping organisational decisions, actors (ie, individuals and organisations concerned with mental health) were the most salient at all four levels. To increase external organisation investments in mental health in LMICs, organisational leadership and understanding are crucial, along with increased political support in source and recipient countries, and a stronger governance structure at the global level.

Introduction

Around the world, 1·2 billion people live with mental disorders (including substance use disorders, dementia, and self-harm), 81% of whom live in low-income and middle-income countries (LMICs).[1] Although mental disorders are the leading cause of disability in LMICs[2] and account for high economic costs,[3] they attract little funding: an average of 1·6% of government health budgets across LMICs[4] and 0·4% of development assistance for health.[5] The *Lancet* Commission on global mental health and sustainable development called for more domestic and external resources for mental health to address this shortfall.[6]

Having been long neglected globally,[7] mental health is now gaining prominence in the global discourse,[8] albeit without concomitant funding. The UN Addis Ababa Action Agenda[9] and the UN Sustainable Development Goals (SDGs)[10] recommend mobilisation of external resources from various sources (eg, development assistance, foreign direct investments) along with a gradual increase of domestic resources to ensure sustainability. External resources are especially key in LMICs, where governments face considerable economic pressures. It is therefore important to understand how external organisations invest in mental health in LMICs and what influences their decision making.

A large and complex ecosystem of external organisations for mental health in LMICs exists across the public, private, and third sectors, yet their contributions are limited.[11] For instance, although development assistance for mental health has increased six times between 1995 and 2015, it still accounts for the lowest amount of development assistance for health per disability-adjusted life-year (ie, year of healthy life loss) across health conditions.[5] Philanthropy plays an essential role, representing one-third of development assistance for mental health compared with one-sixth of development assistance for health.[12]

Diverse arguments have been advanced to increase investments in mental health in LMICs, from public health to economic welfare, economic growth and productivity, equity, sociocultural influence, and political influence.[4] However, commitments have been hampered by poor understanding of mental disorders, shortage of strong metrics, stigma, and competing priorities.[13,14] To my knowledge, no study has yet explored prioritisation of mental health in LMICs by external organisations. A broad body of literature explores the generation of priorities in health at global levels[15] and resource allocation formulas,[16] but little attention is given to factors affecting prioritisation within external organisations.[17]

This Health Policy paper examines the motivations and methods for external organisations' investment in mental health in LMICs over the past three decades, and identifies challenges and opportunities to inform discussion on sustainable financing for mental health in LMICs.

Methods

Data collection

I did 35 elite interviews (from February to December, 2018) lasting on average 1h (0·5–1·5 h) with decision makers working in international organisations in global health and experts in global mental health, who were selected for their strategic position and influence.[18] Participants were selected using purposeful sampling and snowballing until saturation (ie, the point at which additional interviews were unlikely to reveal new information).[19] Purposeful sampling was informed by a systematic review of external organisations active in mental health in LMICs[11] and by documentary searches in websites of key international organisations working in global health and development.

To capture the heterogeneity of the population, participants were sampled for diversity according to their organisation group:[11] public sector (bilateral and multilateral governmental organisations, bilateral and multilateral development finance institutions), private sector (corporations and small and medium enterprises, foundations), third sector (non-governmental organisations), and multisector partnerships (global health initiatives, innovation funds; panel 1). 28 organisations from 12 countries in three regions (Africa, the Americas, and Europe) were represented (appendix p 4).

I did in-depth semi-structured interviews face-to-face and via telephone or Skype in English and Italian. The interview guide was individually adapted to elicit the knowledge of each participant (appendix p 5). Informed consent was obtained from participants in writing or orally before the interview. Interviews were digitally recorded when permitted (n=29) and notes taken. Recordings were transcribed verbatim, along with interview and field notes. To triangulate information across different sources and minimise bias during data analysis,[20] I supplemented interviews with documentary analyses of peer-reviewed and grey literature, and institutional websites for included organisations (eg, scientific papers, charters, strategic plans, policy and financial reports, and public statements).

Data analysis

Thematic analysis was used, organising data into two themes (methods and motivations) and allowing for emergence of new categories.[21] The first theme explored methods through three sub-themes: activities, arguments, and strategies. The second theme explored endogenous and exogenous factors shaping organisations' decisions through four sub-themes: organisations, source countries where organisations were legally registered (not applicable for multilateral actors), recipient countries, and global landscape. To facilitate interpretation within each sub-theme, I grouped results in the four main categories proposed by Shiffman and Smith:[22] actors (ie, individuals and organisations concerned with the issue); ideas shaping the understanding and portrayal of the issue; contexts in which actors operate; and issue characteristics (credible indicators, severity, and interventions). The full analytical framework is included in the appendix p 6.

The unit of analysis was the organisation. To maximise the robustness of data and minimise bias, I triangulated across data sources. Analyses were done in NVivo 12, and to ensure confidentiality, interview quotations were anonymised (appendix p 7). I followed the Standards for Reporting Qualitative Research (appendix p 2).[23] Ethical approval was obtained from the London School of Economics and Political Science Research Ethics Committee (reference number: 000589).

***Panel 1*: External organisations investing in mental health[11]**

Public sector

Governmental organisations providing goods and services to low-income and middle-income countries (LMICs) in agreement with recipient country governments, and development finance institutions (DFIs) offering financial products (eg, loans) in contexts perceived too risky for commercial banks. Bilateral governmental organisations are funded by a single state through aid agencies and other governmental agencies investing in development (eg, US Agency for International Development, ministries of foreign affairs or their equivalents), whereas multilateral governmental organisations are funded by diverse states at the regional, international, and global level (eg, European Commission, WHO). Similarly, bilateral DFIs are funded by a single state offering financial products usually at commercial rates (eg, US Overseas Private Investment Corporation), whereas multilateral DFIs offer financial products usually at facilitated rates and are funded by diverse states at regional, international, and global level (eg, African Development Bank, World Bank).

Private sector

Corporations and small and medium enterprises (CSME), and foundations. CSME are for-profit organisations providing goods and services to or in LMICs through foreign investments (eg, foreign direct investments) and corporate social responsibility (eg, financial and in-kind contributions). Foundations are non-profit organisations often making grants and mostly funded either by for-profit companies (eg, Microsoft Philanthropies) or gift of shares and endowments from wealthy individuals and their families (eg, Bill & Melinda Gates Foundation).

Third sector

Heterogenous non-profit organisations providing goods and services in LMICs, spanning non-governmental organisations (eg, the UK-based BasicNeeds), professional associations (eg, World Psychiatric Association), and research centres.

Multisector partnerships

Multi-stakeholder partnerships initiated by organisations from two or more sectors to increase visibility and resources for global health issues, such as global health initiatives (eg, Global Fund to Fight AIDS, Tuberculosis and Malaria) and innovation funds (eg, the UK's Dementia Discovery Fund).

Results

Over the past three decades, external organisations have invested in mental health in LMICs through a broad range of internal and external activities (table 1). Some organisations have invested in the mental health of their employees through improvement of mental health standards in the workplace, especially among corporations. Other organisations have strengthened their mental health capacity, especially in the public and third sectors, through the establishment of mental health advisors, communities of practice, training, guidelines, and monitoring and evaluation of funded mental health activities. Finally, some organisations have supported external activities, including mental health requirements in funded projects, standalone programmes, integration into existing priorities, new priority areas, and using their convening power to advance the global mental health agenda. Six different arguments have been used to make the case for investment in mental health: public health, human rights, economic effects, country priorities, moral considerations, and happiness (panel 2). External organisations have used two investment strategies: standalone and integrated (panel 3). The following sections identify factors that shaped organisations' decisions to commit to mental health in LMICs (appendix p 7).

	Action	Description
Within organisations		
Organisations' mental health	Wellbeing activities	Wellbeing programmes and activities for all employees aiming to promote mentally healthy environments (interview 5)
	Mental health awareness training	Mental health awareness training aiming to strengthen mental health literacy; for instance, Mental Health First Aid courses to provide employees with knowledge and skills needed to recognise mental health symptoms, and support colleagues in recovery (interview 5)
	Mental health peer support	Peer support groups for individuals living with or caring for people with mental disorders aiming to create a support network and an advocacy entity within the organisation (interview 21); support groups are easier to introduce in organisations that have already established other employee groups (eg, for minorities or women)
	Mental health support	Support programmes for employees living with mental disorders aiming to improve their work experience and recovery (interview 21)
Organisations' mental health capacity	Mental health advisor	Creation of the new role of mental health advisor with the purpose to advise on, coordinate, and amplify the organisations' activities in mental health (interview 21, 29); in larger organisations, this role may be assisted by regional and sometimes country advisors (interview 19)
	Mental health community of practice	Network of employees working in or interested in mental health, aiming to share useful resources and lessons learnt through funded activities, and to offer employees a reference group to turn to for concerted advice (interview 34)
	Mental health training	Mental health training across different departments with two purposes; on the one side, initial learning journeys not only to strengthen mental health capacity but also to identify possible entry points for the organisation (interview 31); on the other side, more regular mental health training, especially recommended in organisations with high staff turn-over
	Mental health guidelines	Production of guidelines describing the organisation-specific approach to mental health, aiming to harmonise contributions across the organisation (interview 30, 34)
	Mental health activities monitoring and evaluation	Monitoring of mental health activities funded outside the organisation to ensure transparency and accountability (interview 20); evaluation to inform future investments and to strengthen mental health capacity through knowledge building and sharing, especially when included in mental health guidelines
Outside organisations	Requirements for all projects	Mental health considerations across all projects, with broad variation in scope: from recommending integration of mental health components to recipients (though with difficult uptake; interview 4), to ensuring all recipients meet relevant development requirements (eg, non-discriminatory practices toward people with mental disorders; interview 27), and requiring the inclusion of mental health components within funded activities (interview 20)
	Standalone programme	Standalone mental health programmes or initiatives, often with a health focus (interview 32; Panel 3)
	Integration in existing programmes	Integration of mental health into organisations' existing priority areas, and across different health conditions, sectors, and themes (interview 31; Panel 3)
	Priority areas	Mental health as a priority area
	Convening power	Use of the organisation's convening power to advance the global mental health agenda and increase contributions (interview 18, 22, 34)

***Table 1*: Organisation activities for mental health**

Panel 2: **Arguments for investing in mental health**

Over the past three decades, six different arguments have been used by organisations to make the case for investment in mental health, often simultaneously, and organisations have responded to different arguments aligned with their values and priorities (interview 4, 26).

Public health

This argument focuses on the scale of the problem and availability of solutions.[6] The size of the problem is described as the product of the number of people affected (eg, prevalence), the amount of disability attached to the condition (eg, disability-adjusted life years) (interview 7, 21), and the amount of unmet need (eg, treatment gap, which is the gap between need for and provision of services). Available effective solutions are recommended to address needs. This argument has been widely used across all organisations. Public health framing has been unsuccessful in the past when benefits of interventions were advanced without adequate evidence (interview 26).

Human rights

This argument focuses on human right abuses (eg, chaining, torture, sterilisation)[24] and inequities (eg, lack of parity between physical and mental health care). Often deploys illustrative before-and-after stories highlighting the effectiveness of available solutions to seize people's imaginations (interview 10) and to create an emotional connection (interview 7). This argument has been most successful among rights-based organisations and organisations in which personal relationships play more prominent roles (eg, small foundations) (interview 10).

Economic effects

This argument highlights productivity losses and societal costs of mental disorders, with economic effects at individual (eg, income loss) and societal levels (eg, gross domestic product loss),[3] and the potential return on investment in interventions.[25] The economic argument has gained prominence across organisations over the past decade due to growing availability of economic data, yet often is an insufficient argument on its own (interview 4). This argument has been especially relevant in for-profit organisations (eg, corporations).

Country priorities

This argument emphasises requests for support from source and recipient countries. Requests for support from source countries highlight the importance of donor-driven priorities, whereas the requests for support from recipient countries align with the principles of ownership (ie, recipient-driven priorities) and sustainability of impact beyond funded activities. This argument has been used especially within public sector organisations (interview 4).

Moral considerations

This argument frames contributions to global mental health as the right thing to do.[26] Less often used, this argument has been justified as aligned with organisational values (interview 5). For instance, in some organisations, ethical considerations led to the integration of mental health components within funded activities (interview 20).

Happiness

This argument portrays mental ill-health as the major cause of unhappiness,[27] and transcends the public health argument (interview 15). This argument has emerged more over the past decade, concomitantly with the happiness and wellbeing agenda globally.

Panel 3: **Strategies used by external organisations investing in mental health**

Standalone strategy

This strategy promotes mental ill-health as a standalone problem, often limited to the health sector (interview 32). Traditionally, it has been the prominent strategy. However, organisations have realised that mental ill-health is a different challenge that cannot be addressed with the same strategies used for other health conditions (interview 13).

Integrated strategy

This strategy pulls together mental health programmes and activities within organisations' existing priorities: different health conditions (eg, HIV/AIDS),[28] sectors (eg, education, employment, criminal justice),[29] and themes (eg, gender, disability, youth;[30] interview 6, 12, 15). It is beneficial not only for addressing mental disorders but also for amplifying the effect of investments in existing priority areas (interview 29). Stronger evidence and better articulation of those links have facilitated the identification of entry points within organisations' existing priorities (interview 15). This strategy is now gaining prominence and success.

The emergence of an integrated strategy has benefitted from traction gained by the multisectoral and life-course approaches in mental health. The multisectoral approach advocates for a whole-society response, coordinated across sectors and areas of life (interview 28, 34). The life-course approach frames the effect of investments over the lifetime, from childhood to adulthood, and across generations (eg, from individuals to their children and vice versa; interview 6). This approach has benefitted from an increased focus on non-communicable disorders already adopting it, and the inclusion of mental disorders within non-communicable disorders (interview 28). Those approaches have been gaining traction especially among organisations in the public sector, possibly due to more sizeable investments and opportunities to adopt a systemic approach, often in partnership with governments of low-income and middle-income countries.

Organisations

Individuals within organisations were pivotal in prioritising mental health in LMICs. First and foremost, leaders were central in shaping priorities from the top down (interview 22, 28) linked to personal expertise and interests, and a desire for personal legacy (interview 32). Along with leaders, champions within the organisations were instrumental in pushing the agenda from the bottom up (interview 5, 23) using diverse arguments to make the case for investments (panel 2), yet their actions were insufficient, and other factors often acted as catalysts (eg, natural disasters; interview 19).

Improved understanding and destigmatisation of mental health within organisations favoured investments. In the past, poor understanding led to missed opportunities (eg, exclusion of mental disorders from non-communicable disease packages; interview 8) or misplaced contributions (eg, to institutions instead of community-based services for people living with mental disorders; interview 1). Over the past decade, better cognisance of mental health as a health issue with multiple effects across sectors and dimensions of life revealed entry points across organisations (interview 5, 21; panel 3). In addition, the global scale of the issue meant that it resonated among most employees as individuals with lived experience or as carers (interview 4, 5).

Organisational contexts shaped commitments in five ways. First, the relevance of mental health for organisations' strategic roles and priorities influenced the type of investments more than its prioritisation (interview 19, 21, 28). In particular, the large number of existing priorities and unfinished work in established areas meant that organisations were less likely

to take on new challenges, unless integrated into existing programmes and activities (interview 13; panel 3). Second, financial capacity and the principle of impact maximisation affected decisions. Organisations often prioritised mental health as a neglected area in which (often small) contributions could have a large social or financial return on investment (interview 1, 5, 12, 14, 19). Third, in the past, a lack of internal capacity hindered commitments (interview 5, 18), often exacerbated by lack of coordination and high staff turnover (interview 29). However, the establishment of activities to strengthen mental health internal capacity (eg, mental health advisors, communities of practice; table 1) facilitated uptake over the past decade (interview 21, 29).

Fourth, an increased interest among individuals and entities to whom organisations were accountable (eg, citizens, member states, shareholders) benefited favourable decisions (interview 11, 18, 32). Often, accountability, risk aversion, and bureaucracy influenced the rapidity of change – less bureaucratic and risk-averse organisations (eg, non-governmental organisations, foundations) were quicker to commit than more bureaucratic and risk-averse ones (eg, bilateral and multilateral governmental organisations; interview 9, 16, 18). Finally, organisations commitments were guided by vested interests, such as economic, social, political, reputational, or personal gain. Although more obvious in the case of commercial arms of corporations and third sector organisations, vested interests were less apparent in other organisations or organisation arms (eg, corporate social responsibility initiatives) in which different types of interests might have coexisted. For instance, in the past, some foundations attached to for-profit companies invested in mental health in LMICs to create new markets (interview 32).

Some characteristics of the field of mental health have hampered organisations' investments for three reasons. The shortage of robust indicators available in other areas of health (eg, mortality data or biomarkers such as blood pressure) was a barrier, especially in organisations strongly driven by social or financial return on investments (eg, corporations, innovation funds; interview 11, 16, 17). Although the burden of mental disorders in LMICs was substantial and has grown over the past two decades, low availability and poor quality of epidemiological and financial data meant that arguments for contributions were difficult to make (interview 22). Finally, the scarcity of simple cost-effective solutions in mental health and the paucity of evidence on their scalability was a major obstacle, especially in for-profit organisations (eg, corporations; interview 3, 12, 14, 16, 21).

Source countries

Political leaders' commitment to mental health in source countries directly or indirectly influenced organisations' contributions to mental health in LMICs, especially in public sector organisations. After the neglect of mental health for many years, its ascent on domestic agendas is slowly percolating into development and foreign policy agendas (interview 8, 13, 19). This increase in attention reflects a growing public appetite for mental health (interview 5), facilitated by destigmatisation of mental ill-health and increasingly positive coverage in the media (interview 26). In addition, the tax systems in source countries shaped commitment size and characteristics through tax incentives (interview 10) and disbursement requirements (eg, through channel organisations in the source country; interview 9) for private and third-sector organisations.

Recipient countries

Although mental health needs in recipient countries motivated organisations' commitments to mental health in LMICs (interview 28, 34), political support facilitated them (interview 7, 26), and the absence of political support posed a major obstacle (interview 1, 11), especially in the public sector. Political willingness of recipient countries meant governments were more open to both requesting and receiving external funding (interview 19, 28, 32, 34) and to ensuring sustainability of the impact beyond funded activities (interview 19). Often linked to pervading stigma, little public support in recipient countries equally hindered commitments (interview 4). The readiness of recipient countries influenced investments (interview 4), especially in the private sector. In particular, although little absorptive capacity (eg, low numbers of mental health workers) constituted a major barrier across sectors, poor fiscal space (ie, the capacity of the government to fund public services, such as government mental health budget) and regulatory space (ie, the capacity of the government to make and implement regulations, such as mental health acts and policies) deterred the creation of markets, which was especially discouraging for for-profit organisations (eg, corporations; interview 32).

Global landscape

Although the lack of momentum was a barrier for investments historically (interview 8), during the past decade, global mental health moved from exceptionalism to an emerging new market (interview 10, 35), gaining prominence in the development discourse (interview 5) among external actors in health and beyond (interview 8, 19). However, organisational relationships were fraught with historical tensions, especially with regard to pharmaceutical companies (interview 1) and the larger for-profit sector (interview 17). A "permanent system of influence" (interview 10) – a group of charismatic individuals – was important in propelling mental health higher up the agenda and fuelling excitement across organisations (interview 10, 16, 18), yet these individuals' strong research focus is starting to show its limitations in influencing non-research organisations (interview 11, 19). The growing advocacy movement of strong grassroot organisations led to increased visibility of mental health and provided the external pressure that was instrumental in spurring organisational investments (interview 19, 21, 28).

The fragmentation of the mental health community led to the coexistence of a multiplicity of different understandings and portrayals of mental ill-health, which increased confusion and hampered organisational investments (interview 5, 16, 32). The *Lancet* Commission on global mental health and sustainable development6 provided a clear description of mental health issue to the mental health community, combining different approaches and attempting to unite the field, although the Commission is not without its critics.[31] Conversely, although stigma was a barrier in the past, the destigmatisation of mental health over the past decade and deinstitutionalisation contributed to illuminate the size of the burden and available solutions, facilitating investments (interview 1, 26).

Some events created policy windows that galvanised action (eg, the 2004 tsunamis in Banda Aceh, Indonesia and Sri Lanka; interview 19, 22), whereas others were considered as missed opportunities (eg, 2014–16 Ebola virus outbreak in west Africa; interview 25). Most of the events constituted stepping stones, gradually influencing investments with a cumulative effect over time (interview 19, 26). Events were numerous and included not only humanitarian emergencies, but also global conventions and plans, and high-level and less formal meetings. For instance, the inclusion of mental health in the SDGs,[10] in global

conventions (eg, Convention on the Rights of Persons with Disabilities),[32] and plans (eg, Mental Health Action Plan 2013–2020)[33] helped elevate the issue in the development discourse (interview 29) and provided frameworks for action (interview 12, 14), but these acts were rarely followed by financial commitments (interview 3, 11, 19). Similarly, high-level meetings focusing on mental health were instrumental in energising the mental health community and increasing political attention (interview 4, 10, 16, 17), yet they were successful in influencing commitments only when some actors were already willing to invest (eg, G8 Dementia Summit convened by the UK Prime Minister David Cameron in 2013)[34] (interview 21). Less formal roundtables and meetings organised by non-state actors played important roles in stoking leaders' interest and prompting commitments from key external actors, highlighting the importance of informal networks and relationships (interview 4, 5, 6, 10, 25).

Finally, although the absence of a global governance structure might have hampered investments, the creation of coordination groups helped to spur interests among and collaborations across organisations. These included the Inter-Agency Standing Committee reference group on mental health and psychosocial support in emergency settings established in 2007 (interview 24), the International Alliance for Mental Health Research Funders in 2010, and the first permanent donor group on psychosocial support in humanitarian settings in 2018 (interview 18).

Discussion

Over the past three decades, external organisations invested in mental health in LMICs through a panoply of internal and external activities, including activities strengthening employees' mental health, organisational capacity, and investments. Among the numerous factors that shaped the decisions, actors were the most salient ones across all levels – from leaders and champions within organisations, to political leaders supporting mental health in both source and recipient countries, and a group of charismatic individuals and grassroot organisations advocating at the global level.

Challenges and opportunities

Several challenges to external organisations' investments in mental health in LMICs can be identified across the four levels of analysis (table 2). The main barriers for organisations were shortage of individual support especially at the leadership level, poor understanding of mental ill-health (worsened by stigma), and unfavourable contexts, such as lack of relevance for the organisation's strategic role and priorities, competing priorities, and lack of internal capacity. The findings identified in this study support previous studies[13,14] that identified poor understanding of mental ill-health, stigma, and competing priorities as barriers to investments in mental health in LMICs. The prominent role of committed individuals spurring change within organisations aligns with the large literature on norm entrepreneurs in global health.[35]

Additional barriers were posed by the characteristics of the field of mental health: shortage of clear outcome indicators, low availability and poor quality of data, and scarcity of simple cost-effective interventions. Although poor metrics hampering investments in mental health in LMICs aligns with previous studies,[13,14] this finding calls for caution. The experience of the Safe Motherhood Initiative, which addressed similar measurement issues, sheds light on potential problems mental health metrics could face, including distorting priorities[36] and narrowing the policy agenda.[37]

For source and recipient countries, the main obstacles were lack of political and public support, and unfavourable contexts, such as low tax incentives in source countries, and little absorptive capacity and fiscal and regulatory spaces in recipient countries. Little political will is a major barrier for scaling up mental health services in LMICs,14 although new political interest is emerging.[38] Common concerns of absorptive capacity in global health question the effectiveness of, and diminishing return on, investments in LMICs, yet low-income countries and less developed health systems are more likely than countries in higher income groups and with more developed health systems to use received contributions, especially those countries with political stability.[39]

Globally, the main deterrents were lack of grassroot organisations, tensions across organisations, especially in relation to for-profit organisations, and unfavourable contexts, such as missed policy windows and lack of a global governance structure. Those results support previous findings.[7] The generation of political attention for global health issues, such as maternal mortality and newborn survival, have been hampered by similar problems of incohesive community, unexploited windows of opportunities, and fragmented global governance.[15,22] Tensions with for-profit organisations and conflicts of interest have increased in global health because of its financialisation[40] and the rise of philanthropy.[41]

However, opportunities are emerging (table 2). New, strong leaders and champions within organisations and a better understanding of mental ill-health, along with its destigmatisation, are unlocking opportunities for commitments across organisations. In addition, an expanding evidence base on the growing burden of mental disorders and cost-effective interventions is offering a clearer depiction of the problem and available solutions. Increased public and political support for mental health in source countries is slowly trickling down from domestic to development and foreign policy agendas. Political support and creation of fiscal and regulatory spaces in some recipient countries present favourable conditions for investments. Proliferation of organisations, a nascent global governance structure, and a growing number of high-level and other meetings on mental health are building momentum at a global level, spurring awareness and interest.

Those barriers and opportunities operate across organisations, although with broad variation depending on organisation type. For instance, organisations driven by social or financial return on investments are particularly affected by clear outcome indicators, for-profit organisations by simple cost-effective interventions and absorptive capacity in recipient countries, and public organisations by political and public support in source and recipient countries.

	Challenges	Opportunities
Organisations	Shortage of individual support, especially at the leadership level; poor understanding of mental ill-health, worsened by stigma; lack of relevance for the organisation's strategic role and priorities; large number of competing priorities; lack of internal capacity; unfavourable characteristics of mental ill-health as an issue	New, strong leaders and champions; better understanding of mental ill-health, along with its destigmatisation; expanding evidence base on mental ill-health burden and interventions
Source countries	Little political and public support; little tax incentives	Increased public and political support
Recipient countries	Lack of political and public support; little absorptive capacity and fiscal (eg, government mental health budget) and regulatory (eg, mental health acts and policies) spaces	Political support in some recipient countries; fiscal (eg, government mental health budget) and regulatory (eg, mental health acts and policies) spaces in some recipient countries
Global landscape	Scarcity of grassroot organisations; tensions across organisations, especially for-profit organisations; missed policy windows; absence of governance structure	Proliferation of organisations; growing number of high-level and other meetings on mental health; emerging global governance structure

***Table 2*: Challenges and opportunities for increasing external organisations' investments in mental health in low- and middle-income countries**

Limitations

This Health Policy has some limitations. Qualitative methods raise issues regarding robustness – triangulation across different sources of data aimed to minimise bias. Purposeful sampling might have led to selection bias, especially concerning geographies, although possibly partly mitigated by sampling for diversity according to organisation group. In particular, the sample represented predominantly external actors in high-income countries, even though those from other LMICs are gaining importance.[42] Although the leadership position of participants was essential for the study, the absence of individuals in other positions might have led to an overestimation of the influence of actors within organisations. I (a female, non-native English speaker, trained in clinical psychology and health policy, with over 10 years of experience in mental health policy and practice research, affiliated with a university in a high-income country) informed and influenced data collection and analysis.[43] It was not possible to record some interviews due to participant preferences, but although this meant it was not possible to provide illustrative quotations from them, detailed notes were made, and data quality was similar to recorded interviews.[44]

Recommendations

External organisations play crucial roles in addressing mental health needs in LMICs,[45] and are expected to be increasingly important owing to demographic and epidemiological transitions and deterioration of social determinants of mental health (eg, growth in inequalities),6 which will probably be exacerbated by COVID-19, the effects of lockdowns, and their socioeconomic consequences.[46] This study points to five strategic actions to increase and amplify external organisations' investments in mental health in LMICs. First, all external actors[11] could invest in global mental health through different activities aligned with their missions and priorities to unlock additional resources while ensuring relevance for their organisations (table 1). New leaders and champions could guide strategic investments using different arguments (panel 2) and strategies (panel 3), and benefitting from a better understanding of mental ill-health and its destigmatisation. Growing evidence is available to organisations for contributing to mental health through numerous entry points, not only within mental health systems and services (eg, WHO Mental Health Atlas),[47] but also across other health conditions,[28] sectors,[29] and social determinants of mental health.[31] Measuring and evaluating funded activities should be encouraged using available tools[48] and frameworks[10,33] to ensure transparency, accountability, and learning, especially with regard to cost-effectiveness and scalability of interventions. People with lived experience should be part of the process as citizens, users, and consumers (eg, Global Mental Health Peer Network).

Second, source countries could catalyse external organisations' investments by increasing political support through financial commitments to organisations in the public sector, and incentives for the private and third sectors. Co-funded by Australia, Canada, and the UK, the Alliance of Champions for Mental Health and Wellbeing aims to catalyse action to address mental health:[49] country members could amplify their effect, prioritising mental health not only in their domestic agenda but also their development and foreign policy agendas, particularly when integrating responses to mental ill-health and COVID-19.

Third, recipient countries could favour external organisations' investments by increasing political support and creating fiscal and regulatory spaces. More than 70 LMICs across six regions have prioritised mental health.[50] The WHO Special Initiative for Mental Health (2019–2023) is expected to accelerate universal health coverage for mental health in 12

countries and to improve their absorptive capacity.[49] Available tools could be used for mental health policy planning and service development, such as the Mental Health Atlas[46] and guidance packages.[51]

Fourth, a global coordination mechanism involving all actors in global mental health could coordinate and monitor efforts over time, favouring partnerships and improving the effect of investments. A global partnership for mental health has been recommended[52] and some smaller coordination groups (eg, donor group on psychosocial support in humanitarian settings) are emerging, and the Countdown Global Mental Health 2030 will monitor progresses in mental health across countries globally.[53] A more robust governance structure could also be instrumental in strategically coordinating and taking advantage of high-level and other meetings on mental health, and other policy windows. The growing base of grassroot organisations could play an important role by exerting pressure on external organisations.

Finally, ethical considerations could be integrated into decision making to ensure sustainable and ethical financing of mental health in LMICs. In particular, sustainability of impact beyond funded activities should be ensured through partnerships with local actors, exploring the issues associated with the financialisation of global mental health,[54] such as equitable access to health care[55] and conflicts of interest.[56] These ethical considerations could help in addressing tensions in the global mental health community, which is especially essential for for-profit organisations.

The research agenda to understand external organisations' contributions to global mental health continues to expand. Qualitative studies could explore contributions of external organisations in different settings and for different mental disorders (eg, common *vs* severe mental disorders) using this study's analytical framework to ensure consistency and comparability. Case studies could investigate contributions of single organisations, including WHO and the World Bank. Finally, studies could examine ethical issues related to external organisations' commitments, especially across different organisational groups and across for-profit and not-for-profit arms of the same organisation.

Conclusion

Mental health is ascending the global agenda: existing external organisations are scaling up commitments and new organisations are now beginning to invest. This Health Policy paper presents an analysis of their methods and motivations for investing in mental health in LMICs over the past three decades. It provides an analytical framework for future policy planning and research in sustainable financing for global mental health and global health. It is time to invest, "the stars are aligning, and we need to act now" (interview 5).

Contributors

VI conceived and designed the study; collected, transcribed and analysed the data; interpreted the results; and wrote the manuscript.

Declaration of Interests

I declare no competing interests.

Data sharing

Qualitative data cannot be shared due to ethical restrictions.

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Supplementary material

Appendix 1: Standards for Reporting Qualitative Research (SRQR)

SECTION	No.	SRQR ITEM	REPORTED ON PAGE #
Title and abstract			
Title	S1	Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	1
Abstract	S2	Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	1
Introduction			
Problem formulation	S3	Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	2
Purpose or research question	S4	Purpose of the study and specific objectives or questions	2
Methods			
Qualitative approach and research paradigm	S5	Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale[a]	2–3
Researcher characteristics and reflexivity	S6	Researchers' characteristics that may influence the research, including personal attributes, qualifications/ experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	13
Context	S7	Setting/site and salient contextual factors; rationale[a]	2–3
Sampling strategy	S8	How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale[a]	2–3; Panel 1
Ethical issues pertaining to human subjects	S9	Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	3
Data collection methods	S10	Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale[a]	2–3
Data collection instruments and technologies	S11	Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	3; Appendix 3
Units of study	S12	Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	2–3; Appendix 2
Data processing	S13	Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/deidentification of excerpts	3
Data analysis	S14	Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale[a]	3; Appendix 4
Techniques to enhance trustworthiness	S15	Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale[a]	3

SECTION	No.	SRQR ITEM	REPORTED ON PAGE #
Results/findings			
Synthesis and interpretation	S16	Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	4–10; Table 1; Panels 2 and 3
Links to empirical data	S17	Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	Appendix 5
Discussion			
Integration with prior work, implications, transferability, and contribution(s) to the field	S18	Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	10–14; Table 2
Limitations	S19	Trustworthiness and limitations of findings	13
Other			
Conflicts of interest	S20	Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	14
Funding	S21	Sources of funding and other support; role of funders in data collection, interpretation, and reporting	15

Adapted from the original publication.[1] The authors created the Standards for Reporting Qualitative Research (SRQR) by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research. [a]The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

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Appendix 2: Participant characteristics

	Number of participants (%)	Interviews
Sex		
Female	18 (51%)	1,2,3,5,7,9,12,17,18,25,27,28,29,30,31,33,34,35
Male	17 (49%)	4,6,8,10,11,13,14,15,16,19,20,21,22,23,24,26,32
WHO Region[a]		
African Region	2 (6%)	7,16
Region of the Americas	11 (31%)	6,15,17, 21,25,27,28,29,32,34,35
European Region	22 (63%)	1,2,3,4,5,8,9,10,11,12,13,14,18,19,20,22,23,24,26, 30,31,33
Organisation group		
Public sector		
Bilateral GOs	6 (17%)	6,13,18,29,31,33
Multilateral GOs	6 (17%)	5,11,24,26,28,34
Bilateral DFIs	1 (3%)	27
Multilateral DFIs	1 (3%)	15
Private sector		
Corporations and SMEs	3 (9%)	21,23,32
Foundations	4 (11%)	1,2,5,9
Third sector		
Nongovernmental organisations	6 (17%)	3,12,17,19,30,35
Multisector partnerships		
Global Health Initiatives	1 (3%)	20
Innovation Funds	1 (3%)	14
Others		
Experts	6 (17%)	7,8,10,16,22,25

DFIs=development financial institutions. GOs=governmental organisations. SMEs=small and medium enterprises. [a] Twelve countries were represented: two in the African region, two in the region of the Americas, and eight in the European region.

Appendix 3: Interview guide

Introduction
Interviewer background
Study description
Interview details

Warm up
Participant current role
Participant relevant previous positions

Decision-making (experience)
Organisation activities in mental health
Organisation decision-making process

Factors influencing decisions (experience)
Factors within the organisation (e.g. organisation strategic role)
Factors at the donor country level [*if relevant*]
Factors at the recipient country level
Landscape (e.g. other external actors, development discourse, development finance 'discourse', events, meetings)
Issue characteristics (e.g. indicators, burden, solutions)

Future investments (opinion)
Challenges for future investments
Facilitators of future investments

Cooling down questions
Summation (checking)

Appendix 4: Analytical framework

Theme 1

	T1: METHODS
S1: Activities	
S2: Arguments	
S3: Strategies	

S=sub-theme. T=theme.

Theme 2

	T2: MOTIVATIONS			
	Actors	Ideas	Contexts	Issue
S4: Organisations				
S5: Source countries				
S6: Recipient countries				
S7: Global landscape				

S=sub-theme. T=theme.

Appendix 5: Illustrative quotations for themes and subthemes

THEME	SUB-THEME	EXAMPLE QUOTATIONS
Methods	**Activities**	**Within organisations: organisations' mental health** 'Our organisation is really good at internal wellbeing support, so we have regular Mental Health First Aid training for staff, we have mental health first aiders around the place…' (interview 5) 'We have employee groups for minorities, for women, for LGBTQ employees, and these employee groups support each other, and they advocate for their interests within the company… and they also engage in philanthropy *on behalf* of the organisation for their community. So, we decided to start an employee group for our employees who live with mental illnesses either themselves or as caregivers... So, we really started to *destigmatise* (mental ill-health) and make (it) part of our culture' (interview 21) **Within organisations: organisations' mental health capacity** 'I'm the mental health advisor for my organisation. This is a new role... and the role is to bring all the organisation into the effort to transform mental health care worldwide… My role is to… try to *amplify* the overall impact of what we're doing… and to… make sure that we're really taking advantage of all our strengths.' (interview 21) 'And I think that that (=gap in human capacity within the organisation) had actually led me to this need for establishing a community of practice… establishing this model of learning from each other programmes, what works, what doesn't… and establishing that important level of exchange.' (interview 34) **Outside organisations** '…we would not do any testing for HIV unless we added a basic counselling service. But it was not under mental health…it was almost an ethical issue, that if you get to test people and tell them they're (HIV) positive, what is the implication that you have next?' (interview 20) 'I think that was similarly a very important high-level meeting that brought together key agencies, where *also* one organisation was very clear about its dedication to invest in mental health, as long as agencies that were coming around the table were also kind of putting forth their own commitment within their own agencies.' (interview 34)
	Arguments	**Public health** 'When we saw the numbers and the need, it became a bit clear to our Chief Executive Officer and others that this is something that we needed to really pick and act more deeply on.' (interview 21) **Human rights** '…the use of the human rights (argument): people being in an institution, people tortured, people being in chains. Those stories touch people, so they do react, and they do want to do something about it.' (interview 3) **Economic effects** 'Economic arguments are being paid more attention in the last few years…To use the economic argument is helpful, (but) it is not sufficient.' (interview 4) **Country priorities**

THEME	SUB-THEME	EXAMPLE QUOTATIONS
		'In many cases the political argument is not that people need help, it's that people *want* help. And that's the political argument, that if people want something, it must be provided.' (interview 4) **Moral considerations** '…we should ethically do those things because it would be unethical not to (do them).' (interview 5) **Happiness** '…the main factor associated with *misery* (is) not poverty *per se* but mental illness. So, that kind of argument in which you transcend the public health narrative and try to bring the solid understanding of programmes such as mental illness or substance abuse and their impact on society.' (interview 15)
	Strategies	**Standalone** '…we pushed for so many years, we tried to *push* mental health onto the agenda by telling people how important it was.' (interview 32) **Integrated** '…more and more we need to think about broader issues, how they connect rather than only thinking about freestanding problems…It's not just to focus on one simple problem but *how* the investment, let's say, in health have a positive spill-over effect on education attainment and labour productivity in terms of having more social capital, more safe societies, or less crime, more opportunities, more integration…' (interview 15) ***Multisectoral*** '…we are very aware that mental health *needs* a multisectoral approach and that it is not only a health issue and (that) the response needs to be like a 'whole society' response.' (interview 28) ***Life-course*** '…when we talk about aging, aging starts when you're born and it goes up to when you die and aging is always happening, then… I think it (=mental health) *should* be there all the time.' (interview 6)
Motivations	**Organisations**	**Actors** '…(since the) first of January we had a new executive director, who has increased the focus on adolescents as an age group… mental health is such a big part of the morbidity and also mortality of this age group.' (interview 28) 'There were some champions within the organisation, who felt very strongly about this. And they were petitioning and pushing and calling meetings and wanting the organisation to do (more in mental health). And for a few years we thought they shifted. And interestingly the main *catalyst* for actually moving forward in a concrete way was the Tsunami (in Banda Aceh in 2004).' (interview 19) **Ideas** '…because it (=mental health) is such a diverse issue and there are so many angles you can come and see it from. That's one of the reasons why it's so heavily bought into from across my organisation.' (interview 5) 'I found that everybody had a personal story in their own family and often times even in their own lives…. What I think is different about *this time* is that we're not just trying to help others. We understand that this is something very personal that affects every family and that we haven't

THEME	SUB-THEME	EXAMPLE QUOTATIONS
		talked about it openly because of the *stigma* and some of the misconceptions about mental health.' (interview 21) **Contexts** 'Because *some* issues are just too big, some issues have already a lot of funding… but maybe *proportionally* our inputs, although small, may be bigger in mental health, we'd be more impactful.' (interview 12) 'We're part of the government and that means that we also have to respond to the country political priorities… we have to make sure that whatever funding choices we're making line up with the government policy. And, I think, at the moment that's a very positive thing, because there are policies about trying to make sure we reach the most vulnerable in society, and policies around improving the lives of disabled people' (interview 18) 'Which was one of my objectives in globalising and aligning our philanthropy with the business, that it was important to be able to solve those kinds of issues in the environment, and if the foundation was the mechanism that we could do it, we couldn't do through the company what the foundation could… When I say shape the environment, I don't mean sell our product. I mean create an environment where products like the ones that we are investing in can be used, can be recognised as being valuable and useful for treating patients… we call it 'enlightened self-interest'… if by helping others to understand, you may be able to help yourself…' (interview 32) **Issue** '…that's a much harder set of metrics when you got… the ability for someone to get better in mental health for a period of time and then do worst again, and then get better… It's hard to understand… at what point out from an intervention would you say: 'This person is definitely better, definitely not better.'' (interview 17) 'So, then there were many international studies… If you look at the data of these international studies, I'm still extremely surprised by the enormous difference you see between countries… which I don't think there is any good reason to explain that apart from some epidemiological or statistical problems. I think the situation now of the epidemiological data is much better than at the end of 1990s (and) at the beginning of the 2000s.' (interview 22) 'We don't have some knock-out intervention, like 'Give us the money and we'll vaccinate kids and they won't get the disease for the rest of their life.' It's not as simple as that.' (interview 11)
	Source countries	**Actors** '…the general popular consensus around mental health has, very fortunately for us, come through as a priority issue in the domestic agenda. And that *inevitably* has gone across… to the development sector.' (interview 19) 'Another thing is *media*. So, the more the CNN (=Cable News Network) focuses on the plight of the people, the more likely there would be interest.' (interview 26) **Ideas** Not available. **Contexts**

THEME	SUB-THEME	EXAMPLE QUOTATIONS
		'And these tax rules and these tax benefits are in our country, so we feel a loyalty to it.' (interview 9)
	Recipient countries	**Actors** '…the need of countries is what is steering us and… we need to have a partnership and an interest and an *ownership* from the country, from the country government.' (interview 28) **Ideas** 'And, of course, there is the stigma against mental health, which is all pervading. And that prevents many funders from doing what they should be doing.' (interview 4) **Contexts** 'And in many cases the need is high but the readiness is low, in which case we have limited resources and we may decide not to (invest).' (interview 4)
	Global landscape	**Actors** 'You've got a steady drip drip drip of more donors coming on board… you're getting more agencies that want to *do* the work on one hand, and you're getting more agencies that want to *fund* the work on the other hand. So, you're beginning to get, in classic market-place terms, a market.' (interview 10) '… charismatic public figures do have a big influence…. (They) kind of catch the imagination of people through TED talks and really innovative approaches. So, I think those things also count for quite a lot and just sort of get people excited about this very neglected area.' (interview 16) '… we see it as a very fragmented field (=mental health field), with different disciplines, quite silos, sometimes fighting, pulling into different directions.' (interview 5) **Ideas** 'I think it's coming out of the shadows. People are talking about their suffering and people start realising that the problem (=mental health) is much bigger than previously thought.' (interview 26) 'One of the things that gets it (=mental health) heard is getting people out of institutions and into the community where they start to have real lives, and valued roles, and they have jobs, and they have friends and neighbours. And I think that's the best antidote to stigma really, physical proximity…' (interview 1) **Contexts** 'In 2004, the Tsunami (in Banda Aceh) was another big event that made clear that mental health was an important component in complex emergency settings… maybe not in the first days of the emergency, but probably more in the reconstruction phase.' (interview 22) 'We often really kind of reference those (=Sustainable Development Goals) whenever we are discussing or talking to donors and governments, but a lot of times decision to fund mental health or even specific emergencies… is very politically driven…' (interview 34)

Ellipses indicate removed text to shorten quotes, while preserving meaning. Parentheses contain text added by the author to facilitate comprehension. *Italics* reproduce participants' emphases.