Closing The Treatment Gap: Insights Into Implementation Strategies for Task-Shared Counselling for Depression and Unhealthy Alcohol use In South Africa

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Abstract

Background: Task-shared psychological counselling can be an effective approach to meet mental health needs in low-resource settings. Evidence on how to sustain and scale such approaches is required. This study was nested in the Project MIND cluster randomised controlled trial which investigated integrating a new, task-shared counselling service in 24 primary care facilities in South Africa. The current study aimed to describe and distil experiences of primary healthcare managers in whose facilities counselling was implemented.

Methods: Focus group discussions and in-depth interviews were conducted with 15 Primary Health Care (PHC) facility and operational managers (urban and rural facilities). Interviewers used a semi-structured topic guide to explore overall experiences of the programme and barriers to wider implementation. Normalisation process theory guided analysis.

Results: Managers highlighted their relational work in communicating with staff on the value of the new intervention, to reduce resistance. Their leadership role in promoting support for the intervention, teamwork and onward referral of clients was key to embedding this new approach. Managers emphasized the need for reorientation and upskilling of staff to be foster openness to mental health practice and for counsellors to have adequate time to provide quality counselling. Strengthening within-facility referrals and referrals to external organisations were both noted as crucial for sustained implementation, as well as cycles of monitoring and feedback.

Conclusion: This study presents experiences and perceptions of health care managers developed into a multicomponent implementation approach for embedding a task-shared package of care for problem alcohol use and depression in primary care.

Contributions To The Literature

- This study presents insights of primary health care service managers for development of a multicomponent implementation strategy for a service innovation in the South African primary care context, contributing to the emerging literature on implementation strategies in low- and middle-income countries.
- The experiences and insights of managers in this study relate to their work in resource constrained contexts which hamper introduction of new evidence-based practices. This experience is relevant to researchers, managers and policy makers in other health systems experiencing intransigent resource constraints.
- The study provides an example of contextually driven co-development of implementation approaches with health service providers which can be adapted and employed in other low- and middle income settings.

Background

South Africa faces a complex burden of infectious and noncommunicable diseases, including mental disorders (1, 2). Multimorbidity of physical and mental disorders is prevalent and generates a complex array of treatment needs (3). As in other low- and middle-income countries (LMIC), the treatment gap for common mental disorders (CMDs), such as depressive, anxiety and alcohol use disorders, is large (4).

Task-sharing mental health services refers to the approach under which responsibility for screening for mental disorders and delivery of psychological interventions is transferred from specialist mental health providers to non-specialist cadres, with referral to more specialist cadres if needed. Task-shared psychological interventions involving non-specialist nurses and facility-based lay counsellors has been central to the global mental health movement, and has gained traction in South Africa (5–10). Increasingly, there is acknowledgement that difficulties in bridging the treatment gap are primarily due to implementation issues (11–13). There is also increasing acknowledgement that implementation strategies, systematic processes for introducing and sustaining practices in routine care, need to accompany the introduction of health innovations to overcome these implementation issues (14). These can be stand-alone strategies (e.g. training workshop) or multicomponent (e.g. ongoing training, supportive supervision, monitoring and feedback cycles) (14). While trials provide evidence of effectiveness, detail on strategies for supporting the routinization of these practices is less readily available (15). In the South African primary health care (PHC) context (for which task-shared psychological interventions are designed), facilities continue to grapple with basic challenges of drug stock outs, inadequate infrastructure, long waiting times, and staff shortages (16, 17). Even in high-income countries (HIC), implementing evidence-based psychological interventions at scale is not straightforward, relying on the coordination of a variety of individuals, relationships and processes (18, 19). Information on strategies to support embedding of complex mental health interventions in routine practice in South African primary care is needed to overcome these implementation issues.

Normalisation process theory (NPT) is one theoretical model that has been used to engage with this complexity [22, 23]. NPT comprises four constructs that can assist implementers in developing strategies to integrate and sustain new complex interventions within health services. Within this theory, *relational integration* refers to the fit of the intervention with the prevailing knowledge and relationships in the setting; *skill set workability* relates to how the intervention affects the current work of staff; *interactional workability* focuses on how the intervention impacts on working relationships and teamwork; and *contextual integration* considers how the innovation fits in the particular organisational context [24].

In constrained South African PHC settings, facility and operational managers play a pivotal role in embedding innovations (13). Their leadership is necessary for building trusting working relationships, influencing organisational climate and ensuring sufficient resources to support implementation (20–24). These managers are professional nurses who have been promoted to management roles, often with limited management training (25), although many become expert in navigating their work environment to influence change (21, 25).

The current study is nested in the Project MIND cluster randomised controlled trial (RCT) which has investigated two approaches to integrating a new, task-shared counselling service for depression and unhealthy alcohol use into chronic disease care for HIV and diabetes in the Western Cape Province (26). In this service, facility-based counsellors (FBCs), a cadre of community health workers employed to provide health promotion and HIV adherence counselling services, were trained to deliver a structured three-session blended motivational interviewing and problem-solving (MI-PST) intervention. This intervention and the FBC training is described in detail elsewhere (10, 26, 27). Patients who required additional counselling or psychiatric medication were referred to external organisations or family physicians in the facility for further care. An initial pre-trial study found substantial variation in facility preparedness to implement this programme, influenced by the leadership style of managers and the overall facility environment (28). These findings suggest that the introduction of mental health innovations into PHC facilities needs to be accompanied by interventions to enhance organisational preparedness for implementation. To guide the development of a suitable organisational intervention package, this study aimed to describe managers' experiences of having this counselling implemented in their facilities and their insights into potential implementation strategies.

Methods

This study is presented according to COREQ guidance for reporting qualitative research (29). The MIND counselling service was implemented in 16 PHC facilities in the Western Cape, with another 8 facilities being treatment-as-usual sites. After obtaining support for the study from the Provincial Department of Health and health sub-district managers, the first author contacted the facility and/or operational managers of the 16 intervention sites by email and telephone and invited them to participate in a focus group discussion (FGD) at the end of the counselling implementation period. We initially planned to host one FGD per health sub-district but finding suitable times and dates for managers to participate in these FGDs proved challenging due to conflicting commitments and operational demands of facilities. Two FGDs were conducted with seven managers (four from urban facilities and three from rural facilities). We conducted individual in-depth interviews with eight remaining managers and one manager declined to participate (16 facilities in total).

FGDs and individual interviews were conducted by experienced qualitative researchers (female, with PhDs), who were known to participants through previous studies but were not linked to the Department of Health. To minimise socially desirable responses, one researcher had not been involved in the execution of the trial. The second researcher had been involved in the roll out of the trial, but in the introduction to the interviews, emphasis was placed on the aim of collecting data that reflected both positive and negative experiences.

Interviews were conducted in a private space at participants' place of work or telephonically. Interviewers used a semi-structured topic guide. This topic guide explored overall experiences of the programme and barriers and facilitators to wider implementation (See Supplementary Information for Interview Schedule). Interviews and FGDs were conducted in English, with some participants responding in Afrikaans. This is

common in verbal communication in the Western Cape, where English is the official business language, but many people use both languages in conversation. Interviews and FGDs ranged from 45 to 60 minutes in duration. Interviews were transcribed verbatim. Afrikaans sections were transcribed and translated by a bilingual member of the research team.

NVivo 12 qualitative software was used to store data and enable framework analysis (30). This analysis approach is commonly used for studies with health policy/practice goals and *a priori* factors being investigated (in this case, implementation strategies) (30). In this approach the first and second author conducted initial familiarisation with the data and preliminary coding and discussion. Following this, a working analytical framework was developed using the four concepts of NPT as *a priori* major themes in relation to the study data. The remaining transcripts were coded according to this framework (30). The first and second author coded five transcripts independently using this working framework, then met for coding discussion. A framework matrix was created to aid interpretation of the data. When half of the transcripts were coded, Cohen's kappa was calculated for intercoder comparison. Subsequently, coders (first and second authors) met to discuss coding, focusing on codes for which the kappa indicated less coding agreement. Coding then continued independently until saturation of data, indicated by a full understanding of participants' perspectives on implementation (31). Kappa was calculated with final average unweighted value 0.7, showing good agreement between coders.

Results

All participants interviewed were female between the ages of 30 and 50. This reflects the gendered make up of the health service, with managers having been promoted from amongst facility nursing staff. Participant data mapped onto the four themes based on the components of NPT. These themes relate to factors within facilities including staff skills and working relationships, the facility organisational culture as well as the broader community context.

Theme 1: Relational Integration - Existing Knowledge and Relationships

Most participants described their facility context as challenging due to diminishing resources and increasing patient numbers. With this background, participants emphasized the importance of their leadership for ensuring good working relationships amongst staff members for facilitating implementation. They recognized their own role in promoting teamwork required for the smooth running of the MIND programme, including onward referral of MIND patients from FBCs for additional support or medication review.

'Yes, everybody needs to be together and then when we have something that we have to solve as a group...everybody has a part to play. This morning... I spoke to some of the staff members, we are here 8 hours of the day...so here we need to be like a family'. – Participant 11

Participants described the role of managers in introducing and building staff support for this new service. For managers, this involved investing time to personally *'understand it and internalise'*- Participant 11, to develop an approach for integrating the new service with current operations. In introducing the new service to staff, participants highlighted the importance of consultation and communicating the added value and benefits to patients, providers, and the health system overall. They viewed this aspect of relationship work as critical given the hierarchical health system where top-down communication and decision making made staff resistant to new services. When discussing project MIND specifically, participants reflected how they would emphasize (i) the potential for clinical improvements in patients receiving counselling (reduced viral load for HIV risk of treatment failure patients, better controlled diabetes); (ii) patients' improved awareness and attitudes to wellbeing; (iii) improved adherence to chronic medication due to reductions in alcohol use; (iv) better understanding of staff on underlying health conditions and the intersection of social difficulties and health conditions; (v) providing a service to refer patients with complex social and health issues which was previously unavailable; and (vi) up-skilling existing FBCs' counselling skills. Regular facility meetings (staff meetings, clinician meetings, Heads of Departments meetings) were proposed as opportunities to present this information, build buy-in and provide feedback on individual patients and the service. One manager described communicating the success of Project MIND to their facility staff through presenting positive changes observed in their patients.

'His [MIND client] whole life was transformed...He would wake up in the morning and drink and he would just sit and his family came in to complain. His wife would say she is fed up, she can't anymore. He didn't have a relationship with his children... And I was trying to get them to help him with the ARVs. And they were like "why should we help him, if he is so difficult?" And after Project MIND, this man was like a different person. And he also says he felt like he's got his life back and he was pleasant. It was like his whole personality changed and his family were all so supportive. And that was just one patient'. – Participant 14

Theme 2: Skill Set Workability

Participants noted contingencies between the number of patients that nurses screened and referred for MIND counselling and sustained implementation of this service. To ensure sufficient referrals to the programme, participants emphasized the need to improve staff competencies in detecting mental health concerns. They described how staff tended to avoid asking patients about their mental health because of a lack of knowledge and confidence in this area of practice. If they did detect mental health concerns, they tended to refer these patients to specialist providers.

'I think they [nursing staff] are not in tune because mental health has always been separate. It is a specialty, so much so that people are asking to have advanced psychiatry, to manage the mental health patients whereas all of us can do a screening. We were taught.' - Participant 3

Participants thought this could be addressed through repositioning mental health as everybody's business and not just the responsibility of staff with specialized training. To achieve this, participants

recommended all facility staff receive a basic orientation to CMDs and the MIND counselling package so that they could realize the potential value of the service and conduct patient screening and referral.

In addition, participants noted that in some instances, staff roles and responsibilities would need to be expanded to incorporate mental health care. Managers recognized through project MIND that FBCs were well placed to provide counselling once trained but noted that sustained implementation would require their current job descriptions to be reviewed and expanded. Managers noted other competing task demands of their current role include running chronic clubs, managing preparation and collection of chronic medication, as well as adherence counselling and HIV counselling and testing. With this workload several participants felt that something would have to *'give in the system'* – *Participant 3*. They recommended redefining FBCs' roles and responsibilities to *'create capacity'* *Participant 1* for some counsellors to focus specifically on mental health counselling. This would enable them to develop key competencies in this area and *'sit and provide quality'* counselling– *Participant 3*. The related suggestion of hiring additional counsellors focusing just on this counselling was also made, with participants acknowledging the resource constrained primary healthcare context.

'They [FBCs] must do all the running around to get the folders. If there is no medication they must make sure that the clinicians re-board the patient, take the folders to the pharmacy, and wait for the medication, ask the pharmacist to pack the medication and bring it back to the clinic. So in the morning when the patients come here then the medication is ready for them. In the afternoons it is actually very busy. But if there can be one or two counsellors specifically for [MIND counselling] that will be the ideal thing. That will be the ideal thing because now they have to cut themselves in pieces to cover all their tasks for the day.' – *Participant 16*

Theme 3: Interactional Workability – Promoting Well-being Through Onward Referral

Onward referral for further psychiatric assessment, counselling, medication provision and social welfare services is an important aspect of the MIND counselling service requiring interactional workability. FBCs generally referred MIND patients to social workers (where available), and nursing/clinical staff, including mental health nurses within their facility. Participants highlighted the benefit of these referral pathways in improving clinical care. Participants felt the MIND counselling, and referrals as needed, enabled the facility to begin engaging with patients' underlying problems that impact on their health, such as interpersonal conflict, violence and financial hardship. This contrasted with the facilities' usual practice of focusing only on the presenting health concern rather than psychosocial issues contributing to the health problem. Participants highlighted the importance of developing clear referral pathways and processes for facilitating onward referral of patients to ensure successful implementation.

They described several implementation strategies that could support this intervention component. These included physical positioning of FBCs close to facility social workers or mental health nurses to facilitate ease of referral and encourage relationship development amongst these staff. Others recommended formalizing the referral process, using the standard referral letters of the facility. Several participants also

suggested potential for use of the 'integrated stationery' on patient folders for facilitating referrals. This stationery has a section for mental health screening but is not used in all facilities. Despite the underlying perception that social workers and mental health nurses are overstretched, participants felt these cadres were glad to receive referrals since the referred individuals were those most in need of psychosocial support.

'I think it [Project MIND] was very good, especially for the clients. And for us also because the clients that you [Project MIND] took and referred back to us – those ones we could initiate or change the treatment' - Participant 12

Participants also noted the importance of strengthening referral pathways to external community-based organizations providing mental and substance use disorder treatment. They raised concerns about how the shortage of these services might impact on the implementation of the MIND programme. Despite this shortage, participants suggested that mapping out existing services, developing a network of providers to whom they could refer patients and strengthening relationships between the facility and external organisations (such as religious organisations and non-profit organisations (NPOs) would be important strategies for supporting onward referral. Participants described existing relationships with several NPOs that could be strengthened for wider implementation.

...actually in [area name] there are quite a few NPOs that are working in the community. They have little centres like the Community Centre and there's another centre near the church where they do rehab. So I think maybe if you [MIND] join up with one of the existing NPOs that's there. It could actually work. It could be quite successful, especially the ones that are well known– Participant 14

Theme 4: Contextual Integration of Counselling

Participants defined the organisational climate of their facility by its lack of resources, increasing patient numbers and related resistance to change. A minority described their staff as willing and open to service changes. Participants noted the challenge in keeping all staff up to date with constant changes to policy and practice. As managers they also felt overstretched and lacking time to address some issues with the attention they would have liked. The need to build resilience among staff, raise morale, and have meaningful engagement with the public around services needs were put forward as key organizational needs.

Participant 11: As a facility manager you need to be everywhere and you need to be on top of everything... it really gets to you at the end of the day

Interviewer: So you don't have time to think about your own new things that you might want to do?

Participant 11: You try - because I change the staff around, so there are other people in the TB room. I can see that it's getting better but I can't zoom into it. I think if I get my power in there, there will be a difference, but as I said I really don't have the time because now it's stats time again, so I can't go there....And then you as a manager need to get the people motivated to take that extra on.

Given this context, participants proposed a process for integrating MIND counselling into routine practice. Drawing on their experience as managers and clinicians, they proposed specific planning, communication and monitoring strategies considered necessary for supporting sustained implementation.

First, participants proposed strategies for ensuring sustainability, namely by building in a process for identifying patients most in need of counselling, ensuring that counselling provision for these patients was prioritised, with appropriate referral for others that the clinic's counselling service would not have capacity to serve. It was suggested that identification and prioritization of patients for counselling could be achieved by using existing screening guidelines. Second, participants made various practical suggestions for reducing facility barriers to patients' uptake of counselling, including locating counsellors near clients in the waiting room, planning counselling sessions for the afternoon when most clients have been seen by nursing staff, and ensuring eligible patients were seen as soon as possible with convenient appointment times. The most frequently described constraint for planning this service was the difficulty in designating an appropriate private space for counselling due to facility infrastructure constraints unlikely to improve in the short term. Strategies for addressing this barrier included holding counselling sessions outdoors when weather permitted, using space at nearby community centres and NPOs, and erecting temporary structures in the outdoor space of the facility.

'Maybe you must look at having it in containers on the premises or maybe one container of the premises that you can have as a counselling room. That will solve your problem because remember the patient is here for the day, kind of for most of the day, so it is not something that is going to be extra or that they have to take off work because some of them do work, so you wouldn't want them to come back or to lose them on that day'. – Participant 13

Third, participants noted the importance of external and internal stakeholder engagement and communication as strategies for supporting counselling implementation. They described the need to engage with a range of external stakeholders including the community served by the facility's catchment area (via the facility's health committee, street committees and community policing fora) to raise awareness of the new service and promote patient uptake. Stakeholder engagement was also seen as critical to building a supportive network of intersectoral partners to which health providers could refer patients should they require additional assistance after receiving MIND counselling. Participants highlighted the importance of early communication with internal stakeholders about the proposed new service to both inform and build buy-in among all facility staff, including those not directly involved in the service. Managers recommended first communicating the need for and value of counselling to facility Heads of Department who would then filter the information to frontline staff. Participants further proposed integrating the counselling intervention into current facility functioning through regular meetings (e.g. staff meetings, morning check in meetings, and multidisciplinary team (MDT) meetings where challenging cases are discussed) as a regular 'agenda item' for communication and improvement. Managers noted the importance of communicating to staff about the proposed service prior to providing any training so that any resistance to change could be addressed.

Staff should also understand that it's not that we want to give them more work but as I say, as long as it is clarified properly, they should understand. If it is part of the routine care, ideally there should be an agreement between line manager and staff member in terms of expectations. – Participant 1

As part of integration into the facility, participants articulated the importance of monitoring the number of patients counselled per month. Linking changes in patient outcomes to the counselling was put forward as a means of justifying resource allocation for counselling. The suggestion was made to include counselling as part of the facility annual audit where numbers of patients treated and their outcomes for a range of health conditions are assessed against pre-specified targets, looking at a sample of patient files to assess the impact of additional counsellors and resources on patient health outcomes.

'I think we would be keeping it on the radar, so it would be good to know what their [FBC] statistics are that are reported.... This person has seen this number of clients this month who have completed the modules.... So having it as a stat and the expectation, so we expect the counsellor to see 5 patients a day and with two counsellors seeing 10 patients a day, in a week 100 patients a week.... ' – Participant 2

Discussion

Primary healthcare managers are a key lever in the translation of policy to implementation (32), but their views on possible strategies for supporting implementation of task-shared psychological counselling have rarely been explored. [34]. This study begins to address the lack of evidence on implementation strategies involving managers.

Findings from this study indicate broad support for continued and wider implementation of the Project MIND counselling. Participants acknowledged challenges to provision of this new service (e.g. lack of private counsellor space, counsellor time) amongst the variety of contextual factors that influence implementation climate more generally (e.g. high workloads, resistance to change) (33, 34). They emphasized the need to build resilience amongst their staff, raise morale and to engage with the public to improve their services and grapple with contextual challenges.

With these challenges in mind, participants highlighted several appropriate implementation strategies. Findings from this study suggest that multi-component implementation strategies may be needed to support embedding of this new service. Using normalisation process theory as a framework, we describe a multi-component implementation strategy (outlined in Table 1) that reflects managers' insights into the complexity of the intervention and community and health system contextual influences. This implementation strategy includes components targeting service planning and preparation, ongoing communication with internal and external stakeholders, service monitoring, and supervision and support for those delivering the counselling. These approaches align with prior recommendations for supporting the delivery of task-shared interventions in other areas of health care (35).

Table 1

Context appropriate implementation strategy for MIND psychological counselling in primary care

Implementation Approach	Facility level	Community level
1. Service Planning	<p>Identify key actors:</p> <ul style="list-style-type: none"> • Counsellors • Heads of Departments • Mental Health Nurses • Social Workers <p>Consult with key actors on:</p> <ul style="list-style-type: none"> • Space for counselling • Appointment times 	<p>Map community actors:</p> <ul style="list-style-type: none"> • Health committee (reinstate if needed) • NPOs and/or religious organisations • Department of Social Development (social workers) <p>Communicate with key actors on:</p> <ul style="list-style-type: none"> • Possible referrals • Community venues for counselling
2.Orientation and Training	<p>Subdistrict facility manager meetings</p> <ul style="list-style-type: none"> • Challenges and approaches for this new service <p>Staff meeting:</p> <ul style="list-style-type: none"> • Introduction to service • Mental health and wellness check in with staff • Mental health reorientation for all staff <p>Heads of Department meeting:</p> <ul style="list-style-type: none"> • Present benefits of programme • Present roles and responsibilities, referral pathways <p>Training workshops:</p> <ul style="list-style-type: none"> • Counselling skills training for counsellors, mental health nurses, social workers (doctors and other nurses) <p>Introducing service to community:</p> <ul style="list-style-type: none"> • Waiting room talks • Printed and social media 	<p>Health Committee Meeting</p> <ul style="list-style-type: none"> • Introduction to the service • Introduction to counsellors • Printed/social media introducing service

Implementation Approach	Facility level	Community level
3. Ongoing Monitoring	Monitoring Meetings <ul style="list-style-type: none"> • Clinical and MDT meetings • Feedback and follow up as needed Staff meetings <ul style="list-style-type: none"> • Standing agenda point for feedback and discussion on programme Monitoring statistics and reporting <ul style="list-style-type: none"> • Targets for counselling sessions • Feeding into monthly and annual reports (facility and NPO) 	Health Committee Meetings <ul style="list-style-type: none"> • Standing agenda point • Feedback to facility manager • Referrals to NPOs and feedback • Patient feedback through suggestions box and to health committee

Managers provided guidance on the process needed for sustainable contextual integration. This included appropriate introduction of staff to the ‘new’ work in a way that would minimize resistance. Managers also described the need for a cycle of communication and feedback between counsellors, those involved in clinical care and those planning implementation. This type of ‘responsive feedback’ is vital for enabling a project/service to respond to complex and changing contexts that affect intervention delivery, and can keep interventionists on course to enable desired outcomes (36). Participants identified various areas in which the service needed to be integrated into existing processes including job descriptions, performance contracts, meetings, and monitoring processes.

In terms of *relational integration*, managers described their role in promoting teamwork and good working relationships. This enabled them to build support for the new service and staff appreciation for its value. Managers in this study described how they used their leadership position to diffusing information by translating overarching plans/policy into day-to day activities for frontline staff and synthesizing information to make it relevant to staff and justify the service change. They also described their role in reframing challenges (e.g. through presenting the benefits of the innovation) and promoting positive engagement amongst staff, strengthening social networks within the organization and the wider community as described in other studies (20, 37). Building networks and relationships both within and outside their organisation and strengthening teamwork were identified as key roles of managers in promoting resilience, as described in other studies [23](23, 24). Staff relationships and working routines are a key aspect of resilience that can be purposefully strengthened [27] in the way described by managers in this study. Agency amongst staff and team approaches to load sharing have also been noted as integral (13). This will be increasingly relevant, not only for introducing new services but for coping with the COVID-19 pandemic and stress and burnout for health workers in the future.

Under the theme of *skill set workability*, managers underscored perceptions of staff that all mental health conditions should be treated by a mental health specialist. They described a lack of skills and confidence

amongst primary care staff with regards to screening for and treating CMDs, which guidelines specify may be addressed in primary care. This may be due to resource constraints and lack of capacity building and support for staff in implementing these guidelines in primary care (38). Part of the implementation approach suggested (Table 1) (and supported by previous South African research) (13) is reorientation for whole facilities with regards to mental health in primary care (e.g. through staff meetings or workshops, not off-site training which is unlikely to be feasible). Meetings such as those outlined in this study (and in Table 1) are key to working relationships and interprofessional collaboration and can be optimized to enhance multidisciplinary team functioning [49]. Addition of counsellors to facilities would also enable those counsellors to focus on developing appropriate counselling skills

In relation to *interactional workability*, managers stressed the need for an environment in which counsellors were able to refer clients to more specialized sources of support (e.g. social workers, mental health nurses) and to incorporate this into planning for implementation (Table 1). Managers linked referral needs to the range of non-health related issues people encounter in their daily lives. The upward referral or collaborative care is an integral aspect of task sharing for mental health care (39). The recommendation of participants on strengthening external referrals to NPOs in the community is also recognized as part of this collaborative care (39). Thus the implementation strategy (Table 1) could be an avenue for strengthening the role of primary care facilities in coordinating integrated holistic care (40) across the health and social services platforms (41) and community oriented primary care (COPC) (42). There remain intractable challenges in the provision of collaborative care: social workers are not universally present at facilities, and lack of access to social work services was drawn out as a key barrier to comprehensive care. In the broader context - ongoing investment in human resources for mental health (also including mental health nurse specialists) in South Africa remains inadequate (43).

Given the multiple responsibilities and key role that managers play in supporting the implementation of health innovations in PHC facilities (21), managers may require additional support to support implementation. The South African health system is characterized by a hierarchy in which managers and policy makers develop plans and policies which are filtered to the primary level, without accompanying guidance on implementation (13). Staff on the frontlines can feel overwhelmed by concurrent changes to work routines. The COVID-19 pandemic and its associated effects on mental health and health system capacity add a further layer to this complexity. Applying the implementation strategy described in Table 1 may assist managers in implementation of this and other innovations. Leadership development interventions for managers that include peer mentoring and support, opportunities for sharing of experiences and reflection on practice have been proposed as a means of building capacity among health managers for the introduction and sustained implementation of new evidence-based practices (25, 44). A variety of these interventions exist, including the Leadership and Organizational Change Intervention (LOCI) (45), but these would require contextual adaptation to ensure appropriateness for the South African health system context.

Limitations

Participants were from a range of MIND intervention sites (urban, rural), all within the Western Cape province which may be better resourced for health services compared with other provinces, potentially limiting the applicability of implementation strategies in facilities with differing organisational climates and community contexts.

Conclusion

This paper has presented experiences and perceptions of PHC managers on implementing an innovative task-shared counselling intervention for problem alcohol use and depression amongst patients with HIV or diabetes. Using normalization process theory as a conceptual framework, it highlights key pre-implementation activities in a multicomponent strategy for supporting implementation. The study highlights the leadership role of managers as conduits for creating an organisational environment conducive to sustained implementation. Investing in managers' capacity to support implementation of health innovations could leverage their potential to impact on a variety of health goals in resource-constrained contexts.

Declarations

Ethical approval and consent to participate

Ethical approval was granted by the South African Medical Research Council Ethics Committee (EC004-2-2015). The study was fully described and written informed consent was obtained.

Consent for publication

Not applicable

Competing interests

None declared.

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Author contributions

CBS, BM and KS conceptualized the study. CBS and PPW conducted interviews and analysis and prepared the manuscript first draft. PPW was second coder. JK and HM provided health systems and public health specialist consultation and facilitated engagement with managers. All authors edited and agreed on the final manuscript.

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Availability of data and materials

Data from the study may be made available upon reasonable request.

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