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D2.3 Innovative solutions in Low- and Middle-Income Countries

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Executive Summary

This document presents Deliverable 2.3 (D2.3) of the EQUICARES project, produced under Task 2.3: *Reciprocal Innovation in Accessible Mental Health Services — Lessons from Low- and Middle-Income Countries*. The deliverable systematically maps and analyses innovative mental health solutions developed and implemented in low- and middle-income country (LMIC) settings, with the aim of identifying approaches with potential for reciprocal innovation in the EQUICARES European pilot contexts. The study is grounded in the concept of reciprocal innovation — a bidirectional and iterative exchange of health innovations across diverse settings — and draws on the observation that LMICs have developed pragmatic, community-based, and scalable approaches to mental health care that offer genuine lessons for European systems confronting rising demand, workforce shortages, and persistent inequities in access.

The specific objectives of this deliverable were to:

- identify innovative mental health services, programmes, and community-based solutions from selected LMIC contexts;
- analyse how these innovations improve access to mental health care using the Levesque Framework;
- examine the mechanisms, contextual conditions, and implementation features that shape their effectiveness;
- assess the transferability of these innovations to other settings, including the EQUICARES pilot contexts; and
- support equitable knowledge exchange by synthesising findings in a way that can inform future adaptation, co-creation, and implementation processes within the project.

The study employed a sequential qualitative design combining three analytical phases. In the first phase, a qualitative document analysis was conducted across five regions — the Middle East and North Africa, the Caucasus, Sub-Saharan Africa, Latin America, and South-East Asia — using a multi-source search strategy that identified 258 mental health innovations through consortium partner consultation, targeted searches of major global health organisation websites, and broader web-based searches. Innovations were assessed against predefined inclusion and exclusion criteria requiring LMIC implementation and documentation across three domains: descriptive evidence, impact

evidence, and implementation guidance. Of the 258 innovations identified, 47 met all criteria and were retained for in-depth analysis. In the second phase, each of the 47 innovations was scored on four transferability dimensions — feasibility, agility, co-creation, and clarity — by two independent reviewers, generating a weighted composite transferability score. In the third phase, digital ethnography was conducted on the 25 highest-scoring innovations, examining their social media content across LinkedIn, Instagram, TikTok, Facebook, and YouTube; 11 of the 25 had active accounts with original posts published within the 90-day review period and were included in the content analysis.

The 47 innovations retained for analysis were implemented predominantly in Sub-Saharan Africa and Asia, with India, Jordan, Ethiopia, South Africa, Uganda, Kenya, Sierra Leone, Pakistan, and Nigeria each contributing four or more innovations. The majority were implemented in community settings (46.8%) or healthcare settings (40.4%). Nearly half did not focus on a specific diagnostic category, reflecting a widespread emphasis on general or transdiagnostic approaches. The most frequently targeted specific condition was depression (21.3%), followed by perinatal mental health conditions (12.8%).

Analysed by innovation type, the vast majority of the 47 innovations fell under the cluster of Service Delivery and Integration (89.4%, n=42), with task-sharing with health workers (63.8%), integration of mental health into health services (55.3%), task-sharing with community members (42.6%), and intersectoral collaboration (38.3%) as the most common subtypes. Person-Centred and Community Approaches were the second most common cluster (51.1%, n=24), led by peer-led support groups and group therapies (34.0%). Digital Mental Health Solutions were identified in 29.8% of innovations (n=14), while System-Level Interventions (17.0%), Arts-Based Approaches (10.6%), and Research Capacity Building (8.5%) were less frequent. As innovations could be classified under more than one cluster, percentages do not sum to 100%.

Analysed through the supply-side dimensions of the Levesque Framework, the 47 innovations most comprehensively addressed approachability and availability — primarily through primary health care (PHC) integration, community outreach, task-sharing, and decentralisation of services. Acceptability was addressed through the widest range of strategies, including cultural adaptation, stigma reduction, peer-led delivery, and rights-based approaches, reflecting the complexity of social and cultural barriers to mental health care in the included settings. Affordability was addressed primarily through free or low-cost service provision and reduction of indirect costs. Appropriateness was the most multidimensional area, encompassing timeliness, quality assurance, responsiveness to clinical and social needs, and demonstrated effectiveness. Demand-side dimensions of the Levesque Framework were outside the scope of this analysis.

Composite transferability scores across the 47 innovations ranged from 2.90 to 4.95 (mean 4.10, SD 0.51). Thirteen innovations reached the higher transferability threshold of 4.5 or above, including the Friendship Bench (Zimbabwe, 4.95), the Thinking Healthy Programme (Pakistan), the MANAS Project (India), and the Common Elements Treatment Approach (Thailand). A further 17 innovations fell within the moderate transferability range of 4.0 to 4.49. Inter-rater reliability of the scoring process was good, with averaged reviewer scores yielding an intraclass correlation coefficient of 0.843 (95% CI: 0.607–0.926; $p < 0.001$). Structural features consistently associated with higher transferability included: reliance on existing or readily trainable workforces; use of structured, well-documented protocols; documented history of cross-context adaptation; and meaningful involvement of service users and communities in design and delivery.

The digital ethnography of 11 active innovations across social media platforms identified five communicative typologies — Psychoeducation and Literacy, Stigma Reduction and Lived Experience, Community Building and Peer Support, Crisis Intervention and Service Promotion, and Self-Care and Motivational Aesthetics — and found clear platform-specific patterns: psychoeducation content dominated on YouTube (60%), stigma reduction and lived experience content was most prevalent on Instagram and TikTok (40%), community building was most common on Facebook (40%), and crisis intervention and service promotion predominated on LinkedIn (40%). Different stakeholder types — public health authorities, NGOs, private foundations, and individual practitioners — showed distinct content priorities and communicative voices.

The findings of this deliverable have direct implications for the subsequent tasks of the EQUICARES project. The 25 innovations selected for in-depth profiling on the basis of their transferability scores will be subjected to further analysis using the Framework for Reporting Adaptations and Modifications-Enhanced (FRAME) in Task 2.4, set to produce structured adaptation briefs for use by the European pilot sites. The Levesque Framework analysis provides a structured basis for examining how the same access dimensions are addressed in the European adaptation of each innovation. The digital ethnography findings offer practical guidance for pilot site communication strategies. Across all tasks, the project remains committed to the ethical principles of reciprocal innovation — equity, reciprocity, and responsible knowledge use — ensuring that the communities and organisations whose innovations are being studied are acknowledged as knowledge contributors and, where possible, actively involved in adaptation processes.

The present deliverable fulfils the objectives of Task 2.3 (*“Reciprocal innovation in accessible mental health services: lessons from LMICs”*) by identifying, analysing, and synthesising innovative mental health service solutions implemented in LMICs. The deliverable presents a structured mapping of these solutions, including their key characteristics, accessibility dimensions, and transferability potential to European contexts. Furthermore, the work contributes directly to Milestone 3 (*“Mapping*

of innovative solutions for access in mental healthcare”), alongside Deliverables D2.1 and D2.2, by expanding the evidence base beyond European and pilot contexts. In line with the project’s KPIs, the deliverable exceeds the target of screening at least 20 digital communities in LMICs, with a total of 25 innovations analysed through digital ethnographic methods, including both active digital presence and patterns of digital absence. The results of this deliverable provide a critical input for subsequent tasks, particularly T2.4 (evaluation and adaptation analysis) and WP4 (design and implementation of pilot interventions).

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List of abbreviations and acronyms

Name(s)	Beneficiary
ADAPT-ITT	Decision, Adaptation, Production, Topical experts, Integration, Training, and Testing Framework
AFFIRM	Africa Focus on Intervention Research for Mental health
CBT	Cognitive Behavioral Therapy
CETA	Common Elements Treatment Approach
COPSI	Care for People with Schizophrenia in India
DWM	Doing What Matters in Times of Stress (WHO guide)
EASE	Early Adolescent Skills for Emotions
FRAME	The Framework for Reporting Adaptations and Modifications-Enhanced Assessment,
HCW / HW	Healthcare Worker / Health Worker
INSPIRE	Innovative Approaches to Adolescent Perinatal Mental Health
LMIC	Low- and Middle-Income Country
MENA	Middle East and North Africa
mhGAP	Mental Health Gap Action Programme
mhGAP-IG	Mental Health Gap Action Programme Intervention Guide
NGO	Non-Governmental Organization
OCD	Organisation for Economic Co-operation and Development
PHC	Primary Health Care
PTSD	Social Media Health Literacy (Framework)
SoMeLit	Social Media Health Literacy (Framework)
SW	Social Worker
THP	Thinking Healthy Programme

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1. Introduction and Conceptual Framework

1.1. Defining Innovative Solutions in LMICs

According to the OECD, an innovation is “a new or improved product or process (or combination thereof) that differs significantly from the unit’s previous products or processes and that has been made available to potential users (product) or brought into use by the unit (process)” (OECD/Eurostat, 2018). The OECD framework distinguishes four main types of innovation: product innovation, which introduces new or significantly improved goods or services; process innovation, which involves changes in production or delivery methods; organisational innovation, which refers to new ways of organising work, business practices, or external relationships; and marketing innovation, which encompasses new approaches to product design, promotion, or pricing (OECD/Eurostat, 2018). A further distinction that is particularly relevant in the context of health and social development is that between technological innovation — which involves the application of new tools, devices, or digital platforms — and social innovation, which refers to new ways of organising services, engaging communities, and structuring relationships between providers and users in order to address social needs more effectively (Phills et al., 2008; European Commission, 2013). While technological and social innovations are often treated separately, in practice they frequently intersect: a new digital platform may simultaneously introduce a new service delivery model, a new organisational structure, and a new form of community engagement.

In health systems, innovation is understood not only as entirely new interventions but also as the adaptation or implementation of existing approaches in ways that improve effectiveness, accessibility, or equity of care. The World Health Organization defines health innovation as “the creation and implementation of novel processes, products, services, programmes, policies or systems that lead to transformations or improvements in health outcomes and equity.” Innovation may arise from new or improved ideas and can take multiple forms, including digital health solutions based on disruptive technologies as well as social innovations that introduce new service delivery models, strengthen participation and partnerships, promote empowerment, and make more creative use of resources to address public health challenges (WHO, 2026).

In practice, this broad understanding is reflected in a wide range of health initiatives across settings. Innovation in health care can take multiple forms, including task-shifting, community engagement, digital health technologies, and other adaptations in service delivery. What these approaches have in common is that they introduce a change from routine practice with the aim of improving health outcomes and promoting equity. This is illustrated by diverse initiatives across low- and middle-income countries (LMICs). For example, the Indigenous Community Health Agent Professionalization

Programme (ICHAPP) in Brazil improved care in remote indigenous communities through culturally tailored training for local health agents, combining traditional medicine, biomedical approaches, and general education (Social Innovation in Health Initiative, 2025a). In Zanzibar, Tanzania drone and smartphone technology were used in a malaria control programme to identify mosquito breeding sites and support elimination efforts (Morgan, 2022). In Comapa, Guatemala, a community-based and interdisciplinary approach addressed Chagas disease through participatory vector control, improved local diagnosis, treatment, and prevention of mother-to-child transmission (Social Innovation in Health Initiative, 2025b). In the Philippines, the National Telehealth Service (NTS) improved access to specialist care in remote areas by linking rural health workers with specialists through SMS- and email-based telemedicine (Social Innovation in Health Initiative, 2025c).

Building on this broad framing, this study adopts a pragmatic approach to identifying and analysing innovations. Rather than focusing solely on novelty, attention was given to interventions that introduce meaningful changes in how mental health services are organised, delivered, or accessed, particularly in ways that may be relevant beyond their original context. Specifically, we assessed how services were structured, who delivered them, and through which modalities they were provided. This included examining whether the intervention involved alternative delivery models (e.g., peer-led approaches, task-shifting), different service organisation (e.g., integration into primary care or other sectors), the use of digital or e-health technologies, or system-level changes such as policy or workforce development initiatives. The assessment was guided by an implicit reference model of conventional mental health service delivery, typically characterised by specialist-led, facility-based, and appointment-driven care. It should be noted that this reference model reflects the predominant structure of mental health systems in the LMIC settings under study, where digital delivery, online therapy, and hybrid care models remain far less routinised than in many high-income country contexts. In European settings, where online CBT, self-guided digital interventions, and peer-to-peer platforms have become increasingly mainstream (Andersson et al., 2019), the boundary between conventional and innovative care is more fluid, and the innovations identified in this study should be interpreted accordingly. Innovations were therefore identified as approaches that diverged from this conventional model by introducing new actors, delivery pathways, or organisational structures — such as the involvement of non-specialist or peer providers, integration of services into non-specialised settings, the use of telehealth or digital platforms, and initiatives focused on strengthening workforce capacity or mental health policy.

1.2. The Concept of Reciprocal Innovation

Developed countries have overcome many healthcare challenges that low-income countries continue to face, while developing countries strive to learn from wealthier nations in order to achieve high-

quality, widely accessible healthcare services (Turan et al., 2023). It might seem that developed countries have already moved beyond those stages and have little to learn from developing countries, which are still struggling to reach that level. However, the unique challenges in developing countries generate knowledge and strategies for addressing health problems that are often not apparent to developed countries. A good example of health innovation flowing from a low-income to a high-income setting is the case of low-cost portable ultrasound machines that were originally designed by General Electric for use in rural China because the cart-based machines were expensive (Immelt et al., 2009). The cost-effectiveness of those portable devices made them attractive to the broader healthcare market, and the innovation was subsequently widely adopted in the United States. Another instance in which the vulnerability of the healthcare system in developed countries was tested was the COVID pandemic, during which healthcare facilities were flooded beyond their capacity. In such scenarios, learning from countries that have already experienced and managed resource scarcity would be beneficial. A concrete example beyond service delivery is the SORMAS (Surveillance Outbreak Response Management and Analysis System), a disease surveillance platform originally developed through Nigerian-German collaboration during the 2014–2015 Ebola outbreak in West Africa; during the COVID-19 pandemic, Germany and several other European countries adopted SORMAS precisely because Nigeria's sustained experience with outbreak management had produced a more mature and field-tested system than those available in high-income settings (German Federal Ministry for Economic Cooperation and Development, 2020). Apart from the COVID pandemic, the healthcare systems of developed countries are not flawless, and service delivery in these countries can still be improved by learning from the best practices of other nations. Such knowledge is particularly important for addressing healthcare challenges in resource-constrained settings and in unexpected circumstances such as disasters and infectious disease outbreaks. Thus, there is a clear need for collaboration among countries to ensure optimal healthcare delivery.

Reciprocal innovation is a bi-directional, co-created, and repetitive exchange of ideas, resources and innovations to tackle health challenges across diverse settings (Sors et al., 2023) and, more formally, a distinct research approach that identifies, develops, and exchanges health innovations across global settings to address shared challenges in an equitable and mutually beneficial manner (Kupfer et al., 2024). In contrast to the predominant vertical flow of health innovations from high-income countries to low-income countries, or reverse innovation, which is a one-way flow of ideas, innovations, and resources from low-income countries to high-income countries (DePasse & Lee, 2013), reciprocal innovation involves both sides contributing to the innovation process, rather than one party simply adopting the invention of the other. Applying a reciprocal innovation approach to research involves several components: developing platforms and funding models that support bidirectional exchange, creating globally accessible repositories of existing and ongoing reciprocal

innovation research, and ensuring that studies involving innovation transfer acknowledge and document the origins of the original innovation (Kupfer et al., 2024).

Reciprocal innovation promotes equity and disrupts neocolonial tendencies in global health. It also helps fill gaps in the health systems of participating countries, and the low-cost innovations developed in low-income contexts enable high-income countries to minimise costs while enhancing care in both settings. For instance, a Brazilian programme to address social isolation was adapted in Baltimore, which in turn motivated the original Brazilian organisation to refine its model (Rid et al., 2024). This example illustrates a defining feature of reciprocal innovation: the exchange is iterative rather than a one-time transfer. Adaptations made in the receiving context feed back to inform and refine the original programme, generating continuous improvement across both settings (Turan et al., 2023).

Mental health is a domain where this iterative potential is especially evident. Over two decades, LMICs have developed major advances in mental health service delivery, including care by non-specialist providers, mobile technologies, and multilevel community-based interventions (Turan et al., 2023). Task-sharing with trained lay workers is one of the most evidence-supported strategies: systematic reviews have demonstrated that task-shared psychosocial interventions are effective in preventing common mental disorders, including depression, in LMIC settings (Prina et al., 2023), and that digital modalities further extend their reach by enabling remote training, supervision, and service delivery (Chakrabarti, 2024). However, translating these models to high-income countries is not straightforward: common barriers include limited reimbursement mechanisms for non-specialist care, resistance from professional associations, and regulatory incompatibilities — challenges that require deliberate policy attention rather than assumptions of direct transferability (Belz et al., 2024; Turan et al., 2023). In high-income countries in Europe and the Americas, community-based approaches for increasing access to mental health are nonetheless gaining momentum, and the adoption of LMIC innovations is increasingly supported by policymakers (Turan et al., 2023; Belz et al., 2024). A critical equity concern remains, however: in most documented cases, LMIC researchers have not been directly involved in the high-income country implementation of innovations they originally developed (Turan et al., 2023). These precedents underscore that the direction of learning in global mental health is not fixed, and that resource-constrained settings generate pragmatic, scalable, and culturally embedded approaches with genuine lessons for European systems grappling with their own access inequities.

Reciprocal innovation nonetheless involves several ethical and operational challenges. Firstly, reciprocal innovation research may disproportionately benefit high-income countries due to power imbalances in the partnerships. In the mental health field, for instance, despite investigators' involvement in most of the original LMIC research, only a few cases have directly involved LMIC researchers in high-income country implementation — a structural asymmetry that undermines the

equity commitments reciprocal innovation is meant to uphold (Turan et al., 2023; Rid et al., 2024). It is also worth noting that South-North knowledge transfer in health has a much longer history than the recent literature on reverse innovation may suggest. Werner et al.'s (2009) *Where There Is No Doctor* — first developed from field experience in rural Mexico and subsequently translated into dozens of languages for use across the globe — represents one of the earliest and most widely disseminated examples of community health knowledge flowing from a low-resource setting to influence health practice worldwide. Equally, South-South knowledge transfer represents an important and frequently underacknowledged dimension of global health learning: Cuba's Escuela Latinoamericana de Medicina (ELAM), established in 1999, has trained thousands of physicians from across Latin America, Africa, and Asia entirely at Cuba's expense, offering a model of health workforce development through solidarity rather than commercial exchange (Cole et al., 2018). While South-South transfer falls outside the scope of this deliverable, which focuses on LMIC-to-European learning, acknowledging its existence is important for an honest account of how health knowledge actually moves across contexts. Secondly, innovations from low-income countries may not be compatible with the strict ethical and regulatory requirements in developed countries, which require some adaptations (Rid et al., 2024). Lastly, the transnational nature of the collaboration makes it difficult to take legal measures in cases of dispute (Rid et al., 2024).

From an ethical perspective, this work is grounded in the principles of equity, reciprocity, and responsible knowledge use that underpin the concept of reciprocal innovation. In this deliverable, we analysed mental health innovations implemented in LMIC settings, focusing on their underlying mechanisms, their influence on access to care through the Levesque Framework, and their potential transferability across contexts. Rather than extracting context-bound practices for one-directional use, our approach seeks to make the knowledge generated through these innovations more accessible, interpretable, and usable across different settings. In line with these principles, this work aims to contribute to a broader cycle of knowledge exchange by synthesising and structuring insights in a way that can be reused by diverse stakeholders, including those in the settings where the innovations originated. By identifying common mechanisms, contextual conditions and access-related impacts, and by explicitly examining transferability, we aim to support more equitable adaptation and application of these innovations. At the same time, we recognise the ethical responsibility to acknowledge the origins of these innovations and the contexts in which they were developed, and to avoid decontextualised or extractive use.

The relevance of reciprocal innovation is especially pronounced in mental health, where LMICs have long confronted structural scarcity — limited specialists, overstretched facilities, and persistent stigma — by developing creative community-based, task-sharing, and digitally enabled responses (Turan et al., 2023; Prina et al., 2023). These conditions are increasingly mirrored in Europe, where mental

health systems face rising demand, workforce shortages, and persistent inequities in access for vulnerable populations (WHO/Europe, 2023). Grounded in this logic, the EQUICARES project systematically explored mental health service innovations from four non-European regions — the Middle East and North Africa, the Caucasus, Asia, Sub-Saharan Africa, and Latin America — to identify solutions with potential for mutual learning and adaptation to European pilot contexts. The methodology, selection criteria, and analytical framework applied to this exploration are described in the following chapter.

1.3. Objectives

This deliverable aims to identify and examine innovative mental health service solutions developed in LMICs that may offer lessons for reciprocal innovation in accessible mental health care.

Its specific objectives are to:

- identify innovative mental health services, programmes, and community-based solutions from selected LMICs;
- analyse how these innovations improve access to mental health care using the Levesque Framework;
- examine the mechanisms, contextual conditions, and implementation features that shape their effectiveness;
- assess the transferability of these innovations to other settings, including the EQUICARES pilot sites;
- support equitable knowledge exchange by synthesising findings in a way that can inform future adaptation, co-creation, and implementation processes within the project.

2. Methodology

2.1. Study Design and Analytical Approach

This study employed a qualitative research design combining qualitative document analysis and digital ethnography. The research was conducted in three sequential phases.

1. A qualitative document analysis was conducted using an interpretive approach to identify and examine mental health interventions. The analysis was guided by a predefined codebook and informed by two analytical frameworks: the global reciprocal innovation approach, which was used to identify and characterize innovations, and the Levesque Framework, which was used to examine how these interventions addressed different dimensions of access to care.

2. A transferability assessment was carried out based on the extracted data. This phase aimed to evaluate the potential of identified interventions to be adapted and applied across different contexts.
3. A digital ethnography method was used to complement the findings by examining how mental health interventions are represented, communicated, and contextualized in online environments.

2.1.1. Qualitative Content Analysis

A qualitative content analysis was conducted to identify and examine mental health interventions. In this study, an interpretive approach was adopted, going beyond descriptive extraction to examine how interventions were conceptualized and implemented, how they contributed to access to care, and how their transferability and potential relevance across settings could be understood.

The analysis was guided by a predefined codebook and informed by two analytical components.

1. The global reciprocal innovation approach was used to identify and conceptualize innovations, and
2. The Levesque Framework of access was used to examine how these interventions addressed different dimensions of access

2.1.1.1. Global Reciprocal Innovation Approach

This study was informed by the global reciprocal innovation approach, which conceptualises innovation as a bidirectional, co-created, and iterative exchange of knowledge, resources, and practices across different settings (Sors et al., 2023; Kupfer et al., 2024). Unlike traditional models of knowledge transfer, which often assume a unidirectional flow from high-income to low- and middle-income countries, or reverse innovation models that emphasise a one-way transfer in the opposite direction, reciprocal innovation is based on mutual learning and co-development across contexts (DePasse & Lee, 2013; Sors et al., 2023).

Within this framework, innovations were understood not simply as novel interventions, but as context-responsive approaches that introduce meaningful changes in how mental health services are organised, delivered, or accessed, with potential relevance beyond their original setting. The analysis adopted a broad understanding of innovation and specifically examined how interventions differed from conventional specialist-led, facility-based, and appointment-driven models of care. In this sense, attention was given to interventions that introduced alternative delivery actors, service settings, organisational arrangements, or delivery modalities, such as task-sharing, peer-led support, community-based delivery, digital platforms, or integration into non-specialised services.

This perspective was particularly relevant in the field of mental health, where innovations developed in resource-constrained settings such as task-sharing models, community-based interventions, and digital solutions have shown potential for adaptation across settings, although such transfer requires careful consideration of contextual, regulatory, and system-level differences (Turan et al., 2023; Belz et al., 2024; Chakrabarti, 2024). Guided by this approach, the present study identified innovations pragmatically, focusing on interventions that introduced meaningful departures from routine practice and that could offer transferable insights for improving equitable access to mental health care across diverse contexts.

2.1.1.2. Levesque Framework

The Levesque Framework was used to examine how the identified mental health innovations addressed access to care through their underlying service mechanisms. The framework conceptualizes access to healthcare as a dynamic process that occurs at the interface between health systems (supply side) and individuals or communities (demand side). Rather than treating access as a static outcome, the framework understands it as a series of interactions through which people recognize their health needs, seek care, reach services, obtain appropriate care, and ultimately benefit from it. This process is shaped by the alignment between the characteristics of health services and people's abilities to engage with them (Levesque et al., 2013).

On the supply side, access is structured through five key dimensions: approachability, acceptability, availability and accommodation, affordability, and appropriateness. These dimensions represent the ways in which health systems are designed, organized, and delivered. On the demand side, these correspond to individuals' abilities to perceive, seek, reach, pay, and engage with care. Access is achieved not simply when services exist, but when these supply-side characteristics effectively enable and support the corresponding abilities on the demand side (Levesque et al., 2013).

In this study, the analysis focused on the supply-side dimensions of access. Rather than examining individual-level experiences of access, the aim was to explore which features of innovative mental health solutions may contribute to improving the accessibility of mental health care, particularly in terms of how services are designed, organized, and delivered.

- Approachability refers to the extent to which services are made visible, understandable, and perceived as relevant and trustworthy, enabling individuals to recognize their health needs and become aware of available care.
- Acceptability captures the degree to which services are socially, culturally, and ethically aligned with user values and expectations, influencing whether individuals feel comfortable and willing to seek care.

- Availability and accommodation refer to the extent to which services are physically reachable and organized in ways that fit people's daily lives, including geographic distribution, opening hours, and organizational flexibility.
- Affordability reflects the relationship between the costs of accessing care (both direct and indirect) and individuals' capacity to pay, shaping whether care can be used without financial hardship.
- Appropriateness refers to the extent to which services are relevant to users' needs and delivered in a timely, continuous, and quality-assured manner (Levesque et al., 2013).

2.1.2. Transferability Assessment Framework

Assessing whether health innovations developed in one context can be meaningfully adapted and applied in another is a recognised methodological challenge in implementation science. A growing body of frameworks and guidance has been developed to address different aspects of this challenge, reflecting distinct but complementary understandings of what transferability involves and what questions it requires researchers to answer (Movsisyan et al., 2019). A systematic review of adaptation guidance by Movsisyan et al. (2019) identified 35 sources of guidance published between 2000 and 2018 and found broad agreement on the importance of contextual assessment and stakeholder involvement, but also significant gaps — particularly with respect to macro-level and cross-national transfers, which are precisely the kind of adaptation that characterises the present study. No single existing framework fully addressed the task of systematically comparing and ranking a diverse set of LMIC innovations for their potential relevance to European healthcare contexts. The transferability framework developed for this study was therefore informed by a review of the most relevant existing approaches, drawing selectively on the conceptual dimensions that best suited the comparative and prospective nature of this assessment.

2.1.2.1. ADAPT-ITT

The ADAPT-ITT model (Wingood & DiClemente, 2008) is among the most widely used frameworks for adapting evidence-based interventions and consists of eight sequential phases: Assessment, Decision, Adaptation, Production, Topical experts, Integration, Training, and Testing. Originally developed for HIV prevention interventions, it has since been applied across a broad range of health domains and international contexts. The framework is fundamentally a process guide — it prescribes a step-by-step procedure for carrying out an adaptation after a selection decision has been made, rather than providing tools to inform that selection. ADAPT-ITT was therefore not directly applicable to the comparative pre-selection task at the heart of this study, which required assessing the relative adaptability of 47 diverse innovations simultaneously. However, the framework's emphasis on formative assessment of the target population, identification of contextual mismatches, and pilot

testing informed the design of the present study's feasibility and agility dimensions, both of which ask how readily an innovation could be taken up and modified in a new context.

2.1.2.2. FRAME Analysis

The Framework for Reporting Adaptations and Modifications-Enhanced (FRAME; Wiltsey Stirman, Baumann, & Miller, 2019) addresses a distinct but related question: not whether to adapt, but how to document and characterise modifications that occur during or after implementation. FRAME specifies eight dimensions for reporting:

- when in the implementation process the modification was made;
- whether it was planned or reactive;
- who decided on the change;
- what element was modified;
- at what level of delivery, the change occurred;
- the nature of the modification;
- whether the modification is fidelity-consistent with the core intervention mechanisms; and
- the reasons for the change.

The fidelity-consistency dimension is FRAME's most significant contribution to the present study: it draws a crucial distinction between adaptations that preserve the active therapeutic or functional mechanisms of an intervention and those that alter them in ways likely to undermine effectiveness. While FRAME is designed as a retrospective or concurrent documentation tool rather than a prospective ranking instrument, its taxonomy of what can be modified, and at what cost to fidelity, directly informed the co-creation and clarity dimensions of this study's transferability framework. The clarity dimension in particular reflects FRAME's insight that interventions with clearly specified, separable core functions are more reliably adapted across contexts without fidelity loss.

2.1.2.3. TRANSFER Approach

The TRANSFER Approach (Munthe-Kaas, Nøkleby, Lewin, & Glenton, 2020) was developed to support systematic review authors and decision makers in collaborating to assess the transferability of review findings to specific contexts. It provides a structured conversation guide for identifying, a priori, the contextual factors most likely to influence whether a given body of evidence will transfer to the context of interest. The seven categories of transferability factors it examines include population characteristics, intervention features, comparison conditions, outcomes, implementation context, healthcare system characteristics, and socio-political and cultural factors. The TRANSFER Approach is particularly notable for treating transferability not as a fixed property of an intervention, but as a relational judgment that must be made with reference to a specific target context — in this case, the

diverse national and regional contexts of the EQUICARES pilot sites. This relational logic informed the overall design of the present study's framework, which was constructed explicitly to assess transferability to European health system contexts rather than producing context-neutral rankings. The approach's emphasis on stakeholder engagement in defining transferability factors also resonates with the co-creation dimension of the present framework, which specifically rewards innovations that involve service users and communities in shaping delivery and adaptation processes.

2.1.2.4. Intervention Scalability Assessment Tool

Milat and colleagues have developed the most systematic body of work on scalability of health interventions, culminating in the Intervention Scalability Assessment Tool (ISAT; Milat et al., 2020). The ISAT is a decision-support tool designed to help policy-makers and practitioners assess the suitability of health interventions for scale-up, organised around domains including problem definition, intervention characteristics, contextual factors, potential reach, adoption, acceptability, and resource requirements. Unlike process-focused frameworks such as ADAPT-ITT, the ISAT produces a structured assessment that can in principle be applied comparatively across interventions. The ISAT also usefully distinguishes scalability — the capacity of an intervention to expand in reach and adoption within a given health system — from transferability, the capacity to operate effectively in a different context. For the purposes of this study, both concepts are relevant: the 47 identified innovations are assessed for their potential to be transferred to European contexts and, within those contexts, to be adopted at meaningful scale. The ISAT's emphasis on feasibility — particularly resource requirements, workforce fit, and system compatibility — as the primary determinant of scale-up potential provided the strongest direct foundation for the present framework. The weighting assigned to feasibility (30%) in this study's composite score reflects the ISAT's finding that resource and system fit constitutes the most significant practical barrier to adoption, a consideration that is especially acute in the regulated, institutionalised contexts of European health systems.

2.1.2.5. The Transferability Assessment Framework Used in This Study

Drawing on the conceptual landscape described above, this study developed a purpose-built four-dimension transferability framework designed to enable systematic, comparative assessment of 47 mental health innovations for their potential relevance to European healthcare contexts. The framework was constructed to address a specific methodological gap: none of the existing frameworks was designed to rank or compare a large and diverse set of innovations simultaneously, prior to any implementation attempt, and with explicit reference to a defined target context characterised by particular regulatory, workforce, and organisational features.

The four dimensions — Feasibility, Agility, Co-creation, and Clarity — were selected because together they capture the key determinants of cross-context transferability identified across the frameworks

reviewed above. Feasibility, weighted at 30%, assesses the extent to which an innovation can be realistically implemented in another context given available human, financial, organisational, and infrastructural resources; this dimension carries the highest weight in recognition of the consistent finding across the scalability and implementation science literatures that resource and system fit constitutes the primary barrier to adoption (Milat et al., 2020). Agility, weighted at 25%, assesses the capacity of the innovation to adapt to different cultural, linguistic, service, or population contexts without loss of core function; this dimension draws on FRAME's attention to fidelity-consistent adaptation and on the TRANSFER Approach's emphasis on contextual fit as a relational rather than absolute property (Wiltsey Stirman et al., 2019; Munthe-Kaas et al., 2020). Co-creation, also weighted at 25%, assesses the degree to which relevant stakeholders — including service users, communities, and local providers — are meaningfully involved in the design, adaptation, and implementation of the innovation; this dimension reflects a consistent emphasis across adaptation frameworks on stakeholder engagement as both a quality indicator and a prerequisite for contextual relevance (Movsisyan et al., 2019; Wingood & DiClemente, 2008). Clarity, weighted at 20%, assesses the extent to which the innovation's objectives, components, processes, and expected outcomes are clearly defined and documented; this dimension reflects the implementation fidelity literature's finding that standardised, well-documented interventions are more reliably adapted across contexts with less implementation drift (Wiltsey Stirman et al., 2019).

Each dimension was scored on a scale from 0 to 5 by two independent reviewers, with the final score calculated as the mean of the two assessments. A weighted composite transferability score was then derived using the formula: $\text{Transferability score} = (\text{Feasibility} \times 0.30) + (\text{Agility} \times 0.25) + (\text{Co-creation} \times 0.25) + (\text{Clarity} \times 0.20)$. Detailed scoring guidance for each dimension, including illustrative examples, is provided in the codebook (Table 1). It should be noted that this framework was designed to produce a structured comparative ranking to support selection for further analysis, rather than an absolute or context-independent measure of transferability. Scores should therefore be interpreted in relation to each other and with reference to the specific European contexts for which adaptations are envisaged, rather than as standalone verdicts on an innovation's transferability in general terms.

2.1.3. Digital Ethnography

Ethnography has broadened its scope considerably with the advent of the internet era. Traditionally, ethnographers immerse themselves in the physical environment of their research subjects for an extended period of time, building sustained relationships and developing contextually grounded understanding of social life. Digital ethnography adapts this epistemological stance to online environments, making it possible to study the lived experiences, practices, and communicative behaviours of communities without physical co-presence. Digital ethnography is a qualitative research methodology used to study participants in digital spaces through sustained immersion in their

environment (Borkovich, 2022). Like its analogue counterpart, it can be carried out through passive observation — sometimes referred to as lurking — or through direct engagement with participants, and primarily involves producing thick, contextually rich descriptions of the communities studied rather than quantifying observations. What distinguishes digital ethnography from content analysis or discourse analysis is the emphasis on researcher co-presence: the requirement that the observer is embedded in the data, attending not only to what is said but to the social dynamics, silences, and contextual meanings that shape communication (Forberg & Schilt, 2023).

Although there is no universally agreed framework for conducting digital ethnography, a number of methodological approaches have been proposed to guide its application across different research contexts (Delli Paoli & D'Auria, 2025). Cocq and Liliequist (2024) propose that the process unfolds across four phases: planning, data collection, fieldwork wrap-up, and dissemination. In the planning phase, the researcher defines the research question, develops an overview of the platforms to be studied, and selects the field sites. In the data collection phase, the investigator records reflexive field notes, maintains an archive of collected material, and documents analytical decisions throughout. The researcher then concludes the digital fieldwork and proceeds to data analysis. Finally, findings are communicated to both scientific and general audiences. Cocq and Liliequist (2024) also emphasise that ethical observation is not a discrete step but a continuous responsibility that runs through each phase of the process. This ethical dimension is particularly significant in digital research, where the boundaries between public and private content are not always clear, and where the use of data from social media platforms raises ongoing questions about consent, anonymity, and the potential for harm to individuals who may not be aware that their posts are being studied (Cera, 2023). In the context of this study, data collection focused exclusively on publicly available organisational posts — content deliberately published by mental health organisations to communicate with broad audiences — rather than on user-generated or personal content, which substantially reduces the ethical risks associated with this form of observation.

Digital ethnography offers particular advantages for research on health, and mental health specifically. Its use in health care research has grown substantially in recent years, with applications ranging from the study of online patient communities and chronic illness experiences to the analysis of digital health communication by service providers and advocacy organisations (Vainauksienė, 2023). A scoping review of ethnographic and digital ethnographic studies in health care identified five recurring themes in this body of work: social media in health communication, chronic illness and online communities, patient empowerment, health care experiences, and family networks in digital health — a breadth that reflects the analytical versatility of the approach (Sadat et al., 2025). In mental health research specifically, the absence of physical encounter can reduce the social pressure associated with discussing stigmatised conditions, making it easier for individuals and organisations to communicate about mental health more openly in digital spaces (Naslund et al., 2014). The

methodology's emphasis on dense, contextually detailed data — combined with the researcher's capacity to observe not only what is stated but also what is implied, absent, or contested — allows for a depth of understanding that more structured research designs may not capture. Digital spaces are also significant sites of engagement for marginalised communities, including those living with mental health conditions in low- and middle-income countries, who often turn to online platforms for information, peer connection, and support when formal services are inaccessible, geographically distant, or socially unacceptable (Naslund et al., 2014; Naslund & Deng, 2021). In the context of global mental health organisations, digital ethnography provides a window into how innovators communicate their approaches, engage with communities, and represent their services to diverse audiences across platforms — dimensions that documentary analysis alone cannot capture.

In the context of this study, digital ethnography was applied as a complementary method to examine how the selected mental health innovations communicate with and engage communities through digital channels. Digital ethnographic screening was conducted on a total of 25 mental health innovations implemented in Low- and Middle-Income Countries (LMICs), exceeding the project KPI target of screening ≥ 20 digital communities. The 25 innovations with the highest composite transferability scores (see section 3.4) were selected for this phase. For each innovation, platform-specific Google search operators were used to identify official accounts across six platforms — LinkedIn, Instagram, TikTok, Facebook, X (formerly Twitter), and YouTube — using the structure `*"[Project Name]" site:[platform.com]*`. Where no dedicated project-level account was identified, the social media channels of the implementing organisation or primary partner were examined as a proxy, on the grounds that project communication frequently flows through host organisation channels rather than independent project accounts. Additional searches without quotation marks and with relevant keywords were conducted to capture indirect references such as mentions in event materials or third-party content. Posts published within the 90 days prior to data collection were used as the primary criterion for determining whether an account was considered active, a timeframe selected to balance feasibility across 25 organisations and multiple platforms while providing a sufficiently recent and representative snapshot of each organisation's digital communication activity.

Of the 25 selected innovations, 11 were found to have active social media accounts with original posts published within the 90-day review period and were included in the content analysis. The remaining 14 innovations did not meet this criterion: some had no active social media presence; others had not published original content within the review period; and others directed their digital communication primarily toward institutional partners — such as the World Health Organization or the International Medical Corps — rather than toward communities or service users. These 14 innovations did not meet the criterion for inclusion in the content analysis. Rather than treating their digital non-presence as a methodological gap to be noted in passing, the study analyses it as a substantive finding in its own right. The 14 innovations were, therefore, analysed through patterns of digital absence. The patterns

of digital non-presence across these 14 innovations — including concluded projects, dormant standalone accounts, dormant implementer accounts, and complete absence of identifiable digital presence — are examined in section 3.5.4. This approach ensures full coverage of the identified innovation sample and provides additional insights into the sustainability and communication capacity of LMIC-based mental health initiatives.

The analytical approach was guided by the Social Media Health Literacy (SoMeLit) framework (Cho et al., 2022), which provides a typological structure for categorising health-related social media content according to its communicative function. Five content typologies were used to structure the analysis: Psychoeducation and Literacy; Stigma Reduction and Lived Experience; Community Building and Peer Support; Crisis Intervention and Service Promotion; and Self-Care and Motivational Aesthetics. Posts from the 11 active innovations were categorised into five predefined typologies based on their content and communicative intent, with a brief rationale provided for each classification. An artificial intelligence tool working as a large language model (Gemini), was then used to support initial classification with a prompt based on the definition of SoMeLit typologies. Following categorisation, the number of posts corresponding to each typology was counted per platform. All categorisation outputs were reviewed by the research team to ensure consistency with the coding scheme and the definitions of each typology. The distribution of post types across platforms is presented in section 3.5.

2.2. Geographic Focus and Targeted Regions

The geographic scope of this study was defined by the EQUICARES project grant agreement, which assigned the mapping of mental health innovations in non-European low- and middle-income country contexts to Task 2.3, while a separate task addresses European pilot contexts. Accordingly, this study focused on innovations developed and implemented in LMIC settings outside Europe, covering five broad regions: the Middle East and North Africa (MENA), the Caucasus, Sub-Saharan Africa, Latin America, and South-East Asia. These regions were not selected on the basis of exhaustive coverage of the global LMIC landscape, but in accordance with the project's defined scope and the geographic diversity required to capture a meaningful range of health system contexts, resource environments, and innovation approaches. Other LMIC regions — including Central Asia, the Pacific, and parts of Eastern Europe — fall outside the scope of this task and are not represented in the analysis.

Within this scope, the included regions collectively represent a broad spectrum of health system characteristics relevant to the study's objectives. They span contexts with varying levels of specialist mental health infrastructure, different trajectories of task-sharing and community-based care, and diverse cultural and social frameworks for understanding and responding to mental health conditions. This diversity was considered essential for the reciprocal innovation objective of the study: identifying

innovations whose structural features — rather than their specific cultural content — could inform adaptation for European contexts. In this sense, LMIC settings were treated not only as sites of service innovation under resource constraints, but as contexts from which transferable models of care organisation, workforce deployment, and community engagement might emerge.

2.3. Identification and Selection of Mental Health Innovations

The identification and selection of mental health innovations followed a two-stage approach, aligned with the study's sequential qualitative design. In the first stage, a broad pool of innovations was identified through a multi-source search strategy and then screened against predefined inclusion and exclusion criteria to produce a sample for in-depth qualitative analysis. In the second stage, a subset of the retained innovations was selected for the digital ethnography phase based on the results of the transferability assessment.

2.3.1. Search Strategy

Innovations were identified through a combination of three approaches conducted between months 7 and 10 of the project timeline. First, a consultation with consortium partners was conducted in which each partner organisation was invited to recommend innovative mental health solutions from LMIC contexts known to them through their professional networks and prior work. This step drew on the geographic and thematic expertise distributed across the consortium and was designed to identify innovations that may not be well represented in formal databases.

Second, targeted web-based searches were conducted using the websites of major global health organisations, including the World Health Organization, Partners in Health, and the Mental Health Innovation Network. These platforms were selected because they systematically catalogue and document mental health innovations from low-resource settings and provide access to programme descriptions, impact reports, and implementation materials that would not necessarily appear in academic databases.

Third, broader web-based searches were conducted using the following search terms, applied in combination: innovation, innovative, mental health, mental health interventions, mental health services, LMICs, and low-resource settings. These searches were not restricted to academic databases and were designed to capture a broad range of documented innovations including those primarily described in grey literature, organisational reports, and programme documentation. In total, 258 innovations were identified across all three search approaches.

2.3.2. Inclusion and Exclusion Criteria for Qualitative Document Analysis

Each of the 258 identified innovations was assessed against predefined inclusion and exclusion criteria. Innovations were included in the qualitative document analysis if they met all three of the following criteria:

- implemented in low- and middle-income country (LMIC) settings, or in multi-region settings that included LMICs;
- aligned with the study's definition of innovation, defined as introducing a meaningful change in how mental health services are organised, delivered, or accessed; and
- supported by sufficient documentation across all three required domains: descriptive documentation (including peer-reviewed publications, conference outputs, project documents, or media coverage); impact-related documentation (including peer-reviewed articles, annual project reports, or other quantitative reports); and implementation guidance (including intervention frameworks, tools, or documented implementation methodologies).

Innovations were excluded if they were implemented exclusively in high-income country settings, or if they lacked documentation in one or more of the three required domains. All three documentation domains were required to be met simultaneously for an innovation to be retained; partial documentation was not considered sufficient.

Applying these criteria to the initial pool of 258 innovations, 190 were found to have been implemented in LMIC settings. Of these, documentation availability varied across the three required domains: 137 had some form of descriptive documentation; 165 had impact-related documentation; and 70 had implementation guidance available. Based on the requirement that all three domains be satisfied, 47 innovations were retained for in-depth analysis. The selection process is summarised in Section 3.1.

2.3.3. Selection for Digital Ethnography

Following the qualitative document analysis and transferability assessment, the 25 innovations with the highest composite transferability scores were selected for the digital ethnography phase. Selection on the basis of transferability scores ensured that the digital ethnography focused on the innovations with the greatest potential for cross-context relevance to European pilot settings. Of these 25 innovations, 11 were found to have active social media accounts with original posts published within the 90-day review period and were included in the content analysis. The digital ethnography methods are described in detail in section 2.1.3, and the findings are presented in section 3.5.

2.4. Data Extraction and Analysis

Data extracted from the included mental health innovations were analysed using a structured analytical framework designed to systematically capture the main characteristics of each innovation, its relevance to access to care, and its potential transferability across contexts. The analysis was organised into four sequential steps, each corresponding to a distinct analytical objective. All analytical categories were predefined and operationalised in a codebook developed for this study (Table 1), which described what each category captured, how it should be interpreted, and, where relevant, included illustrative examples to support coding decisions and enhance transparency and comparability across cases.

In the first step, innovations were examined according to their general descriptive and implementation-related characteristics, including geographical context (region and country), country income status, availability of supporting evidence (peer-reviewed publications and project or impact reports), implementation track record across different settings, and the availability of implementation or general guideline documents.

In the second step, the analysis was guided by a set of predefined analytical categories drawn from the qualitative content analysis framework described in section 2.1.1. These included: setting, referring to the physical, institutional, or organisational context in which the innovation is delivered; targeted mental health condition; target group; type of innovation; level of prevention; and supply-side dimensions of access based on the Levesque Framework. The Levesque Framework was applied to assess the extent to which each innovation addressed approachability, acceptability, availability and accommodation, affordability, and appropriateness as dimensions of access to care.

In the third step, each innovation was assessed for its transferability using the structured scoring framework described in section 2.1.2. Transferability was defined as the extent to which a mental health innovation could be adapted and implemented in a different context. The assessment covered four dimensions — feasibility, agility, co-creation, and clarity — each scored on a scale from 0 to 5. A weighted composite transferability score was calculated using the formula: $\text{Transferability score} = (\text{Feasibility} \times 0.30) + (\text{Agility} \times 0.25) + (\text{Co-creation} \times 0.25) + (\text{Clarity} \times 0.20)$. Transferability was assessed independently by two reviewers, and the final score for each dimension and the composite score were calculated as the mean of the two independent assessments.

In the fourth step, the 25 innovations with the highest composite transferability scores were selected for in-depth exploration through digital ethnography. This phase examined how these innovations communicate with and engage communities through digital channels, including their self-presentation across social media platforms, the communicative functions of their digital content, and how they

represent their approaches to diverse audiences. The digital ethnography methods are described in full in section 2.1.3, and the findings are presented in section 3.5.

Data extraction was conducted using a predefined and standardised extraction form based on the codebook. One reviewer carried out the initial extraction of innovation characteristics, and a second reviewer subsequently reviewed, expanded, and refined the extracted data to improve depth and consistency. The operational definitions, coding guidance, and scoring criteria for each analytical category are set out in Table 1.

Table 1. Operational definitions, coding guidance, and scoring criteria for each analytical category

Category	Definition	Coding Guidance	Examples
Group 1: Descriptive and Contextual Characteristics			
Region	The broader geographical region where the innovation is implemented.	Use standard regional classifications (e.g., Sub-Saharan Africa, Middle East, South-East Asia); if multi-region, list all.	Middle East, Sub-Saharan Africa
Country	The specific country or countries where the innovation is implemented.	Record all countries involved; if multi-country, indicate all.	Kenya, Mozambique
Country income status	Income classification of the country or countries where the innovation is implemented.	Use World Bank classification; code as LMICs or HICs. If multiple countries are involved, indicate whether there is variation across income categories.	LMICs; mixed (LMIC and HIC)
Peer-reviewed publication	Availability of a peer-reviewed publication reporting on the innovation.	Indicate whether a peer-reviewed publication is available (Yes/No).	Peer-reviewed article available (Yes)
Project/Impact report	Availability of a project report or impact evaluation document describing the innovation.	Indicate whether a project or impact report is available (Yes/No).	Project/impact report available (Yes)
Track record	Extent to which the innovation has been implemented across different settings.	Code as No (single-setting) or Yes (multi-setting) based on whether the innovation has been implemented in more than one country or setting.	Implemented in multiple countries (Yes)
Implementation guideline availability	The presence of implementation guidance used for delivering the innovation.	Assess whether the innovation is supported by a guideline, manual, or structured implementation document. Code as Yes or No.	Implementation guideline available (Yes)

Name of implementation guideline	The title or name of the implementation guideline, manual, or framework used to support delivery.	If a guideline is available, record its name as reported in the source. If not available, leave blank or code as not reported.	WHO mhGAP Intervention Guide; EASE Intervention Manual
Online presence	Availability of the innovation on online platforms (e.g., website, social media, online media). This category also informed the selection of innovations for the digital ethnography phase, which prioritised innovations with active public-facing digital presence.	Record all identified platforms and links. Code each as active (currently maintained and updated with original posts) or inactive/passive (no original posts within the review period or no longer maintained).	Facebook, inactive; website, active; Instagram, active
Group 2: Analytical Categories from the Qualitative Content Analysis			
Setting	The physical, institutional, or organisational context in which the innovation is delivered.	Specify all relevant settings. Main coding options used in this study: • Community-based • Healthcare-based (e.g., primary care, hospital) • Both community and healthcare settings • School-based • Humanitarian or crisis settings	Primary care; community-based; both healthcare and community settings
Targeted mental health condition	The mental health condition or outcome addressed by the innovation.	Record specific condition(s) as reported. If the innovation targets a broad range of conditions or general mental wellbeing, code as "general mental health".	Depression, anxiety, postpartum depression, general mental wellbeing
Target group	The population group targeted by the innovation.	Specify the target group clearly as described in the source. If the innovation does not define a specific target group, code as "general population".	Adolescents; pregnant women; people with severe mental health conditions; general population
Type of innovation	The main strategies used in the intervention, classified according to the approach or mechanism of delivery.	Use one or more of the following categories, based on the primary strategy of the innovation: • Task shifting or sharing with health or social workers • Task sharing with community members • Integration of mental health care with health services • Intersectoral collaboration and	Task shifting with health workers; integration of mental health into primary care

		integration with non-health sectors • Peer-led support groups and group therapies • Advocacy and patient rights • Co-creation and co-design approach • Community and patient forums • Virtual or telehealth service delivery • Digital solutions for training and capacity building • Establishment of mental health information systems • Policy and regulatory interventions • Workforce expansion • Strengthening mental health infrastructure • Art-based approaches • Mental health research capacity building An innovation may be classified under more than one type if it combines multiple approaches.	
Innovation details	Additional descriptive information about the innovation, capturing key contextual, operational, or design features.	Provide relevant details that help further understand how the innovation is implemented, adapted, or structured. This may include delivery context, partnerships, integration with existing systems, specific components, or unique features. Avoid repeating information already captured in other fields.	Task-sharing: Use of trained lay community health workers to deliver IPT-G as counsellors. Digital delivery: Provision of group interpersonal psychotherapy through phone-based modalities. Integration: Embedding depression screening into routine antenatal care visits.
Level of prevention	The stage of prevention targeted by the innovation, based on its primary objective and main activities.	Code as primary, secondary, or tertiary prevention. Provide a brief justification based on the target population, activities, and intended outcomes: Primary: Interventions aimed at promoting wellbeing or preventing the onset of mental health conditions in the general population. Secondary: Interventions focused on early identification, screening, and treatment of emerging mental health conditions. Tertiary: Interventions targeting individuals with established mental health	Primary: Mental health awareness campaign promoting wellbeing and preventing onset of problems. Secondary: Screening programme for early identification of postpartum depression. Tertiary: Community-based psychosocial support for individuals with existing depression to improve recovery and functioning.

		conditions, aimed at reducing severity, disability, or relapse.	
Approachability	The extent to which the innovation increases the visibility, outreach, and community awareness of mental health services, making them easier to identify and reach.	Assess whether the innovation uses community outreach, awareness campaigns, integration into non-mental-health services, or other strategies that increase the visibility of care and reduce barriers to initial contact.	Large-scale community outreach reaching over 1.3 million people; delivery across community settings including prisons, schools, and NGO partnerships.
Acceptability	The extent to which the innovation aligns with cultural and social expectations, reduces stigma, and is perceived as appropriate by the target population.	Assess whether the innovation incorporates cultural adaptation, uses trusted community members as providers, employs peer-led or community-embedded delivery models, or otherwise addresses stigma and social norms that affect help-seeking.	Peer-led group therapy delivered by trained community members, improving cultural responsiveness and reducing stigma associated with formal mental health services.
Availability and Accommodation	The extent to which services are physically accessible, sufficiently available in terms of workforce and capacity, and organised in ways that accommodate users' needs.	Assess whether the innovation increases the number of providers, reduces geographic or temporal barriers (e.g., mobile or home-based delivery), integrates into existing service platforms, or uses task-sharing to increase service capacity.	Task-sharing with community health workers to expand service capacity in rural settings; home-based delivery reducing travel barriers for mothers with young children.
Affordability	The extent to which financial barriers to accessing mental health care are reduced.	Assess whether the innovation eliminates user fees, uses low-cost delivery models, integrates into free public health services, or demonstrates cost-effectiveness that supports scale-up in resource-constrained settings.	Free-of-charge delivery through integration into public primary care; low-cost peer-led model with no user fees.

Appropriateness	The extent to which the innovation provides care that is relevant, effective, and responsive to users' needs, including continuity of care and attention to broader wellbeing outcomes.	Assess whether the innovation addresses the presenting mental health needs of the target population, is supported by evidence of effectiveness, provides continuity of care across episodes or settings, and attends to broader social determinants of mental health.	Evidence-based psychological intervention adapted to local idioms of distress; stepped-care model ensuring continuity from community to specialist services.
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Group 3: Transferability Assessment

Feasibility	The extent to which the innovation can be realistically implemented in another context given the available human, financial, organisational, and infrastructural resources.	Assess whether the innovation relies on resources, workforce, systems, or infrastructure that are likely to be available or can be mobilised in other contexts. Innovations integrated into existing services, using basic or already available infrastructure, or relying on task-shifting through lay health workers or non-specialist providers receive higher scores. Score 0–5 (two independent reviewers; final score = mean of the two assessments).	Score: 4.4 (Reviewer 1: 4.5, Reviewer 2: 4.3)
Agility	The capacity of the innovation to adapt quickly and effectively to different contextual conditions, local needs, or changing circumstances in a new setting.	Assess whether the innovation demonstrates flexibility in design or delivery and can be adapted to different cultural, linguistic, service, or population contexts. Innovations showing cultural and language adaptation, flexible delivery models, or tailoring to local needs and stressors receive higher scores. Score 0–5 (two independent reviewers; final score = mean of the two assessments).	Score: 4.4 (Reviewer 1: 4.5, Reviewer 2: 4.3)
Co-creation	The degree to which relevant stakeholders are meaningfully	Assess whether service users, communities, providers, or other local stakeholders are actively	Score: 4.4 (Reviewer 1: 4.5, Reviewer 2: 4.3)

	involved in the design, adaptation, and implementation of the innovation.	involved in shaping the innovation. Innovations co-designed with service users and local stakeholders, adapted through formative community input, and embedded in local language, concepts, and community ownership receive higher scores. Score 0–5 (two independent reviewers; final score = mean of the two assessments).	
Clarity	The extent to which the innovation's objectives, components, processes, and expected outcomes are clearly defined and documented.	Assess whether the innovation is supported by clear and structured documentation explaining how it should be implemented. Innovations with step-by-step manuals, standardised protocols, clearly described roles, referral pathways, and safety procedures receive higher scores. Score 0–5 (two independent reviewers; final score = mean of the two assessments).	Score: 4.4 (Reviewer 1: 4.5, Reviewer 2: 4.3)
Composite transferability score	A weighted composite score summarising the extent to which a mental health innovation can be adapted and implemented in a different context.	Calculated as: Transferability score = (Feasibility × 0.30) + (Agility × 0.25) + (Co-creation × 0.25) + (Clarity × 0.20) Maximum score: 5 Interpretation: • ≥4.5: Higher transferability potential • 4.0–4.49: Moderate transferability potential • <4.0: Lower transferability potential Final score = mean of two independent reviewers' composite scores.	Composite score: 4.90 (selected for in-depth profiling)

Data analysis for the qualitative document analysis was conducted using an interpretive approach guided by three analytical frameworks, applied sequentially across the four analytical steps described above. In the first and second steps, the global reciprocal innovation approach was used to identify and categorise implemented innovations according to their type, setting, and strategic approach. In the second step, the Levesque Framework was applied to assess the extent to which each innovation addressed supply-side dimensions of access to care, covering approachability, acceptability, availability and accommodation, affordability, and appropriateness. In the third step, the transferability framework developed by the research team was used to score each innovation across four dimensions and produce a composite transferability score. These three frameworks were applied independently to each innovation using the codebook, with findings then synthesised to produce the integrated profiles presented in the findings.

The digital ethnography component was conducted in parallel with the document analysis for the 25 highest-scoring innovations. The methods for the digital ethnography are described in full in section 2.1.3.

3. Mapping of Identified Innovative Solutions

3.1. Overview of Mental Health Innovations

A total of 258 Innovative Mental Health Solutions were identified. The regional distribution of mental health innovations demonstrates a clear concentration in specific parts of the world. The majority of innovations were implemented in Sub-Saharan Africa (n=79) and Asia (n=68), followed by multi-regional initiatives (n=30) and North America (n=25). A smaller but notable number of innovations were identified in the Middle East and North Africa (MENA) region (n=17), South America (n=16), and Europe (n=13) (Figure 1.).

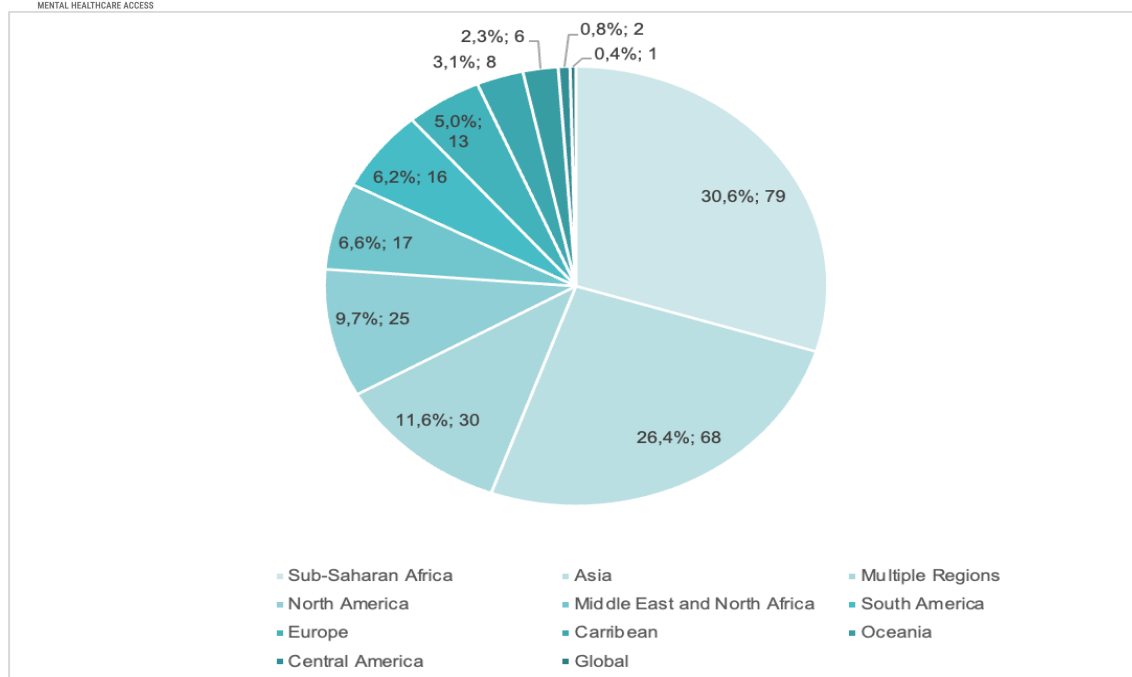


Figure 1. Regional distribution of identified mental health innovations

The distribution of innovations was highly concentrated in a limited number of countries. The highest number of mental health innovations was identified in India (n=35), followed by Pakistan (n=21), Kenya (n=19), Nigeria (n=18), and Uganda (n=17). A relatively high number of innovations were also observed in Canada (n=15) and Nepal (n=13). This pattern suggests a clustering of innovation activity in specific settings, particularly in low- and middle-income countries, alongside a smaller number of high-income country contributions (Figure 2.). Innovations identified in high-income country settings, including those from North America and Europe, were subsequently excluded at the first screening stage, as this study focuses exclusively on innovations implemented in LMIC settings (see section 2.3).

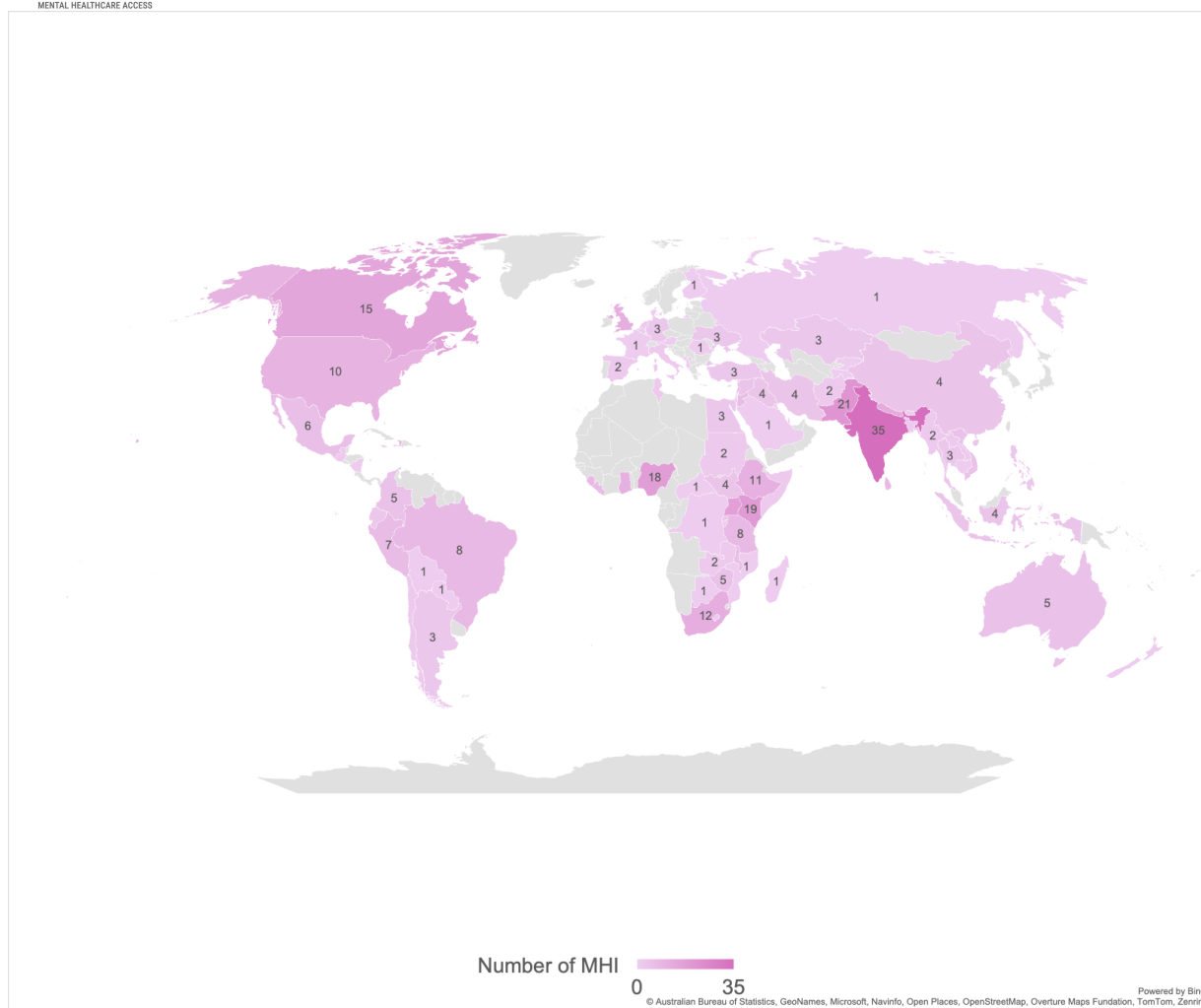


Figure 2. Distribution of identified mental health innovations by country

Following the initial mapping, inclusion and exclusion criteria were applied to identify innovations eligible for in-depth analysis. The full selection process, including criteria and quantitative outcomes at each stage, is described in section 2.3. In total, 47 innovations implemented in LMIC settings and supported by the required documentation were retained for the second-stage analysis (Figure 3).

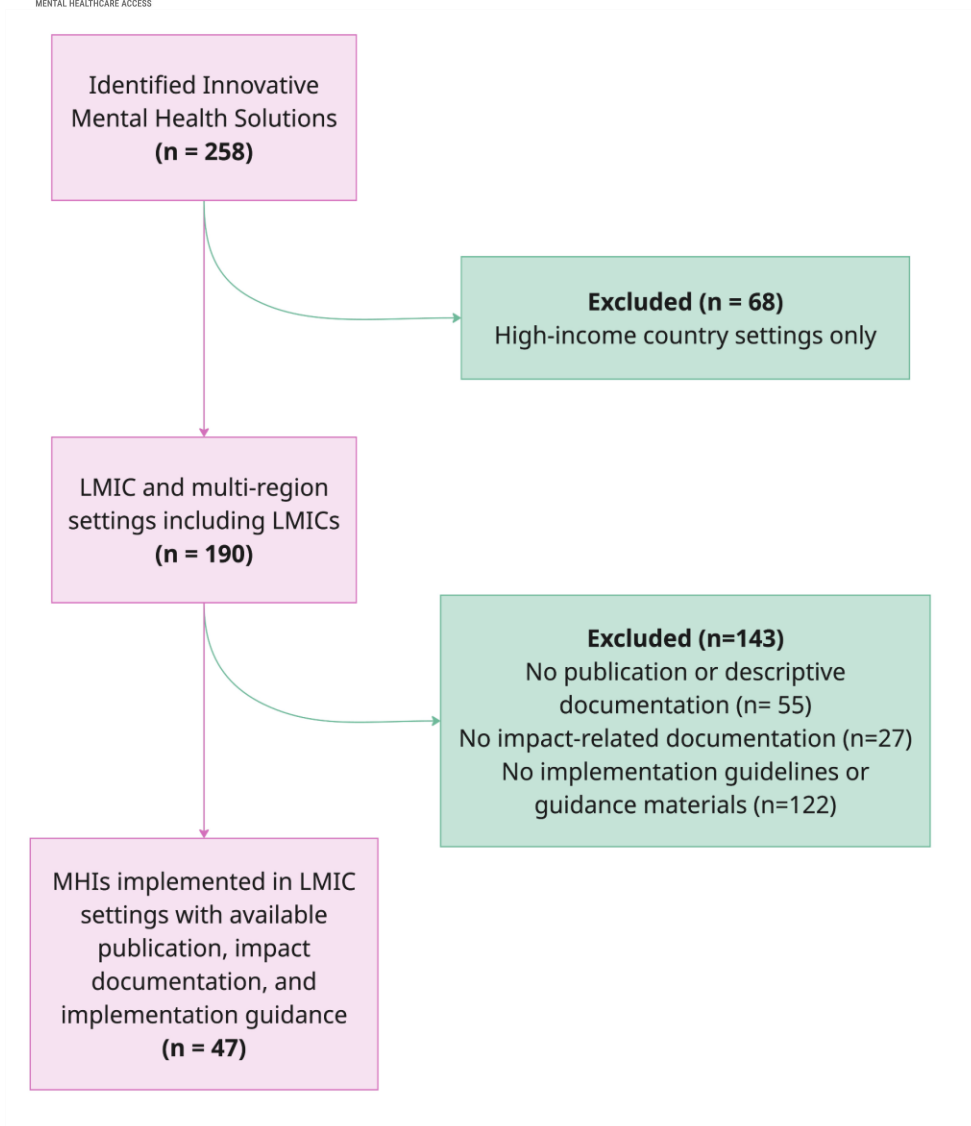


Figure 3. Flow diagram for innovation selection process

Of the 47 Innovative Mental Health Solutions included in the in-depth review, 37 were implemented in a single country, while 10 were multi-country initiatives. The highest number of innovations was identified in India (n=6). This was followed by Jordan, Ethiopia, South Africa, Uganda, Kenya, Sierra Leone, Pakistan, and Nigeria, each with four innovations (Figure 4.)

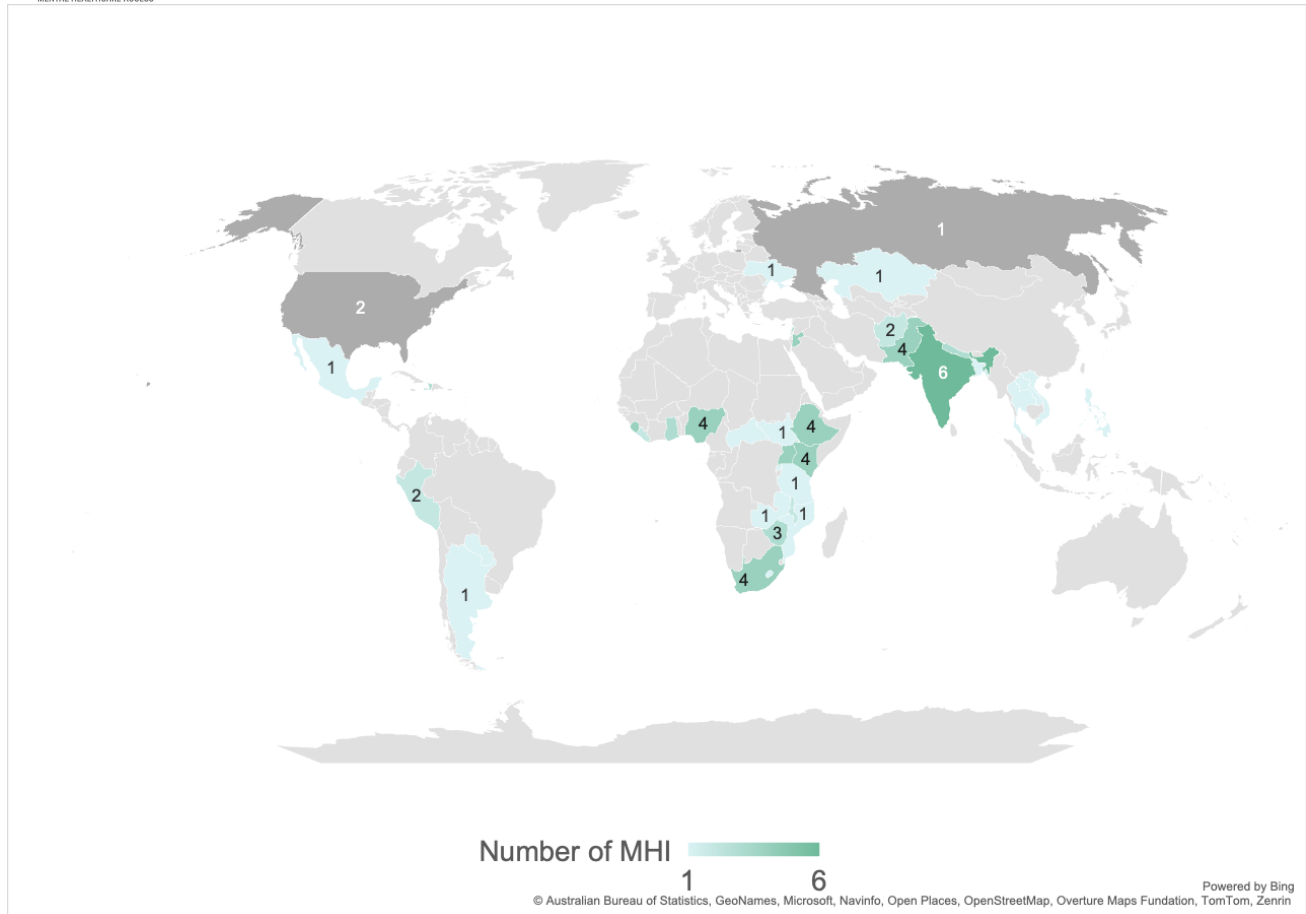


Figure 4. Distribution of selected mental health innovations by country

**Russia and the USA appeared in the dataset because they were part of multi-country innovations. Russia was included in Partners In Health, Cross-Site Mental Health Learning Collaborative implemented across Haiti, Kazakhstan, Lesotho, Liberia, Malawi, Mexico, Peru, Rwanda, and Sierra Leone. The USA was included in two multi-country innovations, StrongMinds in Uganda and Zimbabwe, and the TrustCircle in India.*

The distribution of mental health innovations by setting shows that 22 innovations were implemented in community settings (46.8%), followed by 19 in healthcare settings (40.4%). Six innovations (12.8%) were implemented across both healthcare and community settings. Overall, mental health innovations were predominantly delivered either at the community level or within formal healthcare systems. Among the 22 community-based innovations, two were implemented as school-based interventions (Figure 5.).

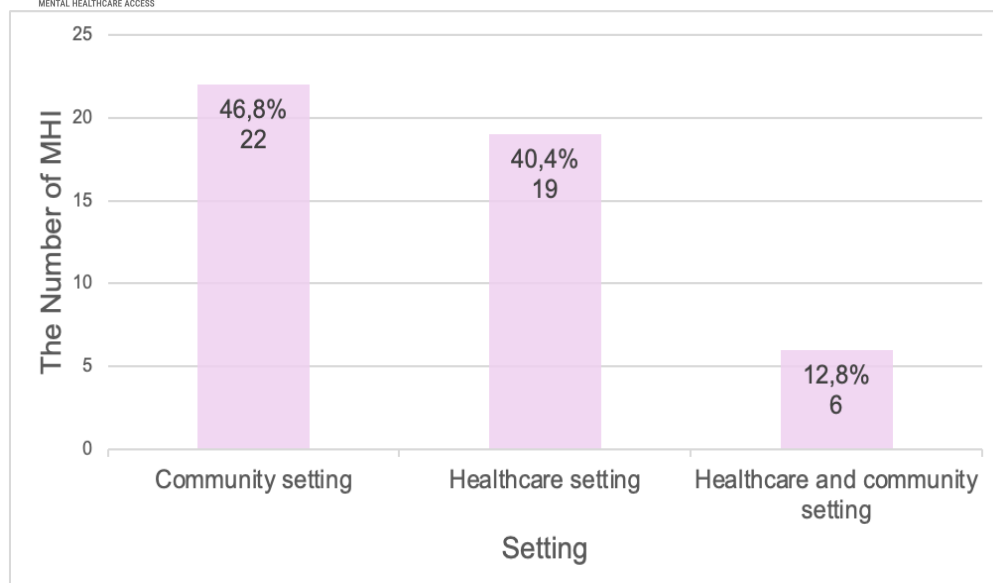


Figure 5. Distribution of mental health innovations by setting

Among the 25 healthcare setting innovations, 22 were implemented at the primary care level (88.0%), 13 at the secondary care level (52.0%), and 8 at the tertiary care level (32.0%) (Figure 6.).

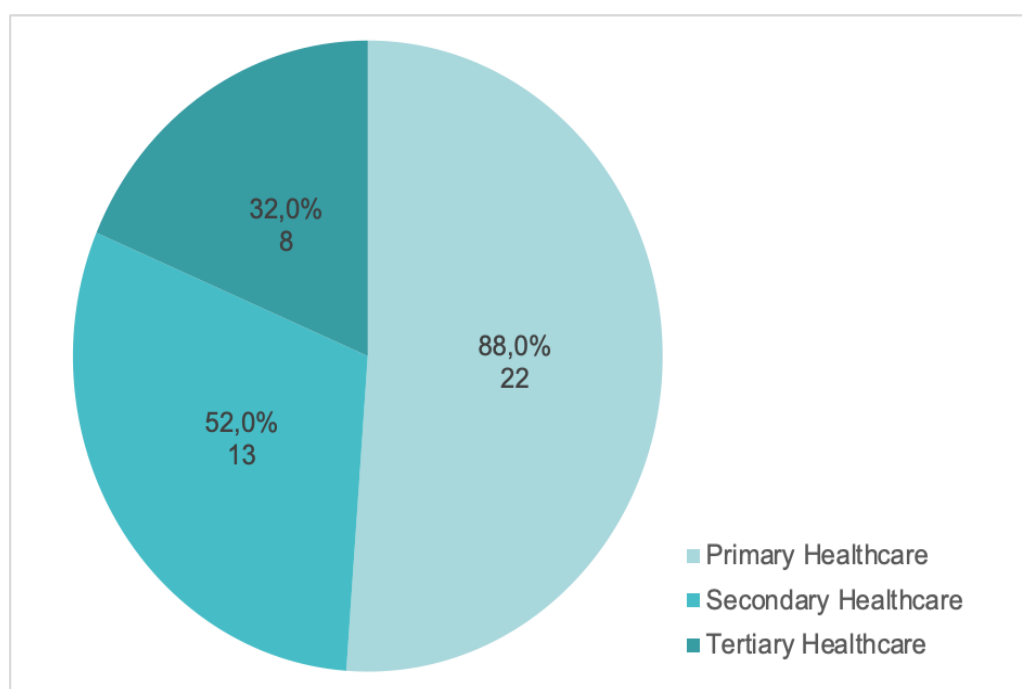


Figure 6. Distribution of mental health innovations by level of care

Specifically, 12 innovations were implemented only at the primary care level (48.0%), 3 spanned primary and secondary care (12.0%), seven covered primary, secondary, and tertiary care (28.0%), 2 were implemented only at the secondary care level (8.0%), and one spanned secondary and tertiary care (4.0%) (Figure 7.).

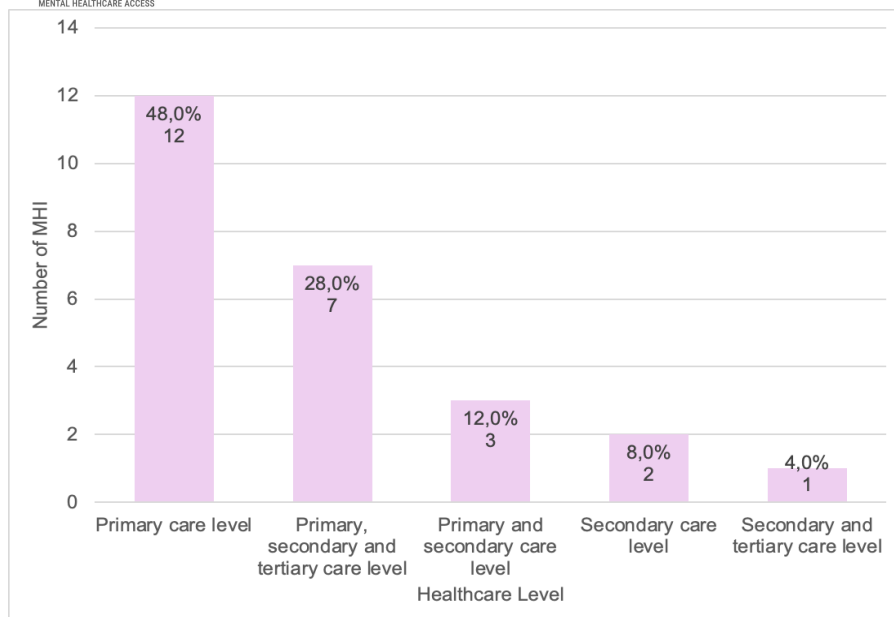


Figure 7. Distribution of mental health innovations across single and multiple levels of care

The distribution of mental health innovations by target population shows that the majority of interventions targeted the general population (57.4%). This was followed by innovations focusing on high-risk groups (27.7%) and healthcare workers (23.4%). Smaller proportions of innovations specifically targeted adolescents and young adults (12.8%), people with mental health conditions (12.8%), and pregnant and/or postpartum women (12.8%). Children were the least frequently targeted group, representing only 6.4% of the innovations (Figure 8.). As innovations could address more than one target group simultaneously, percentages do not sum to 100%.

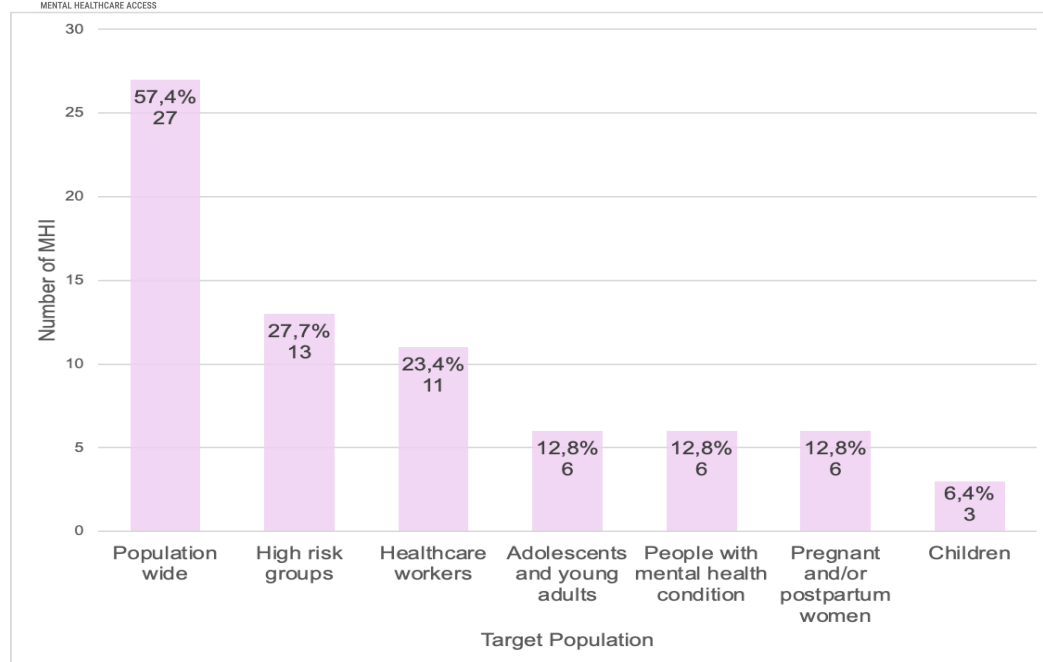


Figure 8. Distribution of mental health innovations by target population

Nearly half of the included innovations (48.9%) did not focus on a specific mental health condition; instead, they addressed mental health more broadly, suggesting an emphasis on general or transdiagnostic approaches rather than disorder-specific models. Depression was the most frequently targeted specific condition (21.3%), followed by perinatal mental health conditions, including depression and/or anxiety (12.8%), and psychosis and schizophrenia (8.5%). Smaller numbers of innovations focused on mental well-being (6.4%), substance use disorders (6.4%), and epilepsy (6.4%). Anxiety, neurodevelopmental disorders, and symptom-focused approaches each accounted for 4.3% of innovations, while post-traumatic stress disorder (PTSD) was the least frequently targeted condition (2.1%). Overall, the included innovations were more often oriented toward broad mental health needs than toward narrowly defined diagnostic categories (Figure 9).

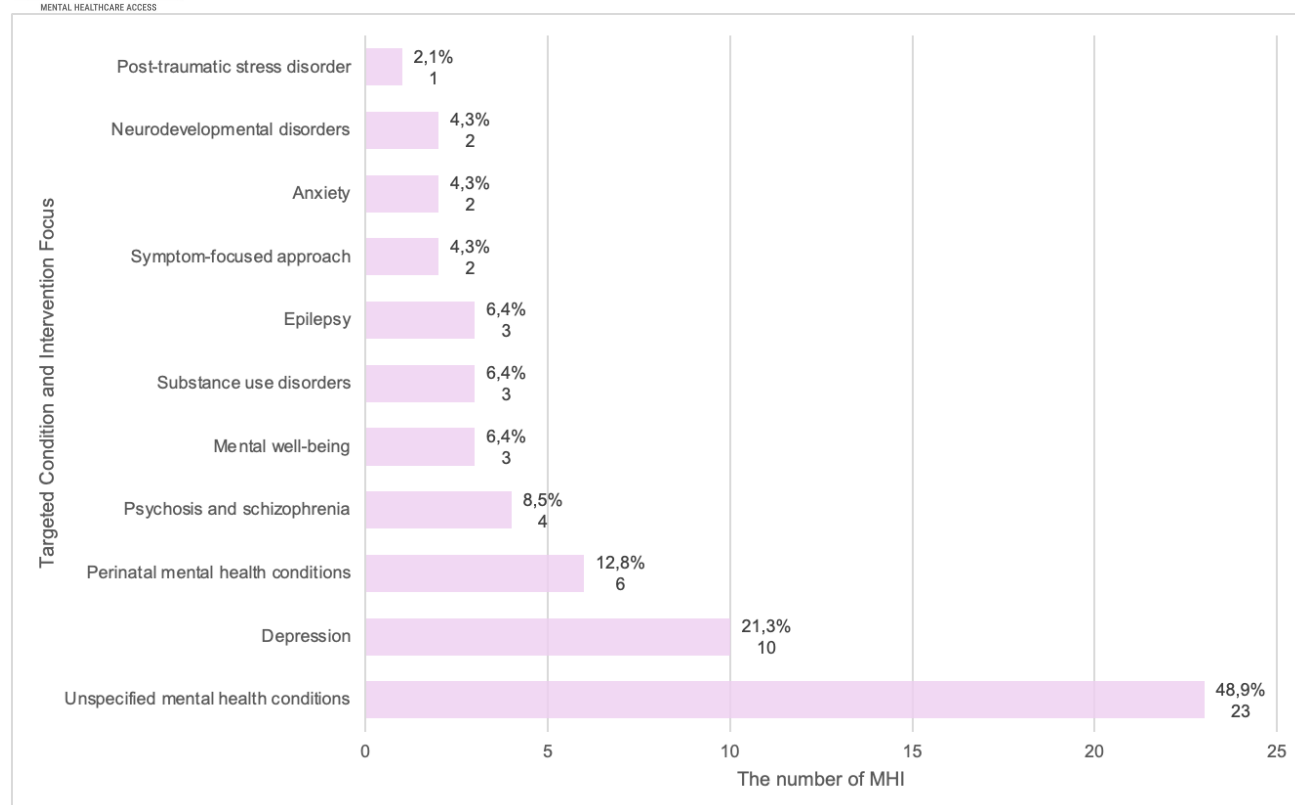


Figure 9. Distribution of targeted mental health condition and intervention focus

3.2. Mental Health Innovations in LMICs

The mental health innovations identified in this study were grouped into **six (6) overarching clusters** based on their main mode of intervention and the level at which they operate within the health system. These clusters represent different but related ways of improving access to care.

Service Delivery and Integration includes innovations that reorganize how mental health services are delivered, particularly by moving beyond specialist-led models. This cluster includes task-sharing with health, social, or community workers, integration into existing health services, and collaboration with non-health sectors. These approaches mainly aim to expand service reach and delivery capacity.

Person-Centered and Community Approaches includes innovations that emphasize participation, empowerment, and responsiveness to lived experience. This cluster covers peer-led support and therapies, advocacy and patient rights initiatives, co-creation and co-design, and community or patient forums. These approaches aim to improve trust, acceptability, and engagement.

Digital Mental Health Solutions refers to innovations that use digital technologies to support care delivery, training, and system organization. These include telehealth services, digital training tools, and health information systems. Such approaches help address geographical, temporal, and resource-related barriers while improving efficiency and scalability.

System-Level Interventions includes innovations targeting the broader structural environment of mental health care. These involve policy and regulatory interventions, workforce expansion, strengthening mental health infrastructure, and, in some cases, health information systems used as system-strengthening tools. Their main aim is to support sustainable, large-scale improvements in access.

Arts-Based Approaches include innovations that use creative and expressive methods, such as storytelling, music, or visual arts, to support mental health and engagement. These often function as complementary or alternative pathways to care.

Research Capacity Building includes initiatives that strengthen local research capacity, evidence generation, and the use of data and evaluation in mental health. Although indirect, these efforts support more context-sensitive and evidence-informed care.

As illustrated in Figure 10, the majority of identified mental health innovations fell under the category of Service Delivery and Integration (89.4%, n=42). This was followed by Person-Centred and Community Approaches (51.1%, n=24) and Digital Mental Health Solutions (29.8%, n=14). System-Level Interventions were less frequently identified (17.0%, n=8), while Arts-Based Approaches (10.6%, n=5) and Research Capacity Building (8.5%, n=4) were the least represented categories. As innovations could be classified under more than one cluster simultaneously, percentages do not sum to 100%. Overall, the distribution shows that most innovations were concentrated in service delivery-oriented approaches, with fewer innovations targeting broader system-level change or research capacity (Figure 10).

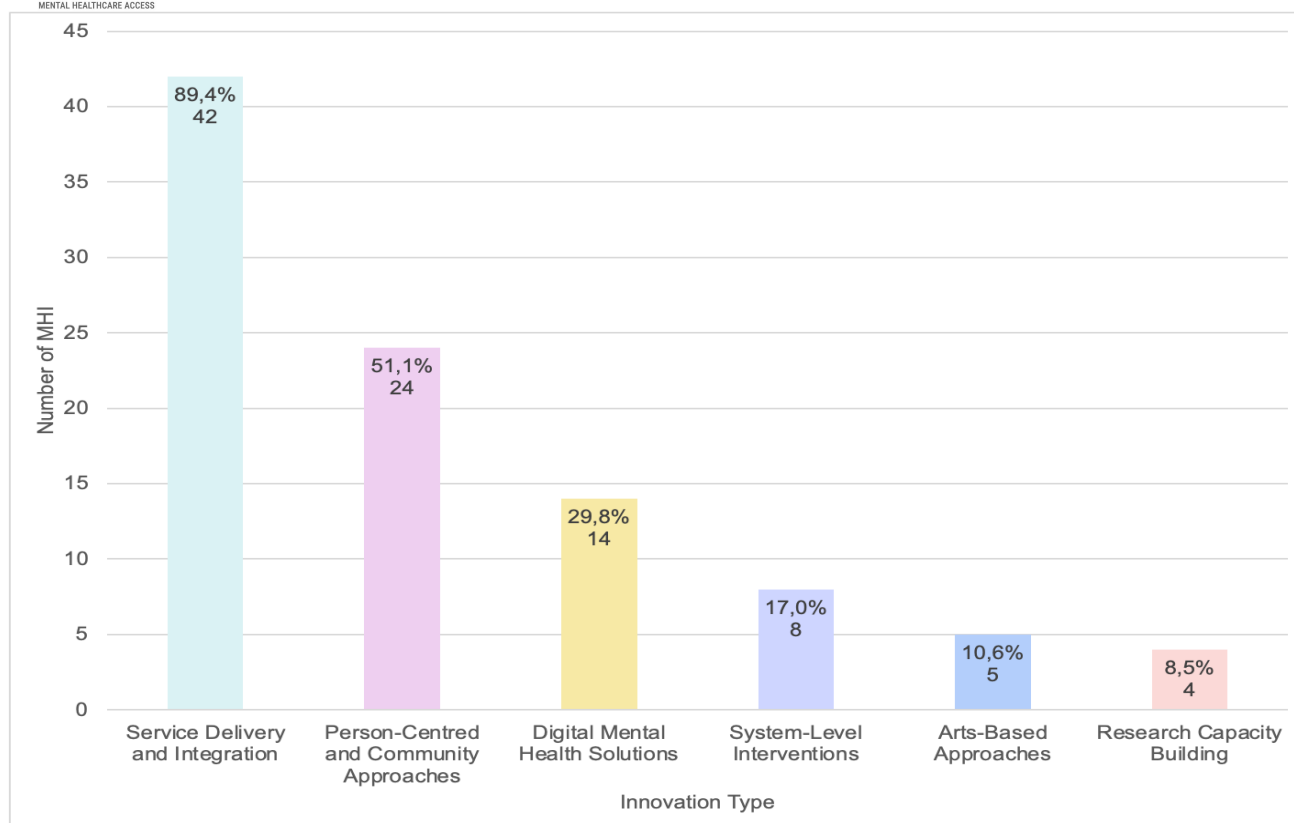


Figure 10. Distribution of mental health innovations by innovation cluster

Within Service Delivery and Integration, task-sharing was the most frequently identified approach in the interventions reviewed (63.8%, n=30), particularly involving healthcare or social workers. This was followed by integration with health services (55.3%, n=26), task-sharing with community members (42.6%, n=20), and intersectoral collaboration with non-health services (38.3%, n=18).

Within Person-Centered and Community Approaches, the most frequently identified subtype across the reviewed interventions was peer-led support groups and group therapies (34.0%, n=16). Other identified subtypes included advocacy and patient rights groups (10.6%, n=5), co-creation and co-design approaches (8.5%, n=4), and community or patient forums (8.5%, n=4).

Among the interventions coded under Digital Mental Health Solutions, virtual or telehealth service delivery was the most frequently observed subtype (23.4%, n=11), followed by digital solutions for training (10.6%, n=5) and the establishment of health information systems (6.4%, n=3).

Within System-Level Interventions, the reviewed solutions most commonly included policy and regulatory interventions (17.0%, n=8), followed by workforce expansion (12.8%, n=6) and strengthening mental health infrastructure (6.4%, n=3).

Finally, Arts-Based Approaches (10.6%, n=5) and Research Capacity Building (8.5%, n=4) were the least frequently identified categories. These categories were not further subdivided in the analysis (Figure 11.).



Figure 11. Distribution of innovative approaches by mental health innovations

3.2.1. Types of Innovations and Their Key Features

3.2.1.1. Service Delivery and Integration

Task shifting or sharing with health or social workers

Task shifting in these innovations was mainly implemented through the redistribution of mental health tasks to health workers and social care staff, rather than relying only on specialists. This included primary healthcare workers (MHIN, 2026a; El Chammay et al., 2016; Adewuya et al., 2025; MHIN, 2026b), hospital nurses (Avan et al., 2022; Kamara et al., 2017), and social workers (MHIN, 2026c; Zanzi Lasante, Legha et al., 2015). Most commonly, these providers were trained to carry out screening, basic psychosocial support, brief psychological interventions, follow-up, referral, and in some cases pharmacological management, usually with mhGAP-based training or other structured programmes (Adebowale et al., 2014; Avan et al., 2022; MHIN, 2026; a MHIN, 2026d; MHIN, 2026e; PIH Liberia, 2025). In several models, specialists continued to play a supervisory role, while non-specialist staff delivered frontline care. Overall, task shifting in this group of innovations was used to expand workforce capacity, integrate mental health into primary and routine care, and increase access to services through trained health and social care workers

Task sharing with community members

Task sharing with community members was implemented by extending mental health service delivery beyond the formal health system to include trained volunteers, peer providers, community figures, and other non-professional actors. These individuals such as local mothers (Rahman, 2007; Rahman et al., 2008), “grandmothers” (Chibanda et al. 2015), barbers (MHIN, 2026f), mentor mothers (Lamaha et al., 2023), and lay counsellors (Muray et al., 2014; Chatterjee et al., 2008; Patel et al., 2011) were trained to deliver basic psychological interventions such as CBT-based or problem-solving approaches psychoeducation (Rahman et al., 2008; Chibanda et al. 2015; Lamaha et al., 2023), case identification (Legha et al., 2015), follow-up, and referral support (Lamaha et al., 2023). In several models, community members also facilitated group sessions (Abubakar et al., 2022), peer-support activities (Chibanda et al., 2015; Bryant et al., 2022; Lamaha et al., 2023; StrongMinds 2025a), and community discussions (James et al., 2020), contributing to both service delivery and social support mechanisms. Their roles were often embedded within community-based or collaborative care models (Chibanda et al. 2015; Lamaha et al., 2023; StrongMinds 2025a), sometimes supported by supervision from specialists or integration with primary care services (Chatterjee et al., 2008; Muray et al., 2014; Rahman et al., 2008). Overall, this approach aimed to increase reach at the community

level, improve cultural acceptability, reduce stigma, and enable more accessible and context-sensitive mental health support.

Integration of mental health care with health services

Integration of mental health care with other health services was a common approach across innovations, primarily achieved through embedding mental health into primary healthcare (Rahman et al., 2008, Chibanda et al. 2015; Friendship Bench, 2026), maternal and child health services (Rahman, 2007; MHIN, 2026c; Lund et al., 2012; De Silve et al., 2016; Avan et al., 2022), and routine care pathways (Chatterjee et al., 2014). In many cases, mhGAP-based models enabled screening, diagnosis, and treatment within existing service structures rather than standalone specialist care, often introducing task sharing with non-specialist providers (Adewuya et al., 2025; MHIN, 2026a; MHIN, 2026b; MHIN, 2026e; Avan et al., 2022). This integration frequently extended to antenatal and postnatal care (Lund et al., 2012; Rahman et al., 2008), child health (Rahman et al., 2008), HIV services (Nakimuli-Mpungu et al., 2014; Haas et al., 2023), and general outpatient care (Adewuya et al., 2025), allowing mental health needs to be addressed alongside physical health conditions. Importantly, several innovations also adopted a high-risk approach, integrating mental health into trauma services (Nakimuli-Mpungu et al), humanitarian settings (Legha et al, 2015), and services targeting vulnerable populations, such as individuals exposed to conflict or displacement. In some models, integration was operationalised through district or national-level care plans (Muray et al., 2014; Ventevogel et al., 2012; El Chammay et al. 2016; MHIN, 2026b; Araya et al., 2009), multidisciplinary teams, and stepped-care approaches (Legha et al, 2015; Chatterjee et al., 2008; Patel et al., 2011), ensuring coordination across different levels of care and continuity between community, primary, and specialist services (Chatterjee et al., 2014; PIH Liberia, 2025).

Intersectoral collaboration and integration of mental health care with non-health sectors

Integration of mental health care with non-health sectors and intersectoral collaboration was implemented through multi-sectoral partnerships that extended service delivery beyond the health system. Innovations involved collaboration between health services, social services (MHIN, 2026c; Saving Brains, 2026; Republic of Lebanon. Ministry of Public Health, 2015), education systems (Abubakar et al., 2022; Tekola et al., 2020), academic institutions (Republic of Lebanon. Ministry of Public Health, 2015), NGOs (Lund et al., 2012; De Silve et al., 2016; MHIN, 2026c; Ventevogel et al., 2012; Swartz et al., 2015; Alan J Flisher Centre for Public Mental Health, 2025), community organisations (Lund et al., 2012; De Silve et al., 2016), and national-level stakeholders (MHIN, 2026c), enabling coordinated design, training, and implementation of interventions. Mental health support was often embedded within education settings (Banafsha et al., 2024; Iqbal et al., 2024), social protection mechanisms (WHO, 2012; de Val D'Espaux et al., 2011), community programmes, and disaster

preparedness activities (James et al., 2020; Welton-Mitchell et al., 2018). In several models, interventions also combined clinical care with social support components, including psychosocial rehabilitation, family reintegration, vocational support, and access to social benefits (Tharoor and Thara, 2020; Friendship Bench, 2026; StrongMinds, 2025b, Cyrus et al., 2020). Additionally, some approaches bridged formal and informal systems, fostering collaboration with traditional healers, religious leaders, and community networks (Adams et al., 2020), while others promoted participatory and stakeholder-driven processes at policy and implementation levels (Ventevogel et al., 2012; El Chammay et al. 2011; ,Mental Health and Psychosocial Support (Phase II) in Palestine, Val D’Espaux et al., 2011).

3.2.1.2. *Person-Centred and Community Approaches*

Peer-led support groups and group therapies

Peer-led support groups and group therapies were widely used as community-based components of mental health interventions, often complementing clinical or task-shared care models. These groups created safe spaces for sharing experiences (James et al., 2020; Welton-Mitchell et al., 2018), mutual support (Chatterjee et al., 2014), and collective problem-solving (Chibanda et al. 2015), while also extending care beyond formal service settings. In many innovations, peer-led approaches involved people with lived experience, caregivers, or community members taking on active roles as facilitators (MHIN, 2026c; Chatterjee et al., 2014; StrongMinds 2025b; Abubakar et al., 2022; Tekola et al., 2020; Lamaha et al., 2023, Brooke-Sumner et al. 2024; Asher et al., 2024; Hijiawi et al., 2013) after training and mentorship. This not only supported service delivery but also fostered empowerment, agency, and ownership, by positioning participants not merely as beneficiaries of care but as active contributors to recovery processes and community support structures. Support groups were frequently integrated with psychosocial rehabilitation (MHIN, 2026; Bryant et al. 2022; Fine et al. 2021; Brown et al. 2023; Lamaha et al., 2023; Nakimuli-Mpungu et al., 2014), livelihood activities (Friendship Bench, 2026), or family and community engagement (Lamaha et al., 2023), reflecting a broader, recovery-oriented approach. Additionally, some models combined group support with evidence-based therapeutic components, such as problem-solving therapy (Chibanda et al. 2015) or group interpersonal psychotherapy (StrongMinds 2025a), while others functioned as platforms for awareness, stigma reduction, and rights-based engagement (Hijiawi et al., 2013).

Advocacy and patient rights groups

Advocacy and patient rights groups emerged as important components of several innovations, particularly at the interface between service delivery and policy change. These approaches focused on mobilising political will, strengthening governance, and advancing mental health as a policy priority,

often through collaboration with ministries, international organisations, civil society actors, and community members (MHIN, 2026h; Abdulmalik et al., 2014). A key feature was the active involvement and representation of people with lived experience and their families, including the establishment of service user associations and advocacy groups (MHIN, 2026h; Abdulmalik et al., 2014, Hijawi et al., 2013, WHO, 2020). These structures enabled users to participate in awareness-raising, training, and national-level policy dialogues, contributing to more inclusive and rights-based mental health systems. In several cases, advocacy efforts were also linked to human rights promotion, stigma reduction, and community engagement, as well as the development and implementation of national mental health strategies. This included activities such as stakeholder mobilisation, public campaigns, and multi-sectoral coordination mechanisms (MHIN, 2026h; Abdulmalik et al., 2014, Hijawi et al., 2013; WHO, 2020)

Co-creation and co-design approach

Co-creation and co-design approaches were central to several innovations, focusing on the development of contextually adapted, system-responsive mental health interventions through multi-level stakeholder engagement. These approaches brought together service users, communities, healthcare providers, policymakers, academic institutions, and international partners to jointly design and refine interventions (Partners In Health, 2026; Lamaha et al., 2023; De Silve et al., 2016; Lund et al., 2012; Friendship Bench, 2026). Co-design was often operationalised through participatory Theory of Change processes and multi-stakeholder collaboration, leading to the development of context-specific service delivery models, including district mental healthcare plans tailored to local health systems, available resources, and population needs (De Silve et al., 2016; Lund et al., 2012; Friendship Bench, 2026). Similarly, this approach was used to facilitate cross-site learning, peer-to-peer exchange, and shared tool development, supporting adaptation across diverse settings (Partners In Health, 2026). More intensive participatory models combined human-centered design, systems thinking, and implementation science, using qualitative and participatory methods such as interviews, focus groups, PhotoVoice, and service mapping to capture lived experiences and system dynamics (Lamaha et al., 2023). Overall, co-creation and co-design approaches aimed to enhance contextual relevance, strengthen stakeholder and community ownership, promote community involvement and empowerment, and improve feasibility and scalability by grounding interventions in both lived experience and system-level realities.

Community and patient forums

Community and patient forums were used as participatory platforms to facilitate dialogue, engagement, and shared learning among diverse stakeholders, including service users, families, healthcare providers, traditional healers, and community leaders. These forums created spaces for

open discussion of mental health experiences, needs, and challenges, while also supporting stigma reduction and increased service utilisation (Hijiawi et al., 2013; Abdulmalik et al., 2014; Adams et al., 2020; CBM Global Disability Inclusion, 2021). In several cases, such initiatives were closely linked with patient-led associations and advocacy groups, enabling individuals with lived experience to actively contribute to awareness-raising, and policy discussions (MHPSS South Sudan). This strengthened the representation of service users and their families in decision-making processes, including national-level dialogues on guidelines and mental health strategies (Hijiawi et al., 2013; Abdulmalik et al., 2014; Adams et al., 2020; CBM Global Disability Inclusion, 2021).

3.2.1.3. Digital Mental Health Solutions

Virtual or telehealth services delivery

Digital mental health, virtual care, and telehealth approaches were used across innovations to expand access, overcome distance and workforce constraints, and support service delivery in low-resource or underserved settings. These approaches included tele-psychiatry (MHIN, 2026g; Iheanacho, et al., 2024; Khoja et al, 2015; Tharoor and Thara, 2020), video-based consultations (Iheanacho, et al., 2024; Khoja et al, 2015; Iqbal et al., 2024; Banafsha et al., 2024), mobile health (mHealth) platforms, digital self-help interventions (Heim et al. 2021; Cuijpers et al., 2021), and phone-based delivery of psychological support (StrongMinds, 2021), showing that digital modalities were used not only for individual care but also for group-based interventions. For example, some innovations delivered group interpersonal psychotherapy via phone (StrongMinds, 2021), while others used virtual therapy sessions (Khoja et al, 2015), digital self-help programmes (Cuijpers et al., 2021; Heim et al. 2021), or anonymous online peer-support platforms (TrustCircle, 2026). Digital tools were often used to support screening (Rahman et al., 2008), diagnosis, treatment, and follow-up (Iheanacho, et al., 2024), as well as to facilitate remote supervision and training of non-specialist providers (MHIN, 2026a; Rahman et al., 2008; Iheanacho, et al., 2024). In several models, mobile and telemedicine platforms enabled real-time connections between primary care providers and specialists, while others offered guided or unguided self-help interventions supported by trained e-helpers (Heim et al. 2021; Cuijpers et al., 2021). Additionally, some interventions incorporated AI-based tools, digital learning platforms, and online peer support systems, extending mental health support beyond traditional care settings. Virtual care approaches, including remote therapy sessions and digital psychosocial interventions, further enabled continuity of care and scalability.

Digital solutions for training and capacity building

Digital solutions for training and capacity building were used to strengthen the delivery, supervision, and scale-up of mental health interventions across diverse settings. These included digital

collaborative learning platforms (Partners In Health, 2026), mobile phone-based software (MHIN, 2026a), tablet-assisted training applications (Rahman, 2007), online courses (Friendship Bench, 2026), and technology-supported teaching tools such as DVDs and projectors (MHIN, 2026c). In some innovations, digital platforms supported cross-site learning and peer-to-peer knowledge exchange, enabling teams to share training materials, clinical guidelines, implementation tools, and practical lessons across countries through virtual meetings and online resource hubs (Partners In Health, 2026). In others, mobile and tablet-based tools were used to train, supervise, and support non-specialist providers in delivering mhGAP-based or other psychosocial interventions, particularly in remote, low-resource, or humanitarian settings (MHIN, 2026a). Overall, these approaches helped overcome distance and workforce constraints, improve access to training, and support more standardised and scalable capacity-building models for mental health care delivery.

Establishment of mental health information systems

The establishment of health information systems was used to strengthen evidence generation, proactive case management, and continuity of care within mental health services. At the system level health information systems were framed as part of broader mental health reform to improve evidence generation for planning, monitoring, and service development (Republic of Lebanon Ministry of Public Health, 2015). At the service delivery level, mHealth systems were adopted to support retention in care and medication adherence, enabling more proactive follow-up of patients in primary care settings (Adewuya et al., 2025; MHIN, 2026i; Khoja et al., 2015). In addition, mobile technologies and electronic health records (EHRs) were used for clinical evaluation, documentation, prescribing, and connection to specialist care, thereby supporting coordination between primary care and higher levels of care (Iheanacho, et al., 2024).

3.2.1.4. System Level Interventions

Policy and regulatory interventions

Policy-level innovations were primarily characterised by system-wide reforms aimed at restructuring mental health systems through national strategies, governance strengthening, and institutionalisation of mental health within broader health systems. These reforms often involved the development and implementation of national mental health policies, legal frameworks, and operational plans, positioning mental health as a core component of general health services rather than a specialised or isolated domain. A consistent feature across settings was the integration of mental health into primary health care (PHC), frequently supported by mhGAP-based approaches and accompanied by task-sharing models, enabling non-specialist providers to deliver care. Policy-level changes were also closely linked with workforce development, including the creation of new cadres, expansion of training

programmes, and establishment of supervision and career pathways to support sustainability (Ventevogel et al., 2012; Heim et al. 2021; Roberts et al., 2014; Araya et al., 2009). In addition, these innovations emphasised decentralisation and the shift towards community-based and recovery-oriented care models, supported by the development of community mental health centres, multidisciplinary teams, and referral systems across levels of care. Many reforms were implemented through multi-sectoral and multi-stakeholder collaboration, involving ministries, international organisations, academic institutions, NGOs, and professional bodies, often alongside advocacy efforts to mobilise political will and elevate mental health on national agendas (Ventevogel et al., 2012; Heim et al. 2021; Adjase et al., 2014; Araya et al., 2009). Overall, policy-level innovations functioned as enabling frameworks that created the structural conditions for scaling up mental health services, improving access and equity, and ensuring long-term sustainability through coordinated system-level transformation.

Workforce expansion

Capacity building and workforce expansion focused on strengthening mental health systems through the training of new and existing cadres, including general practitioners, nurses, psychosocial counsellors, community mental health officers, and clinical psychiatric officers. In several settings, this involved the creation of new workforce categories, development of training curricula and manuals, establishment of training centres, and expansion of specialist and non-specialist career pathways, often linked to task-sharing and integration into primary care (Ventevogel et al., 2012; Araya et al., 2009; Adjase et al., 2014; MHIN, 2026h; WHO, 2012; Shackman and Price, 2013).

Strengthening mental health structure

Mental health infrastructure developments focused on the establishment and expansion of service delivery facilities across different levels of care. This included the creation of mental health hospitals such as facilities with defined bed capacity, inpatient and outpatient units within general and university hospitals, and specialised units such as de-addiction centres and child and adolescent services. In parallel, there was a strong emphasis on developing community mental health centres and decentralised service points, reflecting a shift from centralised, hospital-based care towards more community-based and accessible service models (Ventevogel et al., 2012; Hijiawi et al., 2012; Val D'Espaux et al., 2011).

3.2.1.5. Art-Based Approaches

Art-based and other culturally adapted community approaches were used to support mental health awareness, community engagement, and the contextual adaptation of interventions. In some

innovations, culturally relevant artistic forms such as locally produced music were used to facilitate conversations about mental health, create safe spaces for discussion, and engage specific groups such as young people (MHIN, 2026f). Some context-specific adaptations incorporated coping mechanisms drawing on local stories, songs, and dance, using culturally embedded creative forms to support emotional expression, strengthen engagement, and enhance the cultural relevance of the intervention (James et al., 2020). In others, arts-based methods were integrated into school and community settings to strengthen participation and awareness activities (Iqbal et al., 2024). Yoga-based community groups were also used as part of psychosocial support for people experiencing psychological distress, particularly within broader stepped-care or task-sharing models (Patel et al., 2011). Participatory visual and creative methods were also used within broader co-creation and co-design processes. For example, approaches such as PhotoVoice helped capture lived experiences, contextual barriers, and community perspectives, which then informed the development and refinement of interventions (Lamaha et al., 2023). Overall, these approaches contributed to reducing stigma, increasing acceptability, strengthening engagement, and improving the cultural relevance and accessibility of mental health interventions.

3.2.1.6. Mental Health Research Capacity Building

Capacity building for mental health research was implemented through the development of advanced academic training and research pathways, including Master's-, postgraduate-, MPhil-, and PhD-level programmes in public mental health, psychiatric practice, clinical psychology, and related fields (Araya et al., 2009; Alem et al 2010). These initiatives also supported short courses on research methods, randomised controlled trials, and mental health policy and planning, while promoting knowledge exchange with ministries and partner institutions to strengthen the generation, dissemination, and use of evidence for scaling up mental health services (Lund et al. 2015).

Taken together, the mapping of innovation types across the 47 included interventions reveals several cross-cutting patterns. The overwhelming concentration of innovations within Service Delivery and Integration — particularly around task-sharing and health system integration — reflects the dominant logic of LMIC mental health innovation: expanding access by redistributing care from specialists to non-specialists and embedding mental health within existing service structures. Person-centred and community approaches were the second most common cluster, underscoring the importance of participatory models and lived experience in LMIC innovation contexts. By contrast, system-level and research-focused innovations were considerably less frequent, suggesting that structural and governance-level change — while present — remains a less common mode of innovation in the included sample, likely reflecting the longer timelines and political complexity involved. The high prevalence of multi-cluster classifications, with most innovations combining approaches from at least

two categories, also points to the integrative and layered nature of effective mental health innovation in low-resource settings, where no single approach is typically sufficient to address the full range of access barriers.

In addition to classifying innovations by type, the 47 included innovations were also examined according to the level of prevention they target — primary, secondary, or tertiary. The prevention level analysis is presented in the following subsection.

3.2.2. Prevention Levels of the Innovations

To examine how MHIs contribute across the prevention continuum, interventions were analytically mapped to primary, secondary, and tertiary prevention levels based on their main functional focus within the mental health pathway. This classification was guided by the extent to which innovations aimed to prevent the onset of conditions, enable early identification, or support treatment and recovery processes, acknowledging that many interventions operate across multiple levels simultaneously.

Overall, the distribution indicates a stronger concentration of innovations at the tertiary level (83.0%), followed by secondary (78.7%) and primary prevention (66.0%) (Figure 12). When examining combinations, nearly half of the innovations (46.8%, n=22) addressed all three prevention levels (P, S,T), highlighting the integrated nature of many MHIs. A considerable proportion focused on secondary and tertiary prevention (27.7%, n=13), while fewer interventions targeted only a single level of prevention, such as primary prevention alone (12.8%, n=6) or tertiary prevention alone (4.3%, n=2). Very limited numbers addressed primary and secondary (2.1%, n=1) or secondary prevention alone (2.1%, n=1) (Figure 13.).

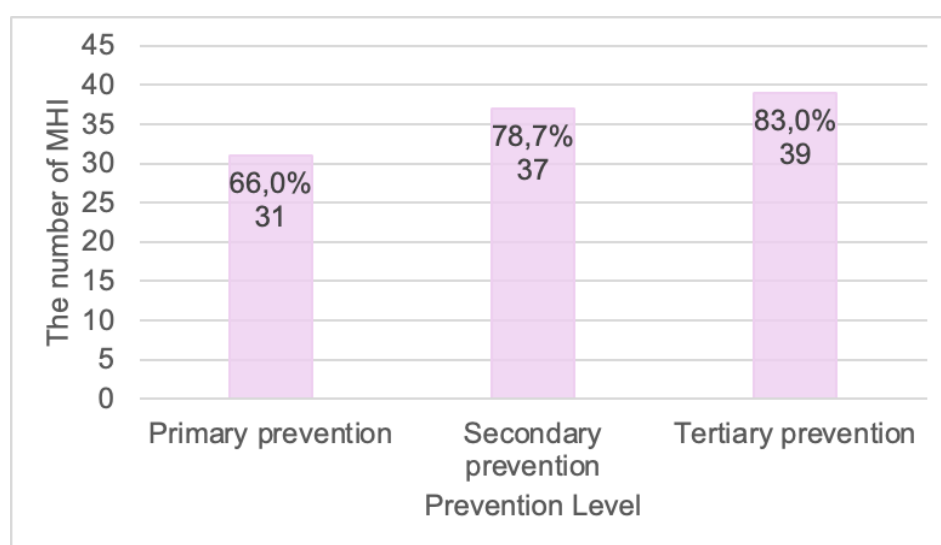


Figure 12. Distribution of mental health innovations by level of prevention

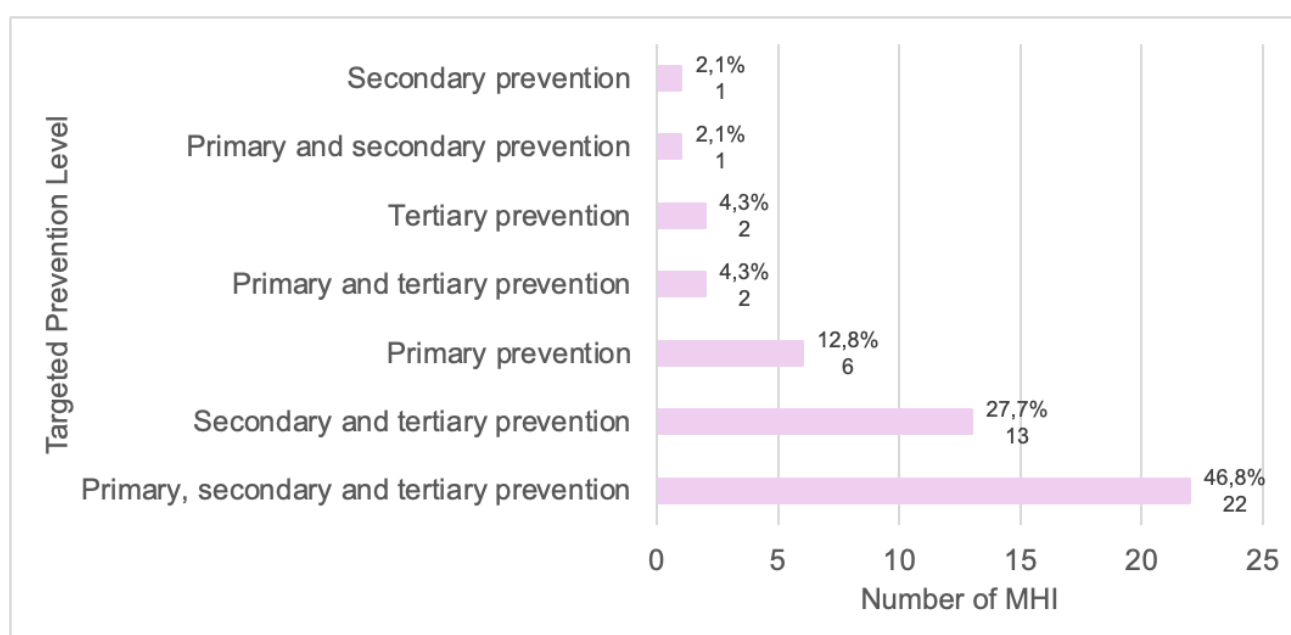


Figure 13. Distribution of mental health innovations by targeted prevention levels

3.2.2.1. Primary Prevention Approach

Primary prevention components were identified in innovations that focused on mental health promotion, awareness-raising, stigma reduction, and psychoeducation at the individual (MHIN, 2026a; Rahman et al., 2008; Lund et al., 2012; De Silve et al., 2016) family (MHIN, 2026a; Rahman et al., 2008; Abubakar et al., 2022), and community levels (Republic of Lebanon Ministry of Public Health, 2015; Adams et al., 2020; CBM Global Disability Inclusion, 2021). These activities included community awareness campaigns, mental health literacy interventions and psychoeducational activities targeting service users, caregivers, families and broader communities. Primary prevention was also reflected in interventions aiming to strengthen wellbeing (MHIN, 2026f; Heim et al., 2021), coping skills, resilience, and supportive social environments (Rahman et al., 2008; Avan et al., 2022; StrongMinds, 2025a; Friendship Bench, 2026). Examples included stress management, behavioural activation, problem-solving, parenting and caregiver support, promotion of respectful maternity care, and activities designed to support early mother–infant relationships and child-friendly home environments (Rahman et al., 2008; Lamaha et al., 2023 MHIN; 2026c; Bryant et al., 2022; Hamdani et al., 2024; Brown et al., 2023; Fine et al., 2021; Saving Brains, 2026; MHIN, 2026c; Nakimuli-Mpungu et al., 2014)

In addition, several innovations incorporated community-based, participatory, and empowerment-oriented activities within their primary prevention components such as peer support, arts-based engagement rights-based awareness and social inclusion approaches (Bryant et al., 2022; Hamdani

et al., 2024; Brown et al., 2023; Fine et al., 2021; StrongMinds, 2025a Friendship Bench, 2026; Iqbal et al., 2024; Avan et al., 2022). Across the included MHIs, primary prevention was therefore mainly represented by activities intended to improve mental health knowledge, reduce stigma, promote wellbeing, and strengthen protective social and behavioural factors.

3.2.2.2. Secondary Prevention Approach

Across the included innovations, secondary prevention predominantly focused on strengthening the early detection and timely identification of mental health conditions. This was mainly achieved through the integration of mental health into primary health care, the capacity building of both specialist and non-specialist providers, and task-shifting approaches that enabled frontline workers to recognize and respond to early signs of mental health problems (Partners In Health, 2026; MHIN, 2026a; MHIN, 2026k; Khoja et al., 2015; MHIN, 2026i; Adjase and Crabb, 2014; MHIN, 2026b). Integration or delivering of mental healthcare into high-risk care settings may also have contributed to earlier detection of mental health needs (MHIN, 2026k; Nakimuli-Mpungu et al., 2014; Muray et al., 2014; Legha et al., 2015; Verdeli et al., 2016). Screening activities represented another major approach to secondary prevention. These mainly took two forms. The first was the integration of screening into service delivery, particularly at the healthcare level, especially in primary care (MHIN, 2026g; MHIN, 2026k; Chatterjee et al., 2008; Rahman et al., 2008), as well as through home visits and outreach activities (Rahman et al., 2008, Abubakar et al., 2022; Tekola et al., 2020), and in HIV care settings (MHIN, 2026k; Nakimuli-Mpungu et al., 2014). The second was a high-risk or group-focused screening approach, targeting populations such as pregnant and postpartum women (Rahman et al., 2008; MHIN, 2026p; Lamaha et al., 2023; Avan et al., 2022; MHIN, 2026l), adolescents (Lamaha et al., 2023; Iqbal et al., 2024), disaster-affected communities (Legha et al., 2015; Verdeli et al., 2016), and conflict-affected communities, trauma survivors, and refugees (Muray et al., 2014). Digital tools and mHealth applications were also used to facilitate self-assessment and proactive monitoring, contributing to earlier engagement with care (TrustCircle, 2026). Overall, secondary prevention strategies reflected a shift toward decentralised, community-oriented detection systems embedded within routine service delivery.

3.2.2.3. Tertiary Prevention Approach

Tertiary prevention was primarily reflected in efforts to establish appropriate care and treatment pathways through capacity building (Partners In Health, 2026) and through combinations of capacity building, task-shifting, integration into primary care, referral pathways across levels of care, and follow-up mechanisms (MHIN, 2026a; MHIN, 2026e; Adewuya et al., 2025; Iheanacho, et al., 2024; Nakimuli-Mpungu et al., 2014). Tertiary prevention was also reflected in the integration of mental

health care into maternal care settings (Rahman et al., 2008; Avan et al., 202; Perinatal Mental Health Project, 2024), HIV care (Nakimuli-Mpungu et al., 2014; Haas et al., 2023), and virtual or telehealth care delivery models (Khoja et al., 2015; Banafsha et al., 2024; Thara and Sujit, 2013; Tharoore and Thara, 2020). In addition, some innovations supported tertiary prevention through workforce expansion and the creation of new mental health cadres (Adjase and Crabb, 2014). Another tertiary prevention approach focused more explicitly on rehabilitation, particularly through community-based rehabilitation and peer-led support groups for people with psychosis and schizophrenia (Brooke-Sumner et al., 2024; Chatterjee et al., 2014).

3.3. Accessibility of Mental Health Innovations Based on Levesque's Framework

To assess how mental health innovations influence access to care, interventions were analysed according to the supply-side dimensions of the Levesque Framework (see section 2.1.1). Each innovation was examined in terms of how it modifies service characteristics related to approachability, acceptability, availability and accommodation, affordability, and appropriateness. This allowed for a more granular understanding of how different types of innovations address specific barriers to accessing mental health care.

3.3.1. Approachability

A key strategy for enhancing approachability is the integration of mental health services into primary health care (PHC) and existing service delivery platforms. Many interventions embedded mental health services within PHC systems, thereby increasing their visibility, familiarity, and accessibility as a first point of contact (Lund et al., 2015; MHIN, 2026c; Chatterjee et al., 2008; MHIN, 2026a; MHIN, 2026e; MHIN, 2026g; Adewuya et al., 2025; Iheanacho, et al., 2024). In some cases, dedicated mental health service packages were developed and implemented at the PHC level, further strengthening service presence at the community interface (MHIN, 2026d). Integration was also achieved through existing health programs, such as immunization services or maternal and child health platforms, where PHC workers were trained to identify, manage, and refer to mental health conditions (Bakare et al., 2014). Similarly, embedding mental health into antenatal and postnatal care, maternal health services, and home-visit-based child health programs increased the routine visibility of services within everyday care pathways (Perinatal Mental Health Project, 2024; Avan et al., 2022; Rahman et al., 2008).

Beyond PHC, integration into non-PHC health services and partnerships with non-health sectors also contributed to improved approachability. Collaborations with NGOs providing HIV care enhanced visibility among specific target populations (Nakimuli-Mpungu et al., 2014), while engagement of community stakeholders and local actors in mental health planning strengthened community-level awareness and trust (Lund et al., 2012; De Silve et al., 2016). Additionally, mental health services were extended into diverse settings such as schools, workplaces, youth organizations, prisons, and police services. These multi-setting and intersectoral approaches enabled services to reach individuals within their daily environments, thereby increasing exposure and familiarity (Iqbal et al., 202; Friendship Bench, 2026; StrongMinds, 2025a; Rahman, 2007; Rahman et al., 2008; MHIN, 2026f).

Awareness-raising activities, information provision, and efforts to improve mental health literacy constituted another major component of approachability. Several interventions provided psychoeducational content to service users, caregivers, and parents to increase understanding of mental health conditions and available services (MHIN, 2026d, Bryant et al., 2022; Hamdani et al., 2024; Brown et al., 2023; Fine et al., 2021). Others utilized diverse communication channels including posters, leaflets, booklets, radio programs, community forums, dramas, videos, and announcements during religious or community gatherings to increase service visibility (Adams et al., 2020; Abdulmalik et al., 2014; MHIN, 2026j). Engagement of community leaders, religious figures, women's and youth groups, media actors, user and family associations, and traditional or faith healers further contributed to increasing trust, familiarity, and destigmatization of mental health services (Nakimuli-Mpungu et al., 2014; El Chammay et al., 2016; WHO, 2013; MHIN, 2026k).

Screening and early identification mechanisms also played a critical role in improving approachability by facilitating earlier recognition of mental health needs and linking individuals to care. These included school-based screening, outreach and home-visit-based identification, and screening at PHC facilities (Banafsha et al., 2024, Bakare et al. 2014; Chatterjee et al., 2008). In some cases, screening tools were designed to ensure privacy, cultural appropriateness, and linguistic accessibility, such as self-administered tools available in multiple local languages and scored by trained staff (The Perinatal Mental Health Project, 2024). Community informant detection tools and home-based screening for vulnerable groups, such as pregnant and postpartum women, further strengthened early detection pathways (De Silve et al., 2016; Rahman et al., 2008). Digital solutions, including interactive voice response systems using free phone lines, also provided low-threshold entry points for screening and referral (Rahman et al., 2008).

Outreach activities and community-based delivery approaches were another important mechanism to enhance approachability by bringing services closer to individuals. Trainings conducted in community meeting halls, service provision through community health clinics, mobile tele-psychiatry services,

and home visits all contributed to making services more visible and accessible within everyday settings (Bakare et al., 2014; MHIN, 2026c; James et al., 2020; Welton-Mitchell et al., 2018; Abubakar et al., 2022; Tekola et al., 2020; Rahman et al., 2008). These approaches shifted service delivery away from facility-based models toward more community-oriented and proactive engagement strategies.

Finally, decentralization of mental health services further strengthened approachability by relocating services closer to communities. The establishment of district-level mental health units and the expansion of services into PHC clinics enabled these facilities to function as the first point of contact for mental health care (MHIN, 2026j; WHO, 2012). This structural shift reduced reliance on centralized, specialist-driven systems and improved the visibility and accessibility of services at the local level.

3.3.2. Acceptability

Acceptability of mental health services was enhanced through multiple interrelated strategies addressing service delivery models, provider attitudes, interpersonal quality, stigma reduction, cultural responsiveness, and user involvement.

Task-shifting approaches played a central role in improving acceptability. Delivery of services by primary health care workers or community health workers increased acceptability, as these providers are often more familiar and less stigmatized than specialized mental health professionals (Lund et al. 2015; MHIN, 2026d; MHIN, 2026e; MHIN, 2026i; Chatterjee et al., 2008; Rahman et al., 2008). Similarly, the involvement of non-specialist providers, including community volunteers, lay health workers, and peer facilitators, contributed to greater acceptability by embedding care within trusted community structures (Bryant et al. 2022, MHIN, 2026c; MHIN, 2026k, Rahman et al., 2008). Peer-led and mother-to-mother delivery models further enhanced trust, relatability, and perceived relevance of services (MHIN, 2026k; Rahman et al., 2008).

Delivering care outside formal mental health settings also reduced stigma and increased acceptability. School-based screening, virtual mental healthcare, integration into PHC, and community-based service delivery all contributed to normalizing mental health care and lowering barriers associated with specialized facilities (Iqbal et al., 2024; Banafsha et al., 2024; Chatterjee et al., 2008; Bryant et al., 2022; StrongMinds, 2025b; MHIN, 2026k).

Improving interpersonal quality of care was another important determinant of acceptability. Capacity-building efforts focusing on communication skills, empathy, confidentiality, and rapport-building strengthened trust between providers and service users (MHIN, 2026l; MHIN, 2026m). These relational aspects of care were essential in fostering positive care experiences.

Stigma reduction approaches were widely integrated into interventions to improve acceptability. Activities included psychoeducation addressing stigma and discrimination (Chatterjee et al., 2014), art-based stigma reduction methods (Iqbal et al., 2024), and training programs for healthcare workers (Kamara et al., 2017). Community-level interventions such as forums, sensitization meetings, and awareness campaigns contributed to reducing stigma and increasing community acceptance of mental health services (Adams et al., 2020; CBM Global Disability Inclusion; 2021). Anti-stigma initiatives led by user and family associations, as well as broader ethical and rights-based approaches, further strengthened acceptability (WHO, 2020; Avan et al., 2022).

Human rights-based approaches also included advocacy efforts, legal reforms, and empowerment of service users. These initiatives involved establishing user associations, revising mental health laws to align with international standards, and promoting participation of service users and their families in policy-making processes (WHO, 2020). Such approaches contributed to more inclusive and acceptable mental health systems.

Cultural responsiveness and inclusiveness were critical in ensuring acceptability across diverse contexts. Interventions were adapted to local languages, cultural norms, and lived experiences, often through the involvement of local staff and stakeholders (Muray et al., 2014; Banafsha et al., 2024). Gender-sensitive approaches, culturally tailored materials, and context-specific adaptations of global frameworks such as mhGAP enhanced relevance and engagement (Bryant et al., 2022, MHIN, 2026g). Incorporating culturally meaningful practices such as yoga, storytelling, music, and community traditions further increased acceptability (Chatterjee et al., 2008; James et al., 2020; MHIN, 2026f). Participatory and co-design approaches, including theory of change workshops and stakeholder engagement processes, ensured that interventions were locally appropriate and feasible (Lamaha et al., 2023).

Privacy and confidentiality were also key contributors to acceptability. Ensuring confidential service delivery and protecting users' dignity—particularly for vulnerable groups such as women—enhanced trust and willingness to engage with services (Avan et al., 2022).

The involvement of caregivers, families, and service users in service design and delivery further enhanced acceptability. Parental and caregiver engagement was particularly important in interventions targeting young people (Bryant et al., 2022; Hamdani et al., 2024; Brown et al. 2023; Fine et al., 2021). Co-design approaches and participatory models, including user-led initiatives and peer support groups, fostered ownership, inclusiveness, and responsiveness of services (Lamaha et al., 2023; StrongMinds, 2025b; Rahman et al., 2008). Group-based and peer-led interventions, often linked with psychosocial rehabilitation and vocational support, promoted social connection,

empowerment, and recovery-oriented care (TrustCircle, 2026; Lamaha et al., 2023; Brooke-Sumner et al., 2024; Asher et al., 2024)

However, acceptability was also influenced by healthcare workers' attitudes and engagement. Negative attitudes toward mental illness among health workers were reported as a barrier (MHIN, 2026d). In some cases, low acceptability of interventions among providers was reflected in skepticism, limited enthusiasm, and low participation in trainings (MHIN, 2026i). Resistance from professional communities to the inclusion of service users in decision-making processes further highlighted systemic barriers (MHIN, 2026n). To address this, several interventions included training and workshops aimed at improving providers' awareness, emotional well-being, and empathic engagement skills (MHIN, 2026l; Avan et al., 2022).

Finally, overall acceptability of interventions was reflected in user and provider experiences. While initial skepticism and low engagement were observed in some interventions, acceptability often improved over time as participants became more engaged and began to experience benefits (MHIN, 2026o). Many interventions were ultimately reported as acceptable, feasible, and well-received by diverse stakeholders, including service users, families, providers, and communities. Support group formats—whether peer-led, community-based, or online—were consistently identified as acceptable modalities, fostering shared experiences, social support, and collective problem-solving (Bryant et al., 2022; Hamdani et al., 2024; Brown et al., 2023; Fine et al., 2021; StrongMinds, 2025a; Friendship Bench, 2026; Lamaha et al., 2023; Brooke-Sumner et al., 2024; Asher et al., 2024).

3.3.3. Availability and Accommodation

Availability and accommodation of mental health services were strengthened through task-shifting and service integration models, alongside workforce expansion, flexible delivery approaches, and the system-level organization of care pathways.

Task-shifting emerged as a central strategy to increase the availability of mental health services by expanding the workforce beyond specialized providers. Many interventions trained primary health care workers, nurses, community health workers, and lay providers to deliver mental health care, thereby significantly increasing the number of service providers (MHIN, 2026a; MHIN, 2026d; MHIN, 2026e; MHIN, 2026i; Chatterjee et al., 2008; Iheanacho, et al., 2024). This included maternal depression care delivered by community health workers and follow-up care for individuals with severe mental disorders provided at the PHC level (Alan J Flisher Centre for Public Mental Health, 2025). In addition, peer-led and community-based delivery models such as mentor mothers, volunteers, and lay workers further expanded service capacity and reach (Lamaha et al., 2023; Chibanda et al., 2015;

Bryant et al., 2022; StrongMinds 2025a; Brooke-Sumner et al., 2024; Chatterjee et al., 2014; Rahman et al., 2008).

Integration of mental health services into primary health care systems also played a critical role in improving availability by bringing services closer to communities. Through approaches such as mhGAP, CETA, and adapted psychotherapies, mental health care was embedded within routine PHC services, reducing reliance on specialized facilities and increasing service coverage (MHIN, 2026a; MHIN, 2026d; MHIN, 2026e; MHIN, 2026i; Chatterjee et al., 2008; Iheanacho, et al., 2024).

Community-based provision of care improved both availability and accommodation by delivering services in locations that are geographically and socially accessible. Group therapies, training sessions, and support groups conducted in community settings such as community halls, and workplaces reduced barriers related to distance and transportation (Lamaha et al., 2023; Chibanda et al., 2015; Bryant et al., 2022; StrongMinds, 2025a; MHIN, 2026c).

The establishment of structured referral pathways and stepped-care models was another key component of improving availability and accommodation. Interventions created clear linkages between screening, primary care, and specialized services, ensuring continuity of care and appropriate escalation when needed (Banafsha et al., 2024; Chatterjee et al., 2008). Stepped-care approaches allowed service users to receive the least intensive appropriate intervention, with referral to higher levels of care when necessary (Chatterjee et al., 2008). Referral systems also extended beyond health services to include social support mechanisms, with community actors facilitating access and navigation (MHIN, 2026m). Comprehensive models linking facility-based and community-based care, supported by supervision and specialist input, further strengthened continuity and coordination (MHIN, 2026l; Avan et al., 2022; Lund et al., 2012; De Silve et al., 2016).

Digital and tele-mental health solutions contributed to both availability and accommodation by overcoming geographical and logistical barriers. These included telephone-based counselling for pregnant women, online therapy for adolescents at risk, and e-health platforms designed to reach rural and remote populations (Khoja et al., 2025, MHIN, 2026p; Tharoor and Thara, 2020). Additional innovations such as digital self-help interventions, WhatsApp-based counselling, and online support tools further expanded access to care (Heim et al. 2021; Friendship Bench, 2026; TrustCircle, 2026). However, infrastructural challenges, such as limited internet connectivity in rural settings, were also identified as barriers to sustained service delivery (MHIN, 2026a).

Flexible and accommodating service delivery models also enhanced accessibility. Adjustments such as flexible session scheduling, shorter session durations, coordination with schools, and

consideration of participants' family and work responsibilities improved the ability of individuals to engage with services (Bryant et al., 2022; Hamdani et al., 2024; Brown et al., 2023; Fine et al., 2021).

Outreach strategies further strengthened availability by proactively reaching individuals in their own environments. These included home visits, mobile tele-psychiatry services, and community-based follow-up activities aimed at assessing needs, reducing stigma, and supporting ongoing engagement in care (Rahman et al., 2008; Thara and Sujit, 2013; Tharoor and Thara, 2020).

Decentralization of services was another key structural strategy. The establishment of district-level mental health units and hub-and-spoke models enabled services to be distributed across regions, reducing centralization and improving local access (Shackman and Price, 2013; MHIN, 2026k).

Investments in healthcare infrastructure also contributed to increased availability. Some interventions established mental health units within existing hospital systems, while others developed new inpatient and outpatient services within general hospitals, thereby expanding service capacity (Kamara et al., 2017; Hijiawi et al., 2013).

Finally, workforce expansion through the creation of new cadres of mental health workers further strengthened service availability. The development of roles such as Community Mental Health Officers and Clinical Psychiatric Officers, along with associated training models and curricula, contributed to sustainable scaling of mental health services (Adjase and Crabb, 2014).

3.3.4. Affordability

Affordability of mental health services was supported through a combination of free service provision, task-shifting and integration models, outreach and community-based delivery, financial support mechanisms, and efforts to reduce medication costs.

A major strategy for improving affordability was the provision of services free of charge. In several interventions, mental health care was offered at no direct cost to users, often in combination with integration into primary health care and task-shifting models that reduced the cost of service-delivery (MHIN, 2026d; Muray et al., 2014; Chatterjee et al., 2008; Bakare et al., 2014). Similarly, digital and e-health interventions also improved affordability by providing free mental health support tools (Heim et al., 2021; TrustCircle, 2026). Peer-led and community-based service delivery models may also have contributed to affordability by relying on lower-cost modes of care provision (Chatterjee et al., 2014; Lamaha et al., 2023; MHIN, 2026k; StrongMinds, 2025a).

Integration into primary health care, outreach activities, and community-based delivery also helped reduce indirect costs, particularly travel-related expenses and time costs, by bringing services closer

to communities (MHIN, 2026p; Adebowale et al., 2014; MHIN, 2026c). Decentralization of care through the establishment of district mental health units further contributed to affordability by reducing the need for long-distance travel to centralized services (MHIN, 2026j). However, some evidence also showed that indirect costs remained an important barrier; for example, repeated follow-up visits were reported as difficult for some participants because of travel expenses and loss of wages (Chatterjee et al., 2008).

In some settings, specific financial protection mechanisms were introduced to improve affordability. One example involved a registration fee that could be waived for service users who were unable to pay, thereby helping prevent exclusion on financial grounds (Kamara et al., 2017).

Medication-related affordability was addressed through several approaches. In MANAS, generic antidepressant medication was made available through public primary health care facilities (Chatterjee et al., 2008). In other interventions, psychotropic medicines were donated or provided free of charge, reducing out-of-pocket expenditure for service users (MHIN, 2026b; Tharoor and Thara, 2020). In HAPPINESS, a Drug Revolving Fund was established to ensure a stable supply of effective, unadulterated medications at or below market value, representing a more systemic strategy to support medication affordability over time (MHIN, 2026g).

Overall, affordability was improved not only through the elimination or reduction of direct service fees, but also through strategies that lowered indirect costs and improved access to affordable medication.

3.3.5. Appropriateness

Appropriateness of mental health services was strengthened through strategies that improved timeliness, continuity, quality, responsiveness to clinical and social needs, caregiver support, high-risk targeting, participation and involvement in care, empowerment, and overall effectiveness.

A first important dimension of appropriateness was the timeliness and continuity of care. In some interventions, increasing the availability of mental health providers through task-shifting and integration into primary health care helped ensure more timely access to assessment and treatment (MHIN, 2026d; MHIN, 2026p). School-based screening also facilitated earlier identification and more timely provision of support for adolescents at risk (Iqbal et al., 2024). Continuity of care was further enhanced through follow-up mechanisms such as regular home visits, long-term follow-up cohorts, patient-held records, scheduled follow-up appointments, and electronic health records that supported documentation, clinical review, and information sharing across providers (MHIN, 2026c; Lund et al., 2012; Thara and Sujit, 2013; Tharoor and Thara, 2020; Ileanacho, et al., 2024; MHIN, 2026g). System support mechanisms also contributed to appropriateness. One intervention emphasized

integrating mental health into district health information systems and introducing community health worker information systems to improve reporting, medication management, and monitoring at the provincial level (Khoja et al., 2015).

Appropriateness was also improved through efforts to strengthen the quality of care, particularly by investing in supervision, evidence-based practice, and implementation support for those delivering mental health interventions. Several interventions enhanced quality through capacity building and the use of structured, evidence-based approaches (Lund et al., 2015; MHIN, 2026p). Individuals taking on mental health care roles through task-shifting including primary care providers, community workers, lay providers, and peer facilitators often received regular supervision from specialists or senior staff. In some models, this included structured case reviews, monthly supervision, supportive feedback, or telemedicine-based specialist input (Chatterjee et al., 2014; Iqbal et al., 2024; Banafsha et al., 2024; Nakimuli-Mpungu et al., 2014, Chatterjee et al., 2008; MHIN, 2026g). Interventions also drew on established evidence-based techniques such as psychoeducation, stress management, behavioural activation, and problem solving, which supported the delivery of more appropriate and effective care (Fine et al. 2021; Bryant et al. 2022; Brown et al. 2023; Hamdani et al., 2024). Broader workforce development initiatives—including pre-service and in-service training, cascade training models, postgraduate qualifications, continuous professional development, and on-the-job refreshers—further contributed to improving appropriateness by strengthening provider competence and fidelity to intervention models (WHO, 2012; MHIN, 2026b; Avan et al., 2022).

Responsiveness to users' needs was another core component of appropriateness. Some interventions addressed both mental and physical health problems, while others used structured needs assessments and individualized treatment planning to tailor care to the clinical and functional needs of participants (Chatterjee et al., 2014). Need responsiveness was also enhanced through problem-specific group therapies, educational modules tailored to pregnancy stage or child development, flexible session frequency based on symptom severity, and stepped-care models in which individuals with more severe symptoms were referred to more specialized care (Nakimuli-Mpungu et al., 2014; MHIN, 2026c; MHIN, 2026g; MHIN, 2026l; MHIN, 2026m; Verdelli et al., 2016). In some interventions, mental health care was combined with maternal and child health support, child development activities, nutrition, or healthy lifestyle promotion, thereby improving the fit between care and the broader realities of service users' lives (Rahman et al., 2008).

Appropriateness was further enhanced through high-risk and target-group approaches. Some interventions specifically identified and prioritized individuals or groups at increased risk, allowing care to be tailored more closely to their needs. Examples included screening and referral for adolescents at elevated suicide risk, interventions targeting people living with HIV or those affected by war, and tailored services for displaced populations, prison populations, torture survivors, families of the

disappeared, LGBT communities, foreign domestic workers, women facing violence or extreme financial hardship, homeless individuals with severe mental health conditions, and earthquake survivors (Iqbal et al., 2024; Nakimuli-Mpungu et al., 2014; Muray et al., 2014; Haas et al., 2023; Legha et al., 2015; Verdeli et al., 2016; Republic of Lebanon Ministry of Public Health, 2015). This targeting increased appropriateness by aligning intervention content and intensity with users' risk profiles and circumstances.

Appropriateness also depended on responsiveness to social needs. A number of interventions linked mental health care to community agencies, legal and livelihood support, vocational opportunities, social protection, education, physiotherapy, shelter, and gender-based violence services (Chatterjee et al., 2014; MHIN, 2026r; Lamaha et al., 2023; MHIN, 2026m). Some models addressed family reintegration, homelessness, rehabilitation, and community follow-up, while others used peer-led support groups and income-generating activities to address social and economic determinants alongside mental health needs (PIH Liberia, 2025; MHIN, 2026k). These approaches increased the relevance of care by recognizing that mental health outcomes are often shaped by unmet social and material needs. Home visits also allowed providers to assess family support, stigma, participation in daily life, and gaps requiring additional intervention, further strengthening the social appropriateness of care (MHIN, 2026m; Rahman, 2007; Rahman et al., 2008).

Support groups themselves contributed to appropriateness by offering sustained emotional, social, and practical support to service users. These groups created opportunities for shared problem solving, exchange of information, financial and community resource mobilization, livelihood support, social cohesion, and stigma reduction (Nakimuli-Mpungu et al., 2014; MHIN, 2026o). In other cases, psychosocial rehabilitation groups with peer and caregiver involvement supported recovery, reintegration, and participation in social and economic life (PIH Liberia, 2025).

Support for caregivers and families was another major component of appropriateness. Several interventions provided psychoeducation to both participants and caregivers, organized family support groups, or included caregiver sessions designed to strengthen caregiving capacity and social support (Chatterjee et al., 2014; MHIN, 2026m; Brooke-Sumner et al., 2024; Bryant et al. 2022; Lamaha et al., 2023; Rahman et al., 2008). In some perinatal mental healthcare programs, family members including husbands and in-laws were actively involved in care processes, while other interventions combined individual, group, and family sessions to address needs at multiple levels. (MHIN, 2026c; Lamaha et al., 2023). Community-based psychosocial rehabilitation groups and caregiver skills training also promoted recovery, functioning, and the ability of families to provide ongoing support (PIH Liberia, 2025; Abubakar et al., 2022; Bakare et al., 2014).

Empowerment and active engagement in care also strengthened appropriateness. Some interventions used community engagement, caregiver participation, expressive arts, and interactive sessions to build awareness, agency, and help-seeking motivation (Iqbal et al., 2024). Community forums, patient forums, peer-led rehabilitation activities, and community partnerships created spaces for dialogue, mutual learning, and stronger understanding of rights and coping strategies (Adams et al., 2020; CBM Global Disability Inclusion, 2021; MHIN, 2026m). In addition, involvement of service users and families in the planning, development, and evaluation of services made systems more responsive and inclusive, while peer-led support groups and former patient involvement strengthened empowerment and recovery-oriented care (El Chammay et al., 2016; Republic of Lebanon Ministry of Public Health, 2015; Brooke-Sumner et al., 2024; PIH Liberia, 2025). At a macro level, empowerment and engagement were also supported through theory of change approaches and cross-site learning processes, which helped adapt interventions to local health system realities and user needs, thereby promoting more context-sensitive and appropriate care delivery (Partners In Health, 2026).

Some interventions also incorporated mechanisms to capture patient experience and service feedback, which is relevant to appropriateness because it helps assess whether care is perceived as useful, respectful, and responsive. For example, participants were asked to evaluate perceived effects of interventions, group leaders, and their overall impressions of care, while other programs used exit interviews and complaint management systems to monitor women's care experiences and improve service responsiveness (Nakimuli-Mpungu et al., 2014; MHIN, 2026o; Avan et al., 2022).

Finally, intervention effectiveness provided an important indication of appropriateness. Several programs reported improvements in symptoms, functioning, well-being, continuity of care, or psychosocial outcomes. For example, large proportions of service users showed symptom reduction, improved subjective well-being, or recovery under collaborative and stepped-care models (Chatterjee et al., 2008). Community-based collaborative care models also demonstrated improvements in disability and symptoms in some settings (Chatterjee et al., 2014; MHIN, 2026r). CETA delivered by lay counsellors showed strong effects on depression and post-traumatic stress among Burmese trauma survivors in Thailand (Murray et al., 2014). EASE was reported to reduce internalizing problems among adolescents and distress among caregivers in Jordan (Brown et al., 2023), and to improve several psychosocial outcomes among adolescents in Pakistan, while also being viewed as safe, relevant, and effective by the target population (Hamdani et al., 2024). These findings suggest that appropriateness was strengthened not only by how care was organized and delivered, but also by its capacity to produce meaningful benefits for service users.

3.4. Transferability Assessment of Mental Health Innovations

The transferability of each included innovation was assessed using the four-dimension scoring framework described in section 2.1.2, covering feasibility, agility, co-creation, and clarity. Each dimension was scored on a 0–5 scale by two independent reviewers, and interrater consistency was assessed to support the reliability of the scoring process. A weighted composite score was calculated for each innovation. The following subsections present the distribution of scores across the 47 included innovations, examine what drove variation in scores within and across dimensions, and identify the group of innovations that reached the higher end of the transferability range and were selected for in-depth profiling.

It should be noted at the outset that the 47 innovations included in this analysis had already been filtered through inclusion criteria that required LMIC implementation, documented impact evidence, and the availability of implementation guidance. This pre-selection process concentrated the sample on interventions that are better documented, more widely implemented, and more extensively evaluated than the broader landscape of LMIC mental health innovation. As a result, the distribution of transferability scores is relatively concentrated at the upper end of the scale, which is a reflection of the sample composition rather than a limitation of the scoring instrument. Within this group, meaningful variation still exists across and within dimensions, and the scores function as intended — as a comparative ranking tool to identify which innovations are most suitable for further exploration in relation to European health system contexts.

3.4.1. Overview of Transferability Scores

Feasibility scores across the 47 innovations ranged from 2.50 to 4.95 with a mean of 4.04, a median of 4.1, and a standard deviation of 0.75 (Figure 14). Innovations that scored higher on feasibility were typically those that rely on task-sharing with existing healthcare or community workforces, are integrated into primary care or other routine service platforms and are supported by structured training and supervision models that do not require specialised facilities or equipment. Innovations that scored lower on this dimension tended to reflect broader, system-level approaches that are highly context-specific and require substantial structural change, making them less readily implementable in practice. These included interventions dependent on policy or regulatory reform, expansion of the mental health workforce through new cadres or positions, and large-scale investments in mental health infrastructure.

Agility scores ranged from 2.75 to 5, with a mean of 4.21, a median of 4.25, and a standard deviation of 0.57 (Figure 14). Innovations receiving higher agility scores demonstrated a documented history of adaptation across cultural, linguistic, or service contexts, often including evidence of successful replication in settings other than the one where the innovation was originally developed. Transdiagnostic approaches — those designed to address a range of mental health presentations rather than a single diagnostic category — also scored higher on this dimension, as their broad applicability reduces the risk of contextual mismatch. Lower agility scores were associated with interventions whose delivery was closely tied to a specific cultural setting, community structure, or health system configuration, particularly where the intervention was designed in response to a highly localized service delivery problem. Such interventions would be difficult to replicate or adapt elsewhere without substantially altering the intervention’s approach.

Co-creation scores ranged from 2.75 to 5.0, with a mean of 3.87, a median of 3.9, and a standard deviation of 0.59 (Figure 14). Higher scores were associated with interventions developed through participatory processes such as community advisory boards, formative qualitative research, or collaborative theory of change workshops, and with models where individuals with lived experience take on active roles in facilitation, governance, or peer support. Lower scores reflected interventions where design and decision-making remained primarily in the hands of external researchers or clinical specialists, with limited mechanisms for community input or user-led adaptation.

Clarity scores ranged from 3.4 to 4.95, with a mean of 4.32, a median of 4.5, and a standard deviation of 0.45 (Figure 14). Interventions with higher clarity scores were supported by standardised manuals, structured training curricula, clearly defined provider roles, and documented referral and supervision pathways. This documentation makes it possible to identify the core active components of the intervention and to distinguish them from elements that are culturally specific and may require adaptation. Interventions with lower clarity scores tended to rely more heavily on practitioner discretion, general principles, or loosely defined community processes, which, while appropriate in their original contexts, make it more difficult to specify what precisely would need to be preserved or modified in a transfer.

The reliability of the transferability scoring process was assessed using intraclass correlation coefficients. Agreement between the two reviewers’ independent transferability scores fell in a moderate range (ICC = 0.729, 95% CI: 0.453–0.860; $p < 0.001$). Because the final transferability score for each innovation was calculated as the mean of the two reviewers’ ratings, the reliability of these averaged transferability scores was also evaluated and was higher (ICC = 0.843, 95% CI: 0.607–0.926; $p < 0.001$), reflecting a good level of consistency in scoring and supporting the use of the composite transferability score as a stable basis for comparison across innovations.

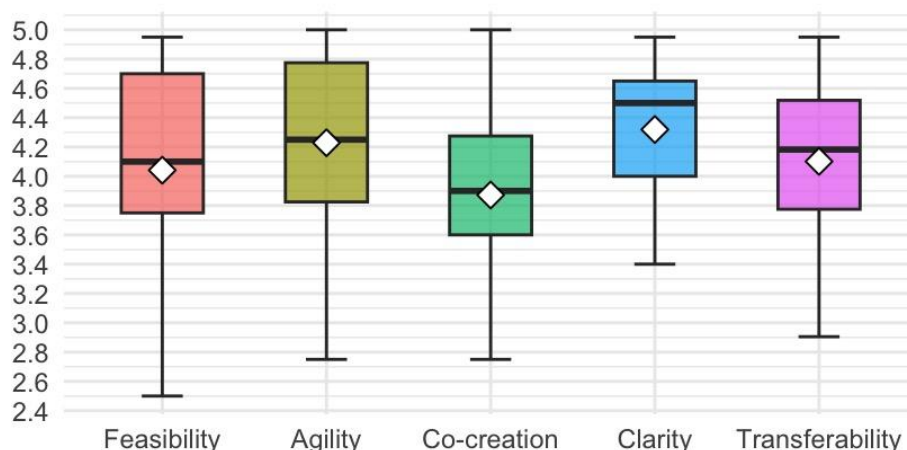


Figure 14. Distribution of Transferability Scores

Overall transferability scores ranged from 2.90 to 4.95, with a mean of 4.10, a median of 4.18, and a standard deviation of 0.51 (Figure 14.). Scores between 4.0 and 4.5 were classified as indicating moderate transferability potential; 17 innovations fell within this range, while scores of 4.5 and above were classified as indicating higher transferability potential, represented by 13 innovations. As noted above, the concentration of scores in the upper portion of the scale is consistent with the characteristics of the included sample. Within this range, the composite scores provide a meaningful basis for prioritisation, and the variation across dimensions offers additional analytical insight into which specific aspects of transferability present the greatest opportunities or challenges for each innovation.

3.4.2. Illustrative Examples Across the Transferability Range

To illustrate how the four dimensions interact in practice, three innovations representing different positions within the score distribution are examined in greater detail below. These examples are intended to demonstrate the analytical logic of the framework rather than to rank the innovations in absolute terms.

The Friendship Bench from Zimbabwe received the highest overall transferability score in the dataset (4.95). On the feasibility dimension, the intervention scored highly because it delivers a structured psychological intervention based on Cognitive Behavioral Therapy with an emphasis on Problem-Solving Therapy, implemented by trained lay providers — specifically community grandmothers — rather than relying on specialist mental health professionals. This model builds on an existing and socially embedded workforce and is supported by capacity-building approaches, including training programmes and online courses for community health workers, making it feasible within routine service settings.

On agility, the Friendship Bench has been implemented and adapted across multiple countries, supported by a strong monitoring and evaluation framework that standardises indicators, tracks service delivery and quality, and generates continuous learning to inform programme development. The intervention has also been evaluated through rigorous research designs, including randomised controlled trials, with findings accessible to inform further adaptation. Its delivery across diverse settings — including primary healthcare facilities, HIV clinics, and workplace-based programmes — further demonstrates its flexibility and capacity for context-specific adaptation. Co-creation is embedded in the programme through peer-led community structures such as the Circle Kubatana Tose (CKT) groups, where participants contribute to both psychosocial support and collective livelihood activities. These groups extend the intervention beyond symptom support by fostering social participation, economic resilience, and community ownership. Co-creation is further strengthened through Theory of Change workshops that convene key stakeholders to surface contextual assumptions, identify barriers, and jointly define indicators for assessing the programme’s feasibility, acceptability, and fidelity. Clarity is supported by well-defined intervention components, including structured therapy sessions, clearly delineated provider roles, and standardised implementation procedures, which together facilitate replication and adaptation across settings. Together, these characteristics make the Friendship Bench a well-documented, scalable, and contextually adaptable intervention with strong potential for transfer to European context (Chibanda et al., 2015; MHIN, 2026k; Friendship Bench, 2026)

The mhGAP implementation in Kashmir was among the interventions receiving a moderate transferability score (4.07). Although the WHO mhGAP framework provides a well-documented structure and supports a high clarity score, the programme itself is rooted in a highly context-specific service delivery problem. It is embedded in district-level mental health system arrangements and responds to local challenges including workforce shortages, fragmented patient records, limited monitoring systems, and care pathways shaped by the coexistence of different providers. Its strong grounding in the local district context also contributed to a lower co-creation score, as the intervention was primarily structured as a system-level service reorganisation rather than a participatory process involving communities or service users. Therefore, while mhGAP-based task-sharing may be feasible and clearly defined as an approach, the intervention in this specific form was considered only moderately transferable to European contexts (MHIN, 2026e).

The Scaling-up Central African Republic initiative received one of the lower overall transferability scores in the dataset. The programme was explicitly designed to function in a context of extreme resource scarcity, active displacement, and infrastructural collapse, which shaped every aspect of its design, including the use of highly simplified clinical algorithms and basic flowcharts for non-specialist health workers with minimal training. While these features represent appropriate and pragmatic

responses to an acute humanitarian context, they limit the programme's agility and clarity scores in relation to European contexts, where clinical protocols are governed by regulatory requirements that mandate a higher level of diagnostic specificity and professional oversight. The intervention's core strength — its capacity to deliver any mental health support at all under conditions of near-total system failure — is not a feature that translates directly to well-resourced, institutionalised health systems. This does not diminish the programme's value in its original context; it reflects the inherently context-specific nature of some innovations and reinforces the importance of assessing transferability in relation to a defined target setting (MHIN, 2026b).

3.4.3. Mental Health Innovations with Higher Transferability Potential

Out of the top 25 selected interventions for in-depth profiling, 13 reached an overall transferability score of 4.5 or above. These innovations are not characterised by a single model or approach; rather, they represent a range of intervention types, settings, and target populations that share a set of structural features associated with cross-context adaptability.

Several innovations in this group are built around task-sharing models that train and support non-specialist providers — including community health workers, lay counsellors, nurses, and primary care staff — to deliver structured psychological interventions. These models tend to score well across all four dimensions: they are feasible because they build on existing or readily trainable workforces; agile because the evidence base for task-sharing in mental health has been established across diverse settings; co-created in many cases through engagement with community members and service users in development and delivery; and clear because they are typically supported by manualised protocols and supervision structures. Examples in this group include the Thinking Healthy Programme (Pakistan) (Rahman et al., 2008), the Friendship Bench (Zimbabwe) (Chibanda et al., 2015), the MANAS Project (India) (Chatterjee et al., 2008), and the Common Elements Treatment Approach (Thailand) (Murray et al., 2014).

A second group of high-scoring innovations uses digital and telehealth modalities to extend the reach of mental health support, whether for service delivery, training, or supervision. These innovations scored consistently on feasibility in contexts where digital infrastructure is available, and on agility given the relative portability of software-based delivery across geographical and cultural contexts. They include Step-by-Step (Lebanon) (Heim et al., 2021), Trust Circle (India and United States) (TrustCircle, 2026), and Using mhGAP-IG on Mobile Phones (Kenya) (MHIN, 2026a). It is worth noting that digital innovations require careful assessment of data protection and privacy regulations in any receiving context, particularly in the European Union where the General Data Protection Regulation imposes specific requirements on the handling of health data.

A third group integrates mental health support into existing health service platforms — particularly maternal and child health services, primary care, and HIV care — rather than establishing standalone mental health programmes. This integration model tends to score well on feasibility because it avoids the need to build new service infrastructure, and on approachability and acceptability in the Levesque framework because it reaches individuals within existing care pathways. Examples include the Perinatal Mental Health Project (South Africa) (MHIN, 2026l; The Perinatal Mental Health Project, 2024), the AFFIRM Project (Africa) (MHIN, 2026p; Lund et al., 2015) Learning Clubs (Vietnam) (MHIN, 2026c; Saving Brains, 2026) and the INSPIRE (Kenya and Mozambique) (Lamaha et al., 2023).

A fourth group comprises system-level and participatory innovations that operate at the level of service design, policy, or workforce development rather than direct therapeutic delivery. These include the PRIME Consortium (Lund et al., 2012; De Silve et al., 2016), the Partners in Health Learning Collaborative (Partners In Health, 2026), and the Mental Health System Reform initiatives in Jordan (Hijiawi et al., 2013) and Lebanon (El Chammay et al., 2016; Republic of Lebanon Ministry of Public Health, 2015). These models scored particularly well on co-creation and agility, given their emphasis on multi-stakeholder engagement, participatory planning processes, and adaptation to local health system realities. Their relevance for European contexts lies less in the direct transfer of specific clinical techniques and more in the governance, planning, and implementation models they offer for integrating mental health into broader health systems.

Finally, innovations focused on peer-led support and lived-experience involvement — including PRIZE (South Africa) (Brooke-Sumner et al., 2024; Asher et al., 2024), Our Step Association (Jordan) (MHIN, 2026n), and the Group Psychotherapy Model for Depression among People Living with HIV (Uganda) (MHIN, 2026o; Nakimuli-Mpungu et al., 2014) — scored strongly on the co-creation dimension, reflecting the central role of service user and community involvement in their design and delivery. Innovations that additionally incorporated explicit co-creation and co-design approaches during development or implementation — including Friendship Bench (Friendship Bench, 2026), INSPIRE (Lamaha et al., 2023), and the Partners in Health Learning Collaborative (Partners In Health, 2026) — scored strongly on co-creation and, where supported by structured manuals or protocols, on clarity as well. These innovations are particularly relevant for European recovery-oriented mental health frameworks and human rights-based approaches to care, and their transferability potential is closely linked to whether existing peer support workforce structures can accommodate them within regulated service environments.

Table 2 provides a comparative overview of the 25 mental health innovations selected for in-depth analysis. Innovations are ordered from highest to lowest transferability score. Detailed profiles of the innovations with transferability scores are presented in the Annex.

Table 2. Characteristics of selected high-transferability mental health innovations (n=25)

Type of Intervention	Target Group	Key Characteristics	Access & Transferability	Brief Actionable Takeaway
The Friendship Bench (Zimbabwe)				
Service Delivery and Integration; Person-Centred and Community Approaches; Task-sharing with community members; co-creation and co-design; integration with health services	Adults with common mental disorders	Community-based intervention in which trained lay community members ("grandmothers") deliver problem-solving therapy on benches near primary care facilities, workplaces, and HIV care units. Free of charge. Hub-and-spoke delivery with WhatsApp-based follow-up option.	Access: Approachability, Acceptability, Availability, Affordability, Appropriateness Transferability: Feasibility, Agility, Co-creation, Clarity	Strong model for lay-worker delivery of problem-solving therapy. Peer-selection and supervision model directly replicable; adaptable to diverse European community settings.
StrongMinds (Uganda, Zambia, USA)				
Service Delivery and Integration Person-Centred and Community Approaches; Task-sharing with community members; peer-led group therapy; integration with NGO and government services	Adults with depression	Structured Group Interpersonal Therapy delivered by trained lay facilitators in-person and via phone. Integrated into government and NGO service structures including schools, prisons, and frontline services. Free of charge.	Access: Approachability, Acceptability, Availability, Affordability, Appropriateness	Highly scalable and low-cost group IPT model with strong evidence base. Directly adaptable for under-resourced European community mental health settings.

Transferability:
Feasibility, Agility,
Clarity

CETA: Common Elements Treatment Approach (Thailand)

Service Delivery and Integration; Task-sharing with community members and HCW/SW; transdiagnostic modular psychological intervention	Refugees and trauma survivors with depression, anxiety, or PTSD	Modular transdiagnostic intervention delivered by trained lay counsellors with lived experience of displacement. Components (cognitive restructuring, behavioural activation, exposure, problem-solving) selected and adapted to individual need.	Access: Acceptability, Availability, Appropriateness Transferability: Feasibility, Agility, Clarity	Highly relevant for European settings serving refugee and migrant populations. Modular design allows adaptation to comorbid presentations without specialist delivery.
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Step-by-Step (Lebanon)

Digital Mental Health Solutions Service Delivery and Integration; Digital self-help; task-sharing with community e-helpers; WHO-developed platform	Refugees and host population with depression, anxiety, or PTSD	WHO-developed guided digital self-help intervention delivered via app or website, supported by trained community e-helpers. Culturally adapted, multilingual, and free of charge. Evidence of positive effects on depression, anxiety, PTSD, and functioning.	Access: Approachability, Acceptability, Availability, Affordability, Appropriateness Transferability: Feasibility, Agility, Clarity	Directly relevant for European digital mental health pilot design. Culturally adaptable and multilingual; subject to GDPR compliance review for EU deployment.
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We Matter Too (Kenya)

Service Delivery and Integration Arts-Based Approaches; Task-sharing	Young men	Barbers trained to initiate mental health conversations using mental health-themed music and deliver brief	Access: Approachability, Acceptability,	Innovative model for reaching young men through trusted community spaces and culturally
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with community members; arts-based engagement; WHO Doing What Matters guide	WHO stress-management support during routine haircuts. Uses trusted community spaces to reach a hard-to-engage population. Free of charge.	Availability, Affordability Transferability: Agility, Feasibility	embedded approaches. Offers a replicable framework for engaging hard-to-reach male populations in European pilot contexts.
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mhGAP-IG on Mobile Phones (Kenya)

Service Delivery and Integration Digital Mental Health Solutions; Task-sharing with HCW/SW; mobile clinical decision support; remote specialist supervision	Non-specialist healthcare workers managing patients with depression	Mobile-based mhGAP Intervention Guide providing real-time clinical decision support in primary care outpatient settings. Enables remote specialist supervision and quality oversight for non-specialist providers.	Access: Approachability, Acceptability, Availability, Appropriateness Transferability: Feasibility, Clarity	Digital tool enabling non-specialist providers to manage depression safely. Directly adaptable for European PHC integration supporting task-sharing and remote supervision.
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THP: Thinking Healthy Programme (Pakistan)

Service Delivery and Integration; Task-sharing with HCW/SW; integration into maternal and child health; CBT-based home visits	Pregnant and postpartum women	16-session CBT-based intervention integrated into routine home visits by Lady Health Workers. Targets the mother-infant dyad. Addresses perinatal depression alongside child development and family support. Manualized and free of charge.	Access: Approachability, Acceptability, Availability, Affordability, Appropriateness Transferability: Feasibility, Agility, Clarity	Strong evidence base and manualized protocol for perinatal mental health via community health workers. Directly relevant for European perinatal mental health pathways.
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COPSI: Care for People with Schizophrenia (India)

Service Delivery and Integration Person-Centred and Community Approaches; Task-sharing with community members; integration with health services; peer-led support; intersectoral collaboration	People with schizophrenia and their caregivers	Collaborative care combining facility-based specialist oversight with community rehabilitation by lay health workers. Includes structured needs assessment, psychoeducation, caregiver support, and links to self-help groups and community resources.	Access: Acceptability, Appropriateness Transferability: Feasibility, Co-creation, Clarity	Model for integrating severe mental illness care with social support in community settings. Relevant for European programmes targeting people with psychosis in community-based rehabilitation.
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PRIZE: Peer-Led Recovery Groups (South Africa)

Person-Centred and Community Approaches; Task-sharing with HW/SW and community members; peer-led support groups for psychosis	People with psychosis and their caregivers	Individuals with lived experience and caregivers trained to facilitate structured community recovery groups. Facilitated by auxiliary social workers. Focuses on personal recovery, mutual support, and group-based problem-solving. Free of charge.	Access: Acceptability, Availability, Affordability, Appropriateness Transferability: Co-creation, Feasibility	Peer-facilitated recovery model co-led by service users and caregivers. Strong fit for European recovery-oriented and rights-based mental health frameworks.
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TrustCircle (India, USA)

Digital Mental Health Solutions Person-Centred and Community Approaches; Peer-led digital support; telehealth; AI-assisted self-assessment	Students and young adults	Mobile platform offering anonymous peer-to-peer interaction, professional counselling, and AI-driven self-assessment. Multilingual with voiceover accessibility. Preventative screening and resilience tracking features. Free of charge.	Access: Approachability, Acceptability, Availability, Affordability, Appropriateness Transferability: Agility, Feasibility	Anonymous digital peer support platform with tiered professional support. Relevant for European youth mental health pilots; requires GDPR and AI governance review for EU deployment.
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EASE: Early Adolescent Skills for Emotions (Jordan, Lebanon, Pakistan, Tanzania)

Service Delivery and Integration Person-Centred and Community Approaches; Task-sharing with community members; group-based transdiagnostic therapy; caregiver involvement	Adolescents aged 10–15 and their caregivers	WHO-developed group psychological intervention for adolescent internalizing problems. Delivered by trained lay community workers with flexible scheduling. Transdiagnostic approach covering depression, anxiety, and distress. Free of charge.	Access: Approachability, Acceptability, Availability, Affordability, Appropriateness Transferability: Feasibility, Agility, Clarity	Multi-country evidence base for group adolescent mental health support via lay workers. Strong fit for European settings with migrant, refugee, or underserved adolescent populations.
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INSPIRE (Kenya, Mozambique)

Service Delivery and Integration Person-Centred and Community Approaches; Arts-Based Approaches; Task-sharing with community members; peer mentorship; co-creation; arts-based approaches	Adolescent mothers	Multi-layered peer-led intervention combining trained young mentor mothers and community health workers with group, individual, and family psychosocial sessions. Human-centred co-design process. Integration with community, health, and social services. Free of charge.	Access: Approachability, Acceptability, Availability, Affordability, Appropriateness Transferability: Co-creation, Agility, Feasibility	Model for human-centred co-designed perinatal mental health support. Relevant for European pilot contexts working with adolescent and young mothers in under-resourced settings.
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Learning Clubs for Women's Health (Vietnam)

Service Delivery and Integration Person-Centred and Community Approaches; Task-sharing with HCW/SW	Mothers with young children	Facilitated psychoeducational group sessions combining health education (nutrition, infant care) with peer psychosocial support. Delivered by	Access: Approachability, Acceptability, Availability,	Psychoeducational group model integrating maternal mental health with infant care and peer support. Adaptable for European
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and community members; peer-led group support; integration with MCH services		Women's Union staff and primary care providers. Home visit follow-up. Free of charge.	Affordability, Appropriateness Transferability: Feasibility, Clarity	community-based maternal support programmes.
Dareecha (Pakistan)				
Service Delivery and Integration Digital Mental Health Solutions Arts-Based Approaches; Intersectoral collaboration (education– health); telehealth; arts- based; Zero Suicide model	School-age young people at risk of suicidal ideation or behaviour	School-based Zero Suicide programme integrating universal screening, teacher training, safety planning, family engagement, referral pathways, and 8-week virtual therapy with clinical psychologists. Culturally adapted arts-based stigma reduction. Free of charge.	Access: Approachability, Acceptability, Availability, Affordability, Appropriateness Transferability: Feasibility, Agility, Clarity	Directly relevant for European school mental health and suicide prevention pilots. Comprehensive model combining screening, education-sector integration, and virtual clinical care.
AFFIRM (Ethiopia, Ghana, Malawi, South Africa, Uganda, Zimbabwe)				
Service Delivery and Integration Mental Health Research Capacity Building; Task-sharing; integration with health services; research capacity-building; policy engagement	Adults with mental disorders in primary care; health workforce	Multi-country task-sharing initiative integrating mental health into primary care with strong emphasis on research capacity (MPhil, PhD, RCT training) and policy engagement. Context-specific adaptation in each setting. Ministry of Health collaboration.	Access: Approachability, Acceptability, Availability Transferability: Feasibility, Co- creation	Offers a model for embedding evaluation, research capacity, and workforce development alongside service delivery. Relevant for European pilots seeking to build an evidence base alongside implementation.

mhGAP Implementation in Lagos (Nigeria)

Service Delivery and Integration; Task-sharing with HCW/SW; integration with health services; mobile phone adherence management	Adults with depression in primary care	City-wide collaborative stepped-care model using WHO mhGAP, delivered by non-specialist primary care workers. Includes mobile phone adherence management. Developed through Lagos Ministry of Health and WHO collaboration. Note: provider acceptability challenges documented.	Access: Approachability, Acceptability, Availability, Appropriateness Transferability: Feasibility, Clarity	Demonstrates scalable PHC integration of depression care at city level. Provider acceptability challenges require attention in any adaptation; useful model for large-scale European PHC integration.
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PIH Mental Health Learning Collaborative (Haiti, Kazakhstan, Lesotho, Liberia, Malawi, Mexico, Peru, Rwanda, Sierra Leone, Russian Federation)

System-Level Interventions Digital Mental Health Solutions; Digital training; co-creation; peer learning; research capacity-building	Mental health programme leads across LMIC settings	Hub-and-spoke virtual peer-learning collaborative connecting PIH-supported programmes. Facilitates cross-site exchange, mentorship, site visits, and shared quality assessment tools. Emphasis on LMIC-to-LMIC knowledge exchange.	Access: Availability (system level) Transferability: Co-creation, Agility	Practical governance model for cross-site learning and knowledge exchange. Directly applicable as a structural model for collaboration across EQUICARES pilot sites.
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Our Step Association (Jordan)

Person-Centred and Community Approaches; Advocacy and patient rights; community and patient forums; rights-based governance	People with mental health conditions and their families	Peer-led advocacy and participation initiative run by service users. Combines awareness-raising, training, advocacy, networking, and representation in national mental health governance. Rights-based approach promoting service user involvement in policy dialogue.	Access: Approachability, Acceptability, Appropriateness Transferability: Co-creation	Replicable model for service user involvement in mental health policy and governance. Directly relevant for European recovery-oriented and rights-based frameworks.
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Group Psychotherapy for People Living with HIV (Uganda)				
Service Delivery and Integration Person-Centred and Community Approaches; Task-sharing with HCW/SW; peer-led group therapy; integration with HIV services	People living with HIV with depression	Culturally adapted manualized 8-session group intervention combining psychoeducation, peer sharing, coping and problem-solving skills, stigma management, and livelihood skills. Delivered through HIV and trauma clinics by trained facilitators.	Access: Acceptability, Availability, Appropriateness Transferability: Co-creation, Clarity	Adaptable for European services targeting people with comorbid chronic illness and mental health needs. Manualized protocol supports replication; cultural adaptation process transferable.
Zanmi Lasante (Haiti)				
Service Delivery and Integration Task-sharing with HCW/SW and community members; collaborative stepped care	General community population	Collaborative stepped-care model integrating mental health into PHC. Community workers screen and provide psychosocial support; complex cases referred to PHC clinics for psychological or pharmacological treatment. Multi-cadre capacity building with supervision.	Access: Approachability, Acceptability, Availability, Appropriateness Transferability: Feasibility, Clarity	Strong template for tiered care pathways integrating mental health into PHC with community outreach. Directly applicable to European primary care integration pilot design.
MANAS (India)				
Service Delivery and Integration; Task-sharing with HCW/SW and community members; collaborative stepped care; integration with PHC	Adults with depression and anxiety	Collaborative stepped-care model integrating depression and anxiety treatment into primary care. Lay counsellors manage cases; physicians prescribe; specialists supervise. Culturally adapted elements including yoga. RCT evidence base. Free of charge.	Access: Approachability, Acceptability, Availability, Affordability, Appropriateness Transferability: Feasibility, Clarity	Landmark stepped-care model with strong RCT evidence. Direct template for integrating common mental disorder care into European PHC with non-specialist delivery and specialist supervision.

The HAPPINESS Project (Nigeria)

Service Delivery and Integration Digital Mental Health Solutions; Task-sharing; integration with health services; telehealth; health information systems	Adults with mental, neurological, or substance use conditions	Cascading task-sharing model training CHWs, nurses, and doctors using mhGAP 2.0. Digital tools (telemedicine, EHRs) support supervision and specialist consultation. Drug Revolving Fund ensures medication access. Self-help groups integrated into PHC.	Access: Approachability, Acceptability, Availability, Affordability, Appropriateness Transferability: Feasibility, Clarity	Useful model for integrating MNS conditions into PHC with digital supervision tools. Drug Revolving Fund mechanism transferable to settings with limited medication access.
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PMHP: Perinatal Mental Health Project (South Africa)

Service Delivery and Integration; Task-sharing with HCW/SW; integration into antenatal and postnatal care; universal screening	Pregnant and postpartum women	Collaborative stepped-care integrated into routine antenatal and postnatal PHC. Universal screening for mental distress by trained non-specialist health workers. On-site counselling and referral to specialist psychiatric care. Multilingual validated tools.	Access: Approachability, Acceptability, Availability, Appropriateness Transferability: Feasibility, Clarity	Universal perinatal screening and on-site counselling integrated into routine PHC. Directly adaptable for European antenatal and postnatal mental health pathways; multilingual tools an asset.
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MHIDP: Mental Health Integrated Disaster Preparedness (Nepal, Haiti)

Service Delivery and Integration Arts-Based Approaches; Task-sharing with community members; intersectoral collaboration; participatory and arts-based methods	Disaster-affected communities	3-day participatory workshop integrating mental health awareness with disaster preparedness. Delivered by trained lay facilitators using peer support and locally meaningful arts (stories, songs, dance). Addresses	Access: Approachability, Acceptability, Availability, Affordability, Appropriateness	Participatory model for community mental health in crisis settings. Relevant for European pilot sites working with displaced or crisis-affected populations; locally meaningful arts-based methods transferable.
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		community resilience and social cohesion. Free of charge.	Transferability: Agility, Feasibility	
PRIME (Ethiopia, India, South Africa, Nepal, Uganda)				
Service Delivery and Integration System-Level Interventions Mental Health Research Capacity Building; Task-sharing; integration with health services; co-creation; district-level mental healthcare planning	General population / health system (district level)	Multi-country programme developing district-level mental healthcare plans integrating mental health into primary and maternal care. Co-designed with ministries, NGOs, and communities. Structured referral pathways, community detection tools, and supervision systems.	Access: Approachability, Acceptability, Availability, Appropriateness Transferability: Co-creation, Agility	Comprehensive planning and co-design framework for district-level mental health system development. Offers a replicable template for EQUICARES pilot site mental health integration planning.

3.5. Digital Ethnography of Selected Mental Health Innovations

A total of 25 LMIC innovations were screened through digital ethnography, exceeding the KPI target (≥ 20). Of these, 11 had active digital presence with original posts published within the 90-day review period and were analysed for content, while 14 were analysed through patterns of digital absence. Social media content was collected from LinkedIn, Instagram, TikTok, Facebook, and YouTube accounts associated with each organisation providing the innovative service (Table 3).

Table 3. Platform presence overview across mental health innovations

Innovation	Account Owner	LinkedIn	Instagram	Facebook	YouTube	X	TikTok
StrongMinds	Own account	Active	Not identified	Active	Not identified	Active	Not identified
The Friendship Bench	Own account	Active	Active	Active	Not identified	Not identified	Active
TrustCircle	Own account	Active	Not identified	Active	Not identified	Active	Not identified
Zanmi Lasante	Own account	Active	Active	Active	Not identified	Active	Not identified
CETA	Own account	Active	Inactive	Inactive	Inactive	Inactive	Not identified
Our Step Association	Own account	Not identified	Not identified	Active	Not identified	Not identified	Not identified
PMHP	Own account	Not identified	Active	Active	Not identified	Not identified	Not identified
Dareecha	PHC Global	Active	Active	Active	Not identified	Not identified	Not identified
MANAS	Sangath	Active	Active	Not identified	Active	Active	Not identified
MHIDP	TPO Nepal	Active	Active	Active	Not identified	Active	Not identified
PIH / MHLC	Partners In Health	Active	Active	Active	Not identified	Inactive	Not identified
AFFIRM	Own account (web site)	Not identified	Not identified	Not identified	Not identified	Not identified	Not identified
INSPIRE	Own account	Not identified	Not identified	Inactive	Inactive	Inactive	Not identified
mhGAP Lagos	Own account	Not identified	Not identified	Not identified	Not identified	Inactive	Not identified

PRIME	Own account	Not identified	Not identified	Inactive	Inactive	Not identified	Not identified
PRIZE / SAMRC	SAMRC	Not identified	Not identified	Inactive	Inactive	Not identified	Not identified
SPARK	Own account	Not identified	Not identified	Not identified	Not identified	Inactive	Not identified
Step-by-Step	MoPH / WHO website only	Not identified	Not identified	Not identified	Not identified	Not identified	Not identified
The Happiness Project	Happiness Health Care Foundation	Not identified	Inactive	Inactive	Not identified	Inactive	Not identified
We Matter Too	Sentum Scientific Solutions	Inactive	Not identified	Not identified	Not identified	Inactive	Not identified
COPSI	No account identified	Not identified	Not identified	Not identified	Not identified	Not identified	Not identified
Group Psychotherapy / PLWH	No account identified	Not identified	Not identified	Not identified	Not identified	Not identified	Not identified
Learning Clubs for Women	Website only (RTCCD)	Not identified	Not identified	Not identified	Not identified	Not identified	Not identified
mhGAP-IG Kenya	AMHF accounts closed	Not identified	Not identified	Not identified	Not identified	Not identified	Not identified
Thinking Healthy	No account identified	Not identified	Not identified	Not identified	Not identified	Not identified	Not identified

Posts were categorised into five typologies using the Social Media Health Literacy (SoMeLit) framework (Cho et al., 2022). Following categorisation, the number of posts corresponding to each typology was counted per platform. The resulting distribution is presented in the section 3.5.2. It should be noted that these figures reflect the actual distribution of posts reviewed within the 90-day window and are specific to the sample of 11 active innovations; they should not be interpreted as representative of the broader digital communication landscape of LMIC mental health organisations. The other 14 innovations that did not have active accounts or original posts within the review period are not discussed in this section, but they are analysed in chapter 3.5.4 through patterns of digital absence; their exclusion from the digital ethnography analysis is noted in section 2.1.3 as a limitation of this component.

The structural analysis of mental health content on social media reveals a sophisticated ecosystem where digital ethnography serves as a lens to understand how various actors bridge the treatment gap (Naslund et al., 2014; World Health Organization, 2010). Through the examination of contemporary initiatives, we can categorize social media usage into five distinct typologies that reflect

the current "*Social Media Health Literacy*" framework (Cho et al., 2022). This framework emphasizes not only the consumption of health information but also the ability to navigate, evaluate, and apply it within digital social networks — competencies. In low- and middle-income countries (LMICs), where more than 75% of individuals with mental health conditions remain without treatment (WHO, 2010), social media platforms have emerged as critical sites of psychoeducation, stigma reduction, and community mobilization (Naslund & Deng, 2021).

The first typology, Psycho-education and Literacy, focuses on disseminating evidence-based knowledge to improve public understanding of mental health conditions. Organizations like Sangath, a pioneering Indian NGO co-founded by global mental health researcher Vikram Patel (Patel, 2022), utilize platforms like YouTube to host educational series on topics such as Autism in multiple languages, including Hindi and Marathi, alongside testimonials regarding school-based programs. This content aims to demystify clinical definitions by grounding them in daily observations and developmental milestones. Similarly, the Perinatal Mental Health Project (PMHP) shares research publications on culturally grounded interventions, such as musical engagement, to educate professionals and the public on maternal well-being. Research supports the value of such culturally embedded, non-stigmatizing, low-cost interventions as promising avenues for supporting maternal mental health, particularly in LMICs (Sanfilippo et al., 2021; Lawson et al., 2021).

The second category, Stigma Reduction and Lived Experience, leverages personal narratives to normalize mental health struggles. This is prominently seen in the "*Humans of MANAS*" series and StrongMinds' use of therapy graduate testimonials from individuals like Rebecca and Gok. The Friendship Bench also utilizes visual storytelling on TikTok and Instagram, featuring grandmothers sharing their lived experiences to normalize help-seeking behavior. These approaches align with established anti-stigma research demonstrating that public disclosures on social media, particularly those that evoke empathy and perceived similarity in audiences, can yield significant reductions in mental illness stigma at the population level (Lim et al., 2025). In LMICs specifically, digital contact-based anti-stigma strategies — such as the sharing of personal recovery narratives — have been identified as a promising approach to bridging the gap between high mental health need and scarce specialist resources (Naslund & Deng, 2021; Thornicroft et al., 2016, as cited in Whitehead et al., 2022). These narratives shift the focus from clinical pathology to human resilience, effectively challenging the social isolation often associated with mental illness (Stuart, 2016; Naslund et al., 2014).

Community Building and Peer Support, the third typology, fosters interactive spaces for mutual aid. Our Step Association utilizes Facebook to facilitate "*mental health check-ins*," asking followers about their support systems and encouraging them to vocalize when they feel mentally tired. These interactive prompts create a digital community hub where followers can validate each other's

experiences. TrustCircle similarly emphasizes the power of having a safe space to be heard, highlighting how student-led reflections can multiply impact across a learning environment. This typology is supported by a growing body of evidence on online peer-to-peer support, which demonstrates that social media provides individuals living with serious mental illness opportunities for greater social connectedness, feelings of group belonging, and the sharing of strategies for coping with daily challenges (Naslund et al., 2016; Rayland & Andrews, 2023). Research utilizing digital ethnography in online peer support forums further shows that community-building is one of the most frequently enacted affordances of such platforms (Laing et al., 2025).

The fourth typology, Crisis Intervention and Service Promotion, provides direct pathways to care and professional opportunities. TPO Nepal and Our Step Association frequently post helpline numbers and contact details for immediate psychological support. Beyond crisis support, this category includes institutional dissemination such as job openings for research associates and project coordinators, which are common on LinkedIn profiles for organizations like PHC Global and Sangath. This function reflects the WHO Mental Health Gap Action Programme (mhGAP) imperative to scale up mental health service delivery through non-specialist and community-based channels, particularly in low-resource settings where trained mental health workers remain critically scarce (WHO, 2010; Kohrt et al., 2023).

Finally, Self-Care and Motivational Aesthetics focuses on the everyday management of emotional well-being through reflective practices. TrustCircle's content often revolves around daily emotion logging and the simplicity of intentional reflection. This category frequently utilizes inclusive language and interactive prompts to encourage users to reimagine their own mental health journeys. Such content aligns with the *Social Media Health Literacy (SoMeLit)* framework's emphasis on evaluation competency — specifically, users' capacity to assess whether social media content reflects authentic lived experience and supports their own wellbeing (Cho et al., 2022).

3.5.1. Institutional Mapping

The prioritization of these categories varies significantly across stakeholder groups. Public Health Authorities, such as the Ministry of Public Health in Lebanon, prioritize Crisis Intervention and Service Promotion, focusing on the nationwide scale-up of digital services like the Step-by-Step program to bridge treatment gaps. Their communication style is largely informative and centered on national health strategies — an approach consistent with the WHO's mhGAP framework, which urges governments in LMICs to integrate evidence-based mental health programming into existing primary health care infrastructure (WHO, 2010; Kohrt et al., 2023).

NGOs and Non-profits, including Sangath, StrongMinds, and TPO Nepal, are the most versatile actors, maintaining high activity across Psycho-education, Stigma Reduction, and Community

Building. They often act as the primary bridge between clinical research and community-led awareness. Sangath, for example, has pioneered task-sharing approaches in which lay community health workers are trained to deliver evidence-based psychosocial interventions, a model that has been shown to be both feasible and effective across diverse LMIC contexts (Patel, 2022; Gonsalves et al., 2021).

Private Clinics and Innovation Foundations, such as CETA Global and TrustCircle, tend to focus on Psycho-education and Strategic Scaling. Their content often highlights technical innovations, such as AI simulators for health officials or data management for ethical AI. They prioritize professional visibility and the measurable impact of their tools in institutional settings.

Individual Practitioners and Influencers, represented by project founders like Dixon Chibanda or Sachin Chaudhry, often blend Lived Experience with Authoritative dissemination. Dr. Chibanda's Friendship Bench — which trains community elders as lay health workers to deliver problem-solving therapy — has demonstrated significant reductions in common mental disorder symptoms and has been scaled across all 10 provinces of Zimbabwe, reaching more than 300,000 individuals (Chibanda et al., 2016; Munetsi et al., 2021). On social media, such founders use their personal platforms to advocate for mental health as a fundamental human right, often bridging the gap between grassroots efforts and global policy discussions.

3.5.2. Prevalence Matrix and Distribution of Post Types

The following table presents the distribution of post types across platforms, based on the actual count of posts reviewed from the 11 active innovations and categorised using the SoMeLit framework. Figures represent the proportion of posts assigned to each typology within each platform, rounded to the nearest 5%. Platforms on which a given innovation had no active account were excluded from that innovation's platform count.

Table 4. Distribution of post types across platforms based on the SoMeLit Framework

Post Typology	LinkedIn	Instagram / TikTok	Facebook	YouTube	X
Psycho-education & Literacy	30%	15%	20%	60%	25%
Stigma Reduction & Lived Experience	10%	40%	25%	20%	15%
Community Building & Peer Support	15%	20%	40%	10%	10%
Crisis Intervention & Service Promotion	40%	10%	10%	5%	45%
Self-Care & Motivational Aesthetics	5%	15%	5%	5%	5%

LinkedIn functions primarily as a Crisis Intervention and Service Promotion channel (40%), reflecting its role as a professional recruitment and institutional visibility platform, where job postings and programme announcements generate the highest levels of engagement. Instagram and TikTok, analysed together in this table given the overlap in visual content strategies, are dominated by Stigma Reduction and Lived Experience content (40%), consistent with these platforms' emphasis on visual storytelling, personal testimony, and aesthetic-driven community formation. Facebook serves primarily as a Community Building and Peer Support platform (40%), functioning as a digital living room for many organisations — a space where interactive prompts, community celebrations, and emotional check-ins generate high comment engagement and peer solidarity. YouTube is overwhelmingly oriented toward Psychoeducation and Literacy (60%), functioning as a digital lecture hall where webinars, research presentations, and expert-led educational content are archived and accessed by professional and lay audiences alike.

X emerges as primarily a Crisis Intervention and Service Promotion channel (45%), used for job postings, programme announcements, and direct calls to action. However, its engagement levels are consistently the lowest across all platforms for the innovations studied. Analysis of Sangath's X account — one of the more active in the sample — suggests that the platform functions as a *scientific archive* rather than an interactive community space: posts are consumed passively by journalists, policymakers, and academics who may use the content off-platform for research or advocacy without leaving visible traces of engagement.

3.5.3. Linguistic Analysis: Voice and Tone

Beyond the distribution of content typologies, the digital ethnography also examined the linguistic register and communicative tone of posts across the five typologies, revealing distinct voice strategies aligned with each typology's purpose.

Psycho-education content typically adopts a Clinical and Authoritative tone, using precise language to describe conditions like Autism or OCD while remaining accessible to a general audience. The voice is that of a "trusted expert" providing reliable data.

Stigma Reduction and Community Building posts employ an Empathetic and Relatable voice. Phrases like "*It's Okay to Ask for Help*" or "*You Are Not Alone*" are central to this tone. This style prioritizes inclusive language and interactive prompts to spark honest dialogue and connection a strategy aligned with research findings that perceived empathy and similarity between disclosers and audiences are key drivers of anti-stigma effects on social media (Lim et al., 2025).

Crisis Intervention and Service Promotion content utilizes an Instructional and Promotional tone. It is direct, often featuring clear calls to action, such as *"send a Hi to begin the booking process"* or *"We're Hiring"*. This voice is functional and designed to facilitate immediate user movement from information to action.

Strategic and Innovation-focused content, particularly from private stakeholders, maintains a Visionary and Impact-Oriented tone. It emphasizes *"scalable solutions," "system-owned programs,"* and *"transformative partnerships"*. This language is designed to build trust with donors, partners, and health officials by highlighting sustainability and long-term impact.

In conclusion, the digital ethnography of these mental health solutions demonstrates a move toward integrated, community-led care that utilizes social media not just for broadcast, but for meaningful engagement (Rayland & Andrews, 2023; Frontiers in Digital Health, 2025). By aligning digital content with the specific needs of diverse populations, displaced persons, youth, or expectant mothers these institutions are successfully moving mental health support from clinical rooms into the everyday digital spaces of the people they serve (Naslund & Deng, 2021; Cho et al., 2022). The patterns identified through this digital ethnography complement the transferability analysis presented in section 3.4 and will inform the selection and adaptation of innovations for the EQUICARES pilot contexts in the subsequent tasks of this work package.

3.5.4. Digital Absence: A Typology of Inactive Digital Presence

Of the 25 innovations selected for digital ethnography, 14 did not meet the criterion of active social media presence with original posts published within the 90-day review period. Rather than treating this digital absence as a methodological gap to be noted in passing, this section analyses it as a substantive finding that reveals important patterns in how mental health innovations in LMICs sustain or fail to sustain digital communication capacity over time. Digital absence in this context does not have a single cause or meaning. Analysis of the 14 excluded innovations reveals four distinct patterns of digital absence.

The first pattern is that of concluded projects. AFFIRM has formally ended its primary research phase, and no institutional digital activity has been recorded in the review period. However, the project retains a residual digital presence through personal social media activity by individuals associated with the project, including YouTube interviews and LinkedIn mentions by former researchers. While these traces remain discoverable, they do not constitute active organisational communication and may create ambiguity for external actors seeking to assess the project's current status or contact its implementers.

The second pattern is dormant standalone accounts. PRIME, SPARK, INSPIRE, and mhGAP Lagos each maintain their own project-level social media accounts, but none were active within the 90-day

review window. PRIME's Facebook and YouTube accounts have not been updated in approximately six years, despite the project having generated a substantial body of research evidence across five countries. SPARK's X account has been inactive since June 2024, and its official website has not published news updates since April 2024. INSPIRE's X account — operating under the name of its implementing organisation, the Design in Mental Health Network — last posted in January 2024, with nine YouTube videos available but none recently uploaded. mhGAP Lagos presents a more complex picture; its standalone X account has been dormant since September 2024 and its official website is non-functional, yet the project retains indirect visibility through personal LinkedIn posts by affiliated researchers — one of which received 72 likes, 15 comments, and 11 reposts — and through Lagos University's Facebook page, which published project-related content as recently as February 2026. This suggests that in some cases, informal personal networks sustain a degree of digital visibility even when institutional channels have gone silent.

The third pattern is dormant implementer accounts. We Matter Too and The Happiness Project do not maintain standalone social media accounts; accordingly, the accounts of their implementing organisations — Sentum Scientific Solutions and the Happiness Health Care Foundation respectively — were examined as proxies. Both were found to be digitally inactive across all platforms within the review period. Sentum Scientific Solutions' LinkedIn profile has 36 followers and its most recent post was shared nine months prior to the search; its X account has been dormant since 2021. The Happiness Health Care Foundation's Instagram account has 51 followers and has not been updated since 2021, with its Facebook and X accounts similarly inactive for over four years. Despite the We Matter Too project having received international media coverage — including a feature on BBC World Service's People Fixing the World (BBC World Service, 2024) — this visibility has not translated into sustained digital engagement by the implementing organisation.

The fourth pattern is the complete absence of identifiable digital presence. COPSI, the Group Psychotherapy Model for People Living with HIV, Learning Clubs for Women's Health and Infant Development, the Thinking Healthy Programme, and the mhGAP-IG mobile phone project in Kenya had no active accounts either standalone or implementer-level that could be identified during the digital search. In the case of mhGAP-IG Kenya, the implementing organisation, the Africa Mental Health Foundation, was found to have closed all associated social media accounts and to have no active official website. Step-by-Step Lebanon represents a distinct sub-case within this pattern: it is an active, nationally scaled programme that has reached over 3,000 users since its launch, yet its digital communication is managed exclusively through the Lebanese Ministry of Public Health and WHO official websites rather than social media channels. This reflects a deliberate institutional communication model rather than a resource or capacity constraint and underscores the point that digital absence on social media does not necessarily indicate programme inactivity or limited community reach.

4. Conclusion and Next Steps

4.1. Main Patterns Across the Identified Innovations

This deliverable mapped 258 mental health innovations from LMIC settings, of which 47 met the criteria for in-depth analysis. The resulting sample represents a diverse but internally coherent landscape of mental health service innovation, concentrated primarily in Sub-Saharan Africa and South and South-East Asia, and spanning a broad range of intervention types, settings, and target populations.

The dominant pattern across the 47 innovations was the reorganisation of service delivery away from specialist-led, facility-based models toward community-based, task-shared, and integrated approaches. Task-sharing with health workers and community members was by far the most frequently observed mechanism (63.8% and 42.6% of innovations respectively), typically embedded within or alongside primary care platforms. This pattern reflects the pragmatic response of LMIC mental health systems to structural scarcity: in contexts where specialist capacity is limited, expanding the provider base and embedding care within everyday community touchpoints has emerged as the most common and, in many cases, most effective strategy for closing the treatment gap.

A second prominent pattern was the transdiagnostic and multi-level nature of effective innovations. Many of the included programmes did not target a single diagnostic category but addressed a broad range of mental health needs, often simultaneously combining task-sharing, peer support, community engagement, and digital delivery. This layered approach, reflected in the high proportion of innovations classified under multiple clusters, suggests that effective LMIC mental health innovation is rarely reducible to a single component and is better understood as a system of complementary mechanisms operating across individual, community, and health system levels.

Digital and telehealth approaches, while present in approximately a third of the innovations, tended to function as enablers of other mechanisms — supporting remote training and supervision, extending the reach of peer support, and facilitating screening and referral — rather than as standalone delivery models. Arts-based and research capacity-building innovations were the least frequent clusters, suggesting these remain relatively niche areas within the landscape, though their contributions to acceptability and evidence generation are noted.

A further analytical dimension that emerges from the prevention level mapping is the predominantly integrated nature of the innovations across the mental health pathway. Nearly half of the included innovations (46.8%) addressed primary, secondary, and tertiary prevention simultaneously, reflecting a tendency toward comprehensive rather than condition-specific or stage-specific approaches.

Tertiary prevention — encompassing treatment, rehabilitation, and recovery — was the most common level addressed (83.0%), followed by secondary (78.7%) and primary prevention (66.0%). This distribution reinforces the finding that LMIC mental health innovations tend to operate across the full continuum of care rather than targeting discrete points of intervention, a characteristic with direct relevance for how they might be adapted within European service pathways that are often more sharply segmented by care level.

4.2. Insights from the Transferability Assessment

The transferability assessment produced composite scores for all 47 innovations, ranging from 2.90 to 4.95 (mean 4.10, SD 0.51). Thirteen innovations reached the higher transferability threshold of 4.5 or above, and a further 17 fell within the moderate range of 4.0 to 4.49. The reliability of the scoring process was supported by intraclass correlation analysis, with averaged reviewer scores yielding an ICC of 0.843 (95% CI: 0.607–0.926; $p < 0.001$), reflecting good inter-rater consistency.

Across the four dimensions, feasibility showed the widest score range and the most variation, reflecting genuine differences in the extent to which innovations rely on resources, workforce, and infrastructure that can be mobilised in other contexts. Innovations integrating task-sharing with existing workforces and embedding care within routine service platforms consistently scored highest on this dimension. Co-creation showed the second widest spread, indicating that stakeholder involvement in design and adaptation varies substantially across innovations — a finding with direct implications for how knowledge transfer should be approached in practice.

The structural features most consistently associated with higher transferability were: reliance on existing or readily trainable workforces rather than new specialist cadres; use of structured, well-documented protocols that facilitate replication without loss of core function; a documented history of successful adaptation across cultural or service contexts; and active involvement of service users and communities in shaping design and delivery. Innovations combining all four of these features — exemplified by the Friendship Bench (4.95) and the Thinking Healthy Programme — represent the strongest candidates for further exploration in European pilot contexts.

4.3. Lessons for European Contexts

The 47 innovations analysed in this deliverable were not developed for European settings, and their direct transfer is neither assumed nor recommended. Rather, the analysis is oriented toward identifying the structural mechanisms — the combinations of workforce, organisation, technology, and community engagement — that have enabled these innovations to improve access to mental health

care in resource-constrained settings, and to examine whether analogous conditions exist or could be created in the EQUICARES pilot contexts.

Several lessons are particularly relevant for European systems. First, task-sharing with non-specialist providers — a mechanism that underpins the majority of the highest-scoring innovations — has growing policy momentum in Europe, driven by workforce shortages and rising mental health care need. The LMIC evidence base offers detailed guidance on how to structure training, supervision, and fidelity monitoring for task-shared models in ways that maintain quality while expanding reach. Second, the consistent finding that integrating mental health into existing health and community platforms improves approachability and acceptability without requiring new infrastructure is directly applicable to European contexts where specialist mental health services are often siloed. Third, the importance of co-creation and lived-experience involvement — reflected in the co-creation scoring dimension and across the Levesque analysis — aligns with the recovery-oriented and rights-based frameworks increasingly central to European mental health policy. Innovations that have embedded co-design from inception offer practical models for how this can be operationalised at the programme level.

Digital innovations — including guided self-help platforms, telehealth supervision, and peer support tools — are particularly relevant for European contexts given existing digital infrastructure. However, the analysis also highlights that digital approaches work best when combined with human support, structured clinical frameworks, and attention to data protection requirements, the last of which is especially pertinent in the European Union where GDPR imposes specific obligations on the handling of health data.

4.4. Limitations

Several limitations of this analysis should be acknowledged. First, the inclusion criteria required that innovations be supported by descriptive documentation, impact evidence, and implementation guidance simultaneously. This filtering necessarily concentrated the sample on better-documented and more widely implemented programmes and may have excluded innovations that are effective but less formally evaluated — a pattern that is itself a reflection of persistent inequities in global mental health research capacity. Additionally, certain categories of innovation are likely underrepresented in this mapping due to their lower rates of formal documentation. Philanthropically-funded initiatives, corporate social responsibility programmes, and mission-driven private sector actors — including B-Corps — have increasingly engaged with mental health in LMIC settings, but their work is less frequently published in peer-reviewed outlets or accompanied by structured implementation guidance, and therefore less likely to have met the three-domain documentation threshold applied in this study. Future mapping exercises should consider complementary search strategies — including direct

outreach to philanthropic networks and impact investors — to capture this segment of the innovation landscape.

Second, the Levesque Framework was applied to supply-side dimensions of access only. Demand-side dimensions — reflecting the capacity, motivation, and ability of individuals to seek, reach, and engage with care — were not systematically assessed. This is a meaningful limitation, as many of the most important access barriers in mental health operate on the demand side, including stigma, low mental health literacy, and the reluctance of individuals to seek help. Future analysis within the EQUICARES project should attend explicitly to these dimensions.

Third, the transferability scores are comparative and context-specific rather than absolute. They were designed to rank the 47 innovations relative to each other and in relation to European health system contexts and should not be interpreted as generalisable verdicts on each innovation's overall adaptability. The inter-rater reliability analysis (ICC = 0.843 for averaged scores) supports the stability of the rankings within this sample, but the narrow score range — a consequence of the sample's pre-selection on documentation quality — limits the discriminatory precision of the instrument at the upper end of the scale.

Fourth, the digital ethnography component was limited to publicly available organisational posts from 11 of the 25 highest-scoring innovations over a 90-day window. Fourteen innovations had no active direct-to-community social media presence during the review period. This component should therefore be understood as illustrative of how selected innovations use digital channels to communicate and engage communities, rather than as a comprehensive or representative account of LMIC mental health organisations' digital engagement.

4.5. Next Steps

The findings of this deliverable feed directly into subsequent tasks within the EQUICARES project. In Task 2.4, the innovations identified here as having higher transferability potential will be subjected to a more detailed FRAME analysis, examining which specific components are core and non-negotiable, which require cultural or regulatory adaptation, and what the conditions for fidelity-consistent implementation in European pilot contexts would be. This analysis will produce structured adaptation briefs for each selected innovation, designed to guide co-creation processes with pilot site teams.

In the European pilot tasks, the typology of LMIC innovation identified in this deliverable — particularly the evidence on task-sharing, integrated care, peer-led support, and digital enablement — will serve as an evidence base for the design of pilot interventions. The accessibility analysis using the Levesque Framework provides a structured lens for examining whether and how the same

dimensions of access — approachability, acceptability, availability, affordability, and appropriateness — are addressed in the European adaptation of each selected innovation.

The digital ethnography findings will be revisited as the project moves into implementation, with attention to whether and how innovations' digital communication strategies can be adapted to engage target communities in the European pilot sites. The patterns identified — particularly the dominance of psychoeducation on YouTube, stigma reduction on Instagram and TikTok, and community building on Facebook — offer practical starting points for pilot site communication design.

The Digital Absence analysis presented in section 3.5.4 also has direct practical implications for the next steps of the project. The four-pattern typology — concluded projects, dormant standalone accounts, dormant implementer accounts, and complete absence of digital presence — provides a structured basis for assessing the current communication capacity and institutional continuity of innovations selected for adaptation in Task 2.4. Innovations with dormant or absent digital presence should not be assumed to be inactive or unsuitable for adaptation; as the Step-by-Step Lebanon case illustrates, strong programme reach and institutional health can coexist with minimal social media presence. However, the typology does highlight that for several innovations, direct contact with implementing organisations will be essential to verify current operational status, update implementation documentation, and establish the relationships needed for co-creation processes with pilot site teams.

The ethical framework underpinning this deliverable — grounded in the principles of reciprocity, equity, and responsible knowledge use — will continue to guide the EQUICARES project's approach to adaptation and implementation. Specifically, the project is committed to ensuring that the researchers, organisations, and communities whose innovations are being adapted are acknowledged as knowledge contributors and, where possible, actively involved in the adaptation process. This commitment reflects the core logic of reciprocal innovation: that the flow of knowledge between contexts should be bidirectional, iterative, and mutually beneficial rather than extractive.

Finally, the findings of this deliverable provide a direct evidence base for the design and implementation of pilot interventions in WP4. In particular, the identification and analysis of 25 high-transferability innovations offer a validated pool of service models that can inform the development of context-adapted solutions in the European pilot sites. The transferability assessment highlights key structural features (such as reliance on non-specialist workforces, community-based delivery models, and scalable digital components) which are especially relevant for addressing access barriers in vulnerable populations. These insights can be operationalised in WP4 through the potential selection of candidate innovations for adaptation, the development of pilot service concepts grounded in empirically validated practices, and the tailoring of implementation strategies to local socio-economic and institutional contexts. Furthermore, the analysis of accessibility dimensions based on the

Levesque framework provides a structured lens for aligning pilot interventions with specific access barriers (e.g. affordability, acceptability, availability), while the digital ethnography findings offer practical guidance for stakeholder engagement, communication strategies, and community outreach within the pilot environments.

5. Acknowledgements

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6. Data Availability

The datasets and supporting materials underlying this report are available upon reasonable request. Requests may be directed to İlker Kayı (ikayi@ku.edu.tr) and Öykü Turunç (oturunc@ku.edu.tr).

7. References

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8. Annex: Overview of the 25 selected mental health innovations

MHI	Key Characteristics	
The Friendship Bench	Country	Zimbabwe
	Overview	A community-based mental health intervention in which trained “grandmothers” deliver problem-solving therapy in a non-clinical setting, typically on benches located near primary care facilities, workplaces or HIV care units. The approach is culturally adapted and designed to make mental health support more accessible, familiar, and socially acceptable within the community.
	Transferability Score	4.95
	Setting	Community-based
	Innovation	• Task sharing with community members • Integration with health services • Intersectoral collaboration and integration with non-health services • Virtual or telehealth service delivery • Digital solutions for training • Co-creation and co-design approach

	Accessibility Assessment	Approachability is supported through integration into primary health care, workplace-based delivery, collaboration with public institutions, and large-scale community outreach. Acceptability is supported by the use of lay health workers from the local community and peer-led support structures. Availability and accommodation are enhanced through decentralised service delivery using a hub-and-spoke model, task-sharing with community members, integration into primary care, referral pathways, and flexible modalities such as WhatsApp-based counselling. Affordability is high, as the service is provided free of charge. Its contribution to appropriateness is also strong, with evidence-based problem-solving therapy, ongoing supervision, continuity through peer support groups, and responsiveness to social and economic needs through income-generating activities.
StrongMinds	Country	Uganda, Zambia, USA
	Overview	StrongMinds is a community-based mental health intervention that delivers a structured form of Group Interpersonal Therapy for depression through trained lay facilitators. The programme uses a simplified, standardized group format focused on relationship-related stressors, problem-solving, and peer support, with the aim of expanding access to evidence-based depression care in low-resource settings.
	Transferability Score	4.86
	Setting	Community-based
	Innovation	• Task sharing with community members • Intersectoral collaboration and integration with non-health services • Peer-led support groups and group therapies

		Virtual or telehealth service delivery
	Accessibility Assessment	Approachability is supported through large-scale outreach, integration into government and NGO service structures, and delivery across multiple community-based settings, including schools, prisons, and frontline public services. Acceptability is supported by peer-led group delivery, which may reduce stigma and improve cultural responsiveness. Availability and accommodation are enhanced through task-shifting, expansion of the lay workforce, and flexible delivery formats, including both in-person and phone-based group therapy. Affordability is high, as the service is provided free of charge. Its contribution to appropriateness is also strong, with reported improvements in depression outcomes, functioning, school attendance, economic activity, social support, and hopefulness, alongside an emphasis on empowerment and sustained coping capacity.
Common Elements Treatment Approach (CETA) in Thailand	Country	Thailand
	Overview	CETA (Common Elements Treatment Approach) is a transdiagnostic psychological intervention designed to address co-occurring mental health conditions, such as depression, anxiety, and PTSD, through a single, structured yet flexible treatment model. In Thailand, it was implemented for Burmese refugees and survivors of trauma. Delivered through task shifting by trained lay counsellors under regular supervision, the intervention draws on a set of evidence-based therapeutic components, including cognitive restructuring, behavioral activation, exposure, and problem-solving, which are selected and adapted according to individual needs.
	Transferability Score	4.77
	Setting	Community-based (Research Project)

	Innovation	• Task sharing with HCW or SW • Task sharing with community members
	Accessibility Assessment	Acceptability is strengthened by the fact that counsellors and supervisors were themselves Burmese refugees and members of the local community, sharing cultural, religious, and political experiences with clients. Availability and accommodation are supported through task shifting, which increases the number of mental health workers able to deliver care. Appropriateness is supported by the use of evidence-based therapeutic components that can be selected and adapted according to individual needs.
Step-by-Step	Country	Lebanon
	Overview	A guided, digital self-help mental health intervention delivered through a smartphone app or website with support provided by trained community e-helpers. It was developed by the World Health Organization (WHO) in collaboration with Lebanon's National Mental Health Programme. It was designed to help address the mental health treatment gap in Lebanon in the context of the Syrian refugee crisis and the country's worsening economic conditions. The intervention has been implemented and tested among both Syrian refugees and the Lebanese host population, with technical support from international academic partners.
	Transferability Score	4.74
	Setting	Community-based
	Innovation	• Task sharing with community members • Virtual or telehealth service delivery

	Accessibility Assessment	Approachability is supported through national-level availability and broad user reach, acceptability through culturally adapted content and optional support from trained e-helpers, and availability and accommodation through flexible digital delivery across different platforms. Affordability is relatively high because the intervention does not require direct user fees. Its contribution to appropriateness is also strong, as it has shown positive effects on depression, anxiety, functioning, post-traumatic stress, and well-being, while supported delivery and supervision may help maintain quality and responsiveness.
Peer-led recovery groups for people with psychosis in South Africa (PRIZE)	Country	South Africa
	Overview	A peer-led psychosocial support intervention for people with psychosis and their caregivers. It trains individuals with lived experience and family caregivers to facilitate structured recovery groups, aiming to strengthen personal recovery, mutual support, and group-based problem-solving within community settings.
	Transferability Score	4.57
	Setting	Community-based
	Innovation	• Task sharing with HW or SW • Task sharing with community members • Peer-led support groups and group therapies
	Accessibility Assessment	PRIZE appears to support accessibility most clearly through acceptability and appropriateness. Acceptability is strengthened by its peer-led design, with groups facilitated by service users and caregivers, which may enhance cultural responsiveness, increase the acceptability of the intervention, and help reduce stigma. Availability and accommodation are supported through task shifting to service users, caregivers, and auxiliary social workers. Affordability is high, as the programme is provided free of charge. Appropriateness

		is supported by the involvement of service users and caregivers, the programme's responsiveness to expressed needs, and its facilitation of social interaction, experience-sharing, joint problem-solving, and support for caregivers. Overall, the programme can be understood as a community-based rehabilitation approach for psychosis.
We Matter Too	Country	Kenya
	Overview	This intervention is a community-based, barber-delivered mental health support model targeting young men. It uses a structured, multi-stage approach in which barbers initiate conversations through music with mental health themes and deliver brief psychosocial support based on WHO's Doing What Matters in Times of Stress (DWM) guide during routine interactions.
	Transferability Score	4.66
	Setting	Community-based
	Innovation	• Task sharing with community members • Art-based approaches
	Accessibility Assessment	Approachability is enhanced by using barbershops as familiar community spaces where young people already gather, creating a natural setting for awareness and engagement. Acceptability is supported by the culturally relevant and youth-oriented design, including the use of locally produced mental health-themed music and the involvement of non-healthcare workers, which may help normalize conversations about mental health and reduce stigma. Availability and accommodation are strengthened through task shifting, with trained barbers expanding the range of people able to provide basic mental health support. Affordability is high, as the intervention is provided free of charge. Appropriateness appears to be supported by the use of

		the WHO's Doing What Matters in Times of Stress guide, which provides a structured and evidence-informed framework for stress management and emotional regulation. Although the intervention is not primarily designed as a treatment model for mental health conditions, the use of this guide supports the relevance and coherence of the support provided.
mhGAP-IG on mobile phones for frontline healthcare workers	Country	Kenya
	Overview	This intervention is a digital task-shifting model that supports non-specialist healthcare workers in delivering mental health care using a mobile-based mhGAP Intervention Guide. It provides step-by-step support for the assessment, management, and follow-up of depression within routine outpatient care. The tool enables real-time, point-of-care decision support in low-resource settings and strengthens service quality through remote supervision, allowing specialists to review clinical decisions and provide guidance.
	Transferability Score	4.65
	Setting	Primary care setting
	Innovation	• Task-sharing with HW or SW • Digital solutions for training
	Accessibility Assessment	Integration of mental health services into primary care and task shifting to primary care workers may improve approachability by increasing providers' capacity to detect mental health conditions. It may also enhance acceptability by delivering care outside specialized mental health settings and strengthen availability and accommodation by bringing services closer to the community. Acceptability may be further supported by efforts to understand healthcare workers' current practices, roles, experiences, difficulties, and suggested solutions through focus group discussions. Affordability is likely improved through the integration of mental

		health into existing care structures. Appropriateness is supported by the mobile mhGAP tool, which provides real-time clinical decision support and enables remote supervision, helping specialists review care decisions and support service quality.
Thinking Healthy Programme (THP)	Country	Pakistan
	Overview	Addressed perinatal depression, a priority for child development. It integrates Cognitive Behavioral Therapy (CBT) into the routine home visits of Lady Health Workers. The 16-session "talking therapy" focuses on the mother-infant dyad
	Transferability Score	4.62
	Setting	Community-based
	Innovation	• Task sharing with healthcare worker (HCW) or social worker (SW) • Task shifting to community members • Integration of mental health care with health services • Virtual or telehealth service delivery • Digital solutions for training
	Accessibility Assessment	Approachability is supported through outreach, home-based screening, and integration into routine maternal and child health services; acceptability through peer-led and primary care-based delivery; availability and accommodation through task-shifting, digital screening, and scalable training and supervision models; and affordability by being free of charge. Its strongest contribution is to appropriateness, as it addresses maternal mental health together with child development, family support, and broader health outcomes.

Care for People with Schizophrenia in India (COPSI)	Country	India
	Overview	A community-based collaborative care intervention developed for people living with schizophrenia and their caregivers in low-resource settings. It combines facility-based specialist care with community-based rehabilitation delivered by lay community health workers, aiming to provide a feasible and scalable model of care. The intervention includes structured needs assessment, individualized rehabilitation and adherence support, psychoeducation for participants and caregivers, attention to physical health needs, and linkages with community resources and self-help groups.
	Transferability Score	4.61
	Setting	Community-based (Research Project)
	Innovation	• Task sharing with community members • Integration with health services • Intersectoral collaboration and integration with non-health services • Peer-led support groups and group therapies
	Accessibility Assessment	Acceptability may be strengthened through efforts to address stigma and discrimination affecting participants and their families. Appropriateness is strongly supported by the intervention's flexible, individualized, and needs-based design, including structured needs assessments, rehabilitation planning, caregiver involvement, attention to physical health, and linkages with community agencies to support social inclusion, legal benefits, and employment. Quality of care is further supported through structured clinical reviews and supervision for community health workers.

TrustCircle	Country	India and USA
	Overview	A mobile digital mental health platform that offers tiered support through anonymous peer-to-peer interaction, professional counselling, and AI-driven self-assessment tools. It uses preventative screening and standardized metrics to help users track their emotional resilience, and stress levels over time. Designed as a secure and low-threshold digital space, the platform aims to support early identification of mental health needs and reduce barriers to help-seeking.
	Transferability Score	4.55
	Setting	Online, Community-based, School-based
	Innovation	• Peer-led support groups and group therapies • Virtual or telehealth service delivery
	Accessibility Assessment	Approachability is supported through awareness-raising activities and global partnerships that increase the visibility and reach of the platform. Acceptability is supported by its user-centered, secure, anonymous, and multilingual design, as well as the inclusion of online peer support groups. Availability and accommodation are enhanced through its digital format, voiceover features for accessibility, and the involvement of community health workers, which may help reach users with limited literacy. Affordability is high, as the platform use is free of charge. Appropriateness is supported by personalization features, peer-led support groups, and anonymous, user-controlled engagement.

Early Adolescent Skills for Emotions (EASE)	Country	Jordan, Lebanon, Pakistan, Tanzania
	Overview	A group-based psychological intervention designed for adolescents aged 10–15 and their caregivers. It is delivered by trained community lay health workers and uses a transdiagnostic approach to address a range of internalizing problems, including symptoms of depression, anxiety, and distress. The intervention was developed for settings with limited access to specialized child and adolescent mental health services.
	Transferability Score	4.54
	Setting	Community-based
	Innovation	• Task sharing with community members • Peer-led service support groups and group therapies
	Accessibility Assessment	Approachability is supported through psychoeducation that helps adolescents and caregivers recognize mental health needs and available forms of support. Acceptability is enhanced by delivery through trained community lay health workers, implementation in community settings, and the involvement of caregivers, although some limitations in gender-sensitive grouping were noted. Availability and accommodation are strengthened through task-shifting, group-based delivery in accessible settings, and flexible session scheduling adapted to participants' daily routines. Affordability is high, as the intervention is provided free of charge. Appropriateness is supported by the use of evidence-based psychological strategies and by findings showing reductions in internalizing problems and improvements in several psychosocial outcomes across settings, although some outcomes, particularly among caregivers, showed more limited improvement.

Innovative Approaches to Adolescent Perinatal Mental Health (INSPIRE)	Country	Kenya, Mozambique
	Overview	INSPIRE is a multi-layered, peer-led mental health intervention targeting adolescent mothers in low-resource settings. It combines task shifting with peer mentorship, where trained young mothers and community health workers deliver psychosocial support, facilitate group sessions, and act as a bridge between communities and formal health services.
	Transferability Score	4.50
	Setting	Community-based
	Innovation	• Task sharing with community members • Intersectoral collaboration and integration with non-health services • Peer-led support groups and group therapies • Co-creation and co-design approach • Art-based approach
	Accessibility Assessment	Approachability is enhanced through its community-based design and integration with local stakeholders, which may increase visibility and trust. Acceptability is strengthened by its human centered design, co-designed approach, peer-led support through mentor mothers, involvement of adolescents and families in both design and care. Availability and accommodation are supported through task shifting, which expands the mental health workforce and enables delivery across community settings. Affordability is high, as the programme is provided free of charge. Appropriateness is strongly supported by the use of trained mentor mothers and a co-designed, multi-component structure that combines group, individual, and family sessions across the perinatal period. Its integration with community, health, and social services, including referral

		pathways, and its adaptive follow-up approach suggest responsiveness to evolving needs and continuity of care.
Learning Clubs for Women's Health and Infant Development	Country	Vietnam
	Overview	A community-based, structured psychoeducational intervention designed to improve maternal mental health and early childhood development. Delivered through facilitated group sessions for women at similar life stages, it combines health education (e.g., nutrition, infant care) with psychosocial support and peer-based problem-solving to reduce social isolation and strengthen maternal self-efficacy. It is delivered through task sharing by trained community-based facilitators, including Women's Union staff and primary care providers, and is supported by collaboration with national stakeholders and the use of simple technologies for training and delivery.
	Transferability Score	4.45
	Setting	Community-based
	Innovation	• Task sharing with HCW or SW • Task sharing with community members • Integration with health services & non-health services • Intersectoral collaboration • Peer-led support groups and group therapies • Digital solutions for training
	Accessibility Assessment	Approachability is supported through partial integration with primary care and delivery in community settings such as meeting halls and health clinics. Acceptability is strengthened by delivery through community

		volunteers and local social workers, which may increase trust and cultural alignment. Availability and accommodation are supported through geographically accessible delivery points and task sharing. Affordability is high, as the programme is provided free of charge, although some indirect costs such as travel may occur. Appropriateness is strongly supported by its family-focused and stage-specific design, use of evidence-based content, continuous follow-up through home visits, prioritization of vulnerable groups, and integration of maternal mental health with child development and broader family needs.
Implementing School-based Zero Suicide Model for Reducing Youth Suicidal Ideations and Behaviors (Dareecha)	Country	Pakistan
	Overview	A school-based suicide prevention and mental health support intervention that integrates screening, early identification, and referral within the educational setting. Using a Zero Suicide approach, the programme combines universal screening for depression and suicide risk with teacher training, safety planning for high-risk students, family engagement, and referral pathways to clinical care. It also includes a digital component through 8-week virtual therapy sessions with clinical psychologists, during which students receive suicide-specific interventions such as safety planning and lethal means counselling. In addition, the programme incorporates arts-based and culturally adapted strategies to raise awareness and reduce stigma among parents, teachers, and the wider school community.
	Transferability Score	4.45
	Setting	School-based
	Innovation	• Intersectoral collaboration and integration with non-health services • Virtual or telehealth service delivery

		Art-based approaches
	Accessibility Assessment	Approachability is enhanced through school-based screening, integration between education and mental health services, and awareness-raising through arts-based methods, as well as capacity building of teachers to identify and respond to mental health needs. Acceptability is strengthened by delivering services within schools, cultural adaptation to the local context, and stigma reduction through participatory and arts-based approaches. Availability and accommodation are supported through the establishment of referral pathways and the inclusion of virtual mental healthcare, which expands access to clinical support. Affordability is high, as the programme is provided free of charge and is likely cost-effective. Appropriateness is strongly supported by its high-risk identification approach, timely screening and referral processes, capacity building in evidence-based suicide care, and meaningful engagement of caregivers and schools.
AFFIRM: Africa Focus on Intervention Research for Mental health	Country	Ethiopia, Ghana, Malawi, South Africa, Uganda, Zimbabwe
	Overview	AFFIRM is a multi-country mental health task-sharing initiative designed to assess the effectiveness and cost-effectiveness of lay health worker–delivered care in sub-Saharan Africa. The programme focuses on integrating mental health into primary care through context-specific task-sharing models, including counselling for maternal depression by community health workers in South Africa and care for stabilized people with severe mental disorders by primary health care workers in Ethiopia. In addition to service delivery, AFFIRM supports capacity building, research training, and policy engagement through academic programmes, short courses, and collaboration with Ministries of Health and other stakeholders to strengthen the evidence base and support scale-up of mental health care in low-resource settings.
	Transferability Score	4.42

	Setting	Health system level, primary care level (Research Project)
	Innovation	• Task sharing with HCW or SW • Task sharing with community members • Integration with health services • Intersectoral collaboration and integration with non-health services • Mental health research capacity building
	Accessibility Assessment	As a multi-country programme, AFFIRM brought together context-specific mental health task-sharing interventions across several sub-Saharan African settings rather than implementing a single standardized care model. Within this structure, task shifting and integration of mental health into primary care may improve approachability by making services more visible and relevant within routine care, enhance acceptability by locating care within familiar service settings and providers, and strengthen availability and accommodation by expanding the workforce and increasing points of access. An important feature of the programme was the local adaptation of interventions in each setting, which likely supported contextual relevance and acceptability. In addition, AFFIRM placed strong emphasis on capacity building and research system strengthening through initiatives such as the MPhil programme in Public Mental Health at UCT and Stellenbosch University, support for PhD students, and short courses on randomized controlled trials and mental health policy and planning. Inter-sectoral collaboration and stakeholder engagement were also central, including knowledge exchange with Ministries of Health and the development of policy briefs and communication materials to support future evaluation and scale-up of task-sharing interventions.
mhGAP Implementation in Lagos	Country	Nigeria
	Overview	A collaborative stepped-care depression intervention based on the WHO mhGAP framework and delivered through non-specialist health workers. Developed through collaboration between the Lagos State Ministry of

		Health, the World Health Organization, and local academic partners, it aimed to expand mental health care beyond tertiary psychiatric hospitals and into community and primary care settings at a city-wide scale.
	Transferability Score	4.40
	Setting	Primary care setting
	Innovation	• Task-sharing with HW or SW • Integration with health services • Establishment of health information systems
	Accessibility Assessment	Integration of mental health services into primary care and task shifting to primary care workers may improve approachability by increasing the capacity of providers to detect mental health conditions. It may also enhance acceptability by delivering care outside specialized mental health settings and strengthen availability and accommodation by bringing services closer to the community. Appropriateness is supported by the use of trained health workers, the mhGAP framework, and proactive adherence management through mobile phone support. However, the relatively low acceptability of the intervention among primary care workers may pose challenges for effective implementation.
Partners In Health, Cross-Site Mental Health Learning Collaborative (MHLC)	Country	Haiti, Kazakhstan, Lesotho, Liberia, Malawi, Mexico, Peru, Rwanda, Sierra Leone, Russian Federation
	Overview	A multi-country peer-learning and knowledge-sharing initiative that connects mental health leads across PIH-supported programmes, particularly in low- and middle-income countries, to strengthen and scale mental health services in resource-constrained settings. Using a hub-and-spoke model, the collaborative facilitates cross-site learning through regular virtual exchange, mentorship, site visits, and shared quality assessment tools. It places particular emphasis on peer learning across LMIC contexts, enabling programmes facing

		similar structural constraints to exchange practical strategies for service delivery, supervision, supply systems, community engagement, and advocacy.
	Transferability Score	4.34
	Setting	Health system level
	Innovation	• Digital solutions for training • Co-creation and co-design approach • Research capacity building
	Accessibility Assessment	Overall, the MHLC appears to support accessibility mainly at the health system level rather than through direct service delivery. Its contribution to approachability is more indirect, by improving implementers' awareness of effective mental health strategies through knowledge exchange, shared tools, and dissemination of best practices. Acceptability is strengthened through Theory of Change, co-creation and local adaptation processes that support culturally and contextually relevant service models. Its strongest contribution is to availability and accommodation, particularly through training, mentorship, task shifting, and the scale-up of interventions that can be delivered by non-specialist providers across different settings. Affordability is addressed indirectly through the promotion of scalable, lower-cost care models. Appropriateness is supported through iterative quality improvement, and continuous cross-site learning, which help align interventions with local needs and health system realities.
Our Step Association	Country	Jordan
	Overview	Our Step Association is a peer-led advocacy and participation initiative established to strengthen the inclusion of people with mental health conditions and their families in community life and decision-making.

		Implemented by service users themselves, the initiative combines awareness-raising, training, advocacy, networking, and representation in national forums. It functions both as a support and empowerment platform and as a patient rights association, promoting the active involvement of service users and families in policy dialogue, rights-based advocacy, and mental health governance.
	Transferability Score	4.29
	Setting	Community-based
	Innovation	• Advocacy and patient right groups • Community and patient forums
	Accessibility Assessment	Approachability is enhanced by its visibility through community awareness-raising activities, patient forums, and representation in national governance structures, as well as partnerships with international organizations. Acceptability is strongly supported by its peer-led structure, which centers the perspectives and needs of people with lived experience, although some resistance from professionals remains. Appropriateness is supported by its strong focus on empowerment, advocacy, co-creation, and the meaningful involvement of service users and caregivers in policy, service design, and governance.
Group psychotherapy model for depression among people living with HIV	Country	Uganda
	Overview	A culturally sensitive, structured, and manualized group-based psychological intervention designed to treat depression among people living with HIV (PLWH) in low-resource and post-conflict settings such as northern Uganda. Delivered through existing HIV care and trauma clinic services, the intervention integrates mental health care into routine services for high-risk populations. It consists of eight weekly group sessions that combine psychoeducation on depression and HIV, opportunities for participants to share and externalize

		their experiences, and the development of coping and problem-solving skills, including strategies to manage stigma and discrimination. The intervention also incorporates basic livelihood skills to address socioeconomic stressors linked to depression, providing a holistic and contextually adapted approach to mental health care.
	Transferability Score	4.26
	Setting	Community-based (Research Project)
	Innovation	• Task sharing with HCW or SW • Integration with health services • Peer-led support groups and group therapies
	Accessibility Assessment	Approachability is moderately supported through community sensitization activities, involvement of local leaders, and partnerships with HIV-focused NGOs, which may enhance awareness and trust among PLWH. Acceptability is strengthened by culturally sensitive design processes, including community consultations and adaptation based on local perceptions, as well as gender- and problem-specific group structures. Availability and accommodation are supported through group-based delivery and task shifting. Appropriateness is strongly supported by the use of a structured, manualized intervention delivered by trained facilitators with ongoing supervision, as well as by its responsiveness to local needs, including stigma, socioeconomic challenges, and the specific vulnerabilities of PLWH and conflict-affected populations.

Zanmi Lasante	Country	Haiti
	Overview	A community-based mental health care model designed to expand and strengthen mental health services through integration into the primary care system. It uses a collaborative stepped-care and task-sharing approach in which community-level workers conduct screening, follow-up, and basic psychosocial support, while more complex cases are referred to primary care clinics for psychological or pharmacological treatment. The model combines capacity building for multiple provider levels, including traditional birth attendants, community health workers, nurses, and physicians, with supervision and quality oversight to support scalable, integrated mental health care within the public health system.
	Transferability Score	4.25
	Setting	Primary care
	Innovation	• Task sharing with HCW or SW • Task sharing with community members • Integration with health services
	Accessibility Assessment	Overall, the intervention appears to support accessibility across multiple dimensions, particularly approachability, availability, and appropriateness. Approachability is enhanced through integration into the primary care system, implementation across multiple hospitals and clinics, mobile outreach to hard-to-reach areas, and active case finding by community health workers. Acceptability is strengthened by cultural adaptation of the screening tool, developed with input from Haitian psychologists, medical professionals,

		traditional healers, community elders, and religious leaders. Availability and accommodation are supported through broad geographic coverage, delivery at PHC level, outreach activities, and a stepped depression care pathway that links community-based identification and treatment with referral to more specialized services when needed. Affordability may be supported through integration into routine care. Appropriateness is supported by the contextual adaptation of the model, its evidence-based stepped-care structure, and the use of clearly defined provider roles across levels of care, with supervision and quality oversight built into the system.
Manas	Country	India
	Overview	MANAS is a collaborative stepped-care intervention developed to integrate the treatment of depression and anxiety into primary care in Goa, India. The model combines task shifting with collaborative care, with trained lay health counsellors providing case management and psychosocial interventions, primary care physicians delivering pharmacological treatment, and mental health specialists offering supervision and referral support. By embedding mental health care within routine primary care services, the intervention aims to reduce the treatment gap for common mental disorders in low-resource settings.
	Transferability Score	4.22
	Setting	Primary care setting
	Innovation	• Task sharing with HCW or SW • Task sharing with community members • Integration with health services

		Art-based approaches
	Accessibility Assessment	Approachability is enhanced through integration into primary care and routine screening, which may increase recognition of mental health needs. Acceptability is supported by delivery within primary care settings, reducing stigma associated with specialist services, and by culturally relevant components such as yoga, as well as positive patient experiences with screening. Availability and accommodation are strengthened through task shifting, establishment of referral pathways, and a stepped-care approach that brings services closer to the community and matches care intensity to patient needs. Affordability is supported through free provision of services within primary care and the availability of generic antidepressant medications in public primary health care facilities. Appropriateness is strongly supported by continuity of care, proactive follow-up, specialist supervision,
The HAPPINESS Project	Country	Nigeria
	Overview	A primary care–integrated mental health intervention that uses a cascading task-sharing model to expand access to care for mental, neurological, and substance use conditions. It trains community health workers, nurses, and doctors in community health centres to provide screening, evidence-based treatment, and referral using the WHO mhGAP Intervention Guide 2.0. The programme also incorporates digital tools, including mobile telemedicine and electronic health records, to support clinical documentation, specialist consultation, supervision, and continued medical education. In addition, it promotes community-based self-help groups supported by primary care teams to strengthen ongoing support beyond formal services.
	Transferability Score	4.19
	Setting	Primary care setting

	Innovation	• Task sharing with HCW or SW • Integration with health services • Peer-led support groups and group therapies • Virtual or telehealth service delivery • Establishment of health information systems
	Accessibility Assessment	Approachability is supported through integration into primary health care, capacity building of providers, and routine screening, although there is limited evidence of explicit community-level awareness activities. Acceptability is strengthened by the cultural adaptation of mhGAP training materials and by the inclusion of community engagement and client-led self-help groups, although engagement with some traditional and informal providers remains challenging. Availability and accommodation are strongly supported through integration into PHC, task sharing, digital telemedicine solutions that function in low-connectivity settings, and the establishment of referral pathways. Affordability is improved through mechanisms such as the Drug Revolving Fund, which helps ensure access to essential medications at lower cost. Appropriateness is supported by contextual adaptation, delivery through trained providers, a stepped-care model with clear referral pathways, peer support structures, and the establishment of health information systems that support continuity, follow-up, and quality of care.
Perinatal Mental Health Project	Country	South Africa
	Overview	A collaborative stepped-care intervention developed to reduce the treatment gap for perinatal mental disorders in South Africa. Integrated into routine antenatal and postnatal care within PHC, the model combines universal screening for mental distress with on-site counselling delivered by trained non-specialist health workers and referral of more severe cases to specialist psychiatric care.

	Transferability Score	4.18
	Setting	Primary care setting
	Innovation	• Task sharing with HCW or SW • Integration with health services
	Accessibility Assessment	Approachability is enhanced through integration into routine antenatal and postnatal services, multilingual screening, and staff training that increases awareness of perinatal mental health and empathic engagement. However, because the model remains largely facility-based and depends on women presenting for care, its broader approachability may be limited. Acceptability is supported through training and workshops in empathic engagement skills for providers, which may enable more understanding, respectful, and supportive interactions with women. Availability and accommodation are strengthened through task shifting, on-site counselling linked to antenatal visits, and a stepped-care model with referral pathways to psychiatric and other on-site support services, although implementation appears concentrated in urban areas. Affordability may be supported through integration into routine care. Appropriateness is supported by delivery through trained providers, regular supervision, structured referral systems, and care pathways matched to women's risk profiles and severity of need,
Mental Health Integrated Disaster Preparedness in Nepal and Haiti (MHIDP)	Country	Nepal, Haiti
	Overview	A community-based, integrated disaster preparedness and mental health programme implemented in Nepal and Haiti. It combines mental health awareness with disaster preparedness through a structured 3-day workshop delivered by trained lay facilitators. The model uses peer support and participatory group discussions to explore local understandings of distress, stigma, and preparedness. By integrating mental

		health into disaster preparedness and using task shifting to community members, it aims to strengthen resilience, social cohesion, and community capacity.
	Transferability Score	4.15
	Setting	Community-based
	Innovation	• Task sharing with community members • Intersectoral collaboration and integration with non-health services • Peer-led support groups and group therapies • Art-based approaches
	Accessibility Assessment	Approachability is enhanced through outreach activities, psychoeducation, and delivery in community settings. Acceptability is strengthened by cultural adaptation, the involvement of local facilitators in implementation and adaptation, and the use of locally meaningful elements such as stories, songs, and dance. Availability and accommodation are supported through outreach and community-based delivery, although implementation was affected by contextual disruptions such as insecurity, unrest, and fuel shortages. Affordability is high, as the programme is provided free of charge. Appropriateness is supported by supervision from psychologists and senior clinicians, opportunities for peer support, social cohesion and collective coping, the inclusion of practical emotional regulation and coping skills.
Programme for Improving Mental Health Care (PRIME)	Country	Ethiopia, India, South Africa, Nepal, Uganda
	Overview	A multi-country research initiative aimed at generating high-quality evidence on how to implement and scale up mental health services in low-resource settings. Conducted across five low- and middle-income countries including Ethiopia, India, Nepal, South Africa, and Uganda, the programme developed and evaluated district-

		level mental healthcare plans (MHCPs) that integrate mental health into routine primary and maternal healthcare. The model combines task sharing, with non-specialist providers delivering care supported by specialists, and community-level engagement through tools such as community informant detection and referral systems. PRIME emphasizes co-design and multi-stakeholder collaboration, involving Ministries of Health, academic institutions, NGOs, and community actors to ensure context-specific adaptation, policy relevance, and scalability. Through structured implementation, supervision, and evaluation of these district-level care packages, the programme provides a comprehensive framework for strengthening mental health systems in low-resource settings.
	Transferability Score	4.10
	Setting	Health system level, primary care level (Research Project)
	Innovation	• Task sharing with HCW or SW • Task sharing with community members • Integration with health services • Intersectoral collaboration and integration with non-health services • Co-creation, co-design approach • Mental health research capacity building
	Accessibility Assessment	As a multi-country programme, PRIME appears to support accessibility across multiple supply-side dimensions through district-level mental healthcare plans adapted to diverse low-resource settings. Approachability is enhanced through integration into routine primary and maternal health care, awareness-raising and stigma reduction activities, and community-level detection and referral using tools such as the Community Informant Detection Tool. Acceptability is supported by the use of a participatory Theory of

		Change process to design locally feasible and contextually appropriate mental health care plans, alongside integration into primary care and the involvement of non-specialist providers, community actors, caregivers, and local organizations. Availability and accommodation are strengthened through task sharing, scale-up across primary care facilities, and the establishment of training, supervision, and referral systems. Affordability was not explicitly described as a core component. Appropriateness is strongly supported by context-specific adaptation of district mental healthcare plans, use of mhGAP-based evidence-informed guidelines, provision of both psychosocial and pharmacological care, structured referral pathways for complex cases, and inclusion of continuing care, rehabilitation, and recovery support.
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