Workforce involvement and peer support networks in low- and middle-income countries

About this report

This report forms part of Wellcome s 2020 Workplace Mental Health Commission. The aim of the commission was to understand the existing evidence behind a sample of approaches for supporting anxiety and depression in the workplace, with a focus on younger workers.

You can read a summary of all the ndings from Wellcome s 2020 Workplace Mental Health Commission on our website: https://wellcome.org/reports/understanding-what-works-workplace-mental-health

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'Considering workplace involvement and peer support networks as effective strategies to improve workplace mental health in low-and-middle-income-countries.'

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Contents

1. Executive summary[1]

Background

Involving peers (persons with lived experience) to help others improve their health has gained momentum in the past two decades particularly within the global mental health sector. Therefore, we selected the following as our proposed promising approach.

'Involving the general workforce and a peer support network' to improve workplace mental health in the low- and middle-income countries (LMICs) with a focus on those under 25 years of age.

Our project aims to investigate the evidence for the effectiveness and acceptability of workforce involvement and peer support networks for supporting mental health in the workplace through a focused insight literature review and a series of expert consultations conducted using theory of change approach.

General workforce involvement means ways in which members of the general workforce can draw on their understanding or experiences of mental health problems and apply these proactively to prioritise and develop mental health in the workplaces and organise and evaluate the effectiveness of mental health service and policies in the workplaces.

Peer support has been defined as psychosocial support provided to one another by persons with lived experience of a mental illness or persons who are empathetic towards mental health problems.

A peer support network is a system of providing peer support among employees of an organisation. Within organisations this system peer support is envisaged across workplace hierarchies. Furthermore, this peer support can also operate as a network between organisations creating a web of support among different workplace sectors such as corporate, health services, academic institutes, and non-profit organisations.

Methods

We carried out a focused insight literature review examining the current evidence about general workforce involvement and a peer support network to address workplace mental health problems in the LMICs.

Through the peer reviewed database search of four search engines, we found 266 studies using key words strategy. After independent review process, we selected 17 studies that met the eligibility criteria. We selected only those papers written in English.

We also hosted a series of expert consultations with young employees, majority from India and a few from the countries in Africa. The expert consultations were part of a qualitative exploratory study based on the theory of change approach to explore the acceptability, feasibility and barriers to implementing workforce involvement and peer support networks at the workplace. There were 62 participants in total. Most of them were from India while some hailed from countries in Africa such as Ethiopia, Ghana, India, Morocco, and

[1] Executive summary is not included in the word count

Zambia. Their work profiles ranged from researchers, public health service providers, psychiatrists and psychologists to corporate professionals.

Results:

Overall, there is a limited evidence in the literature about the effectiveness of workforce involvement and peer support networks as approaches to supporting workforce mental health in the LMICs and there is a need for further evaluation of these approaches. However, feedback from expert consultations suggests a strong willingness to explore this approach among young employees.

Analysis of the literature and feedback from expert consultations have also highlighted important pre-requisites, barriers and facilitating factors that need to be considered as part of implementing these approaches in practice**.**

The results are presented under three major themes as follows:

Pre-requisites, barriers and facilitating factors.

'Pre-requisites' are preparatory factors necessary to set up a conducive ecosystem to implement the general workforce involvement and peer support network in the workplaces. We found pre-requisites including regular mental health assessments, encouraging better communications, enhancing a sense of security among employees, promoting mental health awareness, developing an inclusive policy framework and equitable resource allocations.

'The barriers' are low trust, stigma, negative judgement and social isolation of persons with mental health problems, poor mental health related policy implementation and productivity centric approach restricting any mental health intervention in the workplaces.

'The facilitating factors' include inter-personal support, social support for psychosocial wellness, mixed approach of internal peer support with external psychological support, role model approach of involving high level managers, value-based approach emphasising human resource value in the workplace, and a decentralised approach to include the voices of those marginalised and therefore typically not heard.

Although a focused insight literature review included evidence for both formal and informal work sectors, we were unable to include the participants from informal work sectors such as agricultural labourers, domestic workers, and street vendors in the expert consultations. This is a limitation of our study.

The reasons for not including the informal work sector participants in the expert consultation were time constraints and the nature of workshops where we relied on the virtual platforms due to ongoing Coronavirus (COVID-19) pandemic.

Conclusion and next steps

Our review identifies the potential for workforce involvement and peer support networks to be promising approaches in the low-and-middle-income countries. However, before implementing these approaches, organisations need to recognise the pre-requisites, barriers and facilitating factors to these approaches and there is a need to further evaluate the impact of these interventions in the future."

Based on all we have learned through our review; we have two recommendations for policymakers and business leaders:

a) Introduce workplace mentors.
b) Create a peer support network among the general workforce in cities, state and countries

Workforce mentors is a special cadre selected from workforce members comprising of persons with lived experience of mental health problems or those volunteering to provide more time and efforts and supervise activities conducted to improve mental health in the workplace.

The peer support network is a system of providing peer support among employees of an organisation. Within organisations this system of peer support is envisaged across workplace hierarchies. Furthermore, this peer support can also operate as a network between organisations creating a web of support among different workplace sectors such as corporate, health services, academic institutes, and non-profit organisations. The peer support network can provide intersectoral mental health support and share the learning from this network with each other to improve through mutual support.

The study provides an initial starting point for understanding the evidence for and assessing the acceptability of general workforce involvement and peer support networks as complimentary strategies for supporting mental health in the LMICs. However, feasibility testing, and further evaluation are needed to understand the effectiveness and expediency of these approaches.

2. Purpose of the report:

To investigate the evidence for the effectiveness and acceptability of workforce involvement and peer support networks for supporting mental health in the workplace in low-and middle-income countries with a focus on younger workers under 25 years of age.

3. Introduction and background

3.1 Problem Statement

Globally, awareness of the need to address mental health problems has increased in the recent past. Mental health problems account for 13 per cent of the global burden of disease and are projected to become the leading cause of both mortality and morbidity within next decade by the year 2030 (WHO, 2019e). In terms of disability, depression is the first and anxiety is the sixth leading cause globally, making both anxiety and depression a major public health concern (Wipfi et al, 2018).

Depression and anxiety typically occur first during adolescence and young adulthood (Thapar et al, 2012). Strategies for preventing or intervening early in young people can therefore mitigate the substantial, long-term burden of these disorders on individuals and workplaces. Young people, especially those aged 18 and older, spend a substantial

amount of time at work which has an impact on shaping their coping skills and can impact their future professional career, performance and achievements (Thapar et al, 2012).

According to the World Health Organization (WHO), depression and anxiety disorders together cost the global economy an estimated 1 trillion United States Dollars (USD) per year through loss in productivity thus providing a compelling economic reason to address these problems (WEF, 2019b). The WHO estimates that for every 1 USD invested into treatment and support of mental disorders sees a return of 4 USD in improved health and productivity (WHO, 2019e).

If the world is to achieve the sustainable development goals by 2030, concerted efforts are required to reduce the global burden of anxiety and depression with a focus on young people below 25 years who constitute approximately 25 per cent of the world population. Workplaces can be one of the focus areas to reduce mental health problems among the young persons between 18-25 years (WEF, 2019b).

3.2 Why general workforce involvement and peer support network is necessary?

In this Commission, our chosen approach is *'mental health support by involving the general workforce and creating peer support networks'* to prevent and address anxiety and depression in the workplaces in the LMICs with focus on those under 25 years age.

General workforce involvement and creating a peer support network are two complementary strategies that are formed on a conceptual foundation of 'patient public participation' approach.

Patient and public participation or involvement (PPI) is arguably most widely used term after 'service user involvement' in the mental health domain. PPI is defined to mean "the ways in which patients can draw on their experience and member of the public can apply their priorities to the evaluation, development, organisation and delivery of health service (Tritter et al, 2009)

Our review examines the potential for using these two strategies together to address anxiety and depression in the workplaces, based on evidence from the literature and expert consultation with stakeholders.

1. **General workforce involvement**

General workforce involvement means ways in which members of the general workforce can contribute to sharing organisation's approach in mental health and those members with lived experience of mental illness can draw on their experience about mental health problems.

In both these contexts, the members of the general workforce can contribute to

a. Prioritise mental health in the workplace
b. Develop mental health services in the workplace
c. Evaluate the effectiveness of mental health services and policies in the workplace
d. Organise the delivery of mental health services in the workplace (Tritter et al, 2009)

The term 'involvement' is a multi-faceted concept with different meanings in different contexts. This term is often used synonymously with participation, engagement and

collaboration. Many researchers have attempted to differentiate involvement as direct or indirect, individual or collective and proactive or reactive (Tritter et al, 2009).

For example, the Indian health system has Rogi Kalyan Samiti (RKS) as a community mobilization and participation initiative in the community health centres. RKS is a patient welfare committee board facilitating local community members to participate and ensure the proper management and functioning of the public healthcare facilities (Adsul and Kar, 2013).

2. Peer support network

Peer support providers are defined as persons with lived experience of mental illness who are able to offer services and support to others who are not as far along in their own recovery process (De Silva et al, 2014). Peer support has been defined as psychosocial support provided to one another by persons with lived experience of a mental illness or persons who are empathetic towards mental health problems (De Silva et al, 2014)

Peer support may take many forms. Several different models of service delivery have emerged in the past decade, including self-help groups, internet-based support, peer-delivered services, peer run or operated services, peer partnerships and peer employees (Cohen et al 2012).

Our work for this commission considers peer support and peer delivered services within workplaces and peer support networks across different workplaces to support creating a workplace ecosystem.

A fundamental tenet of peer support is that it must be built on shared experience and empathy focusing on individual and collective strengths, not weaknesses, and working towards individual and collective mental health (Linnan et al, 2013).

The term ‘peer support’ is used synonymously for self-help groups, internet online support, peer delivered services, peer run or operated services, peer partnerships and peer employees (Cohen et al, 2012).

In the workplace context, peer support is conceptualised as a psychosocial support provided to one another by persons with the lived experience of a mental illness or persons who are empathetic towards the mental health problems.

The ‘peer support network’ is a system of providing peer support among employees of an organisation with the main objective of offering mental health support through peers. Within organisation, this system of a peer support is envisaged across workplace hierarchies. Furthermore, this peer support is also considered as a network between organisations creating a web of peer support network among different workplace sectors such as corporate, health services, academic institutes, and non-profit organisations.

3.3 Rationale for selecting a promising approach

Traditional approaches used in recent times to improve mental health in the workforce range from health activities to mindfulness interventions, financial security and improving work conditions.

One of the major challenges with such interventions is that they are often non-participatory in nature. They do not involve the general workforce in the design or delivery of the intervention and see them as passive beneficiaries or recipients of care from professionals (Salzer et al, 2004). In many workplaces, employees who are already burdened with work deliverables neither have enthusiasm nor time resources to effectively benefit from such traditionally implemented approaches to addressing mental health issues (Salzer et al, 2004).

Various studies have shown the efficacy of peer support and consumer led involvement in improving mental health status. Self-help groups led by peer support networks can improve symptoms, increase participants' social networks and quality of life for persons with severe mental illness (Cohen et al, 2012). In return, peer supporters also get the opportunity to practice their own recovery, to engage in self-discovery, build their own support system and engage in professional growth including building job skills and moving towards a career goal (Linnan et al, 2013).

The involvement of peer supporters is of proven benefit among many sectors including global mental health domain because of their expertise based on their own needs and unique perspective about their condition with better chances of social inclusion and care (Linnan et al, 2013). This strategy can be extended to workplaces to strengthen efforts to address mental health issues for employees.

Both the general workforce involvement and peer support are concepts based on the premise of an individual's (here an employee) choice and ability to actively participate and regain control over the functioning, goals and the ultimate destiny of the group responsible for the successful functioning of this group and ecosystem (here the workplace) (Linnan et al 2013).

3.4 Study aims

The purpose of our research was to assess the evidence on the effectiveness, feasibility and acceptability of general workforce involvement and peer support networks towards improving workplace mental health in a fair, efficient and sustainable way.

The primary aim of this project was therefore to investigate the current evidence for using general workforce involvement and peer support networks to improve mental health in the LMICs. The secondary aim was to explore the potential for using workforce involvement and peer support networks as a strategy from the perspective of young working populations in the LMICs, through stakeholder consultations.

The geographical parameter for this project was low- and middle-income countries. The focus was on the young working population below 30 years.

Our focused insight literature review examined evidence from both formal and informal workforce sectors in the LMICs.

While some of the literature looked specifically at peer support and engaging the workforce, we also reviewed articles that looked more broadly at approaches to supporting mental health at work in the low-and middle-income countries.

We were unable to include the participants from informal work sectors in the expert consultations. The reasons for not including the informal work sector participants in the expert consultations were time constraints and the nature of workshops where we relied on the virtual platforms due to ongoing Coronavirus (COVID-19) pandemic.

4. Methodology

We conducted a focused insight literature review closely followed by a qualitative exploratory study based on expert consultations with the young employees working in the low- and middle-income countries (LMICs).

4.1 Focused insight literature review

The purpose of the focused insight literature review was to address the primary aim of the Commission: investigate the current evidence and experiences of general workforce *involvement* and a *peer support network* to improve mental health in the LMICs.

In relation to workforce involvement, the focus of this review was to examine the evidence of 'direct' general workforce involvement and not indirect involvement.

In indirect involvement, policy and decision-makers *invite* people to inform policy decisions, service delivery and research priority. This is seen as a tokenistic approach where views of peers are sought but the right to make final decision is retained by policy and decision-makers (Tritter et al, 2009).

Direct involvement in contrast, is based on people taking part in actual decision making to design mental health services, policy initiatives and research priorities.

For example, a scenario where a member of general workforce proactively conceptualises, design and create an advisory group to address mental health problems in their workplace and this advisory group has the power to make policy and take decision about any task related to mental health in that workplace will be considered as a direct involvement.

The review included evidence for individual or collective and proactive or reactive involvement as long as it is the direct involvement of the general workforce. It also included evidence of peer support networks within organisations and working across organisations aimed at preventing and addressing depression and anxiety in workplaces in the LMICs. While framing the search strategy it was envisaged that many studies may present evidence for workforce involvement and peer support network in a narrative report manner. Hence narrative peer reviewed studies were also included in the review.

4.1.1 Search strategy

For a focused insight literature review we examined evidence of general workforce involvement and peer support network in all age groups. This was because during the initial literature review at the proposal writing stage, we had found that the evidence from workforce involvement and peer support among the young workforce in the LMICs is weak. We included only those studies conducted in the LMICs since this was the geographical parameter of our commission.

Only papers written in the English language were included in the insight review as it was found that most of the published reports on the internet are available in English. Given the limited time and resources to carry out this work, we did not include evidence from the native languages from the LMICs (e.g., Hindi language in India) particularly for grey literature (published website materials) as they were not easily available online and would require translation to English.

We searched data from PubMed Embase, PsycINFO and Web of Science (all from the start date of the database until October 2020) for peer reviewed articles (Abigail and S.C. 2014).

The electronic search strategy used for peer reviewed literature database is mentioned in detail in the **Appendix 1: PICO Search strategy** of this report. The search strategy is developed using PICO search framing technique (Metter and Tove, 2018). The key concepts used for the database search were 'general workforce involvement' or 'peer support network' and 'workplace and mental health' and 'low and middle-income countries'.

Inclusion criteria

Studies with quantitative design, qualitative design and mixed method research design and narrative design studies presenting evidence on involvement of general workforce of all age groups or peer support of all age groups in the LMICs were included. The review included studies looking at mental health support in the workplace in the LMICs and also some of the studies examined general workforce involvement or peer support outside typical workplace contexts such as public health systems.

Exclusion criteria

Studies conducted in the high-income countries were excluded. Research protocols do not present evidence but discuss the proposed interventions. Therefore, research protocols were excluded from a review. Commentaries and letters were excluded to avoid subjective bias.

4.1.2 Study selection process

First step was to search papers through the peer reviewed database search engines. We searched data from PubMed Embase, PsycINFO and Web of Science (all from the start date of the database until October 2020) for peer reviewed articles (Abigail and S.C. 2014).

Based on the PICO search technique mentioned in appendix 1, two independent reviewers searched peer reviewed data-based search engines using 'advanced search strategy'. From all search engines, the report and list of papers containing study title and abstracts were downloaded and reviewed by two reviewers independently and then both the lists were compared.

We found 266 studies through the peer-reviewed literature using the key words search strategy and a report was generated including title and abstract for each paper. After removing duplicates, 253 studies were assessed independently by two team members for inclusion by reading the article abstracts.

During the abstracts review stage, 214 out of 253 studies were found to not meet the inclusion criteria of discussing either general workforce involvement or peer support network or workplace mental health or were not conducted in the LMICs.

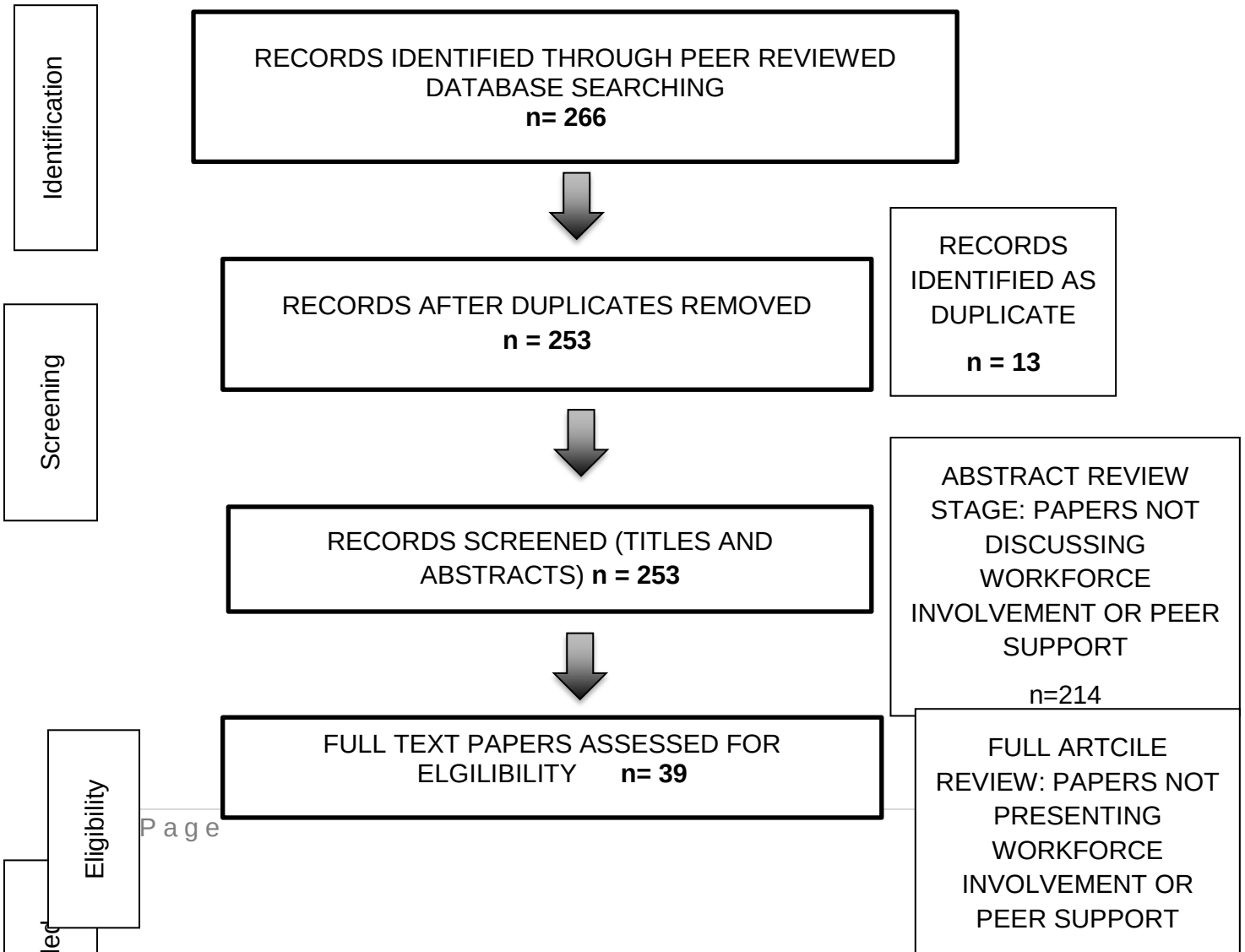
39 selected papers were deemed eligible and relevant for full article review stage and the same team members then screened the full-text papers to arrive at a final decision whether these papers met the inclusion criteria for our review.

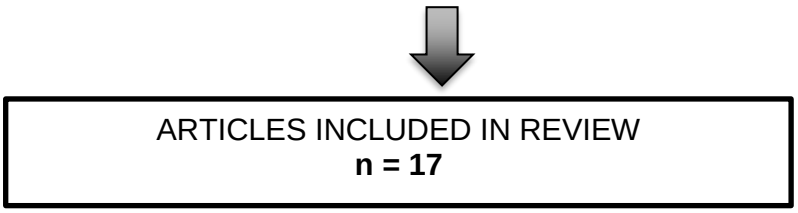
We excluded four protocols and one commentary during the screening stage as the protocols discussed study aims and methods and did not present evidence for the effectiveness or implemented workforce involvement/peer support while the commentary discussed subjective opinions regarding effectiveness of these strategies and did not present evidence or experience of workforce involvement or peer support.

For grey literature, we used OpenGrey, PsycEXTRA, Open Doar and Google Scholar to search reports but the selected sources did not yield relevant reports. Therefore, based on our initial scoping during proposal stage, we searched for reports on the websites of the organisations working globally in the workplace mental health domain. Both the World Health Organisation (WHO) and the World Economic Forum (WEF) have published several reports in a series towards workplace improvements and these were included in the analysis.

The flow diagram for the selection of peer reviewed studies is mentioned in figure 1 below.

Figure 1: FLOW DIAGRAM FOR SELECTION OF PEER REVIWED STUDIES





4.2 Exploratory study using the expert consultations

We simultaneously organised expert consultations with young employees aged 30 years or below from LMICs to investigate how general workforce involvement and a peer support network could improve mental health in their workplaces and to ask stakeholders about the acceptability and feasibility of these approaches.

The expert consultation workshops were conducted between August 2020 and October 2020 involving 62 young employees working in the LMICs. Although the focus population under this Commission were young persons below 25 years of age, we realised when designing these workshops that many young persons under 25 years of age may not have sufficient work experience or feel comfortable talking about their mental health needs. Therefore, in order to include as many young employees as possible, we extended as age limit to 30 years for the expect consultations. In addition, due to current COVID-19 pandemic, where current jobs were at risk, newly recruited young employees were considered to be reluctant to be seen as critical of their workplace settings. This was another reason that we extended that age limit to 30 years to recruit participants with longer work experience from diverse economic sectors of the LMICs.

5. Results

We present key findings from both studies followed by a case study.

5.1 Insight Literature review

Overall, the results synthesised from a review of these peer reviewed studies indicate limited and weak evidence for the general workforce involvement or peer support networks to address workplace mental health problems in the LMICs. The practical implementation of these two strategies and their evaluation aspect in the workplace mental health is scarce to the point of absence. However, the literature we reviewed identified important themes- pre-requisites, barriers and facilitating factors for workforce involvement and peer support network that need to be considered when developing workplace mental health strategies in the LMICs.

The methodology of the 17 peer reviewed studies is described in **Table 1** below.

Table 1: Methodology used for 17 peer-reviewed studies.

Number of studies	Methodology used
4	Qualitative exploratory studies
7	Systematic reviews

4	Quantitative survey studies
1	Quasi experimental method study
1	Case study with mixed method

Appendix 2: The characteristics of the 17 included peer-reviewed studies provides details about these included papers and a short summary of each paper is provided below.

5.1.1 Brief summary of the characteristics and results from the insight literature review.

1. Workplace-Based Organizational Interventions Promoting Mental Health and Happiness among Healthcare Workers: A Realist Review

The first selected study was a realist review published in 2019. This study was undertaken to synthesise the evidence of workplace-based interventions at the organisation level promoting mental health and wellbeing among health care workers, to identify what has been receiving attention in this area and why, especially considering how such positive effects are produced. This review presented evidence from 55 selected articles out of which only two studies were from the LMICs. The rest of the articles were from high income countries.

The paper highlights the importance of the engagement of employees across the organisation. This theme has been strongly recognised in the review to be of critical importance in the workplace health promotions interventions. The review discusses that the theme of employee involvement and engagement in the development and/or implementation of the interventions requires management support to allow employees with the time and capacity to participate.

2. Workplace wellness programming in low and middle-income countries: a qualitative study of corporate key informants in Mexico and India

This was a qualitative study conducted between March and July 2016 in Mexico and India to explore corporations' and stakeholders' views, attitudes and expectations in relation to health, wellness and cancer prevention in two middle-income countries, and to determine options for health professions to advance their approach to workplace wellness programming globally. 20 semi-structured key informant interviews were conducted, ten with the corporate stakeholders in India and ten in Mexico.

The study found out that a workplace wellness programme designed for corporate employees vary in the implementation across both countries. The financial burden of implementing effective wellness programme requires leveraging existing resources within organisation and building partnerships and involvement of company leaders. The study

emphasizes a need to collect regular health surveillance data to inform evidence-based wellness initiatives for LMIC settings.

3. Psychological wellbeing in a resource limited work environment: examining levels and determinants among health workers in rural Malawi

This was a cross sectional survey performed in 2013 and repeated in 2015 in 33 primary and secondary health facilities in four rural health districts in Central and Southern Malami, Balaka, Dedza, Ntcheu and Mchinji in rural Malawi with 174 health workers as participants. This study aimed to fill the gap in knowledge by investigating factors associated with psychological wellbeing of mid-level health workers in Malawi.

The study results indicate that health workers with higher satisfaction with inter-personal relationship reported higher psychological wellbeing. The higher workload and poor organisational support among health workers were reported to be strongly associated with poor psychological wellbeing and poor work performance.

4. Work, gender roles, and health: neglected mental health issues among female workers in the ready-made garment industry in Bangladesh

This was a cross sectional exploratory study conducted in two industrial areas of Dhaka in Bangladesh over eight months in 2015 and 2016. Data collection included a literature review, 20 in-depth interviews with married female garment workers and 14 key informant interviews with officials from the Ministry of Labour and Employment, health service providers within the garment factories, factory managers and representatives of the Bangladesh Garment Manufacturers and Exporters Association.

The study identified interlinked factors influencing health and well-being of female garment workers such as work environment level factors and global trade level factors. The study found that workplace health including stress levels of female workers in garment companies is neglected by employers. The study advocated a need for a more holistic understanding and addressing health problems of female workers in this industry through research supported design of interventions including internal and external psychosocial support.

5. Service user and caregiver involvement in mental health system strengthening in low- and middle-income countries: systematic review

This was a systematic review examining the evidence and experience of service user and caregiver involvement in mental health system strengthening in the LMICs. This review also investigates models of base practices for evaluation of capacity building activities that facilitate their greater participation. This review presented evidence from 20 papers.

Overall, this systematic review showed that although there were sign of mental health service user and caregiver involvement in mental health system strengthening in about 26 LMIC countries, there was a lack of high-quality research and weak evidence base for the work that was being conducted across these countries up to the end of 2013. The

reviewed showed that direct involvement of caregivers and service users may lead to improvement in mental health service and outcomes.

In the workplace context, direct involvement of members of the general workforce that have experienced mental health problems as patients or caregivers can mirror this evidence showing improvements in mental health situation in the workplaces.

6. A qualitative study of the role of workplace and interpersonal trust in shaping service quality and responsiveness in Zambian primary health centres

This was a cross sectional qualitative study examining how workplace and inter-personal trust impact service quality and responsiveness in primary health services in Zambia. This multi-case study included four health centres selected from urban, peri-urban and rural setting. This study included case data of 60 provider interviews, 180 patient interviews, 14 key informant interviews and direct observations of facility operations.

The results from this study illustrated a weak provider level workplace trust influenced by poor working conditions, perceptions of low pay and experiences of inefficient health centre workplace management.

The results illustrated three levels of workplaces trust: first level was patient provider trust; second level was trust among workplace colleagues and third level was trust among workplace supervisors. Out of these three, weak trust among workplace colleagues was found to be most important and therefore responsible for service quality and was also found to be week due to poor system of peer support. The study recommended investment to build strong system of peer support thus attaining stronger workplace trust among colleagues ultimately improving service quality.

7. Exploring the influence of trust relationships on motivation in the health sector: a systematic review

This was a qualitative systematic review of empirical studies on health worker motivation and considering what these studies suggest about the possible influence of workplace trust relationships over motivation. This review found 23 articles from LMICs and eights articles from high income countries that met the criteria.

This results from this review suggested that workplace trust relationships with colleagues, supervisors and managers, employing organisation and patients directly and indirectly influence health workers motivation. Motivational factors identified as linked to trust include respect; recognition, appreciation and rewards; supervision; teamwork; management support; autonomy; communication, feedback and openness; and staff shortages and resource inadequacy. This study indicated that workplace trust

relationships encourage social interactions and cooperation among health workers which is often observed in peer support networks in the workplaces.

8. The impact of leadership hubs on the uptake of evidence-informed nursing practices and workplace policies for HIV care: a quasi-experimental study in Jamaica, Kenya, Uganda and South Africa

This was a prospective quasi-experimental study conducted in Jamaica, Kenya, Uganda and South Africa examining the impact of establishing multi-stakeholder leadership hubs on evidence-informed HIV care practices. Hub members were engaged through a participatory action research (PAR) approach. Three intervention districts were purposefully selected in each country, and three control districts were selected.

The study found that leadership hubs, comprising nurses and other stakeholders committed to change and provided with capacity building could collectively identify issues and act on strategies that may improve practice and policy. Overall, hubs did not provide the necessary force to improve the uptake of evidence-informed HIV care in their districts. If hubs were to succeed, they must be integrated within district health authorities and become part of formal, legal organisations that can regularise and sustain them.

The leadership hubs encourage involvement of general workforce at the higher echelons in the system alluding to workforce involvement to improve workplace mental health and simultaneously improving work efficiency.

9. Absenteeism amongst health workers – developing a typology to support empiric work in low-income countries and characterizing reported associations

This was a narrative literature review examining the typology and influencing factors for absenteeism in the LMICs. This review included sixty-nine studies from the LMICs with four from sub-Saharan Africa where the human resource for health crisis was more acute.

The study reported that the forms of absenteeism studied, and methods used vary widely and a typology based on key characteristics was proposed to fill this gap and considers absenteeism as defined by two key attributes, whether it is: planned/unplanned, and voluntary/involuntary. Factors reported to influence rates of absenteeism were broadly classified into three thematic categories: workplace and content, personal and organizational and cultural factors. Notable influencing factors towards absenteeism reported were lack of workforce involvement and stigma associated with employee mental health and wellbeing.

10. Organisational culture and trust as influences over the implementation of equity-oriented policy in two South African case study hospitals

This study used the concepts of organisational culture and organisational trust to explore the implementation of equity-oriented policies – the Uniform Patient Fee Schedule (UPFS) and Patients' Rights Charter (PRC) - in two South African district hospitals thus contributing to the literature on organisational culture and trust in low- and middle-income

country health systems, and broader work on health systems' people-centeredness and "software". This was a cross sectional study with case study method using both quantitative and qualitative data. The respondents were hospital staff in two hospitals (n= 195) and provincial regional, district and hospital managers, as well as clinical and non-clinical hospital staff, hospital board members and patients.

The paper discussed the broader workplace culture created by employee actions, in terms of factors like levels of organisational trust, participative management and consultations with staff members. The paper emphasised the importance of achieving equity in practice requiring managers to take account of "unseen" but important factors such as organisational culture and trust, which were key aspects of the organisational context that can profoundly influence policies.

The study recommended synergy among health manager and hospital staff through a participatory approach. We found this recommendation comparable to the system of peer support requiring active participation from the workforce to support each other through the principles of trust, participative management, and consultation.

11. The power and potential of peer support in workplace Interventions

This study was a literature scoping review considering the concept of peer support in the workplace interventions on both the LMICs and the high-income countries. This study identified 24 reviews of workplace interventions discussing the power and potential of peer support within organisations and also peer support between organisations. The review considered papers published between 2000 and 2011. Of these 24 reviews, 21 were focused on peer support in the prevention or care of a specific health problem area.

This study reported that 'peers for progress' is a developing model that may be helpful in addressing several of the challenges in the workplaces. Especially this model of 'peer support' was found to provide an evidence base for standardisation of workplace interventions. At the same time, this model provided an opportunity to be flexible with plan-adopt and adapt method of tailoring across different worksites, health plans, regions, and countries with their varied cultures and health systems.

The study discussed four key aspects of peer support including assistance in daily management, social and emotional support to encourage management behaviours and coping with negative emotions, linkage to clinical care and community resources, and ongoing support—provide an important way of structuring the design of peer support that is perfectly suited to future research and evaluation studies.

12. The integration of occupational- a household-based chronic stress among South African women employed as public hospital nurses

This study was a cross sectional exploratory study investigating public hospitals-employed, black women nurse' lived experience to understand their stressors and consider intervention that could reduce psychological distress. This study was conducted

in 2015 with semi-structured life history interviews with 71 nurses working in Johannesburg city of South Africa.

The results from this study reported that the structure of the nursing occupation contributed to stress outside the workplace, while the structure of nurses' households contributed to stress and emotional exhaustion.

The paper recommended that mental health interventions specifically addressing anxiety and depression among these nurses could be useful in enabling nurses to gather into support groups for mental health in the public hospitals.

The support groups functioning with public hospitals and also between public hospitals can be compared with the system of the peer support network to address depression and anxiety among black woman nurses in South Africa thus supporting the concept of peer support network to address workplace mental health problems.

13. Worker's well-being. Evidence from the apparel industry in Mexico

This was cross sectional survey conducted among 2200 Mexican factory workers from the apparel industry. This study conducted in 2017 aimed to connect (1) job resources/work conditions and (2) worker well-being with (3) work outcomes in Mexican apparel factories belonging to the apparel supply chain.

The study reported that job satisfaction and self-assessed work performance were positively and directly associated with worker well-being. The study found that job control, trust, respect and recognition were significant correlates of all examined work outcomes (job satisfaction, work engagement and self-assessed work performance), with significant indirect effects on well-being. This study concluded that greater autonomy with workforce involvement is an effective intervention to improve workplace wellbeing.

14. Barriers to and facilitators of employment for people with psychiatric disabilities in Africa: a scoping review

This study was a literature scoping review to explore evidence related to the barriers to and facilitators of employment of persons with psychiatric disabilities in Africa. In this study a literature scoping review conducted using six relevant electronic databases of articles published between 1990 and 2017 and eight studies were identified as eligible for the analysis.

The study reported the merit of peer support as strategy to improve work environment for people with psychiatric disability. The identified barriers to work for people with psychiatric disability included ill health, (anticipated) psychiatric illness, social stigma and discrimination, negative attitudes among employers and the lack of social support and government welfare. Facilitators of employment for people with psychiatric disability included stability of mental illness, heightened self-esteem, a personal decision to work

despite stigma, competitive and supported employment, reduction in social barriers/stigma and workplace accommodations.

15. Rural health workers and their work environment: the role of inter-personal factors on job satisfaction of nurses in rural Papua New Guinea

This study was a cross sectional survey examining inter-personal, and extra-personal factors that influence job satisfaction among rural primary care nurses in Papua New Guinea. The data was collected using self-administered questionnaire from 344 rural nurses attending a training program from 15 of the 20 provinces.

The study provided an empirical evidence that inter-personal relationships: work climate and supportive supervision are the most important influences of job satisfaction for rural nurses in the LMIC such as Papua New Guinea. These findings highlighted that the provision of a conducive environment requires attention to human relations aspects.

16. Associations between healthcare worker participation in workplace wellness activities and job satisfaction, occupational stress and burnout: a cross sectional study in Botswana

This study was a cross sectional quantitative study examining whether participation in Botswana's Workplace Wellness Programme for health workers was associated with job satisfaction, occupational stress, well-being and burnout. The data was collected from randomly selected health workers at 135 public facilities across Botswana.

Results from this study suggested that participation in workplace wellness activities was associated with higher satisfaction with multiple job facets and lower stress, exhaustion and cynicism. Introduction of these activities was reported to help ameliorate high occupational stress levels among health workers. The evidence from this study highlighted that voluntary participation of health workforce in Workplace Wellness Programme resulted in lower burnout, higher job satisfaction and reduced overall stress. We find these results comparable to potential effectiveness of general workforce involvement as a strategy to improve workplace mental health in the LMICs.

17. The effectiveness of workplace health promotion in low- and middle-income countries

This study was a systematic narrative review investigating evaluation studies to examine the effectiveness and factors related to the implementation of wellness health programmes in the LMICs. The study included twenty-six peer-reviewed and grey evaluation studies, published before November 2017.

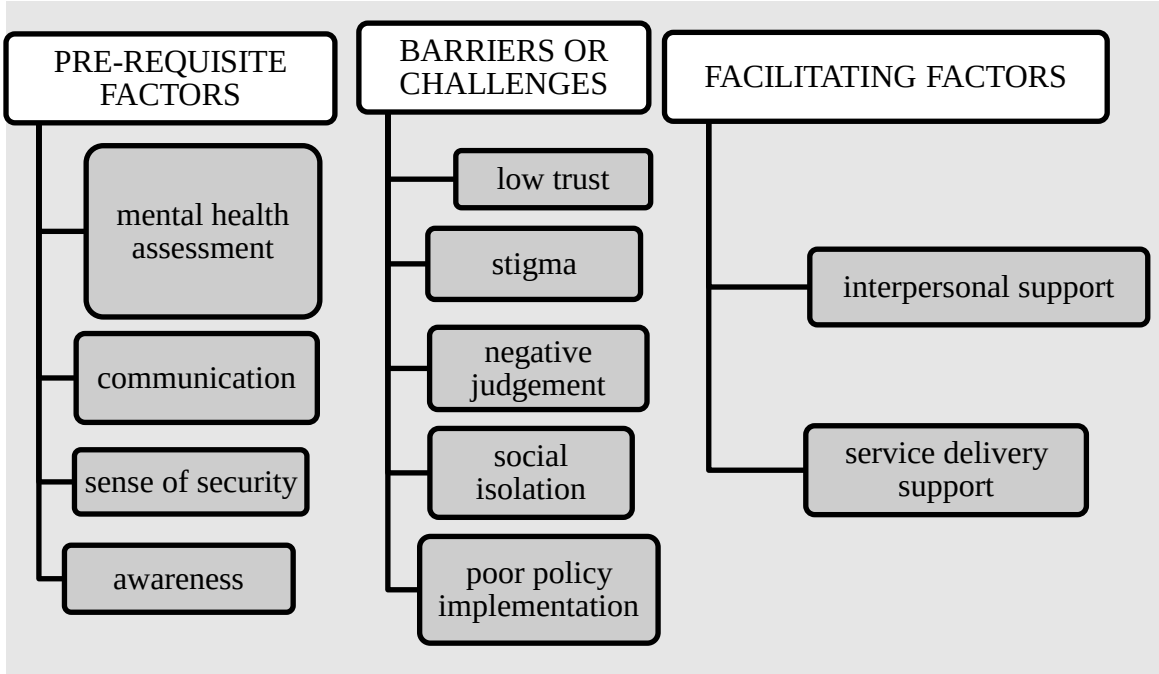
The results from the study reported that wellness health programming interventions in the LMICs were effective in reducing health risks in a wide range of industries and settings, including in resource-poor contexts such as small enterprises and the manufacturing industry. The main factors influencing the effectiveness of the interventions were long intervention time period, and needs-based and active intervention strategies. In addition,

commitment from workplace leaders, the involvement of workers and support from authorities and professionals were factors contributing to a successful wellness health programme. The study reported that the evidence regarding the effectiveness of wellness health programming in the LMICs regarding the health outcomes and business productivity was inconclusive due to the several remaining methodological limitations. The study recommended developments of more rigorous methods of evaluating the effectiveness of wellness health programming activities to produce higher-quality evidence that could inform future practice.

Analysis:

Based on the narrative synthesis of the results from these 17-peer reviewed studies; three themes and 11 sub themes describing pre-requisite factors, challenges and facilitating factors have been identified for implementing general workforce involvement and peer support networks. A visual overview of these themes and their connections with each other is illustrated in the conceptual model in the **Figure 1** below.

Figure 2: Conceptual model on synthesis of the results from the focused insight literature review



5.1.2 Pre-requisite factors

The findings suggested certain preparatory or pre-requisite factors that can potentially build a conducive environment for supporting mental health problems in the workplaces.

The foremost pre-requisite factor consistently mentioned in most of the studies is employee's mental health needs or motivation assessment as a pre-condition before creating a program based on peer support (Linnan et al, 2013). Communication related to mental health, sense of job security and awareness about mental health challenges are also prominent pre-requisite factors discussed in these studies (Edwards et al, 2016).

These pre-requisite factors are essential to create a conducive ecosystem for the proper implementation of any strategy for involving the workforce or introducing peer support networks in the workplaces.

5.1.3 Challenges or experienced barriers

Stigma about mental health problems is the most consistent barrier discussed in most of the studies (Akhter et al, 2017), (Erasmus et al, 2017). Negative judgement about mental health problems precludes an opportunity to implement any strategy to address mental health problems in the workplace at the individual or collective level (Ledikwe et al, 2017). Similarly, fear of social isolation is a strong barrier for employees to disclosing and sharing their mental health problems in the workplace with their peers and managers (Lohmann et al, 2019).

Low trust at workplace coupled with stigma was highlighted as an important barrier restricting the workforce involvement to improve work conditions and mental health (Okello et al, 2015). Although some of the LMICs have policy recommendations to involve the general workforce and create a peer support network to improve the workplace mental health; the ground level implementation is mostly absent. The primary reason for the policy-practice gap is poor policy implementation by the governments (Linnan et al, 2013).

Another strong barrier was a negative perception about employee participation to improve workplace mental health (Akhter et al, 2017), (Belita et al, 2013). Decision makers (usually senior management) often considered employee participation activities as a waste of time and thus barrier to the work productivity (Braun and Clarke, 2006).

5.1.4 Facilitating factors

A. Inter-personal network

In the workplace, inter-personal support with a positive work climate and supportive supervision are found to be the most important influencers of job satisfaction and well-being (Topp et al, 2015). The authors defined positive work climate as the one which has inter-personal trust through a system of peer support Within an organisation.

One study conducted among health workers in Papua New Guinea, highlighted the importance of a peer support network to improve workplace mental health and well-being in the LMICs (Jayasuriya et al, 2012). This study provided an empirical evidence that inter-personal relationships: work climate and supportive supervision were the most important influencers of job satisfaction for rural nurses in the LMIC such as Papua New Guinea. These findings highlighted that a conducive environment for supporting mental health in the workplace requires attention to human relations aspects.

B. Service delivery support group

There is some evidence for the benefits of service delivery support groups. Examples include employment of mental health service users as case managers for people with

Schizophrenia (Cohen et al, 2012) and peer support group led by women in hospitals to reduce moderate maternal depression in India (Gray et al, 2019).

In both the cases, these service delivery support groups, consisting of the general workforce members, were found to have higher motivation to contribute within workplace mental health activities.

5.1.5 Results from the grey literature

Both the World Health Organisation (WHO) and the World Economic Forum (WEF) have published several reports in a series towards workplace improvements. We found five reports most relevant to this review presenting merits, barriers, and facilitators for workforce involvement and peer support networks to improve workplace mental health in the LMICs. The reports are listed in Appendix 4: Selected reports from the grey literature

Since 2005, the WHO has published four reports providing-

A. Policy and programme recommendations to improve workplace mental health.
B. Healthy workplaces: a model for action for employers, workers, policymakers, and practitioners towards healthy workplaces
C. Mental health action plan 2013-2020 for the member states to implement statuary guidelines on improving workplace mental health and
D. Systematic problem approaches for employers, managers, and trade union representatives regarding work organisation and stress.

These reports echo the effectiveness of general workforce involvement and peer support network as an important intervention to address mental health problems in the workplace globally.

The WHO report on ‘Healthy workplaces: a model for action for employers, workers, policymakers, and practitioners towards healthy workplaces’ discussed that one of the most consistent findings about effectiveness research is that in successful programmes the workers affected must be involved in every step of the process from planning to evaluation. Workers and their representatives must not simply be passively consulted but must be actively involved, with their opinions and ideas sought out, listened to and implemented. Due to the inherent dynamics of relations between labour and management, it was found critical that workers have some collective means of expression, stronger than that of individual workers.

A seven-step guide to workplace mental health by the World Economic Forum’s global Agenda Council of Mental Health 2014-2016 endorses peer support network both within and between organisations as a cost-effectives intervention under action SIX (WEF 2014a). this report does nor draw an effectiveness data from the LMICs. The reasons being weak or absent data in the LMICs (WEF, 2014a).

5.2 Exploratory study based on expert consultation workshops

A total of 62 participants working in LMICs attended the expert consultations. Majority of the workshops were organised for Indian participants with one workshop organised for the participants from Ethiopia, Ghana, Morocco, and Zambia. The average number of participants in each workshop was seven. These stakeholders included employees from the formal sectors functioning at either strategic or operational levels irrespective of their working domain.

Based on the findings from the workshops using qualitative research methodology, following major themes have emerged.

5.2.1 Pre-requisites

Policy framework

Participants from the expert consultations remarked that many physical health problems ranging from acute illnesses such as fever to chronic health conditions such as cardiovascular problems have provisions in the workplace policy to provide reimbursements for the treatment sought. Participants suggested that both acute and chronic mental health problems should also be covered under the provisions of workplace policies.

In addition, participants discussed a need for certain workplace policy level changes with respect to workplace mental health. These policy changes should reflect leave guidelines and non-discriminatory workplace guidelines for persons with lived experience of mental illness and persons with current mental illness. Such policy framework changes were deemed as pre-requisites before considering workforce involvement and peer support networks implementation in the workplaces.

Another pre-requisite factor identified by participants was uniform distribution and evaluation of policies across the system hierarchy. Participants noted that workplace mental health policies were neither properly distributed nor regularly evaluated taking employee feedback. The participants expressed a need for a mandatory induction session on mental health and external psychosocial support, along with a platform to create awareness about mental health and legal rights.

Policy level change and ensuring proper evaluation of mental health related policies were found to be essential before considering any intervention to address mental health problems including workforce involvement and peer support network.

Resource allocation

Participants felt that although workforce involvement is envisaged as a voluntary commitment, this involvement should be matched with some incentives. For example, shift in the work schedule to accommodate the additional responsibility for workplace mental health champions/peer supporters and provision of additional resources or collaterals such as mental health awareness kit was mentioned by workshop participants.

5.2.2 Barriers

Stigma

Participants mentioned that stigma and negative discrimination against persons with mental health problems stop personal disclosure of mental health problems at the workplace. Participants noted that persons with mental health problems in the workplaces do not want to reveal their mental health problems in the workplace out of fear from being ostracized and even being removed from the employment. Therefore, often people with mental health problems and even people without mental health problems do not want to be involved in the processes addressing workplace mental health problems.

Productivity centric approach

Participants also highlighted that most employers consider productivity as a core measure of a person's work efficiency and this restricts employees from getting involved in mental health initiatives which may impact their work efficiency negatively. Participants felt employers should take a more humane approach, for example, providing flexibility to employees in terms of work and shared decision making for mental health problems.

5.2.3 Facilitating factors

Mixed approach

Participants highlighted that dedicated external (to the organization) psychological support is required in addition to internal peer support to mitigate confidentiality issues in disclosing mental health problems. Participants highlighted a need for timely external psychosocial support in addition to the internal peer support. The primary objective of peer support network within and between organisations is to provide psychosocial support. The strong web of peer support networks between organisation across workplace sectors in cities and countries could serve secondary purpose a platform to share learning and experiences from peer support.

Participants felt that the composition of the peer support network should be inclusive of various intersectoral systems and represent the diversity within the workplace ecosystem

Role Model Approach

Participants also suggested employees such as senior managers or those higher in the hierarchy must be encouraged and incentivised to become mentors and those leading peer support can be incentivised to become workplace champions.

If senior managers or those higher in the hierarchy were involved as workforce mentors to address mental health problems, this could not only potentially address stigma and negative discrimination towards workplace mental health problems but also encourage employees lower in the hierarchy to benefit from mental health activities. In the 'mentor' role, senior managers were expected to be more active and empathetic towards mental health interventions in the workplaces.

Participants also suggested that employees with lived experience of mental health problems could also to be encouraged and incentivised to operate in the role of 'workforce champions' leading the workplace mental health activities. The concept of workforce

champions could potentially present two advantages in the workplace mental health interventions.

The first advantage could be that involving persons with lived experience of mental health problems could *de-stigmatise* mental health in the workplace where mental health problems were not hidden but discussed in open with formal setup.

The second advantage would be that the workforce champions could use their own experience of coping with mental health problems to help prevent and address workplace mental health problems in their office.

Participants felt that employees experiencing mental health problems must be encouraged to speak out about their problems and recovery, and should be provided with *an incentive* to become workplace mental health champions.

Value-based work culture

Participants emphasized the need for sensitization of the entire workplace with a decentralized approach so that the voices of marginalized employees can also be heard, and there should be a space for assertive training with a choice to say "NO" to additional work beyond the bearable capacity. Participants also noted the need for providing opportunities to foster and improve deficient skill sets within the informal network and space to share personal and professional setbacks which often act as major stressors.

5.3 Case study based on the expert consultations.

An interesting existing intervention was discussed by the participants working in an international mental health NGO.

This intervention used a buddy system with external psychosocial support.

First component of this intervention is a ‘buddy system’. During the joining and induction process, each employee is assigned to a ‘buddy’ in the organisation.

The criteria for ‘buddy’ are that she or he should be an employee,

1. From similar hierarchy
2. From same project office
3. Shall be of same gender and age

Second component is system of regular or periodic external psychosocial screening and support for all the employees across the project offices in the organisations.

The main principles of this psychosocial screening and support are,

Confidentiality- maintain any conversations off records and absolutely confidential between buddies.

Non-reflectivity – not being judgemental or not reflecting upon professional or personal output while listening to buddy or providing advice

Voluntary support- system of buddy support is completely voluntary and therefore any time an employee has a choice to refuse to be part of the buddy support system.

The system of buddy system is comparable to peer support network discussed in this report based on these three principles ensuring timely psychosocial support in workplace, promoting a system of interpersonal trust to promote workplace mental health.

Since this is an international mental health NGO, majority of the employees are mental health researchers with training and experience in providing psychosocial support. This NGO has four project offices and one headquarter office in India. Therefore, volunteers from one project office are assigned to provide psycho-social support to the employees in another project office. The principles of confidentiality and non-reflectivity and voluntary support are strictly enforced in this process in both buddy system and the external psychosocial support.

The workshop participants mentioned that this intervention is implemented in the headquarter office and one project office currently. Therefore, remaining three project offices are not receiving any benefits from this intervention. The effectiveness of the buddy system is not evaluated in this workplace.

6. Discussion

Overall, the review of the literature provided limited evidence about the effectiveness of general workforce involvement and the peer support networks in the LMICs. The review did highlight some potential in these approaches emphasising important pre-requisites, barriers and facilitating factors to implement these approaches in the workplaces.

Feedback from the expert consultations also suggested broad acceptability of these approaches and highlighted key considerations for implementing these approaches in the workplaces.

The results synthesised from review demonstrate consistent evidence for policy level recommendations to improve workplace mental health in the LMICs. We did not find studies examining the effectiveness of the proposed approach among the informal sectors such as agriculture labourers and daily wage labourers in India and other LMICs. A limitation of the qualitative exploratory study is our inability to include participants from the informal workforce sectors such as agriculture labourers or domestic workers or street vendors.

Therefore, whether proposed approach will be as effective among the informal workforce sectors compared to the formal workforce sectors, cannot be inferred from this project.

6.1 Workforce involvement and peer support networks: a case for effectiveness

Policymakers and business leaders globally have taken cognisance of the importance of workplace mental health and well-being in recent decades. The Tokyo Declaration in 1998 adopted a consensus statement acknowledging the economic and technological changes contributing to stress among employees. The World Health Organisation (WHO) in 2008, published WHO'S Global Plan of Action on Worker's Health for 10 years from 2008 to 2017 outlining relevant principles, objectives, and implementation strategies to promote mental health in workplaces (WHO, 2013c). The WHO also produced the "Protecting Workers' Health" report series which provides guidance on common issues such as harassment and stress that can affect the health of workers (WHO, 2010b).

Amidst these important global policy developments, our research has found that implementation and evaluation of evidence-based practices to improve workplace mental health have lagged behind policy recommendations. The concept of general workforce involvement in the form of service user involvement and building a peer support network to improve workplace mental health is not a new concept but has received little attention in the field of workplace mental health. Therefore, there is a need for further research into these approaches and further investigation must be directed also to evaluate their effectiveness in practice.

The findings from a focused insight literature review have highlighted a number of pre-requisites, barriers and facilitating factors must be implemented as strategies when introducing these approaches in the workplace.

Results from the qualitative exploratory study further affirm the acceptability of peer support and workforce involvement, for example through systems of workforce champions, external peer support coupled with internal peer support, buddy systems and strategies to tackle workplace stigma through effective workforce involvement. For all these approaches, it is important to have a rigorous system of evaluation.

6.2 Proposed approach: specific considerations for young employees

We included young working employees below the age of 30 years in the workplace mental health workshops for the qualitative exploratory study. 62 participants working in the LMICs from Asia and Africa participated in eight workshops.

The results from the qualitative exploratory study suggest that young employees working in the LMICs may experience higher levels of stress and burn out and lower awareness about mental health problems resulting in low help seeking behaviour in the workplace. One cohort of the participants in the expert consultations were doctors and nurses who were involved in active duty for the COVID-19 cased management. This cohort participants noted that since 2020, mental health problems have accentuated in the workplaces due to ongoing COVID-19 pandemic and related increased levels of unemployment, economic losses, work from home challenges and associated health risks of working in the COVID-19 services.

The participants being young working employees- fear of job loss, financial uncertainness and lack of mental health awareness- were mentioned as major drivers for mental health problems and even suicidal ideations in the workplaces. The stigma about mental health problems and disclosing mental illness is the greatest challenge for young employees working in the LMICs.

Feedback from our expert consultations indicate the need for strong support to identify and deploy workforce mentors such as senior managers and those higher in the hierarchy to tackle overarching stigma about workplace mental health. Participants also suggested creating a cadre of workforce champions, who have lived experience, to lead peer support networks.

6.3 Study limitations and scope to scale

For the exploratory study, we used a purposive convenience sample which may not be representative of the entire young workforce in these countries. Many of the participants worked in the health sector and hence may be more attuned to mental health concerns.

Due to paucity of time and COVID-19 situation, young working employees from the informal work sectors in India and other LMICs were excluded from the workshops and therefore for the qualitative study.

Currently informal workforce sectors constitute more than 60 per cent of the workforce in the low- and middle-income countries. Due to time bound design of the Commission and

virtual nature of the workshops owing to COVID-19, we decided not to include the participants from the informal workforce sectors.

Large-scale mixed methods study including equal representations from the formal and informal workforce sectors in the LMICs and similarly equal participant distributions from Asia, Africa and South Americas would help further validate the findings.

The focused insight literature review in this Commission has investigated evidence and experience of the proposed approach- general workforce involvement and peer support network- in the low-and middle-income countries. The exploratory study has involved young working participants from the formal workforce sectors working mainly from India and a few participants from African countries.

In terms of generalizability and transferability of the results, the experts participating in the expert consultations were employees working in a range of formal workforce sectors. These included:

1. Information technology corporate sector
2. NGO sector
3. Health services sectors
4. Research organisations
5. Academic institutions

The findings from this Commission can be used to support further investigations into the effectiveness of workforce involvement and peer support networks through feasibility studies or randomised controlled trials and evaluation of scale up of these interventions in different formal workplace sectors.

7. Next steps and recommendations

Based on our review, we recommend two actions for policy makers and business leaders.

First is to **identify workplace mentors** and **to support and mentor the general workforce** to become involved in improving workplace mental health in the LMICs.

Workforce mentors could be persons with lived experience of mental health problems or those volunteering to provide more time and efforts to supervise activities conducted to improve mental health in the workplace.

Second is the **creation of a peer support network** among general workforce in cities, states and countries that can lead to a strong web of intersectoral mental health support.

The peer support network is a system of providing peer support among employees of an organisation. Withing organisations, this system of a peer support is envisaged across workplace hierarchies. Furthermore, this peer support is also considered as network between organisation creating a web of support among different workplace sectors such as corporate, health services, academic institutes, and non-profit organisations. The peer support network can provide intersectoral mental health support and share the learning from this network with each other to improve through mutual support.

This study provides an initial starting point for understanding the evidence for and assessing the acceptability of general workforce involvement and peer support networks as complementary strategies for supporting mental health in LMICs. However feasibility study testing and further evaluation are needed to understand the effectiveness and expediency of these approaches

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Appendices

Appendix 1: PICO Search strategy

General workforce Involvement OR Peer support network AND workplace AND mental health AND low and middle-income countries	
General workforce Involvement OR Peer support network	general workforce involvement or workforce involvement or employee involvement or client involvement or employer involvement or customer involvement or general workforce participation or workforce participation or employee participation or client participation or employer participation or customer participation or general workforce partnership or workforce partnership or employee partnership or client partnership or employer partnership or customer partnership or general workforce engagement or workforce engagement or employee engagement or client engagement or employer engagement or customer engagement or general workforce contribution or workforce contribution or employee contribution or client contribution or employer contribution or customer contribution or peer support network or peer network or support network or caregiver network or caretaker network or care network or family network or colleague network or member network
Workplace	workplace or work place or workplace system or workplace policy or workplace planning or workplace system strengthening or workplace services or workplace administration or workplace governance or workplace finance or workplace monitoring or workplace evaluation or workplace research or workplace information

Mental health	mental health or mental disorders or mental illness or mental disorder or mental health condition or mental distress or drug abuse or drug addict or drug depend or drug dependence or drug withdrawal or drug abuse or addictive disease or addictive disorder or alcoholic employee or psychosis or manic or bipolar or mood or depressive episode or depressive symptom or hypomania or mania or depression or suicide attempt or anxiety or obsessive or compulsive or neurotic or pain disorder or mental confusion or mental disability or mental capacity or psychiatric comorbid or mental comorbid or psychiatry or psychology or wellbeing or well-being or burnout or burn out
Low and middle-income countries	Low - and middle - income countries or low - and middle - income country or low - income country or middle - income country

Appendix 2: The characteristics of the 17 included peer-reviewed studies

Sr no	Author title	Study type	Study settings	Key results relevant to research questions
1	Gray et al	realist review	LMIC	Discusses workplace interventions among healthcare workers
2	Wipfi et al	exploratory study	India and Mexico	workplace wellness program discusses employee participation
3	Lohmann et al	cross sectional survey	Rural Malawi	discusses factors associated with psychological wellbeing at work including inter personal communication (peer support)
4	Akhtar et al	cross sectional exploratory study	Bangladesh	Discusses need for inter Collaboratory network to improve health of the workers
5	Semrau et al	systematic review	LMIC	although this paper discusses mental health service user and caregiver involvement in the mental health system strengthening in LMICS; several papers found in this review discuss involvement of 'caregivers' in the mental health system policy and process. this type of involvement translates to workforce involvement in the system i.e. a workplace

6	Topp et al	multi case study	Zambia	The paper discusses role of workplace and inter personal trust that alludes to peer support network to improve workplace mental health
7	Okello et al	systematic review	LMIC	The discussion on workplace trust alludes to peer support network to improve workplace mental health
8	Edwards et al	prospective quasi experimental study	LMIC four countries	the leadership hub alludes to general workforce involvement in the workplace albeit at higher echelons in the system
9	Belita et al	literature review	LMIC	the paper discusses typology and influencing factors for absenteeism. Notable influencing factors towards absenteeism are lack of workforce involvement and stigma associated with employee mental health and well being
10	Erasmus et al	nested case study design	South Africa	The paper discusses the broader workplace culture created by their actions, in terms of factors like levels of organisational trust, participative management and consultation with staff members
11	Linnan et al	literature scoping review	LMIC	The paper discusses in a detail about the 'peer support network' as an evidence in the workplaces in this review
12	Cohen et al	cross sectional qualitative study	South Africa	The paper discusses enabling nurses to gather into support group for mental health in the workplace alluding to peer support network
13	Węziak-Białowolska et al	cross sectional study	Mexico	The paper discusses greater autonomy with workforce involvement as an intervention to improve workplace mental health
14	D.Eebueny i et al	scoping review	LMIC African countries	The paper reviews evidence for barriers to and facilitators of employment for people with psychiatric disabilities in Africa. The papers reviews merit of peer support as strategy to improve work environment for people with psychiatric disability
15	Jayasuriya et al	quantitative study	Papua New Guinea	This study provides empirical evidence that inter-personal relationships: work climate and supportive supervision are the most important influences of job satisfaction for rural nurses in a LMIC. These findings highlight that the provision of a conducive environment requires attention to human relations aspects.
16	Ledikwe et al	cross sectional	Botswana	Results from this study suggest that participation in workplace wellness

		quantitative survey		activities is associated with higher satisfaction with multiple job facets and lower stress, exhaustion and cynicism.

Appendix 3: List of websites searchers for grey literature

1. The World Health organisation https://www.who.int/
2. The World Economic Forum https://www.weforum.org/
3. European Network for Workplace Health Promotion ENWHP – European Network for Workplace Health Promotion
4. The Organisation for Economic Co-operation and Development (**OECD**) https://www.oecd.org/
5. Association of South Asia Nations https://asean.org/

Appendix 4: Selected reports from the grey literature

1. Work organisation and stress: systematic problem approaches for employers, managers, and trade union representatives
   Published by the World Health Organisation 2010

2. Mental health policies and programs in the workplaces (Mental health policy and service guidance package)
   Published by the World Health Organisation 2005

3. Healthy workplaces: a model for action: for employers, workers, policymakers, and practitioners
   Published by the World Health Organisation 2010

4. Mental health action plan 2013-2020
   Published by the World Health Organisation 2010

5. Actions towards a mentally healthy organisation
   A seven-step guide to workplace mental health by the World Economic Forum's Global Agenda Council on Mental Health 2014-2016

Appendix 5: Consultation workshops: participants' work sectors and country of work

Workforce sectors	**country**	**Number of participants**
Information technology corporate sector	India	9
Non-profit organization working in areas of mental health law and policy	India	9
Doctors and nurses working in the COVID-19 relief services	India	21
Mental health international NGO	India	12
Public Health research organization	India	3
Psychologist working as founder director of health consultancy organization	India	1
Freelance writer working in the medial writing sector	India	1
Psychologist working in the pharmaceutical health service NGO	India	1
Lawyer specialising in the mental health legislations and policy	India	1
Psychiatrist working in the public health sector	Zambia	1
Mental health service provider	Morocco	1
Psychologist working in the mental health service user organisation	Ethiopia	1

User survivor working in the mental health NGO	Ghana	1
Total number of workshop participants		62

Appendix 6: The expert consultation workshops participant information sheet

Title

Theory of Change: a theory-driven approach to develop an intervention package addressing depression and anxiety in workplaces in low and middle-income countries with a focus on those under 25 years of age.

Introduction

We would like to invite you to participate in this workshop. It is important to understand the objective of this workshop and the scope of your participation within this. Please take the time to read the following information and discuss it with your peers if needed. For any queries or further clarification feel free to connect with us.

About Organiser

Centre for Mental Health Law and Policy (CMHLP), Pune is one of the leading organizations working in the field of mental health law, community mental health, and policy. More information can be found on the official website link www.cmhlp.org

About Workshop

Theory of Change (ToC) is an outcome-based approach that applies critical thinking to the design, implementation and evaluation of programmes intended to support change in their contexts.

We aim to design an intervention package based on the proposed approach, to present likely or proven impact in preventing or addressing anxiety and/or depression in the workplace through a series of ToC workshops. The ToC will help to gain understanding and opinion of key stakeholders about involving general workforce and mental health champions with outcomes. This is very crucial to develop and implement a successful intervention of involvement to improve mental health and wellbeing.

We intend to take insights from various sectors like public and private health departments and hospitals, mental health organizations, other social sector organizations, corporate

sectors, and academic institutes. Anyone who is working in the above-mentioned sectors, under the age of 30 years can participate in this workshop.

Risks associated with participating in this workshop.

The structure / content of the workshop is designed meticulously to avoid causing any distress or psychological discomfort or any other harm to the participants. However, there is a remote possibility that on rare occasions, some topics / discussions held during the workshop may trigger or upset the

participants. In such case, you can contact the facilitators on a personal chat and may leave the discussion in the extreme cases.

Benefits of participation in the workshop

We hope that the shared information will help us to develop the intervention package addressing mental health at workplaces. The workshop will act as an instructive and interactive platform to learn about the strategies to prevent and address depression and anxiety in the workplaces and implementing them in real-world settings. There will be no monetary benefits for participating in the workshop.

Privacy and Confidentiality

Any personal information (name, age, gender) about the participants and / or their organization will be kept confidential and will not be reflected or mentioned in any of the findings, reports or other documents related to workshop. Discussions in the workshops will be recorded with the consent of the participants. We will ensure that the recording and notes taken during the session are de- identified and then secured with the CMHLP project team.

Once the sessions are transcript and analysed, the recordings on the tapes will be deleted after a considerable time as per the protocol of the project. The information shared by you will be accessible to other researchers in a de-identifiable manner. We are not legally bound to act on any suspicious or confidential information we receive during the workshop. However, if you or anyone else is found to be at risk of being harmed we will connect to the appropriate support system as per the protocol. Once the overall study is completed, we will inform you about the findings of the study through appropriate channels. We plan to publish the study findings in scholarly journals and at academic conferences.

Participation in the workshop: Your participation in this workshop is voluntary and you can withdraw from the workshop at any time and without giving a reason. You may also ask to withdraw any information you have already provided without having to give a reason. A decision to withdraw at any time, or a decision to take part, will not affect or disadvantage you in any way.

If you have any questions or require more information about this study, please contact the research team.

Appendix 7: Experts consultation workshops details

Workshop serial number	Workshop date in 2020	Number of participants	Target workforce sector
1	14 August	9	Mental Health Organisation
2	19 August	9	IT Sector- Corporate MNC
3	29 August	11	Public Health care sector with COVID-19 service
4	05 September	9	Mental Health International NGO
5	12 September	3	Academic Research Institute
6	19 September	5	Mental Health International NGO, Academic Research Institute, Lawyer
7	26 September	12	Public Health care sector with COVID-19 service, Public Health Organisation, Freelance Writer
8	03 October	4	Mental Health International NGO

Appendix 8: Structure of the expert consultations

The expert consultation workshops followed a structured format consisting of the following:

1. Introductions of the participants and the presenting team
2. Presentation about the importance of the workplace mental health
3. Discussion about the Commission's proposed approach
4. Process of summarizing interventions framework or map based on the expert consultations with the participants. We used theory of change map to demonstrate how intervention framework could be structured as outcome, output, indicators, barriers, assumptions and rationale (De Silva et al, 2014).

After receiving a verbal consent from the participants, discussions from the workshops were recorded and preliminary summaries were documented from each workshop. The findings from the expert consultations were synthesised using exploratory qualitative research methodology. The audio files were first coded by two team members independently, based on well established guidelines (Braun and Clarke, 2006). The guidelines were set as independently listening to the audio files and preparing summary notes to share with a third team member who then synthesized both the summaries for convergence and divergence.

Once all data was coded and collated, the potentially relevant data was extracted into themes following the inductive approach suitable to our analytic interest. The validity of individual themes was considered to determine whether the themes accurately reflect the meanings evident in the data set as a whole and then on mutual agreement of three team members, final themes were generated that formed the basis for the final analysis.

Appendix 9: The expert consultations: Using Theory of Change approach

Theory of Change (ToC) helped this commission to gain understanding and opinion of key stakeholders about involving general workforce and mental health champions with outcomes that were required to be realised to develop and implement a successful intervention of involvement to improve mental health and wellbeing.

Theory of Change is essentially a comprehensive description and illustration of how and why a desired change is expected to happen in a particular context. ToC is focused in particular on mapping out or "filling in" what has been described as the "missing middle" between what a program or change initiative does. It does this by first identifying the desired long-term goals and then works **back** from these to identify all the conditions (outcomes) that must be in place (and how these related to one another causally) for the goals to occur.

Our approach has been informed by the work of Connell and Kubisch (1998) who describe how, in producing a ToC, stakeholders make explicit their theories of what (outcome) they hope to achieve (in the long, medium and short term), how (action) they expect to achieve them and why the proposed actions should deliver intended outcomes (rationale).

Structure of the Workshop using Theory of Change

The latter half of the workshop was dedicated to develop an intervention package using theory of change approach. Much focus was given to involving the stakeholders to visualize and discuss various strategies and experiences based on an understanding of the matter and to set a discourse to enlist the probable challenges and perceived barrier for the desired outcome and final impact in a retrospective manner.

A ToC MAP looks like a driver diagram or logic model which has COMPONENTS termed as,

Impact, outcome, interventions, indicators, assumptions and rationale

These are linked together by causal pathways, which determine the direction of the relationship between these changes and show how they lead to the long-term outcomes and impact to which the project or programme intends to contribute.

During the workshop consultations, we used ToC map to guide development of strategy components for the general workforce involvement and peer support.