



**The Mental Health and Poverty Project: Mental health
policy development and implementation in four
African countries
HD6**

Final report

23 July 2010

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Background information

Title of research programme:	The Mental Health and Poverty Project: Mental health policy development and implementation in four African countries
Reference number:	HD6
Period covered by report:	1 August 2005 – 31 July 2010
Name of lead institution and Director:	University of Cape Town (UCT), Prof Alan Flisher*
Key partners:	World Health Organization
	University of Leeds
	London School of Economics
	University of KwaZulu-Natal, South Africa
	Human Sciences Research Council, South Africa
	Makerere University, Uganda
	Kintampo Health Research Centre, Ghana
	University of Zambia
	Department of Health, South Africa
	Ministry of Health, Uganda
	Ministry of Health, Ghana
	Ministry of Health, Zambia
Countries covered by research:	Ghana
	South Africa
	Uganda
	Zambia

	Planned	Actual
Start date:	1 August 2005	1 August 2005
End date:	31 July 2010	31 July 2010**
Total programme budget:	£ 2,198,552	

* Note: Prof Flisher died tragically of leukemia in April 2010. In the final months of the RPC, Prof Crick Lund (former MHaPP Project Coordinator) has served as Director.

** Note: MHaPP has been granted a no-cost extension to 31 January 2011.

Summary

What the research programme intended to achieve

The following purpose, outputs and activities were developed during the MHaPP inception phase (August 2005 – January 2006).

1.1.1. Purpose

Mental-health policy development and implementation in Ghana, South Africa, Uganda and Zambia are increasingly based on evidence emerging from the mental health RPC and lessons learned are communicated to other developing countries.

1.1.2. Outputs

Output 1: Knowledge is generated concerning the factors necessary for the development of appropriate mental health policy.

Output 2: Knowledge is generated concerning the factors necessary for effective implementation of mental health policies.

Output 3: Communication of study results and promotion of the utilisation of the research findings inform and improve mental health policy-making and practice in the study countries and other developing countries.

Output 4: Research and communications capacity is increased in all participating institutions.

1.1.3. Activities

Activity 1(a): Use policy analysis research methods to understand how policies have been developed. *Activity 1(b):* Assess the appropriateness of the resultant policies in a variety of formats and sectors, using the WHO Guidance Package framework and conceptual approach as assessment tools. *Activity 1(c):* Develop and evaluate interventions to strengthen the policy development process in the study countries.

Activity 2(a, b, c): Investigate mental health policy implementation and develop and evaluate interventions to assist policy implementation at macro, meso and micro levels.

Activity 3(a): Publicise the project. *Activity 3(b):* Encourage exchange between RPC partners and the 4 countries involved. *Activity 3(c):* Disseminate the knowledge base on the links between mental health, policy and poverty. *Activity 3(d):* Communicate research findings and promote their utilisation to inform and improve policy-making and practice in the study countries and elsewhere in Africa, the developing world and globally.

Activity 4(a): Increase the output of completed dissertations/theses at each site. *Activity 4(b):* Establish a Mental Health Policy and Services Research Unit at the University of Cape Town.

Activity 4(c): Arrange two training workshops for mental health policy makers and service users in each African country. *Activity 4(d):* Arrange three training workshops for research officers to equip them to conduct the situation analysis in Phase 1.

What the research programme actually achieved

1.1.4. Outputs/results of the programme

All of the planned outputs of this RPC have been achieved. Knowledge has been generated regarding the factors necessary for the development and effective implementation of mental health policy in the four study countries. The study results have been communicated (or in some instances are in the final stages of preparation for publication), and research findings have been used to inform and improve mental health policy making and practice in the four study countries. We have not yet been able to assess the extent to which these have had an impact on other developing countries. Research and communications capacity have been substantially increased in all participating institutions. All of the above listed activities have been successfully completed, with one exception, namely increasing the output of completed dissertations/theses at each site, which has been limited. However, we have established a Centre for Public Mental Health at UCT, which includes a distance learning curriculum (including a Post-graduate Diploma in Public Mental Health

and a MPhil in Public Mental Health), which will be offered from 2011. This Centre provides the infrastructure for ongoing capacity development in public mental health in Africa.

To summarise the main results of the programme: In Phase 1 (2006-2008) a large scale situation analysis of mental health policy development and implementation was conducted in each country. In all four countries this was the first time that a comprehensive situation analysis of this kind had been conducted. The situation analysis provided new knowledge regarding the countries' mental health systems, through the administration of the WHO Assessment Instrument for Mental health Systems (WHO AIMS); new knowledge regarding current mental health policy, plans and legislation, through the administration of the WHO Checklists for Mental Health Policy and Plans and for Mental Health Legislation; and new knowledge regarding the opinions of a large number of mental health stakeholders about mental health policy development and implementation in each country, through semi-structured interviews and focus groups.

In Phase 2 (2008-2010), on the basis of these situation analyses, several policy, planning, legislation, information systems and district primary health care interventions were undertaken in the countries. These intervention studies provided practical realisation of the RPC's purpose, namely that "Mental-health policy development and implementation in Ghana, South Africa, Uganda and Zambia were increasingly based on evidence emerging from the mental health RPC." The specific interventions included:

1. In Ghana:
 - a. Further development of the national Mental Health Bill and substantial progress towards its adoption.
 - b. Reform of mental health information systems at the three psychiatric hospitals: Accra, Pantang and Ankafu.
 - c. A district demonstration project for the integration of mental health into primary health care (PHC) in the Kintampo District.
2. In South Africa:
 - a. Development of a first draft national Mental Health Policy, which is now being circulated to the 9 provinces for consultation.
 - b. Development of a draft mental health strategic plan for the Northern Cape province.
 - c. Development of mental health information systems in the Northern Cape and KwaZulu-Natal provinces.
 - d. A district demonstration project for the integration of mental health into PHC in the Hlabisa sub-District in rural KwaZulu-Natal.
3. In Uganda:
 - a. Development of a draft national Mental Health Policy and Strategic Plan, which are awaiting adoption by the Ministry of Health.
 - b. Reform of mental health legislation, through the drafting of a new Mental Health Bill, a national consultation process, and preparation of the Bill for review in parliament.
 - c. A district demonstration project for the integration of mental health into PHC in the Mayuge District.
4. In Zambia:
 - a. Development of a national strategic plan for mental health.
 - b. Further development of the national Mental Health Bill and substantial progress towards its adoption, through consultation workshops and re-drafting.
 - c. Training of PHC health workers in mental health in the Lusaka and Mumbwa districts.

In addition to these country-specific outputs, we have engaged in secondary research regarding the relationship between poverty and mental health in low and middle-income countries (LMIC). This has included:

1. The publication of the first systematic review on poverty and common mental disorders in LMIC. Further systematic reviews on poverty and suicide, and poverty and child and adolescent mental disorders are currently being developed.
2. Use of the database from the poverty and mental health systematic review to inform a number of international and local outputs, including:

- a. WHO Mental Health and Development report, to be launched in September 2010, by UNDESA.
- b. A chapter in the report of the WHO Commission on Social Determinants of Health, focusing on mental health and its social determinants.
- c. The Western Cape (South Africa) Burden of Disease report, which is being used by the provincial government for long term strategic planning for health services.

All of these outputs provide evidence on the interventions required to break the vicious cycle of poverty and mental ill-health.

MHaPP researchers have also partnered with a number of international colleagues to contribute to key milestones in the development of global mental health, including authorship in the landmark Lancet series on Global Mental Health 2007 “Call for Action” paper, active membership in the subsequently established Movement for Global Mental Health, and contributions to the development of the WHO mhGAP programme. Furthermore, we have used the MHaPP platform to generate or partner with other projects, through multiplier funding, including the Perinatal Mental Health Project (Cape Town), the BasicNeeds Outcome study (rural Kenya), the development of Adolescent Health Policy Guidelines for South Africa, and the evaluation of the WHO AFRO Regional Strategy for Africa (2001-2010).

1.1.5. Who benefitted and how

Who benefitted	How they benefitted
Mental health policy makers in each study country	Active participation in MHaPP objectives and study design. Receipt and use of MHaPP data for policy. Shared experiences with Ministry of Health partners in other countries. Technical support from MHaPP for the development of mental health policy and legislation.
Mental health service planners at national, regional and district level in each country	Participation in consultation workshops for policy and strategic plan development. Receipt and use of MHaPP data for policy and planning. Technical support from MHaPP for the development of mental health strategic plans and information systems.
Mental health service providers in each study country	Training in mental health care in primary health care settings. Training in development and use of mental health information systems (in Ghana and SA only).
Health information managers and data collectors in Ghana and SA	Training in development and use of mental health information systems.
Mental health service users in each study country	Opportunity to participate in policy, planning and legislative processes in study countries. Participation in a study on user empowerment and participation in policy processes. Receipt of improved mental health services in PHC district demonstration sites.
Research partners in each study country	Capacity development in research design, data collection, qualitative data analysis, academic writing, and production of policy briefs and press releases.
Public Health Students	Teaching in the research methods, findings and interventions conducted in MHaPP
Media	Evidence base to inform media reports as data became available through the project
Parliament	Use of evidence in parliamentary submissions in South Africa
Global mental health community, including researchers, advocates, mental health professionals	MHaPP research methods, tools and findings are available for use in mental health research and advocacy in other settings.

Highlights of the research

The MHaPP RPC is the largest single research programme on mental health policy and systems yet conducted in Africa. MHaPP research has generated new knowledge on the factors necessary for mental health policy development and implementation in Ghana, South Africa, Uganda and Zambia, and in doing so has produced a range of valuable lessons for other low and middle-income countries. The study results have been communicated (or in some instances are in the final stages of preparation for publication), and research findings have been used to inform and improve mental health policy making and practice in the four study countries. We have not yet been able to assess the extent to which these have had an impact on other developing countries. Research and communications capacity have been substantially increased in all participating institutions.

In **Phase 1** (2006-2008) a large scale situation analysis of mental health policy development and implementation was conducted in each country. In all four countries this was the first time that a comprehensive situation analysis of this kind had been conducted. The situation analysis provided new knowledge regarding the countries' mental health systems, through the administration of the WHO Assessment Instrument for Mental health Systems (WHO AIMS); new knowledge regarding current mental health policy, plans and legislation, through the administration of the WHO Checklists for Mental Health Policy and Plans and for Mental Health Legislation; and new knowledge regarding the opinions of a large number of mental health stakeholders about mental health policy development and implementation in each country, through semi-structured interviews and focus groups.

There were a number of common themes that emerged from the findings across the four countries:

1. Mental health was low on the policy agenda in all countries, relative to other health priorities. The low priority given to mental health was disproportionate to the burden of disease for mental disorders, or evidence for cost-effective interventions.
2. Stigma and discrimination against people living with mental illness was widespread, and evident among policy makers, planners, health service providers (including mental health specialists), carers and service users. This frequently perpetuated the low priority given to mental health in policy, planning and resource allocation.
3. Poverty and mental illness were perceived by most stakeholders as interacting in a complex and mutually reinforcing cycle. Stigma was an important mediating factor in the relationship between mental illness and poverty, as demonstrated in Uganda.
4. Mental health services were on the whole extremely under-resourced, and the limited resources that were available were typically concentrated in psychiatric hospitals, particularly in Ghana and Zambia.
5. Although the integration of mental health into primary health care was endorsed at policy level in all the countries, in practice there was weak integration of mental health into primary health care.
6. Information systems for the routine monitoring of mental health care were sparse, and were non-existent in most primary health care settings.
7. In Ghana, Uganda and Zambia, mental health laws were outdated, and were shown by the WHO legislation checklists, and the opinions of a range of stakeholders in the countries, to be inadequate in protecting the human rights of people living with mental illness. Stakeholders strongly advocated for the reform of mental health legislation in these countries.
8. In South Africa, although services were relatively well resourced compared to the other country sites, there was widespread inequity between and within provinces, and services were concentrated on treatment of severe mental illness, with very limited

rehabilitation programmes, or care for people with common mental disorders, such as depression and anxiety disorders.

In **Phase 2** (2008-2010), on the basis of these situation analyses, several policy, planning, legislation, information systems and district primary health care interventions were undertaken in the countries. These intervention studies provided practical realisation of the RPC's purpose, namely that "Mental-health policy development and implementation in Ghana, South Africa, Uganda and Zambia were increasingly based on evidence emerging from the mental health RPC." The specific interventions included:

1. In Ghana:
 - a. Further development of the national Mental Health Bill and substantial progress towards adoption.
 - b. Reform of mental health information systems at the three psychiatric hospitals: Accra, Pantang and Ankaful.
 - c. A district demonstration project for the integration of mental health into PHC in the Kintampo District.
2. In South Africa:
 - a. Development of a first draft national Mental Health Policy, which is now being circulated to the 9 provinces for consultation.
 - b. Development of a draft mental health strategic plan for the Northern Cape province.
 - c. Development of mental health information systems at primary, secondary and tertiary level in pilot projects in the Northern Cape and KwaZulu-Natal provinces.
 - d. A district demonstration project for the integration of mental health into PHC in the Hlabisa sub-District in KwaZulu-Natal.
3. In Uganda:
 - a. Development of a draft national Mental Health Policy and Strategic Plan, which are awaiting adoption by the Ministry of Health.
 - b. Reform of mental health legislation, through the drafting of a new Mental Health Bill, a national consultation process, and preparation of the Bill for review in parliament.
 - c. A district demonstration project for the integration of mental health into PHC in the Mayuge District.
4. In Zambia:
 - a. Development of a national strategic plan for mental health.
 - b. Further development of the national Mental Health Bill and substantial progress towards adoption, through consultation workshops and re-drafting.
 - c. Training of PHC health workers in mental health in the Lusaka and Mumbwa districts.

To summarise the main findings of the intervention phase across the four countries:

1. From the experience of **mental health policy development** in Uganda and South Africa and strategic plan development in the Northern Cape, South Africa and in Zambia:
 - a. High level political mandate, leadership and political will are essential.
 - b. Stakeholders from a range of sectors must be identified and actively involved.
 - c. Awareness-raising and lobbying for mental health should form an integral part of policy and plan development.
 - d. Health managers and policy makers should be equipped with the skills necessary for mental health policy and plan development and implementation. Frequently these core skills needed to be developed further, and there is substantial potential for this ongoing capacity development work in Africa.

- e. Mental health advocates and policy makers need to be flexible, remain patient and persistent, and try to obtain strategic posts. Appointment of mental health advocates in senior strategic posts in Ministries of Health had a major impact in at least one study country.
 - f. “Policy windows” such as wider political reform, as evident in South Africa, present timely opportunities for action on mental health policy development.
2. From the experience of **mental health legislation development** in Ghana, Uganda and Zambia:
- a. During the legislation reform process, competing ideologies, disagreements and power struggles occurred between mental health stakeholders in some countries. To resolve these, regular consultation meetings, transparency and sharing of information were crucial to build consensus over time.
 - b. Widespread stigma and discrimination against the mentally ill has led to resistance to reforms proposed by the Mental Health Bill, for example in Ghana. Awareness-raising activities in the popular media and active lobbying have been important to combat this stigma and the active involvement of service users and their representative organisations in lobbying initiatives has been crucial.
 - c. Legislation reform has been hindered by limited political will and commitment from stakeholders in the Ministry of Health in some countries. To address this, attempts were made to ensure the Ministry of Health led the development and consultative processes of the Bill.
 - d. Technical delays and bureaucratic procedures have drawn out the process of legislation reform in all three countries. This has required commitment, persistence and flexibility on the part of mental health law reformers in the countries.
3. From the experience of **mental health information systems (MHIS) development** in Ghana and South Africa:
- a. Contextual challenges in broader health information systems in the country must be considered when designing and reforming information systems for mental health.
 - b. A range of stakeholders must be included in MHIS design (including indicator selection), development and ongoing implementation, including managers, health workers and data management staff.
 - c. Improved information systems can provide support for increased budget allocation for mental health, but must be accompanied by ongoing lobbying and raising awareness.
 - d. When designing information systems it is important to start small, but keep the big picture in view. Start with process data relating to headcount, such as sex and diagnostic categories, but make a long-term plan to build up to tracking outcomes such as health status and functioning in the community, co-morbid health conditions, and data from other sectors.
 - e. In addition to allocating funding to “hard” factors (such as equipment supply, maintenance and forms) it is important to invest in “soft” factors (such as staff skills, communication, attitudes towards mental health, change management, supervision and management practices). This is particularly crucial for mental health, as a health issue which has long been stigmatised and under-prioritised.
 - f. Reforms of MHIS often highlight the need for broader improvements in mental health systems, by shedding light on key gaps in services or staff skills. It is therefore important to link MHIS development to wider service improvements, where possible.
 - g. Implementing new mental health information systems can lead to a range of positive outcomes, such as better communication and team work, better planning within the hospitals, and better provision of care.

4. From the experience of the **district demonstration projects** in rural Ghana, South Africa and Uganda:
 - a. At the outset it is essential to establish a local community collaborative management forum for mental health, with representatives from a range of sectors, including health, education, police and NGOs. Establishing such forums was shown to be important for improving collaboration across sectors and improving mental health literacy, reducing stigma and mobilizing resources for mental health.
 - b. Increasing mental health personnel to aid service delivery does not necessarily require large financial investments. Use of trained community members to provide manualized treatments and psychosocial rehabilitation within a task shifting supervisory structure was shown to be a potentially effective strategy for increasing the capacity of the district health system to provide mental health services at minimal cost to the system. This approach also promotes culturally competent services given that community members are best placed to understand their own cultural and social realities.
 - c. Promoting user groups appears to be an effective means of treatment, rehabilitation and mental health promotion at a local level as well as increasing community control of mental health.
 - d. For task shifting to be effective it is essential that non-specialists are provided with supervision and support from mental health specialists.

Brief assessments of the impact of these interventions have been drafted as “case studies” and are available on the MHaPP website: www.psychiatry.uct.ac.za/mhapp.

In addition to these country-specific outputs, we have engaged in **secondary research** regarding the relationship between poverty and mental health in low and middle-income countries (LMIC). This has included:

1. The publication of the first systematic review on poverty and common mental disorders in LMIC. Further systematic reviews on poverty and suicide, and poverty and child and adolescent mental disorders are currently in development.
2. Use of the database from the poverty and mental health systematic review to inform a number of international and local outputs, including:
 - a. WHO Mental Health and Development report, to be launched in September 2010, jointly with UNDESA.
 - b. A chapter in the WHO Commission on Social Determinants of Health, focusing on mental health and its social determinants (in partnership with other non-MHaPP researchers).
 - c. Advisory work for the Western Cape (South Africa) Burden of Disease report, which is being used by the provincial government for long term strategic planning for health services (in partnership with other non-MHaPP researchers)

The main findings from this secondary research were:

1. From the systematic review on poverty and common mental disorders (CMD) in LMIC (1990-2008): Of 115 studies that were reviewed from 33 countries, most reported positive associations between a range of poverty indicators and CMD, such as depression and anxiety disorders (Odds ratios with 95%CI>1, or p<0.05). In community-based studies, 73% and 79% of studies reported positive associations between a variety of poverty measures and CMD, 19% and 15% reported null associations and 8% and 6% reported negative associations, using bivariate and multivariate analyses respectively. However, closer examination of specific poverty dimensions revealed a complex picture, in which there was substantial variation between these poverty measures. While variables such as education, food insecurity, housing, social class, socio-economic status and financial stress exhibit a relatively

consistent and strong association with CMD, others such as income, employment and particularly consumption are more equivocal. There are several measurement and population factors that may explain variation in the strength of the relationship between poverty and CMD. By presenting a systematic review of the literature, our research attempts to shift the debate from questions about whether poverty is associated with CMD in LMIC, to questions about which particular dimensions of poverty carry the strongest (or weakest) association. The relatively consistent association between CMD and a variety of poverty dimensions in LMIC serves to strengthen the case for the inclusion of mental health on the agenda of development agencies and in international targets such as the Millennium Development Goals (MDGs).

2. In the WHO Mental Health and Development Report, compelling evidence is provided that people with mental disorders meet criteria for vulnerability, in terms of international development practice. Because they are vulnerable, they merit targeting by national and international development strategies and plans. The report sets out the roles that development stakeholders can play in designing and implementing policies and programmes for reaching people with mental health conditions, and in mainstreaming mental health interventions into sectoral and broader development strategies and plans. Development programmes and their associated policies should protect the human rights of people with mental disorders, and build their capacity to participate in public affairs.
3. In the WHO Commission on the Social Determinants of Mental Health, the chapter on mental health focuses on two mental disorders which are the leading causes of the burden of mental disorder in children (ADHD) and adults (depression). The chapter presents clear evidence that these mental disorders are inequitably distributed in societies, as people who are socially and economically disadvantaged bear a disproportionate burden of mental disorders and their adverse consequences. The dynamic inter-relationship between socio-economic disadvantage and mental illness leads to a vicious cycle that perpetuates poverty among the mentally ill and increases the risk for mental illness among the poor. The chapter reviews a wealth of evidence on interventions that can break this cycle, by addressing both upstream social determinants and vulnerabilities, and downstream health outcomes and consequences through a combination of population- and individual- level actions. A key goal is for health care systems to be responsive to the mental health needs of the population. Efforts to increase coverage of cost-effective interventions must explicitly target disadvantaged populations and health impact assessments of macro-economic policies must consider mental health outcomes. Evidence from low- and middle-income countries remains relatively scarce and more contextual research is required to inform mental health policy and practice. In particular, research is needed regarding the impacts of social and economic change on mental disorder, and the mechanisms through which protective factors strengthen resilience and promote mental health. Longitudinal monitoring of population mental health is crucial for this purpose.
4. In the Western Cape Burden of Disease project, a review of the literature, and consultation with experts in the field, identified six risk areas for mental health, where it was felt interventions would be most useful: 1. Multiple Deprivation (poverty, unemployment, food insecurity, and housing shortages); 2. Substance Abuse (alcohol and drug abuse); 3. Mental Health Systems (prevention and screening, access to treatment); 4. Trauma (prevention of mental illness after exposure to violence); 5. Pre-school (access to affordable, high-quality pre-school facilities); and 6. Recreation (access to a range of sports and other recreational facilities). It was recommended that interventions in these areas should aim to increase social capital and employment: both significant determinants of mental health

MHaPP researchers have also partnered with a number of international colleagues to contribute to **key milestones in the development of global mental health**, including authorship in the landmark Lancet series on Global Mental Health 2007 “Call for Action” paper, active membership in the subsequently established Movement for Global Mental Health, and contributions to the development of the WHO mhGAP programme.

Furthermore, we have used the MHaPP platform to generate or partner with other projects, through **multiplier funding**. This has included a number of initiatives:

1. The Perinatal Mental Health Project (PMHP), led by Dr Simone Honikman, affiliated to the MHaPP RPC in Cape Town in 2007, and is evaluating a novel integrated perinatal mental health service at a local Midwife Obstetric Unit. The PMHP is independently funded, but has partnered with MHaPP due to shared policy, service and research objectives. PMHP work has included the following aspects:
 - Service provision: ongoing screening, counselling and psychiatry service at primary care midwife clinics at Mowbray Maternity Hospital.
 - Training and teaching:
 - Ongoing training in maternal mental health: medical students, nursing staff and M.Phil (Maternal and Child Health) students.
 - Designing an MPhil module on Maternal Mental Health.
 - Design and presentation of a Mental Health Nurse Seminar Series on Maternal and Infant Mental Health with Prof Astrid Berg.
 - Research:
 - Ongoing data collation, monitoring, evaluation and analysis of findings on service and health systems research.
 - Preparation of the validation study for a short mental health screening tool for use in primary care maternal services. This study will investigate the timing of such a screen during pregnancy taking into account the impact of being tested for HIV while pregnant. The protocol has been finalised, and funding has been secured for the second phase of data collection. Logistical issues regarding the implementation of the study are now being addressed.
 - Ongoing collaboration on the district demonstration project with MHaPP Kwazulu-Natal team.
 - Monthly meetings (clinical case presentations) which function as open clinical supervision for PMHP staff and other staff involved in maternal mental health at Mowbray Maternity Hospital.
2. The BasicNeeds Outcome study (rural Kenya): Prof Crick Lund, together with Prof Alan Flisher and BasicNeeds NGO developed a study proposal and subsequently raised independent funds to conduct a cohort intervention study: an evaluation of the BasicNeeds mental health and development model in rural Kenya. Prof Lund visited Kenya in late April 2009, conducted piloting of the instruments and worked with BasicNeeds to train fieldworkers. Fieldwork is now under way and approximately 200 participants have been recruited for the first round of data collection. These participants are now being followed up at 1 year and will be followed up again at 2 years, with evaluation of mental health, quality of life and poverty outcomes. The study will provide new knowledge regarding the outcomes of a community-based mental health intervention that aims to address the cycle of poverty and mental ill-health in low resource settings.
3. The development of Adolescent Health Policy Guidelines for South Africa. We received independent funding from the Centres for Disease Control, through a contract with the national Department of Health, South Africa, to develop national Adolescent and Youth Health Policy Guidelines. We employed two Research Officers, who conducted literature reviews of key health challenges for young people and the policy and legislative environment for Youth and Adolescent Health. We

developed a draft document, updating the 2001 Adolescent and Youth Health Policy Guidelines, engaged in a national consultation workshop with Department of Health colleagues, and finalised the new policy in late 2009.

4. Analysis of lost income associated with mental disorder in the South African Stress and Health (SASH) study – the first representative psychiatric epidemiological study in South Africa. A paper has been submitted for publication on this topic, together with colleagues in the School of Public Health at UCT. This paper provides new knowledge on the relationship between lost income and common mental disorders in South Africa.
5. Evaluation of the WHO AFRO Regional Strategy for mental health in Africa (2001-2010). This study was conducted under contract with the WHO AFRO office, with Prof Flisher and Prof Lund as the Co-Investigators. WHO AFRO had developed a 10-year Regional Strategy for Mental Health, and UCT undertook the task of evaluating the extent to which the objectives of the Regional Strategy had been achieved by 2010. This included employing 2 Research Officers to visit 5 African countries (Cote d' Ivoire, Democratic Republic of Congo, Ethiopia, Mozambique and Tanzania) to conduct semi-structured interviews with key stakeholders in these countries. In addition, the Research Officers collaborated with WHO HQ in Geneva to gather data for the WHO Atlas 2010 from all African member states, which was also used to evaluate the impact of the Regional Strategy. The project will conclude in July 2010, with submission of a report to WHO, and subsequent publication of research findings in peer review journals.

Achievements: Research Outputs and Purpose

What are the research outputs?

1.1.6. What programme outputs were achieved?

In Phase 1, a situation analysis was conducted of mental health policy development and implementation in the four study countries: Ghana, South Africa, Uganda and Zambia, using quantitative and qualitative research methods. This has been documented in a number of policy briefs, media releases and conference presentations (See Annex 5). Academic outputs from this have included:

- A situation analysis of current mental health systems in each study country, using the WHO AIMS.(1-8)
- A situation analysis of current mental health policy and plans in each study country, using the WHO Checklist for Mental Health Policy and Plans. (1-5;9)
- A situation analysis of current mental health legislation in each study country, using the WHO Checklist for Mental Health Legislation.(1;2;4;10)
- A situation analysis of mental health policy implementation in specific district sites in each study country.(3;11-15)
- A review of the major challenges facing mental health systems in each study country, based on semi-structured interviews with a wide range of stakeholders.(16-22)
- Recommendations for the strengthening of mental health systems in each study country, based on semi-structured interviews with a wide range of stakeholders.(18-21;23)
- A situation analysis of child and adolescent mental health services in each study country, and recommendations for strengthening mental health service delivery for children and adolescents, based on semi-structured interviews with a wide range of stakeholders.(8)
- New knowledge regarding mental health stigma in each study country, and its role in mental health policy development and implementation.(24-26)
- New knowledge regarding perceptions of the relationship between mental health and poverty among key stakeholders in each study country.(24;27)
- New knowledge regarding mental health and human rights in Uganda.(28)
- New knowledge regarding mental health and the media in Uganda.(29)
- New knowledge regarding mental health and gender in Ghana.(30)
- Recommendations for inter-sectoral collaboration in South Africa.(31)
- New knowledge regarding the participation of mental health service users in policy development and implementation in South Africa.(32)
- New knowledge regarding mental health and traditional healers in Ghana and South Africa.(33;34)

In Phase 2, a series of intervention studies were undertaken to develop mental health policy, legislation, strategic plans, information systems and primary mental health care services (as described in the previous section). The process of developing these interventions and their impact have been summarised in a series of policy briefs and case studies, which are available from the MHaPP website: www.psychiatry.uct.ac.za/mhapp. In addition, a number of academic journal articles are currently being finalised for submission, which provide lessons for other low and middle income countries who may be engaged in similar processes. These relate to the following outputs:

- Development of mental health policy in South Africa and Uganda.

- Development of strategic plans for mental health at national level (Uganda) and provincial level (South Africa).
- Reform of mental health legislation in Ghana, Uganda and Zambia.
- Development of mental health information systems in Ghana and South Africa.
- Integration of mental health into primary health care in district sites in all four study countries.

As a product of the Intervention phase, planning tools were developed for Community Mental Health Services and Child and Adolescent Mental Health Services in South Africa. These planning tools were developed using data from previous studies, but were made available as spreadsheet models which can be [downloaded](#) from the MHaPP website and adapted to other contexts by adjusting the following assumptions or variables: population size; age distribution; prevalence; comorbidity; levels of coverage; ambulatory care utilisation rates; length of consultation; ambulatory care workloads; and staff profile.(35;36) A paper which calculates the resources needed for an integrated district primary health care package for mental health, using a task-shifting approach, has been submitted for publication.(37) A similar spreadsheet planning tool will be made available for this model, once the paper is published.

In relation to secondary data analysis, a number of outputs have been generated, largely related to documenting the relationship between poverty and mental health in low and middle income countries, and the evidence base for interventions that can be undertaken to address the cycle of poverty and mental illness. These include:

- The first systematic review of poverty and common mental disorders in low and middle-income countries.(38)
- The WHO/MHaPP Mental health and Development report.(39)
- Social determinants of mental disorders (focusing on depression and ADHD) and interventions to address these, from high and low/middle-income countries.(40)
- Mental health and the MDGs in Sub-Saharan Africa.(41;42)
- Engagement in debate with international scholars regarding the poverty/mental health relationship in low and middle-income countries.(43)
- The impact of global trade on mental health.(44)

Members of the MHaPP RPC have also contributed outputs to a number of key milestones in global mental health, in partnership with other international researchers. These have included:

- A call to action for scaling up mental health care in low and middle-income countries, with recommendations for service targets, in the final paper of the Lancet series on Global Mental Health, 2007.(45)
- Calculation of the service resources and costs required for scaling up a core package of mental health care in low and middle-income countries, over 10 years.(46)
- Active membership of the Movement for Global Mental Health, including Editor of the Research pages of the MGMH website (Prof Lund, UCT) which includes a monthly “Feature Study” on global mental health, and compiler of the monthly MGMH newsletter (Ms Skeen, UCT).

1.1.7. Who benefited as a result of these outputs?

Who benefited	How they benefited
Mental health policy makers in each study country	Active participation in MHaPP objectives and study design.

	<p>Receipt and use of MHaPP data for policy. Shared experiences with Ministry of Health partners in other countries. Technical support from MHaPP for the development of mental health policy and legislation.</p>
Mental health service planners at national, regional and district level in each country	<p>Participation in consultation workshops for policy and strategic plan development. Receipt and use of MHaPP data for policy and planning. Technical support from MHaPP for the development of mental health strategic plans and information systems.</p>
Mental health service providers in each study country	<p>Training in mental health care in primary health care settings. Training in development and use of mental health information systems (in Ghana and SA only).</p>
Health information managers and data collectors in Ghana and SA	<p>Training in development and use of mental health information systems.</p>
Mental health service users in each study country	<p>Opportunity to participate in policy, planning and legislative processes in study countries. Participation in study on user empowerment and participation in policy processes. Receipt of improved mental health services in PHC district demonstration sites.</p>
Research partners in each study country	<p>Capacity development in research design, data collection, qualitative data analysis, academic writing, and production of policy briefs and press releases.</p>
Public Health Students	<p>Teaching in the research methods, findings and interventions conducted in MHaPP</p>
Media	<p>Evidence base to inform media reports as data became available through the project.</p>
Parliament	<p>Use of evidence in parliamentary submissions in South Africa.</p>
Global mental health community, including researchers, advocates, mental health professionals	<p>MHaPP research methods, tools and findings are available for use in mental health research and advocacy in other settings.</p>

Table 1. Summary of MHaPP RPC Outputs

OUTPUTS:	Verifiable Indicators (OVI)	Progress	Recommendations/Comments
<p><i>Output 1:</i> Knowledge generated concerning the factors necessary for the development of appropriate mental health policy</p>	<p>1.1 Knowledge products support (or initially challenge) the priorities of policy & programme decision-makers.</p> <p>1.2 Research topics reflect adjustments made during the life of the RPC on the basis of new knowledge, lessons learned.</p> <p>1.3 Knowledge products meet agreed standards for scientific rigour (e.g. journal acceptances; internal peer review for non-published material; policy relevance as judged by research users).</p> <p>1.4 Knowledge products delivered in accordance with</p>	<p>1.1 We have established and in some cases strengthened our relationships with key decision-makers, partly through the Mental Health Advisory Committees (MHACs) and partly through active involvement of MoH partners in MHaPP team work, and quarterly and annual meetings. This enabled us to interact with key decision-makers to establish, support, and at times challenge their priorities. There are good indications that the knowledge products do support the priorities of decision-makers.</p> <p>1.2 Research topics are consistent with those set out in the proposal and Inception Phase Report. Adjustments have taken the form of modifying research methodologies in response to requests from country partners. In addition, the topics for the intervention studies in Phase 2 were based on findings from the Phase 1 situation analysis and agreed upon through a careful process of consultation within the consortium, including Ministry of Health partners.</p> <p>1.3 We have taken steps to ensure scientific rigour, e.g., review of instruments by all consortium members plus external reviewers; piloting of instruments; review of appropriate research methodologies, internally and externally; training of research officers and ongoing support and supervision during fieldwork. We have had a substantial number of papers published or in press in peer review journals and other papers accepted at national and international conferences (see list in Annex 5).</p> <p>1.4 Knowledge products have been delivered in accordance with the research timetable, with 2 <i>provisos</i>. Firstly, the</p>	<p>An initial set of factors necessary for the development of appropriate mental health policy was identified from the Phase 1 Country Reports. These have been further elaborated in the peer review journal articles and policy briefs. From the Phase 2 interventions, a number of lessons have been generated from the practical experience of mental health policy development in the four countries. These have generated further clarity on factors necessary for the development of appropriate mental health policy.</p> <p>This has required a number of steps to lay the foundation for this output, including:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Establishing and strengthening relationships with key stakeholders who are targets for research findings. <input type="checkbox"/> Establishing national structures (such as the MHACs) for advisory and dissemination functions. <input type="checkbox"/> Developing methodology and instruments to gather and analyse the data. <input type="checkbox"/> Training research officers to undertake fieldwork and data analysis.

	<p>research timetable (as adjusted during the life of the RPC).</p>	<p>volume of peer-review journal articles has not been generated at an equitable rate across all countries.as a result of variable capacity in each country. We used a two-pronged approach to remedy this: intensive capacity development workshops (phase 1) and employment of a dedicated person to support countries in this task (phase 2). This has been a very productive approach, in particular the phase 2 strategy (see “Lessons learnt” for details). Secondly, delays in the completion of the situation analysis phase meant that there was less time than originally anticipated to complete the intervention phase. This has resulted in several academic papers still being drafted for publication at the close of the RPC. We have applied for a no-cost extension to use unspent funds to complete the publication and dissemination of this work, and partners have committed themselves to completing these final outputs.</p>	
<p><i>Output 2:</i> Knowledge generated concerning the factors necessary for effective implementation of mental health policies</p>	<p>2.1 Knowledge products support (or initially challenge) the priorities of policy & programme decision-makers.</p> <p>2.2 Research topics reflect adjustments made during the life of the RPC on the basis of new knowledge, lessons learned.</p>	<p>2.1 We have established and in some cases strengthened our relationships with key decision-makers, partly through the MHACs and partly through active involvement of MoH partners in MHaPP team work, and quarterly and annual meetings. This enabled us to interact with key decision-makers to establish, support, and at times challenge their priorities. There are good indications that the knowledge products do support the priorities of decision-makers.</p> <p>2.2 Research topics are consistent with those set out in the proposal and Inception Phase Report. Adjustments have taken the form of modifying research methodologies in response to requests from country partners. In addition, the topics for the intervention studies in Phase 2 were based on findings from the Phase 1 situation analysis and agreed upon through a careful process of consultation within the consortium, including Ministry of Health partners.</p>	<p>An initial set of factors necessary for the implementation of appropriate mental health policy was identified from the Phase 1 Country Reports. These have been further elaborated in the peer reviewed journal articles and policy briefs. From the Phase 2 interventions, a number of lessons have been generated from the practical experience of mental health policy implementation in the four countries. These have generated further clarity on factors necessary for the effective implementation of mental health policy.</p> <p>A number of steps were required to lay the foundation for this output, including:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Establishing and strengthening

	<p>2.3 Knowledge products meet agreed standards for scientific rigour (e.g. journal acceptances; internal peer review for non-published material; policy relevance as judged by research users).</p> <p>2.4 Knowledge products delivered in accordance with research timetable (as adjusted during the life of the RPC).</p>	<p>2.3 We have taken steps to ensure scientific rigour, e.g., review of instruments by all consortium members plus external reviewers; piloting of instruments; review of appropriate research methodologies, internally and externally; training of research officers and ongoing support and supervision during fieldwork. We have had a substantial number of papers published or in press in peer review journals and other papers accepted at national and international conferences (see list in Annex 5).</p> <p>2.4 Knowledge products have been delivered in accordance with the research timetable, with 2 <i>provisos</i>. Firstly, the volume of peer-review journal articles has not been generated at an equitable rate across all countries.as a result of variable capacity in each country. We used a two-pronged approach to remedy this: intensive capacity development workshops (phase 1) and through employment of a dedicated person to support countries in this task (phase 2). This has been a very productive approach in particular the phase 2 strategy (see “Lessons learnt” for details). Secondly, delays in the completion of the situation analysis phase meant that there was less time than originally anticipated to complete the intervention phase. This has resulted in several academic papers from the intervention phase still being drafted for publication at the close of the RPC. We have applied for a no-cost extension to use unspent funds to complete the publication and dissemination of this work, and partners have committed themselves to completing these final outputs.</p>	<p>relationships with key stakeholders who are targets for research findings.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Establishing national structures (such as the MHACs) for advisory and dissemination functions. <input type="checkbox"/> Developing methodology and instruments to gather and analyse the data. <input type="checkbox"/> Training research officers to undertake fieldwork and data analysis.
<p><i>Output 3:</i> Communication of study results and promotion of the utilisation of the research findings to inform and improve</p>	<p>3.1 Implementation of the communication strategy influences key policy makers to develop and implement mental health policies in keeping with the goals of the RPC, through a</p>	<p>3.1 Policy-makers and other stakeholders have been kept informed and engaged in the project via MHAC meetings in each of the four study countries. In addition many national actors (decision makers, media, mental health service users, family members) have been involved in the project via the semi-structured interviews conducted for the</p>	<p>In Ghana, South Africa, Uganda and Zambia, there appears to be a high level of interest and/or participation in RPC activities among key policy makers, particularly in the Ministries of Health. In South Africa, the previously</p>

<p>mental health policy-making and practice in the study countries and other developing countries.</p>	<p>wide range of networks including WHO, DFID and other international and national partners.</p> <p>3.2 Strategy includes changes made on basis of lessons learned during implementation (incl. e.g. changes in decision-makers or influential stakeholders; knowledge emerging from outputs 1 & 2).</p>	<p>research.</p> <p>At international level links have been established with international health and development agencies.</p> <p>Dissemination of project information has also occurred via the MHaPP website, the WHO website on mental health and development, publishing of papers and presentations at international and national conferences.</p> <p>3.2 The communication plan has been revised on the basis of review and input from project partners and DFID colleagues. The revised plan now comprises more targeted strategies and timeframes. (See Annex 4). Communication strategies were discussed as a standing item in our annual meetings, and partners were required to report on past year activities and future communication plans. This enabled us to modify communications according to the stage of the project, and new data that emerged.</p>	<p>mixed response has been replaced with a more positive and open communication, in both directions. This has been assisted by the appointment of key supportive individuals into senior positions within the national Department of Health (independently of MHaPP) and by the sharing of information from the provincial and district level MHaPP intervention projects with national Department of Health partners.</p> <p>A limitation of our impact has been the fact that although we have had good participation from mental health policy makers at the level of Directors of Mental Health, at a more senior level within the Ministries of Health (such as the Minister or Director-General), there remains a lack of clear political support for mental health issues in many instances, despite consistent lobbying with these roleplayers throughout the life of the project. This has resulted in delays in policy, plan or legislation adoption in some settings, and insufficient support for the rolling out of certain initiatives (such as MHIS), within the life of the MHaPP RPC.</p>
<p><i>Output 4:</i> Increase of research and communications capacity in all participating institutions</p>	<p>4.1 Capacity to conduct situation analysis of mental health policy development and implementation in each of the study countries is in</p>	<p>4.1 The capacity is in place to conduct the situation analysis, through the development of the study methodology, instruments and research officer training.</p>	<p>Capacity has been built successfully, corresponding to the stage of the RPC, i.e., capacity has been developed to successfully complete the first phase of the situation analysis in each country.</p>

	<p>place.</p> <p>4.2 Capacity to develop and evaluate interventions for policy development and implementation in each of the study countries is in place.</p> <p>4.3 Capacity to communicate research findings that reflect good practice in getting research into policy and practice (GRIPP) is in place, eg sufficient to persuade policy makers and planners to reform mental health systems in each of the study countries, in keeping with the goals of the RPC.</p>	<p>4.2 Following a needs assessment to assess the capacity of country teams to undertake the interventions, we have gone on to plan interventions according to our means, conducted further training and provided ongoing country site support during the intervention phase.</p> <p>4.3 Initial communication capacity was developed to make contact with senior policy makers and other key stakeholders in each country. We have completed the country reports, policy briefs, posters, press releases, and peer-review journal articles in all countries to effect changes in policy and practice. In the latter stages, the focus of the communications capacity development activities was on effecting changes directly through the interventions in each country.</p>	<p>Through this process, some capacity has been developed to use the evidence from the situation analyses to develop and evaluate interventions (phase 2), and persuade policy makers to reform mental health systems in each country. In the interventions we have worked actively with Ministry of Health partners to bring about changes to various aspects of the mental health systems, such as policy reform, legislation reform, development of information systems, and district demonstration projects.</p> <p>.</p>
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What are the research impacts?

1.1.8. Was the programme's purpose achieved?

The RPC's purpose was: "Mental-health policy development and implementation in Ghana, South Africa, Uganda and Zambia are increasingly based on evidence emerging from the mental health RPC and lessons learned are communicated to other developing countries." In broad terms this purpose has been achieved during the 5 years of MHaPP.

In the first phase of the MHaPP we laid the foundation for achieving our research programme purpose. This foundation included the establishment of the RPC infrastructure, development of the research methodology, production of instruments, training of research officers for the situation analysis, establishment of the MHACs, conducting of fieldwork, data analysis, and dissemination of the research findings via the four country reports and various publications, policy briefs, conference presentations and other communication materials (see Annex 5). These research findings have enabled the production of new knowledge regarding mental health policy development and implementation in four diverse African countries. Many of the country-specific findings have been produced and disseminated, and we are now developing further work on cross-country comparisons that will enable the generation of lessons for a range of low and middle-income countries. The nature of these outputs has been described above.

Subsequently, in the second phase it has been possible to assess more direct impacts of the intervention studies themselves. As mentioned earlier, these interventions have been designed with specific targets in mind, such as the establishment of policies, reform of legislation, development of information systems, and demonstration sites for the integration of mental health into primary health care. These impacts have been documented in a number of case studies, which are listed in Appendix 5, and available on our website: www.psychiatry.uct.ac.za/mhapp. The impact of these interventions is best reported on per intervention. They are summarised in the following table (Table 2).

Table 2. Summary of findings: Research impact of Phase 2 interventions

1. Development of mental health information systems in Ghana	
Summary of intervention	<p>A situation analysis was conducted on the state of mental health in Ghana between 2006 and 2007, using 2005 as the index year. One of the major findings was that the lack of a coherent and universal mental health information system (MHIS) makes it extremely difficult to collect data on patients or any systems in mental health care delivery in Ghana. It is therefore difficult to plan for services, support the mental health bill, and advocate for improvement in service delivery. It was therefore decided to set up a new MHIS for the Ghana Health Service, integrating it into the Health information system.</p> <p>At an early stage the process was hailed by Ministry of Health partners as a much needed improvement in the health information system as a whole. The study is designed with an intervention and research component. The aim is to identify the factors which enable the use of data in policy, planning, monitoring and evaluation (PPME).</p> <p>To begin, prescribers, recorders, nursing and hospital administrators were invited to discuss the findings of the situation analysis and to give feedback on what the new MHIS should look like. A series of meetings with a wider and more senior group led to agreement in the Mental Health community to use the ICD 10 as the basis for the new MHIS, and also on how to aggregate the major categories in a summary to include in the national health information system (NHIS) for Ghana. Training in ICD 10 with all prescribers and record staff in the three psychiatric hospitals has been completed, and a new MHIS computer based system designed for the three hospitals, enabling them to have a uniform data collection system for the first time. The system has been in operation since May 2009, and the Ghana Health Service is reporting on progress with the system each week at its PPME meeting.</p>
Who has benefited already and how?	<ul style="list-style-type: none"> ▪ Prescribers and records department staff have received training in how to use the ICD-10 for diagnosis in mental health. ▪ Records and data entry personnel have received training in how to complete the new forms for gathering patient history and how to enter this into the computer. ▪ The PPME of the Ghana Health Service is using the MHIS as a pilot for getting physicians in general health settings to agree to use the ICD-10 classification system by the same consensus building method. ▪ PPME is also looking at the process by which we will select and define monitoring indicators for reporting formats to planners and managers in order to replicate this in the national health information system. ▪ PPME is hoping to use lessons from the project to graduate the MHIS onto the district health information management system, thus integrating mental health information with the general health information system.

What is the actual or potential impact of the research?	The actual impact of the MHIS intervention, apart from that listed above is that for the first time, all three psychiatric hospitals in Ghana can now report consistent data with standardised indicators, which facilitate comparison between facilities and over time. In addition, the data which are collected can be a strong tool for advocacy in mental health. The unexpected impact is that it has immediately begun to be seen as a model for addressing perennial problems in national data gathering, beyond the mental health sector.
2. Development of mental health legislation in Ghana	
Summary of intervention	<p>A situation analysis was conducted on the state of mental health care in Ghana between 2006 and 2007, using 2005 as the index year. The major finding was that Ghana is still using the Mental Health Decree of 1972 which replaced the Asylum Ordinance of 1888 enacted by the colonial government. This lack of current mental health legislation makes it very difficult to improve access to good quality mental health care. A mental health law is absolutely necessary in addressing the mental health needs of the population by specifying systems that need to be put in place to manage and prevent priority mental disorders and protect human rights. In addition, the legislation can co-ordinate essential services and activities to ensure that treatment and care is delivered to those in need and prevents fragmentation and inefficiencies in the health system.</p> <p>A new draft bill was developed, using the WHO Checklist on Mental Health Legislation, and input from a range of Ghanaian stakeholders. This new bill adopts a human rights based approach to mental disorder in accordance with the UN Charter on Human Rights and international consensus on the health care needs of a person with mental disorder. The bill aims to prevent discrimination and provide equal opportunities for people with mental disorder. It recognizes that progressive legislation which acknowledges the modern trend on human rights can be an effective tool to promote access to mental health care as well as to promote and protect the rights of people with mental disorder. The bill is waiting to be passed into law. It has been accepted by cabinet, sent for revisions to the Ministry of Health, and is now being submitted to parliament to be enacted into law.</p>
Who has benefited already and how?	<ul style="list-style-type: none"> ▪ The media, NGO's (e.g. Basic Needs), religious groups, health workers and traditional authorities been pro-active in lobbying politicians and decision makers. ▪ The ministers, Members of Parliament, policy makers in the Ministry of Health and the Ghana Health Service have been sensitized on the key challenges of the old law and the need for the new law. ▪ The response of general public to the awareness raised by the periodic but well placed radio, newspaper and television articles has being overwhelming and affirmative. In addition, successful fora have been held to educate the public on the new mental health bill and the public have had the chance to have their concerns addressed. ▪ The actual end users of the bill, the mentally ill, stabilized mentally ill people and their carers by the formation of the Mental Health Society of Ghana.

<p>What is the actual or potential impact of the research?</p>	<p>The actual impact of the legislation intervention, apart from that listed above is that Ghana will have a bill that adopts a human rights based approach to mental disorder in accordance with the UN Charter on Human Rights and international consensus on the health care needs of persons with mental disorders. It will prevent discrimination and provide equal opportunities for people with mental disorder. This progressive legislation will acknowledge that the modern trend on human rights can be an effective tool to promote access to mental health care as well as to promote and protect the rights of people with mental disorders.</p>
<p align="center">3. Development of a strategic plan for mental health in the Northern Cape Province, South Africa</p>	
<p>Summary of intervention</p>	<p>A collaboration between MHaPP researchers at the University of Cape Town (UCT) and provincial Department of Health managers, clinicians and service users in the Northern Cape Province produced the first mental health strategic plan for the province. An internal departmental process is underway to move for the adoption of the plan.</p> <p>The draft plan was developed by a drafting committee based on a detailed situational analysis in the province. It emphasises the need for community based mental health services and the integration of mental health into district and regional hospitals. Key objectives include health promotion to reduce mental illness-related stigma and discrimination, improving mental health practitioner capacity, organisation of mental health services and inter-sectoral collaboration to deliver quality mental health care, support to mental health care user participation in their recovery, development of a mental health information system and evidence based planning and service provision.</p> <p>Mental health policy implementation in South Africa takes place through national, provincial and district structures, as set out in the White paper on the transformation of the health system in South Africa, 1997. The national Department of Health provides policy direction to the 9 provincial mental health authorities to which all health services and budgets are devolved. However, strategic planning at the provincial level has been identified as a key barrier to successful policy and legislation implementation for mental health in South Africa. Development of a provincial strategic plan is a key intervention that could address difficulties with policy implementation at provincial level. Lessons generated from this process will be used to inform other provincial strategic planning processes for mental health in South Africa.</p>

<p>Who has benefited already and how?</p>	<p>Membership of the drafting committee included representatives from health, education, social development, the NGO sector, and service users. The inter-sectoral nature of the membership has facilitated the inclusion of several areas for the plan which will require intersectoral attention for effective implementation, and participation has developed individual members' capacity for the development of a strategic plan. Interviews revealed the value of the broader consultation process in raising awareness of the importance of mental health as a public priority, and providing a networking opportunity for role-players who can contribute to addressing mental health in the province.</p>
<p>What is the actual or potential impact of the research?</p>	<p>With the recent inauguration of a new president for South Africa, national and provincial health plans for the next 5 year period are being redrafted. The mental health plan has given direction to the provincial programme manager's input to the broader provincial strategic plan for health submitted to national department of health in July 2009, and will inform submissions for budget allocations to the programme for the 2010-11 period.</p> <p>At provincial level, approval of the plan will also provide support to:</p> <ol style="list-style-type: none"> 1. the mental health programme manager's ongoing lobbying for the allocation of a budget to support identified service development priorities for mental health in the province 2. provide a framework for addressing neglected intersectoral service development issues, 3. address the current insufficiency of accessible community based mental health services for non-urban, poor service users. <p>The research findings from the intervention will be used to inform other provinces, and possibly other low and middle-income countries regarding the process of developing strategic plans for mental health in low resource settings.</p>
<p>4. Developing information systems to monitor mental health care in South Africa</p>	
<p>Summary of intervention</p>	<p>Before MHaPP there was only one indicator of mental health service utilisation at primary care level in South Africa: "mental health visit", and data for this indicator were notoriously unreliable.(4;6) There was no disaggregation of data by diagnosis, age or gender and no treatment or outcome data. In collaboration with local health managers, clinicians and data managers, MHaPP introduced a set of practical input and process indicators – a best practice model for mental health information systems from primary to tertiary level, including basic demographic and diagnostic information, treatment and referral data. The model was pilot tested over a 1-year period in 2 districts in the Northern Cape and 3 districts in KwaZulu-Natal (April 2009 – March 2010).</p>

<p>Who has benefited already and how?</p>	<p>A MHIS task team was established in each province, and has worked closely with the MHaPP team. They have received exposure to the rationale and methods for information system strengthening for mental health services, based on WHO materials and other resources from the MHaPP team. Their capacity for designing and monitoring information systems has been developed through collaboration on the planning and design of the system. Subsequently primary health care nurses, mental health professionals and district and facility Information Officers have received training and a specially developed reference manual for the new MHIS (in March 2009). Data from the first year of the pilot project (April 2009 – March 2010) are now available.</p>
<p>What is the actual or potential impact of the research?</p>	<p>Preliminary feedback from service managers, clinicians and information officers in the provinces was extremely positive. The new system provided previously unavailable data for routine service monitoring. In KwaZulu-Natal, the Department of Health took a decision to roll out the new system to all the remaining districts in the province, before the pilot project was completed, and independently undertook training of clinical and data management staff at its own expense. Both provinces have committed significant resources to the project, including staff time, software design and printing and disseminating clinic and hospital forms. The mental health information system (MHIS) has been adopted by both provinces at the end of the project, and the national Department of Health has expressed interest in extending this to other provinces in South Africa.</p> <p>For the first time a range of input and process indicators are available for planning of mental health service delivery in 2 South African provinces. This will enable service managers and policy makers in these provinces to monitor and plan services in a more cost-effective manner than has previously been possible. The data will also serve as an advocacy tool for mental health programme managers to motivate for more appropriate resource allocation for mental health care. This is particularly important for the provision of community-based mental health services in poor communities, where people living with mental disorders are at increased risk of relapse.</p>

5. The development and evaluation of a pilot community-based intervention for common mental disorders (CMDs) in a rural district in SouthAfrica	
Summary of intervention	<p>This novel intervention study evaluated the use of community-based health care workers to deliver a counselling service for common mental disorders such as depression. As there are inadequate numbers of specialist mental healthcare workers and primary healthcare personnel are overstretched in this remote rural district, the service is delivered by locally trained community-based health workers (CBHWs) under the supervision of a mental health counsellor with a four-year training (Bachelor of Psychology).</p> <p>The intervention included the adaptation and development of a culturally appropriate counselling manual using Interpersonal Psychotherapy (IPT) delivered by CBHWs to treat moderate to severe depression in order to increase accessibility and affordability of the service.</p> <p>Mental health counsellors with a 4-year training (Bachelor of Psychology) provide:</p> <ul style="list-style-type: none"> ○ basic counselling in individual and group form; ○ a referral system for individuals in need of immediate care who are suffering from depression; and ○ support, supervision and training to community-based health care workers in providing a manualized group counselling service for those with depression, including maternal depression.
Who has benefited already and how?	<p>CBHWs have benefitted from manualised training in individual and group forms of counselling dealing with depression and have shown themselves capable of understanding and applying basic approaches to counselling.</p> <p>Preliminary findings of a pilot study indicate positive results with a significant reduction in depressive symptoms, as measured by the Beck Depression Inventory, being found in the intervention participants compared to the controls over 12 and 24 weeks, $F(2,1.739) = 46.645, p < 0.0001$. Similarly, with the overall Hopkins Symptom Checklist (HSC-25) scale, a significant reduction in symptoms of overall psychological dysfunction was found in the intervention group compared to the controls at 12 and 24 week intervals $F(2, 1.651) = 34.55, p < 0.0001$. The results suggest that it is a feasible and potentially effective package of care for depression in rural areas.</p>

<p>What is the actual or potential impact of the research?</p>	<p>People living with depression in the intervention groups have reported improvements in their symptoms and quality of life through strengthened social connections and increased coping skills, which has resulted in greater personal agency. The potential impact is the incorporation of this task shifting model for the treatment of moderate to severe depression into the suite of services offered to patients at outpatient clinics who suffer from common mental disorders, thus contributing to closing the treatment gap for these disorders in South Africa.</p> <p>This intervention has the potential to benefit the vast majority of patients at outpatient clinics presenting with depression who are currently untreated (and frequently go undetected). The establishment of a low cost mental health system that utilises CBHWs and a MHC worker may well address the need for greater treatment access to patients suffering from depression and other common mental disorders.</p>
<p align="center">6. Development of a mental health policy and strategic plan in Uganda</p>	
<p>Summary of intervention</p>	<p>In Uganda, intensive work by the MHaPP team and the Division of Mental Health in the Ministry of Health is leading to the adoption of the country's first comprehensive National Mental Health Policy. The policy is the result of collaboration between Ugandan MHaPP researchers, WHO and policy makers in the Division of Mental Health, Ministry of Health. All partners participated in the design of the intervention. The intervention has followed international best practice in the development and adoption of mental health policy, and been subject to process and outcome evaluation, in order to generate lessons for other countries. The policy development has included a broad stakeholder consultation process that has not been present in previous mental health policy processes. The development of the mental health policy was founded on the first phase of MhaPP, during which a detailed situation analysis of the mental health system in Uganda was conducted.(2)</p>
<p>Who has benefited already and how?</p>	<p>A number of stakeholders have benefited already:</p> <ul style="list-style-type: none"> ▪ The Mental Health Division of the Ministry of Health has a comprehensive mental health policy and strategic plan for the first time. ▪ The wide dissemination of the MHaPP findings in local media and through the policy consultation process has facilitated more open and wider understanding of mental health in the public, tackling key issues, such as stigma and discrimination against the mentally ill. ▪ The policy consultation process has also boosted the involvement of NGOs in mental health, particularly those representing mental health service users. This has contributed to their empowerment, to the policy content and potentially to the implementation of the policy.

<p>What is the actual or potential impact of the research?</p>	<ul style="list-style-type: none"> ▪ Currently the policy has been submitted to the Ministry of Health, and is awaiting approval by the top management committee of the ministry. On approval, the policy will be widely disseminated to all stakeholders, and is expected to contribute significantly towards structuring and improving mental health services in the country. Development of a specific mental health strategic plan, based on the policy is also under way and will be evaluated, as part of the intervention study. ▪ The mental health policy and strategic plan are likely to lead to a more systematic approach to the planning and delivery of mental health services in Uganda. ▪ The strategic plan also includes specific programmes to improve mental health service delivery at district level, for example targeting district health leadership for sensitization on mental health, to improve budget allocations at this level. ▪ The MHaPP research findings have also prompted plans to reform Uganda's mental health law of 1964. This outdated legislation has been an obstacle to the protection of human rights for people living with mental illness, and the reform of the legislation has the potential to more adequately protect the rights of this vulnerable group.
<p align="center">7. Strengthening the integration of mental health into primary health care (PHC) in a model rural district in Uganda</p>	
<p>Summary of intervention</p>	<p>Findings of the situational analysis of the mental health systems in Uganda point to low priority given to mental health most especially at the PHC level. Mental health services were sparse in urban areas and nonexistent in rural areas at this level. There were very few mental health workers. There were no training programmes in mental health care for primary health care personnel, no mental health services for children and adolescents, and no evidence for any activity geared at mental health promotion and prevention of mental disorders.</p> <p>In this context MHAPP Uganda together with the mental health division at the Ministry of Health headquarters undertook a project that aimed to implement and evaluate models of best practice for the integration of mental health into primary health care at district level. Lessons from this intervention would be used to inform policy development. Interventions included re-orienting the district health management on mental health and the need to strengthen mental health care; establishing a multisectoral forum and orienting forum members on their role in mental health care; strengthening in-service training for health care workers on identification and management of mental disorders; and establishing support and self help groups for service users.</p>

<p>Who has benefited already and how?</p>	<ul style="list-style-type: none"> • The district health management have been able to scale up mental health services through the integration of mental health into PHC, and training health workers in identification and management of people with mental disorders. • Wide dissemination of findings and sensitizations to public, local authorities has facilitated understanding of mental health and improved the identification and referral of patients for health care. • The community is beginning to take responsibility for and protect the rights of the mentally ill. Many people with mental illness were tied up with ropes in back yards as the family lacked capacity to seek help. • General health care workers will be more competent in identifying and managing mental health cases. • Establishment of multi-sectoral forum has paved the way for the inclusion of mental health into activities of other sectors. Mental health users and their families are now included in other programmes. • Mental health programmes in school have gained credibility. Due to the noted changes in behaviours of substance abusing and delinquent students, school administration would like to scale up mental health services as other alternatives to disciplining. • Before the intervention, few psychotropic medicines were available at the health units, because of lack of demand from health care workers and service users. But after the intervention the volume of medicines requisitioned increased as more patients were identified. • The district intervention has generated lessons for best practice in mental health care delivery in PHC settings. It will also generate lesson for policy makers and planners about improvement of mental health at district level.
<p>What is the actual or potential impact of the research?</p>	<p>We have noted an increase in level of knowledge among general health workers and more patients are being identified with mental disorders in the primary health care setting and referred for treatment. Communities are beginning to appreciate mental health, identify patients and seek mental health care. Local leaders are becoming more responsive to rights of the mentally ill. Efforts at incorporating mental health services into the school curriculum are underway-head teachers in schools visited want to have their senior woman and senior man teacher receive training in mental health care. Caretakers are hopeful of the treatment and are positive about benefiting from support groups.</p> <p>The district intervention will generate lessons for best practice in mental health care delivery in primary health care settings in African countries. It will also generate lessons for policy makers and planners about improvement of mental health at PHC level. Before the intervention, few psychotropic medicines were available at the health units- because of low demand from service users. After the intervention the volume of medicines requisitioned has increased significantly as more service users were identified.</p>

8. Reform of mental health legislation in Zambia	
Summary of intervention	<p>One of the key findings from MHaPP's situation analysis of Zambia's mental health system was that the current mental health law is outdated and fails to protect the rights of those living with mental illness. Thus, the Zambian MHaPP team felt that it was essential to transform the legislation, in accordance with international human rights standards. A number of steps were taken:</p> <p><u>July 2008:</u> MHaPP devised and submitted to Ministry of Health (MoH) "<i>MHAPP Position Paper on Mental Health Legislation</i>" on how the legislation should be changed.</p> <p><u>October 2008:</u> MHaPP lobbied to get the Bill placed on Parliament's agenda</p> <p><u>June 2009:</u> MHaPP met with MoH to agree on a common position</p> <p><u>June 2009:</u> Consensus-building meeting with all relevant stakeholders in order to discuss the revised Bill organized by MHaPP and MoH.</p> <p><u>July 2009:</u> Revised Bill submitted to the Justice Department to transform it into legal discourse, and submit to Parliament.</p> <p>In the meantime, the MHaPP Zambian team has started disseminating results from the situation analysis to key parliamentarians. MHaPP has also contacted various stakeholders (including students from the University of Zambia, mental health service users and their families, as well as the three mental health NGOs in the country) to hold banners about the Mental Health Bill outside of parliament on the day of the sitting. Currently, MHaPP is also organizing media coverage in a local newspaper.</p>
Who has benefited already and how?	<p>Mental health advocates in Zambia have benefitted by having access to MHaPP data and technical support, to lobby for reforms to the mental health legislation in Zambia. The Ministry of Health has received input from MHaPP regarding international human rights standards that should be adhered to in the development of mental health legislation. The Ministry of Health has also benefitted through access to MHaPP quantitative and qualitative data on the mental health system in Zambia.</p>
What is the actual or potential impact of the research?	<p>MHaPP research and interventions have the potential to transform the current mental health system in Zambia. MHaPP has generated recommendations for how the mental health system can be better co-ordinated; has lobbied for the implementation of a new law; as part of the law reform process, has conducted consensus building efforts involving different actors thus bringing greater visibility to the issue of rights of persons with mental disorders; and has generated immense awareness about mental health, which in turn will help address the ubiquitous stigma surrounding mental illness in the country. Ultimately, all of these initiatives have the potential to improve the detection, management and treatment of mental disorders among poor and marginalised people in Zambia.</p>

1.1.9. What is, or is likely to be the programme's impact on poverty?

As initially conceptualised, the “big idea” of the MHaPP RPC was that mental health and poverty interact in a vicious cycle that increases the risk of mental illness among the poor, and leads to a slide into (or maintenance in) poverty among those living with mental illness. To break this cycle, a number of national (and at times international) policies and interventions are required. These can address either “direction” of the cycle – in the first instance by developing mental health policies and services that provide affordable, accessible and appropriate mental health care to people living with mental illness, or by delivering a number of poverty alleviation interventions that carry mental health benefits.

In this context, the MHaPP RPC has largely contributed to the first of these potential “directions”, by developing mental health policies, plans, legislation, information systems and district PHC services that are pro-poor. These interventions have been particularly concerned with promoting the human rights of people with mental disorders, and providing mental health care to those who are poor and marginalised within the study countries. At this stage it is too early to assess the extent of these interventions' impact on the poor. In most instances the interventions have only recently been completed, and evaluations have centred on processes of implementation and preliminary impact. However, if the processes initiated within the study countries are sustained by the Ministry of Health and other partners, then they are likely to lead to policy development and implementation that do substantially influence the poverty/mental illness cycle in the study countries. These would need to be evaluated further in the long term, eg at 5-year intervals.

In addition, we have developed planning tools to assist in the scaling up of community mental health services, child and adolescent mental health services, and an integrated package of primary mental health care services, using a task shifting approach. These take the form of spreadsheets which model the resources that are required to provide services for a given target population and set of conditions. The planning tools are available for free download from the MHaPP website, and potential users can refer to details of the methodology from the relevant published peer review journal articles. If taken up by planners and policy makers, these tools have the potential to substantially impact the poverty/mental illness cycle, through rational evidence-based planning that addresses the needs of people living in poverty with mental illness.(35-37)

1.1.10. What is, or is likely to be the programme's impact on the wider environment (i.e. at national, international level beyond those directly involved in the research)?

It is perhaps in relation to the secondary data analysis that a wider impact is likely to be made on poverty, beyond the study countries. As mentioned above, these outputs have included:

1. The publication of the first systematic review on poverty and common mental disorders in LMIC, presenting epidemiological data from 115 studies conducted in 33 countries between 1990 and 2008. Further systematic reviews on poverty and suicide, and poverty and child and adolescent mental disorders are currently in development.
2. The WHO Mental Health and Development report, to be launched in September 2010, by UNDESA.
3. Use of the database from the poverty and mental health systematic review to inform a chapter in the WHO Commission on Social Determinants of Health, focusing on mental health and its social determinants (in partnership with other non-MHaPP researchers).

This secondary data analysis carries the potential for a much broader impact on poverty, by drawing on evidence from a variety of low and middle-income countries, and targeting a wide range of international development policy makers and practitioners. For example, the systematic review on poverty and CMD in LMIC provides a distillation of the epidemiological evidence base from 33 countries over 19 years regarding the strength and consistency of associations between mental illness and a range of poverty indicators. This has shifted the debate from whether poverty and mental illness are linked in LMICs(43;47) to a focus on the specific socio-economic deprivation measures which carry the strongest associations with mental illness.(38) This provides the basis for the development and evaluation of more targeted interventions that can address the poverty/mental illness cycle.

In terms of providing data to a range of international development policy makers and practitioners, the WHO/MHaPP Mental Health and Development Report, to be launched jointly with UN DESA in September 2010, perhaps carries the potential for the biggest impact. As mentioned above, the report presents compelling evidence that people with mental disorders meet criteria for vulnerability, in terms of international development practice, and because they are vulnerable, merit targeting by national and international development strategies and plans. The Report sets out the specific roles and strategies that need to be adopted by a range of national and international development actors including governments, NGOs, bilateral and multilateral agencies, human rights bodies, global partnerships, foundations, and academic and research institutions.

Similarly, partnership with BasicNeeds Kenya has provided an opportunity to evaluate the long term mental health, quality of life, and, importantly, economic impact of community mental health interventions in poor rural communities. As the 2 year follow-up of this intervention will only be completed in August 2011, it is not yet possible to provide data on the impact of this intervention on poverty. However, based on other BasicNeeds evaluations, it is likely to contribute to the evidence base that can be used to deliver interventions that have a tangible and practical impact on the lives of people living in poverty with severe mental illness.

In addition, partnership with other initiatives has provided further data that have the potential to impact on poverty. This has included analysis of the South African Stress and Health Survey (SASH) data, which provides new knowledge on lost income associated with mental disorder in South Africa. This provides support for the economic argument for investment in mental health care, as a means of mitigating the economic costs of mental illness, associated with reduced productivity. This paper has recently been submitted for publication.(48)

Partnership with the wider Movement for Global Mental Health (established following the 2007 Lancet Series on Global Mental Health) and the Centre for Global Mental Health at the London School of Hygiene and Tropical Medicine and the Institute of Psychiatry, has led to a number of productive collaborations, including the outputs mentioned above and ongoing contributions to the MGMH website, as described earlier. This has laid the foundation for potential future research collaborations, for example in applications for a future RPC to improve mental health services in low income settings.

1.1.11. The effectiveness of the delivery of the communication strategy and how it supported the achievements of the programme purpose and outputs

The extent to which each of the targets set out in the communication strategy were achieved is presented in Annex 4. On the whole, the communication strategy was delivered effectively, within the constraints of the resources at hand. The overall RPC

communication strategy was adapted at country level, and reviewed annually by the consortium as a whole. At our annual meetings all partners were required to describe their communications activities during the previous year, we reviewed these reports in some detail, and plans were made for communication work in the following year. This enabled us to modify communications according to the stage of the project, and new data that emerged. As our WHO partners were leading this aspect of MHaPP, they were able to make use of their extensive communication networks to maximise the impact of our messages. We also made use of both the MHaPP website, and the WHO Mental Health and Development website to disseminate our key findings and products.

Feedback received from DFID during the Mid-term review (MTR) was particularly useful in refining our communications work. For example, we received the following feedback in the MTR: “It is recommended that there is a much greater focus in the second half of the project, and now that the research phase is over (sic), on targeting and engaging policy makers, civil society and community organisations in the four countries.” In the second phase of the MHaPP we took active steps to address this recommendation by targeting and engaging these stakeholders, through the intervention studies. This included, for example working with a range of stakeholders to develop mental health policies and laws in the study countries, strengthen information systems, and integrate mental health into primary health care in the district demonstration sites. In this sense, communications activities in the second phase were related to a more engaged process with a range of stakeholders than in the first phase.

However, there were limitations to our communications work. Although the requirement that we spend 10% of our budget on communications was helpful in allowing us to focus time and resources on this aspect, it would have been perhaps more helpful to have a dedicated full-time communications expert employed by the RPC. Having a full-time communications officer in the RPC would have doubtless strengthened the effectiveness of the delivery of the communications strategy further.

The communication strategy supported the achievement of the programme purpose in the following way:

- RPC products (country reports, publications and conference presentations) are now available to influence mental health policy development and implementation in the study countries and beyond. These findings have been used to shape a number of policy related interventions in the four countries, as described above.
- Changes have been made to policy and practice in all 4 countries. These are influencing policy (in Uganda), strategic planning (in Uganda and SA), legislation (in Ghana, Uganda and Zambia) information systems (in Ghana and SA), and the delivery of primary mental health care services that are making a concrete difference to people’s lives in all 4 countries.
- Attribution to the work of the mental health RPC is judged to be at a reasonable level for the current stage of development.

The communication strategy supported the achievement of the programme outputs in the following way:

- Policy-makers and other stakeholders have been kept informed and engaged in the project via MHAC meetings in each of the four study countries. In addition many national actors (decision makers, media, mental health service users, family members) have been involved in the project via the semi-structured interviews conducted for the research.
- At international level links have been established with international health and development agencies.

- Dissemination of project information has also occurred via the MHaPP website, the WHO website on mental health and development, publishing of papers and presentations at international and national conferences.
- The communication plan has been revised on the basis of review and input from project partners and DFID colleagues. The revised plan now comprises more targeted strategies and timeframes. (See Annex 4).

1.1.12. How the research is reaching the targets set out in our communication strategy

National stakeholders, (including government policy makers, mental health service user and family representatives and health professionals) were kept informed of project activities and progress via meetings of the MHACs in Ghana, South Africa, Uganda and Zambia. Links have been (and continue to be) established with international organisations and development agencies (via face to face meetings, teleconferences and email) in order to inform them of the MHAPP and engage them in the work. Project partners have participated in the publication of several international mental health papers, published in prominent journals, aimed at disseminating knowledge about mental health as a major public health issue for low and middle-income countries (see Annex 5).

In addition, members of the research team have published a number of other papers that involve public mental health. These papers are not directly relevant for the project, but certainly contribute to achieving the broad overall project goals (see Annex 5).

The project has also been represented by different project partners at several international and national events and conferences (see Annex 5) with invitations received for presentations at several upcoming meetings. The website on mental health, poverty and development (www.who.int/mental_health/policy/development/index.html) as well as the Report on Mental Health and Development (described above), also represent important means for publicising the project and its research findings and will be widely disseminated to key stakeholders at national and international levels.

An overview of the extent to which each of the specific targets set out in our Communication strategy has been achieved is provided in the Table in Annex 4. The key achievements included:

- ❑ Development and updating of databases. Several databases have been created in order to facilitate communication and dissemination of project information and research results. These databases, which were updated on an ongoing basis throughout the project, include data on:
 - i. national and international stakeholders and targeted communication channels
 - ii. international and national events, conferences and meetings
 - iii. international and national journals relevant for dissemination of project information and research findings
- ❑ Engagement with international organisations. Meetings have been held with key international agencies in order to discuss the project, create partnerships and actively involve organisations in the work being undertaken in the area of mental health, poverty and development. In the past meetings and discussions have occurred with DFID, the WHO Commission on the Social Determinants of Health, the WHO Department of Health Policy, Development and Services, the Development Bank of South Africa, the World Bank Group, European Bank for Reconstruction and Development, the International Finance Corporation. Through the launch and dissemination of the WHO Mental Health and Development report, from September

2010, these and other key stakeholders will be targeted for the key messages of the report.

- ❑ The WHO website on mental health, poverty and development has been updated on an ongoing basis. The website, in addition to highlighting the links between mental health, poverty and development, contains the following additional features:
 - Factsheet on breaking the cycle of mental health and poverty, and on mental health and prisons (more factsheets to be developed, on mental health and development, e.g., vulnerable groups)
 - Links to key organizations and contacts including directory of development agencies and of NGOs in countries
 - Databases of Journals & conferences relevant to mental health and development issues
 - MHaPP national and international Policy Briefs on different issues related to the project
 - MHaPP country reports for Ghana, South Africa, Uganda and Zambia
 - Testimonials from different actors in the field of mental health and development - mental health service users, families and carers, NGOs, mental health professionals and service providers, policy makers, and development agencies and funders (currently under development).
 - An 'in the press section' - comprising press release and coverage related to mental health and development (currently under development).
 - Link to the MHaPP website.
 - Acknowledgment of DFID.

- ❑ Elaboration of knowledge base on the links between mental health, development, policy and poverty. This has taken the form of the WHO Mental Health and Development report, the systematic review on poverty and common mental disorders, and contribution of a chapter on mental health to the WHO Commission on the Social Determinants of Health.

- ❑ Dissemination of information about MHAPP. In addition project partners have used international and national meetings and events as an opportunity to present the project to relevant actors and stakeholders in the area of health and development. A list of conference outputs has been provided in Annex 5. A list of papers submitted for publication and papers that are in the process of being developed have also been provided in Annex 5. National and international MHaPP policy briefs as well as information sheets have been developed on different aspects of the project, and a list is provided in Annex 5. All policy briefs can be downloaded from the MHaPP website: www.psychiatry.uct.ac.za/mhapp

- ❑ The media has been actively engaged in the study countries, for example, in Uganda a good number of staff from the media (both print and electronic) took part as respondents in the semi-structured interviews, which has led to an increase in advocacy and publicity for the project. In Ghana, the MHaPP findings have been used by key advocacy groups and the media to create public awareness regarding the need to adopt the Mental Health Bill.

1.1.13. What evidence is there that policy makers and stakeholders have increased awareness of your research findings and that has this led to changed attitudes and practice?

In the early stages of the MHaPP, there was evidence that policy makers and stakeholders had increased awareness of our RPC, and of our objectives, as shown in letters of support, attendance at meetings, and approval of the research required to

conduct the initial situation analysis. Ongoing interactions with policy makers have taken place in four broad areas:

- ❑ Ongoing functioning of the MHACs in Ghana, South Africa, Uganda and Zambia.
- ❑ Collaboration with the MoH/DoH partners in developing the protocols for the situation analysis and intervention phases.
- ❑ Partnership with policy makers and other stakeholders in each of the countries to implement the intervention studies.
- ❑ Involvement of policy makers or local Ministry of Health implementers in the writing up of evaluation studies for the interventions, e.g., inclusion of some MoH partners as authors on academic papers.

Given the nature of the interventions, the intervention phase involved a great deal more interaction with policy makers and other stakeholders than the situation analysis, in that the interventions were largely owned and driven by the MoH/DoH partners.

Among policy makers and stakeholders who participated in the MHaPP RPC from the outset (eg as the key MoH partners, or as MHAC members), there is clearly an increased awareness of our research findings. In the case of these stakeholders, this has led not so much to changed attitudes and practice, as a reinforcing of their commitment to scaling up mental health services, and developing and implementing policies that address the cycle of poverty and mental ill-health. This has varied to some extent between countries, with some countries (particularly Uganda, Ghana and more recently South Africa) having a strong buy-in and support from the MoH, and others (particularly Zambia) contributing less actively to the work of the MHaPP RPC.

However, among a broader group of policy makers, particularly those at a more senior level who are not directly involved with mental health (such as Ministers and Directors General or Permanent Secretaries), it has been more difficult to change attitudes and practice. There remains an ongoing challenge of persuading these senior policy makers regarding the importance of mental health, and the need to commit appropriate resources that give mental health parity with other health priorities. This is the challenge that faces future work in this area, for example related to the integration of mental health into primary health care settings and the scaling up of an affordable and appropriate core package of mental health services.

1.1.14. What progress was made on capacity development?

Capacity development was regarded as an integral part of the research programme, involving individuals, institutions and networks. It included improving people's skills and competencies, and improving the environment within which people work, such as management structures and resource availability. It also involved changing attitudes or building commitment among project partners and their institutions (research and non-research), research advisory groups, research participants and stakeholders, government, health providers and civil society.

In the first phase, research officers and PIs were trained in the research methodology for the situation analysis, including development and use of the instruments and related software. This took place through specifically organised training workshops (e.g., Durban, July 2006) and training events attached to our annual face-to-face meetings. Research officers were supervised and supported in their fieldwork by more experienced researchers. In keeping with our commitments, emphasis was placed on mentoring and training junior researchers and fieldworkers from previously disadvantaged groups. Through the MHACs, various stakeholders were exposed to the broad methodology of our study, and the importance of mental health policy development and implementation.

In recognition of the importance of ongoing capacity development, the lead partner for capacity development (Leeds) consulted with research partners on capacity development options and circulated a capacity development needs questionnaire to all partners in February 2007. Responses to this questionnaire were compiled and used to plan a Research Officers' training workshop in Cape Town in April 2007. Research Officers were trained in qualitative data analysis (using NVivo), integrating analysis of quantitative and qualitative instruments, academic writing and the use of citation software (Reference Manager). The Workshop also provided an opportunity for all partners to develop their coding frames and led to a compilation of an agreed coding frame that was entered into NVivo and circulated to research officers to use in a flexible way, to integrate emerging themes. The capacity development needs assessment was sent to all research collaborators and officers to help them identify their capacity development needs.

Once the Phase 1 country reports were produced, the focus of the capacity development work of the RPC shifted to writing various outputs including policy briefs, press releases and academic papers. These needs were addressed to a large extent through the academic writing workshop, conducted in Cape Town in January 2008, and documented in more detail in the 2008 annual report. Ongoing work to support the production of academic papers has occurred through support of country partners and the appointment of a full-time Research Officer, who has worked with each of the country teams to develop papers for publication, as set out below (see Lessons learnt: Good practice/innovation).

During the second phase of the project, capacity development has been linked to the specific objectives of the interventions. Policy makers, planners, clinicians, information officers – largely based in Ministries of Health in the four study countries – have attended training workshops or activities as part of the particular interventions, such as policy development and information systems development.

These capacity development activities have been crucial to the overall success of the consortium, in two ways:

- They have provided the necessary tools to successfully conduct the research.
- They have been integral to the successful implementation of the interventions in Phase 2, e.g, policy development in Uganda, legislation development in Ghana and Zambia, strategic plan development in South Africa, information systems in Ghana and South Africa, and district demonstration sites in all four countries.

The following groups have benefited from the capacity development work in these interventions:

- Research Officers, Principal Investigators and Ministry of Health partners in MHaPP have all received training in research methodology, data collection, data analysis, academic writing, publication and communication of research findings.
- Health service managers, clinicians and information officers have received training in mental health information systems.
- Policy makers and senior managers have attended workshops, setting out the steps for the development of national mental health policy, plans and legislation.
- District health management and clinical staff have attended workshops on the integration of mental health into primary health care in the district demonstration sites in each country.

As a result of these capacity development activities:

- MHaPP partners are now equipped to independently conduct research on mental health policy development and implementation in the countries in which they are based.

- ❑ Health service managers, clinicians and information officers are now equipped to run mental health information systems in Ghana and South Africa.
- ❑ Policy makers and senior managers will be in a position to facilitate the ongoing development and implementation of mental health policy and plans (in Uganda and South Africa) and legislation (in Ghana and Zambia).
- ❑ The consortium as whole has benefitted from interactions with each other, particularly peer education regarding research methodologies (quantitative and qualitative), as well as policy development and implementation processes.

In addition to this, Research officers were encouraged to submit a portion of their research as a PhD thesis or Masters dissertation. A summary of the current state of Research Officers' PhD or Masters theses is provided in Table 1.

Table 3. Summary of the current status of Research Officers' PhD or Masters theses

Country	Candidate	Theme	Notes
Ghana	Bright Akpalu	Mental health policy implementation in Ghana	Currently registered for a Masters degree at the University of Ghana
Ghana	Alex Ghartey	The impact of information system development on mental health policy and planning in Ghana	Is developing a proposal for a PhD, to be registered either at UCT or the University of Ghana
South Africa	Sharon Kleintjes	The role of mental health service users in policy development and implementation	Has registered for a PhD at UCT, submitted a research protocol, and is in an advanced stage of writing up her PhD, with the goal of submission in February 2011.
South Africa	Sara Cooper	Narrative case studies of the experiences of people living in poverty with mental illness in South Africa	Is in the early stages of developing a proposal for a PhD at UCT
Uganda	Joshua Ssebunnya	Understanding the mental health needs of adolescents in Uganda	Has registered for a PhD at UCT. Protocol not yet submitted.
Uganda	Dorothy Kizza	Suicide in Northern Uganda - A Qualitative Psychological Autopsy Study	Has registered for a PhD at the Norwegian University of Science and Technology and is currently busy with course work

Unfortunately no Research Officers have graduated with these post-graduate degrees at the end of the MHaPP RPC. A major reason for this appears to have been the fact that most of the Research Officers have not had time to commit to their own studies, because of their RPC research and communications activities. This was despite attempts to negotiate with each of the Research Officers and country teams regarding potential synergies between Masters and PhD topics and ongoing work of the MHaPP RPC. A

second major reason was the high turnover of Research Officers in two of the country sites, namely Ghana and Zambia.

A potential solution to this for future RPCs might be to have PhD or Masters Fellowships yoked to particular research objectives. This would allow candidates to be employed as PhD or Masters Fellows and devote uninterrupted time to these dual research and capacity development objectives.

Finally, a major achievement for capacity development in MHaPP was the establishment of infrastructure that will enable ongoing capacity development for mental health policy and research in Africa, namely the Centre for Public Mental Health at UCT. The CPMH will be officially launched in August 2010. The Centre is currently finalising curricula for two distance learning training programmes, which will be offered from 2011:

- Post-graduate Diploma in Public Mental Health
- MPhil in Public Mental Health

This is the first academic research and teaching Centre of its kind in Africa, and the first to offer courses in Public Mental Health. This Centre will serve as a lasting legacy of the work of the MHaPP RPC.

Table 4. Summary of MHaPP RPC Purpose

PURPOSE:	Verifiable Indicators (OVI)	Progress	Recommendations/Comments
<p>Mental-health policy development and implementation in Ghana, South Africa, Uganda and Zambia are increasingly based on evidence emerging from the mental health RPC and lessons learned are communicated to other developing countries.</p>	<p>1. Mix of quantitative evidence, including:</p> <ul style="list-style-type: none"> • references to RPC products in speeches, policy documents, media reports in the 4 study countries and in other developing countries; • development of policy-related documents by targeted decision-makers, incorporating RPC material in the 4 study countries and in other developing countries; • secondary products, e.g. research commissioned by targeted decision-makers on basis of RPC products. <p>2. Changes made to policy and practice in mental health reflect RPC priorities and are sufficient to make a difference to people's lives.</p> <p>3. Attribution to the work of the mental health RPC is judged to be at a reasonable level.</p>	<p>1. RPC products (country reports, publications and conference presentations) are now available to influence mental health policy development and implementation in the study countries and beyond. These findings have been used to shape a number of policy related interventions in the four countries.</p> <p>2. Changes have been made to policy and practice in all 4 countries. These are influencing policy (in Uganda), strategic planning (in Uganda and SA), legislation (in Ghana, Uganda and Zambia) information systems (in Ghana and SA), and the delivery of primary mental health care services that are making a concrete difference to people's lives in all 4 countries.</p> <p>3. Attribution to the work of the mental health RPC is judged to be at a reasonable level for the current stage of development.</p>	<p>Our partnership with Ministries of Health indicates that MHaPP findings are considered valuable enough by the Ministries of Health in Ghana, South Africa, Uganda and Zambia to be used in the development of policies, legislation, information systems and district demonstration projects. In South Africa, despite past difficulties, there has been increasingly open communication and engagement with the national Department of Health. This has been evident in the sharing of information from the provincial intervention projects, and recent invitations for input on a national level with revising the national mental health policy and information systems.</p>

Lessons learnt

Working with Partners

The work of the consortium has on the whole been conducted in a pleasant and collegial manner. This has included the tone of face-to-face meetings as well as e-mail communications, teleconferences and individual telephone calls.

An ongoing challenge has been communication between project partners. During the early stages (2005-2006) we worked with our annual face-to-face meetings, email and ad hoc telephone meetings, according to the targets we had established. However, the need for more regular communication and accountability led us to establish quarterly teleconferences of all partners. We have continued this practice, which has greatly improved communication, support and morale within the consortium. These meetings coincide with the submission of quarterly financial reports, and provide an opportunity for each partner to provide an account of progress. We have also continued with quarterly narrative reports, which are submitted before the teleconferences, compiled into a single RPC quarterly report by the UCT management team and circulated to all. Teleconference discussions can then focus on questions and key issues arising out of the narrative reports. This provides a detailed documented account of project activities, and a useful platform for discussion at teleconferences.

In addition the Research Officers established a monthly teleconference in which they can discuss particular challenges that they face in each country, and provide peer support for their ongoing work. During phase 2, once the interventions had been established, this was replaced by a monthly group email, to be initiated by country partners in turn.

A major lesson learnt from programme management is that a great deal of time is required to manage a large consortium separated by geographical distances. This time should be carefully budgeted for in the planning of the consortium. For example, decisions that require input of all partners require consultation via e-mail or teleconferences; reports need to be circulated to all partners for comment before they can be submitted; and it is important to budget support trips from the consortium management, to the other country sites. In particular, the scale of the consortium meant that a great deal of time and effort was spent with establishing the infrastructure, and reaching agreement on the terms of reference and consortium agreement. The benefits of a multi-country study, with partners from a range of other countries need to be planned for, and account taken of the costs of time and resources spent establishing the infrastructure to allow the consortium to function. However, it should be emphasised that once a foundation was laid in the inception phase, more time did become available to the UCT management team to devote to matters of research substance, such as conducting the situation analysis and the literature reviews. The major lesson is that if effort is taken with establishing a legal framework and agreement on terms of reference, this lays a good foundation for subsequent management of the consortium.

Good practice/innovation

The advantages of face-to-face meetings cannot be under-estimated, and time in our annual meetings was often used for multiple purposes, from reaching common agreement on administrative procedures, to the substance of the research, to capacity development to conduct the research, to communication strategies and problem-solving for specific issues. In 3 of our annual meetings, for example, we added training workshops for 1-2 days before or after the 3-day meeting, linked to capacity development needs at the particular stage of the RPC. We also used our annual meeting to conduct

management meetings to address issues relevant to RPC management. We have also used other opportunities, such as conferences to meet to discuss relevant RPC activities.

We have continued the use of “internal pages” on our website. These are accessible only to consortium members, and we use the pages to post research protocols, instruments, research findings, minutes of meetings, conference notices, log forms for publications and draft papers for publication.

As the lead partners at UCT, we had been concerned about the limited number of peer-review journal articles that were being produced from the situation analysis in years 2 and 3. In Year 4, we therefore used unspent roll over funds from the previous financial year to employ a Research Officer, based at UCT, who would provide support to Ghana, Uganda and Zambia in the publication of findings from Phase 1. This person visited Ghana in April, Zambia in May and Uganda in June 2009. She drew up a list of papers, in collaboration with the country teams, and assisted with writing and publication of 8 papers in a special issue of the African Journal of Psychiatry. She has also worked with the UCT team and the country teams to develop a further set of 8 papers, which are in press with the International Review of Psychiatry, and 4 papers, which are in press with the Journal of Culture and Mental Health. A chapter for an “Africa Focus” book, published by HSRC Press, has also been produced through this process.

Collaboration with others

Drawing independently funded partners into the work of MHaPP has been a major benefit for all parties. For example, working with the Peri-natal Mental Health Project in Cape Town has emphasised the importance of maternal mental health and early childhood development in our work. It has also provided a support and supervision function for the PMHP that has enabled them to generate research outputs and policy/practice impacts that are consistent with the objectives of MHaPP. Similarly, Dr Ritz Kakuma, a Post-doctoral Fellow from McGill University, Canada brought a new emphasis on the issue of stigma in our work, and her generous and energetic involvement in the work of the consortium facilitated improved capacity development for many of the MHaPP partners. In turn, she was able to gain valuable experience of working in mental health in Africa and gather data for her post-doctoral research.

Long-term sustainability of the Research

How will the research be promoted once research programme funding ends?

This will occur through a number of processes:

- In the months that follow the ending of MHaPP, research findings will be presented at several academic conferences.
- Summaries of the major findings of MHaPP will be presented (or in some cases have been presented) to Ministries of Health in the study countries.
- The WHO/MHaPP Mental Health and Development Report will be launched jointly with UN DESA in New York in September 2010.
- For those partners who remain in their roles, research will be promoted as part of ongoing teaching, and the development of new research proposals.
- In the case of the specific interventions, in most cases the interventions have been adopted by the Ministry of Health, as part of their ongoing programme of work, and will therefore be sustained into the future. These include the following aspects:

- Members of the Ghana MHIS team will continue to follow the MHIS intervention until it has been completely institutionalized and work with Ghana Health Service to go National with support from both GHS and Dept of Psychiatry, University of Ghana Medical School.
- In Ghana, work is ongoing from the Ghana Health Service, led by Dr Akwasi Osei, to have the Mental Health Bill enacted into law by parliament.
- In South Africa, the provincial mental health plan in the Northern Cape will be taken up by the provincial mental health coordinator and steered through senior management approval processes.
- In South Africa, the mental health information systems in KwaZulu-Natal and the Northern Cape have been integrated into the routine District Health Information System, and will continue to function as part of that system.
- In South Africa, the national Department of Health is taking responsibility for circulating the draft national Mental Health Policy to provincial stakeholders for consultation.
- In Uganda, the Ministry of Health is continuing to support the Mental Health Policy and Strategic Plan for approval by senior management and the Permanent Secretary.
- In Uganda, the Ministry of Health is continuing to support the passage of the Mental Health Bill into law, through interactions with the Attorney-General's office.
- In Zambia, the Ministry of Health will continue to work on reform of the mental health legislation, and implementation of the national strategic plan for mental health.

How will people access the research products once the research programme's funding ends?

A full list of research products from the MHaPP RPC will be available on the MHaPP website. There will be a number of mechanisms available for gaining access to these products:

- Peer review journal articles will be available through the journals.
- Where copyright provisions do not prohibit the distribution of research products, all products will be available for free download from the MHaPP website.
- Summaries of major research findings will be available through Policy Briefs, Case Studies. These will be actively disseminated to a range of stakeholders during the no-cost extension period.
- The WHO Mental Health and Development website will also make research products related to this theme available for free download.

All MHaPP partners have been asked to develop a responsible closure programme, which includes feedback to all major partners of the findings of the study. At the time of submission of this report, the MHaPP leadership at UCT has received programmes from Uganda, UKZN/HSRC, Leeds and WHO.

Have any follow-on research programmes been agreed, which build on the outputs from this research programme? If so, please give details.

The UCT, Uganda, UKZN, HSRC, Leeds and WHO partners have collaborated with new partners from the Centre for Global Mental Health (London School of Hygiene and

Tropical Medicine and the Institute of Psychiatry), University of Addis Ababa and the Public Health Foundation of India to develop a proposal for a new mental health RPC: Improving mental health services in low income countries. This consortium has been shortlisted by DFID, and is in the process of developing a full tender proposal.

In addition to this, the Centre for Public Mental Health, established at UCT as an output of the MHaPP RPC, will continue to develop a research programme, and approach funders for support for its capacity development programme, aimed at Ministries of Health in African countries.

Annexes

Annex 1. Logical Framework

Narrative Summary (NS)	Verifiable Indicators (OVI)	Means of Verification (MOV)	Risks
<u>GOAL:</u>			
A contribution to breaking the cycle of poverty and mental ill-health, and the achievement of the MDGs through the production and uptake of new knowledge.	-	-	-
<u>PURPOSE:</u>			
Mental-health policy development and implementation in Ghana, South Africa, Uganda and Zambia are increasingly based on evidence emerging from the mental health RPC and lessons learned are communicated to other developing countries.	<p>1. Mix of quantitative evidence, including:</p> <ul style="list-style-type: none"> • references to RPC products in speeches, policy documents, media reports in the 4 study countries and in other developing countries; • development of policy-related documents by targeted decision-makers, incorporating RPC material in the 4 study countries and in other developing countries; • secondary products, e.g. research commissioned by targeted decision-makers on basis of RPC products. <p>2. Changes made to policy and</p>	<p>1. RPC assessments of these & other sources presented in annual reports and independently assessed in mid-term review & final review.</p> <p>2. RPC assessments of these &</p>	Changes in policy and programme implementation are undermined by lack of long-term support by governments.

Narrative Summary (NS)	Verifiable Indicators (OVI)	Means of Verification (MOV)	Risks
	<p>practice in mental health reflect RPC priorities and are sufficient to make a difference to people's lives.</p> <p>3. Attribution to the work of the mental health RPC is judged to be at a reasonable level.</p>	<p>other sources, presented in annual reports and independently assessed in mid-term review & final review.</p> <p>3. Stakeholder interviews & assessment of the policy environment in mid-term review & final review.</p>	
OUTPUTS:			
<p><i>Output 1:</i> Knowledge generated concerning the factors necessary for the development of appropriate mental health policy</p>	<p>1.1 Knowledge products support (or initially challenge) the priorities of policy & programme decision-makers.</p> <p>1.2 Research topics reflect adjustments made during the life of the RPC on the basis of new knowledge, lessons learned.</p> <p>1.3 Knowledge products meet agreed standards for scientific rigour (e.g. journal acceptances; internal peer review for non-published material; policy relevance as judged by research users).</p> <p>1.4 Knowledge products delivered in accordance with research timetable (as adjusted during the life of the RPC).</p>	<p>1.1 Reviews of priorities by Consortium members, presented in annual reports; independent assessments through stakeholder interviews at mid-term review & final review.</p> <p>1.2 Reviews of research agenda and topics by Consortium members, presented in annual reports; independent assessments at mid-term review & final review.</p> <p>1.3 Internal RPC assessments during implementation, recorded in annual reports; independent assessments at mid-term review & final review.</p> <p>1.4 Internal RPC monitoring presented in annual reports; independent assessment at mid-term review & final review.</p>	<p>DFID and other development partners (including the study and other developing country governments) do not have the motivation and capacity to utilise new knowledge for poverty reduction, improvement of MH status and achievement of MDGs.</p> <p>Political pressure or bureaucratic inertia in study countries inhibits the use of research results in policy and practice.</p> <p>Lack of experience and research capacity in countries yields low quality research products from the situation analysis (Phase 1).</p>

Narrative Summary (NS)	Verifiable Indicators (OVI)	Means of Verification (MOV)	Risks
<p><i>Output 2:</i> Knowledge generated concerning the factors necessary for effective implementation of mental health policies</p>	<p>2.1 Knowledge products support (or initially challenge) the priorities of policy & programme decision-makers.</p> <p>2.2 Research topics reflect adjustments made during the life of the RPC on the basis of new knowledge, lessons learned.</p> <p>2.3 Knowledge products meet agreed standards for scientific rigour (e.g. journal acceptances; internal peer review for non-published material; policy relevance as judged by research users).</p> <p>2.4 Knowledge products delivered in accordance with research timetable (as adjusted during the life of the RPC).</p>	<p>2.1 Reviews of priorities by Consortium members, presented in annual reports; independent assessments through stakeholder interviews at mid-term review & final review.</p> <p>2.2 Reviews of research agenda and topics by Consortium members, presented in annual reports; independent assessments at mid-term review & final review.</p> <p>2.3 Internal RPC assessments during implementation, recorded in annual reports; independent assessments at mid-term review & final review.</p> <p>2.4 Internal RPC monitoring presented in annual reports; independent assessment at mid-term review & final review.</p>	<p>DFID and other development partners (including other developing country governments) do not have the motivation and capacity to utilise new knowledge for poverty reduction, improvement of MH status and achievement of MDGs.</p> <p>Political pressure or bureaucratic inertia in study countries inhibits the use of research results in policy and practice.</p> <p>MHACs are malfunctioning.</p> <p>Lack of experience and research capacity in countries yields low quality research products from the situation analysis (Phase 1).</p>
<p><i>Output 3:</i> Communication of study results and promotion of the utilisation of the research findings to inform and improve mental health policy-making and practice in the study countries and other developing countries.</p>	<p>3.1 Implementation of the communication strategy influences key policy makers to develop and implement mental health policies in keeping with the goals of the RPC, through a wide range of networks</p>	<p>3.1 Internal RPC members' reviews of strategy in annual reports, mid-term review, final review.</p>	<p>Country context requires adaptation of programme strategy for mass-dissemination</p> <p>MHACs do not represent key stakeholders/not functional</p> <p>Findings of the study are not relevant</p>

Narrative Summary (NS)	Verifiable Indicators (OVI)	Means of Verification (MOV)	Risks
	<p>including WHO, DFID and other international and national partners.</p> <p>3.2 Strategy includes changes made on basis of lessons learned during implementation (incl. e.g. changes in decision-makers or influential stakeholders; knowledge emerging from outputs 1 & 2).</p>	<p>3.2 Internal RPC members' reviews of strategy in annual reports, mid-term review, final review.</p>	<p>to other developing countries.</p>
<p><i>Output 4:</i> Increase of research and communications capacity in all participating institutions</p>	<p>4.1 Capacity to conduct situation analysis of mental health policy development and implementation in each of the study countries is in place.</p> <p>4.2 Capacity to develop and evaluate interventions for policy development and implementation in each of the study countries is in place.</p> <p>4.3 Capacity to communicate research findings that reflect good practice in GRIPP is in place, eg sufficient to persuade policy makers and planners to reform mental health systems in each of the study countries, in keeping with the goals of the RPC.</p>	<p>4.1 Internal RPC members' reviews of strategy in annual reports, mid-term review, final review.</p> <p>4.2 Internal RPC members' reviews of strategy in annual reports, mid-term review, final review.</p> <p>4.3 Internal RPC members' reviews of strategy in annual reports, mid-term review, final review.</p>	<p>Capacity that has been developed in particular individuals is lost because those individuals move to other countries/settings.</p> <p>Organisations and individuals in whom capacity is being developed do not have the wider support and infrastructure to make use of the new capacity.</p>

ACTIVITIES:			
Output 1			
<p>Activity 1(a): Use policy analysis research methods to understand how policies have been developed</p>	<p>Research into MH policy-making in and across four study countries conducted by October 2007</p> <p>Study results/recommendations for National/International MH policy-makers published in international journal(s) by January 2008</p>	<p>Regular programme progress reports (common for all activities)</p> <p>Activity-specific reports (methodology/protocol synthesis, analysis)</p> <p>Programme financial statements</p> <p>Publication in International journal(s)</p>	<p>Study countries' political/other environment is not appropriate for policy-relevant research.</p> <p>African country partners not able to participate fully due to political pressure or bureaucratic inertia</p> <p>Other demands make it impossible to prepare the manuscripts</p>
<p>Activity 1(b): Assess the appropriateness of the resultant policies in a variety of formats and sectors, using the WHO Guidance Package framework and conceptual approach as assessment tools</p>	<p>Research/assessment of appropriateness of MH-related policies to poverty alleviation conducted and ways of improving appropriateness of MH policies in study contexts identified by October 2007</p> <p>Study results/recommendations for National/International MH policy-makers published in international journal(s) by January 2008</p>	<p>Regular programme progress reports (common for all activities)</p> <p>Activity-specific reports (methodology/protocol synthesis, analysis)</p> <p>Publication in International journal(s)</p> <p>Programme financial statements</p>	<p>African country partners not able to participate fully due to political pressure or bureaucratic inertia</p> <p>Other demands make it impossible to prepare the manuscripts</p>

<p>Activity 1(c): Develop and evaluate interventions to strengthen the policy development process in the study countries</p>	<p>Interventions to strengthen MH policy development processes are developed and tested in study country contexts by July 2009</p> <p>Study results/recommendations for National/International MH policy-makers published in international journal(s) by January 2010</p>	<p>Regular programme progress reports (common for all activities) Activity-specific reports (protocol for introducing interventions, analysis) Publication(s) in International journal(s) Programme financial statements</p>	<p>Consensus not able to be achieved African country partners not able to implement interventions due to lack of political will or bureaucratic inertia Other demands make it impossible to prepare the manuscripts</p>
<p>Output 2</p>			
<p>Activity 2(a, b, c): Investigate mental health policy implementation and develop and evaluate interventions to assist policy implementation at macro, meso and micro levels</p>	<p>Research into MH policy implementation at macro, meso and micro levels in and across four study countries conducted by October 2007</p> <p>Interventions to improve implementation of MH policies at macro, meso and micro levels are developed and evaluated in study countries by January 2010</p> <p>Study results/recommendations for National/International MH policy-makers published in international journal(s) by July 2010</p>	<p>Regular programme progress reports (common for all activities) Activity-specific reports (methodology/protocol synthesis, analysis) Correspondence, minutes of meetings/workshops with stakeholders Minutes of meetings of MHACs Publication(s) in International journals, correspondence with International MH policy-makers (WHO, etc) Programme financial statements</p>	<p>Necessary consensus unable to be achieved Other demands make it impossible to prepare the manuscripts Unable to secure support of people or organizations who are lobbied MHAC's not established or are malfunctioning Climate not conducive to implementing interventions Ministries of Health unwilling to participate in intervention phase because they wish to retain ownership/control over policy development/service reform.</p>

Output 3			
<p>Activity 3(a): Publicise the project</p>	<p>Press releases are completed at national and international levels by May 2006 Networks of collaborators are established by April 2006 Launch event and media campaign begun in each country by May 2006 National and international dissemination channels are established by 15 April 2006 Brochure is completed by December 2005 and disseminated throughout the life of the RPC Upcoming national and international conferences and meetings are identified in an ongoing way RPC website is online by February 2006 and maintained for the life of the project Potential journals identified by 15 April 2006</p>	<p>Press releases Database of networks Database of dissemination channels List of conferences at which RPC members present findings Conference proceedings Brochure Website List of journals Minutes of MHAC meetings</p>	<p>Press releases do not match media priorities Potential collaborators reluctant to become involved Unable to attract high profile policy makers to launch event Dissemination channels do not reach key policy makers, or if key policy makers are reached, they are reluctant to support mental health and poverty issues MHAC members not able or willing to fulfill commitments Website cannot be appropriately maintained</p>
<p>Activity 3(b): Encourage exchange between RPC partners and the 4 countries involved</p>	<p>Establishment and maintenance of the RPC website by February 2006 Regular meetings of the RPC Ongoing e-mail, telephone and teleconference meetings Sharing of meeting reports for RPC meetings and MHAC meetings within the consortium (ongoing)</p>	<p>Functioning website itself Minutes of RPC and MHAC meetings E-mail correspondence and records of telephone and teleconference meetings</p>	<p>RPC partners have multiple demands on their time and are therefore not able to give the necessary attention to the RPC Communication technologies (internet connectivity, telephones) are not reliable</p>

<p>Activity 3(c): Disseminate the knowledge base on the links between mental health, policy and poverty</p>	<p>Upcoming national and international events/conferences are identified at which members of the RPC can present the knowledge base, establish networks and partnerships with other potential collaborators</p> <p>Mental health and development website is online by September 2007 and maintained on an ongoing basis</p> <p>Press releases and media campaigns are conducted on mental health and poverty by November 2007</p> <p>Article submitted to peer-review journal on new knowledge base/website by September 2007</p>	<p>Proceedings of conferences</p> <p>List of partners/collaborators</p> <p>Website design specifications (both technical and contents-relevant)</p> <p>Financial statements/sub-contract with IT expert(s)</p> <p>Functioning website itself</p> <p>Press releases</p> <p>Peer-review journal article</p>	<p>Delegates at conferences do not see RPC presentations as relevant to their concerns</p> <p>Website cannot be appropriately maintained</p> <p>Press releases do not match media priorities</p> <p>Dissemination channels do not reach key policy makers, or if key policy makers are reached, they are reluctant to support mental health and poverty issues</p> <p>MHAC members not able or willing to fulfill commitments</p> <p>Article not accepted by journals</p>
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<p>Activity 3(d): Communicate research findings and promote their utilisation to inform and improve policy-making and practice in the study countries and elsewhere in Africa, the developing world and globally</p>	<p>Papers are published in the peer-reviewed scientific literature as set out in Activities 1 and 2 (above) Press releases, factsheets, articles in newsletter are released for each publication (where relevant) (to coincide with submission of publications, above) Research findings/recommendations are posted on the project website and on the Poverty and Mental Health Website (as and when data becomes available) MHACs and WHO country representatives are informed of findings (as and when data becomes available) Research findings are disseminated via meetings, teleconferences, e-mail (as and when data becomes available) An ongoing dissemination strategy is discussed with all RPC partners (final meeting of RPC, November 2009)</p>	<p>Papers published in peer-reviewed journals Press releases, factsheets, articles and newsletter Content of website Minutes of MHAC meetings Correspondence with WRs Minutes of final RPC meeting Programme financial statements</p>	<p>Article not accepted by journals Press releases, factsheets, articles not seen as relevant by target audience Sufficient time and resources not available due to other RPC demands</p>
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Output 4			
Activity 4(a): Increase the output of completed dissertations/theses at each site	Outputs of dissertations/theses at each site increased by the end of programme	Dissertations/theses submitted Programme financial statements	Candidates not able to be identified Candidates not able to deliver as planned Proposed projects turn out not to be feasible owing to unanticipated barriers Not enough resources are ear-marked for this activity (eg RO time, supervisors' time)
Activity 4(b): Establish a Mental Health Policy and Services Research Unit at the University of Cape Town	MH policy and services research unit is established and functioning by August 2008	Correspondence with /Approval by appropriate research authorities at the University of Cape Town. Constituent documents for MH Policy and Services Research Unit	Bureaucratic/legal barriers for establishing MH policy and services research unit Approval not granted at all levels Lack of sustained financial support for MH policy and services research unit at UCT.
Activity 4(c) Arrange two training workshops for mental health policy makers and service users in each African country	Training workshops covering approximately 100 attendees in each study country are held during April 2008 and May 2009	Training materials Workshop minutes/feedback forms Programme financial statements	Insufficient uptake of workshop Trainees do not have sufficient political authority to institute changes in their health system.
Activity 4(d)* (new activity) Arrange three training workshops for research officers to equip them to conduct the situation analysis in Phase 1	Training workshops addressing data collection, analysis, writing up and publishing are conducted for all ROs: Durban (July 2006); Entebbe (Nov 2006); Cape Town (April 2007)	Training materials Workshop minutes Programme financial statements	ROs do not make use of training material for fieldwork, analysis and writing ROs do not have the capacity to make full use of the training materials.

Annex 4. Communication strategy

Latest update and revision: 31 August 2009

Responsible partners for the Communication Strategy: WHO

Objectives of the Communication strategy

- ✚ Objective 1: To publicize the Project - Mental health policy development and implementation in four African countries: breaking the cycle of mental ill-health and poverty
- ✚ Objective 2: To encourage exchange between RPC partners and between 4 countries involved
- ✚ Objective 3: To disseminate the knowledge base on the links between mental health, policy and development
- ✚ Objective 4: To communicate research findings and promote their utilisation to inform and improve policy-making and practice in the study countries and elsewhere in Africa, the developing world and globally

Background information

- ✚ This communication plan is not final but rather an evolving document that will change and be refined over the course and duration of the project. For example one of the major foci in the first half of year 1 was the launching of the project, whereas in subsequent months and years the major focus was on the launching of research results and the Centre for Public Mental Health at the University of Cape Town. Furthermore the details of the communication plan have been refined as we launched into new phases of activity.
- ✚ Time has been set aside during each annual meeting of the RPC to enable all partners to discuss the effectiveness of the communication strategy (are we meeting our objectives? Are the timeframes realistic? What is working, what is not working and what needs to be changed, lessons learned etc.), and these discussions have formed the basis of the modifications. However, discussion and reviews of the communication strategy have occurred on an ongoing basis, as and when the need arises, and teleconferences (either to discuss communication issues in relation to a particular project output or on the communication strategy as a whole) have been organized on an ad hoc basis.
- ✚ Although WHO is leading the communications strategy, the success of the project has also depended on the active involvement and contribution of each of the RPC partners, and inputs on the communication plan have therefore been sought from all partners on a regular basis. For example partners have helped to:
 - Identify collaborators and stakeholders at international and national level who need to be involved in the project.
 - Identify dissemination channels that are already in place that we can take advantage of for the project.
 - Track 'windows of opportunity' upon which we can piggy-back to showcase the project, for example international and national meetings, conferences and events, as well as opportunities to submit articles and information to the international and national media, special interest newsletters and magazines as well as peer reviewed journals, relevant websites etc.

- ✚ The Mental Health Advisory Committees (MHACs) that have been established in each of the four countries, are made up of members representing key national stakeholder groups. The MHACs therefore have a critical role to play in raising awareness on the project and disseminating research findings, and have consequently been actively involved in many of the activities mapped out in the communication plan below.
- ✚ DFID Research has a communications team which has provided us with support and advice for the planning, development and implementation of the communication plan.
- ✚ In order to ensure that engagement with different stakeholders is effective and sustainable throughout the different phases of project, regular briefings have been given via different stakeholder-targeted channels, including face to face meetings, presentations at conferences and other means of direct communication. In order to keep the media engaged for the duration of the Project, press releases have been issued on a regular basis, disseminating information on significant results, events or milestones of the project. Interviews and media articles have also been undertaken where possible.
- ✚ All partners have been asked to keep a record of communication successes/achievements. The MHaPP website will host a space where all partners will post press releases that have been issued, press clippings, articles, papers and other documentation which highlights the dissemination of information in relation to the project. This space will also host the different databases of the communication strategy (international and national journals; events and opportunities for dissemination; targeted dissemination/ communication channels and measures etc.) that all partners can access and keep updated.
- ✚ The Final/Exit Report (2010) will examine the strengths and weaknesses, successes and challenges, of implementing the communication strategy, as well as the lessons learned from our experience.

Target group categories:

- ✚ **Development/Poverty-Reduction/Health/Mental Health Organizations:** these include international and bilateral organizations and agencies (eg. WHO, NCIHD, African Development Bank, UNDP, World Bank, UN Millenium Development Project, Oxfam, DFID, NEPAD (New Partnership for Africa's Development) and other bilateral agencies, etc.) as well as national organizations or groups working in these areas.
- ✚ **Government Policy makers:** this includes decision makers at different government levels (national, local, district) and from different government sectors (health, social welfare, education, criminal justice, housing etc.)
- ✚ **Academic and research institutions:** this includes both national and international institutions
- ✚ **User and family organizations:** This includes both international and national organizations
- ✚ **NGOs:** This includes Mental health , human rights and advocacy NGOs

- ✚ **Professional associations:** these include international professional associations/organizations (Eg. World Psychiatric Association, World Federation for Mental Health) as well as national professional associations/organizations
- ✚ **Health workers:** this means general health and mental health workers in countries

All press releases emanating from the project should include an acknowledgment of DFID using the following wording (see also the generic press release prepared by WHO in April 2006):

Note to editors:

The Mental Health and Poverty Project: Improving Mental Health, Reducing Poverty (MHaPP) is funded by the UK's Department for International Development (DFID).

DFID leads the British Government's fight against world poverty. DFID's Central Research Department (CRD) commissions research to ensure tangible outcomes on the livelihoods of the poor and to put poverty reduction and the needs of the poor at the forefront of global research efforts.

DFID has committed £2.2 million to the MHaPP project over 5 years.

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COMMUNICATION PLAN

OBJECTIVE 1: TO PUBLICISE THE PROJECT

Strategy 1: Raise awareness of development partners and key stakeholders on the Project

Indicator: At least 1 major organization from each of the target group categories (development partners, government policy makers; academic and research institutions; NGO, user and family organizations; professional associations; health workers) have disseminated information on the project through a recognized network

Activity	Target audience/stakeholders	Responsible project partner	timescale	Output	Achieved?
Create databases identifying key national and international stakeholders and targeted dissemination strategies	Project Partners	WHO with the support of all project partners	March 2006 - ongoing (the database will be updated throughout the Project)	Databases created for: a) key national and international stakeholders and targeted dissemination and communication channels for each of these stakeholder groups b) international and national events, conferences and meetings c) relevant international and national journals to publish papers on project	Databases created. Databases b and c available online at http://www.who.int/mental_health/policy/development/en/index.html ; Ongoing update
Describe project and its objectives through academic peer review journals, presentations at international and national events, conferences	Academic and research institutions; Professional associations;	All project partners	March 2006 - ongoing	National and international stakeholders informed of project via articles and papers in journals, events, conferences and meetings and other targeted channels	A full list of research products and publications available in Annex 5.
Disseminate information on the Project to key stakeholders via face to face meetings or video and teleconference meetings, or via letters of information,	Development partners/agencies; Government Policy makers; Relevant WHO Departments and other relevant	All project partners Country MHAC's	Feb 2006 - Feb 2007	Key stakeholders made aware of the project and engaged in its activities where appropriate	Completed

dissemination of the project brochure, and WHO newsletters to media and strategic partners ¹	stakeholders				
Create and maintain project website with information and resources related to the Project (information on the website will be disseminated whenever info on the overall project is disseminated. In addition links between the MHaPP website and other key agencies and organizations will be encouraged)	Development partners/agencies; Government Policy makers; Academic and research institutions; NGO, User and family organizations; Professional associations; health workers	UCT with the support of all project partners	January 2006 - improvements and additions ongoing	Widely accessible website with key information and resources related to the project as well as ongoing updated info of progress being made	MHaPP website created and regularly updated; webpages dedicated to mental health and development with acknowledge ment of DFID created and maintained within the WHO MIND website.

¹ Three WHO Newsletters:

- 1) Newsletter to an extensive list of 4000 donors, including Foundations, Government Aid Agencies, National Missions as well as a number of other strategic partners.
- 2) In-house WHO information newsletter to Non communicable disease cluster as well as senior WHO staff and management at HQ, Regional and Country Offices
- 3) Newsletter to all WHO media contacts (approx 400 contacts around the world including Independent, Sunday Times, AP, NY times, CBS, Time, Newsweek and key international journals s/as the lancet, BMJ etc.)

Strategy 2: Launch the project in each of the four Project countries

Indicator: Project launched in each country and attended by representatives from each of the major stakeholder categories (see above)

Activity	Target audience/stakeholders	Responsible project partner	timescale	Output	Achieved?
National project partners and members of National MHACs to identify and engage key people at national level to be involved in the project and attend the launch	Development partners/agencies working at national level; Development partners/agencies; Government Policy makers; Academic and research institutions; NGO, User and family organizations; Professional associations; health workers	National project partners and country MHACs	Feb 2006 - Sept 2006	Creation of a network of key national development partners/agencies and other key stakeholders who are informed of the project and engaged in activities (where appropriate)	Yes
Contact, inform and engage WHO country office in the project and launch activities	WHO country offices	WHO HQ and National project partners	Feb 2006 - Sept 2006	WHO country offices informed and engaged in project and activities	Yes
Launching event in each of the four partner countries (Ghana, South Africa, Uganda, Zambia)	Development partners/agencies working at national level; Development partners/agencies; Government Policy makers; Academic and research institutions; NGO, User and family organizations; Professional associations; health workers	National partners and country MHACs	April 2006 - Sept 2006	Projects launched at national level and key stakeholders and potential collaborators informed of and/or engaged in project	Yes
Issue press releases and factsheets about the Project as part of national launch	Development partners/agencies working at national level; Development partners/agencies; Government Policy makers; Academic and research institutions; NGO, User and family organizations; Professional associations; health workers	National project partners WHO to prepare generic press releases and factsheets	April 2006 - Sept 2006	Information, provided to potential stakeholders and collaborators via the media Media at national level informed/engaged in the project	Yes

OBJECTIVE 2: TO ENCOURAGE EXCHANGE BETWEEN ALL RPC PARTNERS

Strategy 1: Establish mechanisms and means for ensuring effective and sustainable communication flow and exchange of information between all project partners

Indicator: Each of the communication mechanisms functional and utilized

Activity	Target audience/ stakeholders	Responsible project partner	timescale	Output	Achieved?
<p>Create a protected space on Project website for project partners to:</p> <ul style="list-style-type: none"> i) share and post info (eg. relevant MHAC meeting reports, upcoming events etc.) ii) exchange ideas and keep each other informed of progress, challenges etc. iii) post documentation highlighting the successes of communication (eg. press releases, press clippings, articles, papers etc.) iv) access and update different databases developed as part of communication strategy) 	All project partners	UCT with the support of all project partners	Jan 2006 - improvements, additions and updates ongoing	Project Website helping to facilitate exchange of expertise, knowledge, experiences between partners and access to information and resources related to the project.	Yes
<p>Organise annual meetings to be attended by all project partners to share information and discuss progress, problems of the project.</p> <ul style="list-style-type: none"> - brief update with local country MHAC at national annual meetings <p>Organise regular teleconferences/videoconferences (every 3 months) involving all partners to discuss, in turn, each of the project outputs.</p> <p>Organise regular teleconferences</p>	All project partners	<p>National partners with the support of UCT</p> <p>UCT with the support of all project partners</p>	<p>Annual meeting dates 2005 - 2010 have been set</p> <p>March 2006 - ongoing (on 3 monthly basis)</p>	Mechanisms for regular direct communication and exchange of information in place via face to face meetings and teleconferences-	Yes

between project research officers					
Mechanisms for regular informal contact via e-mail, telephone, mail between all RPC partners and between research officers	All project partners	All project partners	Ongoing and in place	All partners in regular informal contact for ongoing exchange of information	Yes

OBJECTIVE 3: TO DISSEMINATE THE KNOWLEDGE BASE ON THE LINKS BETWEEN, AND INTERVENTION RELATED TO, MENTAL HEALTH, DEVELOPMENT, POLICY AND POVERTY

Strategy 1: Create a web space dedicated to raising awareness and providing information and knowledge base on mental health and development issues.

Indicator: Web space established and being accessed

Activity	Target audience/stakeholders	Responsible project partner	timescale	Output	Achieved?
Determine the scope and key content of Mental Health and Development website	Website targeted at Development partners/agencies; Government Policy makers; Academic and research institutions; NGO, User and family organizations; Professional associations; health workers	WHO with the support of all project partners	Nov 2006 - Jan 2007	Scope and content of website determined, in line with existing capacity and resources for this work	Yes
Create a basic 'draft' version of the website (including developing and gathering materials to be put on the website) to build upon and develop	See above	WHO with the support of all project partners	Dec 2006 - Mar 2007	Basic website up and running, ready for contributions from all project partners	Yes
Continuous elaboration of the website and invitations to all relevant organizations, groups and individuals to contribute materials to the website	See above	WHO with the support of all project partners	Ongoing	Broadening of the information base on mental health, development , policy and poverty via contributions	Ongoing

				from international and national stakeholders working in this area	
Develop a strategy for maintaining the webspace after completion of the project	See above	WHO with the support of all project partners	November 2009 - Ongoing	Sustainable forum for accessing information on mental health, development , policy and poverty	Strategy developed

Strategy 2: Disseminate information on mental health and development knowledge base.

Indicators:

- a. At least 1 major organization from each of the target group categories (development partners, government policy makers; academic and research institutions; NGO, user and family organizations; professional associations; health workers) have received information on the mental health and development knowledge base
- b. Knowledge base described in a paper submitted to at least one academic journal

Activity	Target audience/stakeholders	Responsible project partner	timescale	Output	Achieved?
Submit an article on the knowledge base to a peer reviewed journal (database of key international and national journals has been created and can be used for this purpose).	Development partners/agencies Professional organizations Academic and Research institutes	WHO with inputs from project partners	July 2007 - Dec 2007	Article produced informing (researchers and academics) on the existence of a new knowledge base on mental health and development	Yes
Create a database of key development partners at international and national level (same database as in Objective 1; strategy 1 above) to whom information on new knowledge base should be disseminated	Project Partners	WHO with inputs from project partners	March 2006 - ongoing (the database will be updated throughout the Project)	Database created with information on key development partners to whom the new knowledge base should be disseminated	Completed, ongoing update
Issue press releases on major issues related to the knowledge base	Development partners/agencies; Government Policy makers; Academic and research institutions; NGO, User and family organizations; Professional associations; health workers	WHO with inputs from project partners	July 2007 - Dec 2007	Key stakeholders at national and international levels informed of new knowledge base via media	Press releases and articles produced both at international and national levels in all MHaPP countries (to

					be found at http://www.who.int/mental_health/policy/inthepress/en/index.html)
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OBJECTIVE 4: TO COMMUNICATE RESEARCH FINDINGS AND PROMOTE THEIR UTILISATION TO INFORM AND IMPROVE POLICY-MAKING AND PRACTICE IN THE STUDY COUNTRIES AND ELSEWHERE IN AFRICA, THE DEVELOPING WORLD AND GLOBALLY

Strategy 1: Ongoing promotion, communication and dissemination of research findings

Indicator:

- a. At least one publication in an international journal on an annual basis
- b. At least one press release at national level on an annual basis
- c. At least 1 major organization from each of the target group categories (see above) have disseminated information on the project through a recognized network

Activity	Target audience/stakeholders	Responsible project partner	timescale	Output	Achieved?
Submit articles on research findings of the Project to peer reviewed journal (database of key international and national journals has been created and can be used for this purpose).	Development partners/agencies Professional organizations Academic and Research institutes	All Project partners	Ongoing throughout project - 2007 to 2010	Research findings and recommendations published in peer reviewed journals Development partners, health professionals, researchers and academics informed on Project findings	Ongoing. A full list of research products and publications available in Annex 5.
Disseminate information to key stakeholders on major milestones, issues, findings and events of the project via face to face meetings or video and teleconference meetings or via	Development partners/agencies; Government Policy makers; Relevant WHO Departments and other relevant stakeholders	All Project partners Country MHACS	2007 - 2010 (Periodically throughout the Project when major research data and	Key stakeholders informed of project research findings and recommendations	Ongoing

letters of information to key stakeholders and WHO newsletters to media and strategic partners ²)	Country MHACS		findings becomes available)	throughout the project	
Issue press releases and factsheets on major milestones, issues, findings and events of the project	Development partners/agencies; Government Policy makers; Academic and research institutions; NGO, User and family organizations; Professional associations; health workers	All project partners (WHO to prepare generic press releases and factsheets if/when appropriate)	Ongoing throughout project - 2007 to 2010	Key stakeholders at national and international levels informed of major milestones, issues, findings and events of the project Media kept informed and engaged in the project	Ongoing. A full list of research products and publications available in Annex 5.
Post research findings on the project website and on the Poverty and Mental Health Website as and when data and information becomes available (all RPC project partners)	Development partners/agencies; Government Policy makers; Academic and research institutions; NGO, User and family organizations; Professional associations; health workers	UCT with the support of all project partners	Ongoing throughout project - 2006 to 2010	Major milestones, issues, findings and events of the project widely accessible to all stakeholders via the Project Website and the Mental Health and Development	Ongoing

² Three WHO Newsletters:

- 1) Newsletter to an extensive list of 4000 donors, including Foundations, Government Aid Agencies, National Missions as well as a number of other strategic partners.
- 2) In-house WHO information newsletter to Non communicable disease cluster as well as senior WHO staff and management at HQ, Regional and Country Offices
- 3) Newsletter to all WHO media contacts (approx 400 contacts around the world including Independent, Sunday Times, AP, NY times, CBS, Time, Newsweek and key international journals s/as the lancet, BMJ etc.)

				Website	
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Strategy 2: Launch of project findings in each of the Project countries

Indicator: Launch/roundtable debates held with active engagement from key stakeholders (development partners, government policy makers; academic and research institutions; NGO, user and family organizations; professional associations; health workers)

Activity	Target audience/stakeholders	Responsible project partner	timescale	Output	Achieved?
Launching event or roundtable debates bringing together key stakeholders at the end of the Project to communicate findings and hold discussions in each of the four partner countries	Development partners/agencies working at national level; Development partners/agencies; Government Policy makers; Academic and research institutions; NGO, User and family organizations; Professional associations; health workers Country MHACs	National partners Country MHACs	End of project - 2010	Key national partners and stakeholders informed of project research findings and recommendations and involved in discussion and debate emanating from findings	Launch events took place, but final dissemination events not yet achieved
Issue press releases and factsheets about the Project findings as part of high profile national events	Development partners/agencies working at national level; Development partners/agencies; Government Policy makers; Academic and research institutions; NGO, User and family organizations; Professional associations; health workers	National project partners (WHO to prepare generic press releases and factsheets)	End of project - 2010	Project data and findings to key national partners and stakeholders via the media	Not yet achieved

Strategy 3: Ensure the ongoing dissemination to key stakeholders of information and findings beyond the project

Indicator: Strategy developed with clear responsibilities for each partner set out

Activity	Target audience/stakeholders	Responsible project partner	timescale	Output	Achieved?
Discuss strategies for the ongoing dissemination of information and findings beyond the project with all Project partners	Development partners/agencies working at national level; Development partners/agencies; Government Policy makers; Academic and research institutions; NGO, User and family organizations; Professional associations; health workers	All Project Partners	Annual RPC meetings in 2009 and 2010	Distribution strategy in place for the ongoing dissemination of research findings and recommendations beyond the project	Yes

Annex 5. Products and publications

PEER REVIEWED PUBLICATIONS

The following papers are direct MHaPP publications on findings from the Phase 1 situation analysis:

1. Flisher, A.J., Lund, C., Funk, M., Banda, M., Bhana, A., Doku, V., Drew, N., Kigozi, F., Knapp, M., Omar, M., Petersen, I., & Green A. (2007). Mental health policy development and implementation in four African countries. **Journal of Health Psychology** 12: 505-516.
2. Lund, C., Stein, D.J., Flisher A.J., Mehtar, S. (2007). Challenges faced by South African health services in implementing the Mental Health Care Act. Editorial. **South African Medical Journal** 97:352-353.
3. Lund, C., Stein, D.J. Corrigan, J., Bradshaw D., Schneider M., Flisher, A.J. (2008). Mental health is integral to public health: a call to scale up evidence-based services and develop mental health research. Editorial. **South African Medical Journal** 98: 444-446.
4. Flisher, A. J., & Lund, C. (2009). The Mental Health and Poverty Project: Some preliminary findings. **Mental Health Reforms**, 1, 11-13.
5. Petersen, I., Bhana, A., Campbell-Hall, V., Mjadu, S., Lund, C., Kleintjes, S., Hosegood, V., & Flisher, A.J. (2009) Planning for district mental health services in South Africa. A situational analysis of a rural district site. **Health Policy and Planning**, doi:10.1093/heapol/czn044
6. Draper, C., Lund, C., Kleintjes, S., Funk, M., Omar, M., Flisher, A.J., and the MHaPP Research Programme Consortium (2009). Mental health policy in South Africa: development process and content. **Health Policy and Planning**. doi:10.1093/heapol/czp027.
7. Lund, C., Kleintjes, S., Kakuma, R., Flisher, A.J., and the MHaPP Research Programme Consortium (2009). Public sector mental health systems in South Africa. **Social Psychiatry and Psychiatric Epidemiology**. DOI 10.1007/s00127-009-0078-5.
8. Ssebunnya, J., Kigozi, F., Lund, C., Kizza, D., & Okello E.S., (2009). Stakeholder Perceptions of Mental Health Stigma and Poverty in Uganda. **BMC International Health and Human Rights** 9:5 doi:10.1186/1472-698X-9-5.
9. Kigozi, F., & Ssebunnya, J. (2009). Chronic Poverty, wars and mental health: the East African perspective. **International Psychiatry** 6(2): 31-32.
10. Ssebunnya, J., Kigozi, F. (2009). Integration of mental health into primary health care in Uganda: opportunities and challenges. **Mental Health in Family Medicine**. 6:37-42.
11. Lund C, Flisher AJ. (2009). A model for community mental health services in South Africa. **Tropical Medicine and International Health**,14: 1040-1047.
12. Kigozi, F. Ssebunnya, J., Kizza, D. Cooper, S. Ndyabangi, S. (2010). An overview of Uganda's mental health care system: results from an assessment using the world health organization's assessment instrument for mental health systems (WHO-AIMS). **International Journal of Mental Health Systems**, 4(1).
13. Lund, C., Breen, A., Flisher, A., Kakuma, R., Corrigan, J., Joska, J., Swartz, L., Patel, V. (2010). Poverty and common mental disorders in low and middle income countries: A systematic review. **Social Science and Medicine**. 71: 517-528.

The following direct MHaPP publications have been published in a special issue of the African Journal of Psychiatry, devoted to the MHaPP Phase 1 findings:

1. Flisher, A.J., Lund, C. and the MHaPP Research Programme Consortium (2010) Mental health policy in Africa. Guest Editorial. **African Journal of Psychiatry**. 13:81-83.
2. Akpalu, B., Lund, C., Doku, V., Ofori-Atta, A., Osei, A., Ae-Ngibise, K., Awenwa, D., Cooper, S., Flisher, A.J. and the MHaPP Research Programme Consortium (2010). Scaling up community-based services and improving quality of care in the state psychiatric hospitals: the way forward for Ghana. **African Journal of Psychiatry**. 13: 109-115.
3. Kakuma, R., Kleintjes, S., Lund, C., Drew, N., Green, A., Flisher, A.J., and the MHaPP Research Programme Consortium (2010). Mental health stigma: what is being done to raise awareness and reduce stigma in South Africa? **African Journal of Psychiatry** 13: 116-124.
4. Kigozi, F., Ssebunnya, J., Kizza, D., & Ndyabangi, S. (2010). Media and mental health in Uganda. **African Journal of Psychiatry**. 13:125-127
5. Kleintjes, S., Lund, C., Flisher, A.J., and the MHaPP Research Programme Consortium (2010). A situational analysis of child and adolescent mental health services in Ghana, Uganda, South Africa and Zambia. **African Journal of Psychiatry**. 13:132-139.
6. Ofori-Atta, A., Read, U.M., Lund, C., and the MHaPP Research Programme Consortium (2010). A situation analysis of mental health services and legislation in Ghana: challenges for transformation. **African Journal of Psychiatry**. 13:99-108.
7. Ssebunnya, J., Kigozi, F., Kizza, D., & Ndyabangi, S. (2010). Integration of mental health into primary health care: a case of one rural district in Uganda. **African Journal of Psychiatry**. 13:128-131.
8. Awenwa AD, Read UM, Ofori-Atta AL, Doku VCK, Akpalu B, Osei A, Flisher AJ and the MHaPP Research Programme Consortium (2010). From Mental Health Policy Development in Ghana to Implementation: What are the Barriers? **African Journal of Psychiatry**. 13: (in press)
9. Kapungwe, A., Cooper, S., Mwanza, J., Mwape, L., Sikwese, A., Kakuma, R., Lund, C., Flisher, A.J., and the MHaPP Research Programme Consortium (2010). "*I hope that one day a person like me could walk head up into a psychiatry unit and not feel afraid ...*": Mental illness stigma in Zambia. **African Journal of Psychiatry**. 13: (in press).
10. Lund, C., and the MHaPP Research Programme Consortium (2010). Mental health policy implementation in Ghana and Zambia. Guest Editorial. **African Journal of Psychiatry**. 13: (in press).

The following publications are not direct products of MHaPP data, but have been authored or co-authored by partners in the consortium (in bold), and the findings support the overall objectives of MHaPP:

1. **Kleintjes, S, Flisher, AJ**, Fick, M., Railoun, A, **Lund, C**, Molteno, C., Robertson, B.A. The prevalence of mental disorders among children, adolescents and adults in the Western Cape, South Africa, *South African Psychiatry Review*, Vol 9, Issue 3, August 2006, p.157-160.
2. Chisholm, D., **Lund, C.**, Saxena, S. (2007). The cost of scaling up mental health care in low- and middle-income countries. *British Journal of Psychiatry*. 191, 528-535.
3. The Lancet Global Mental Health Group. (2007). (Writing group in alphabetical order: Chisholm D, **Flisher AJ, Lund C**, Patel V, Saxena S, Thornicroft G, Tomlinson M). Scale up services for mental disorders: a call for action. *The Lancet* Published online September 4, 2007 DOI:10.1016/S0140-6736(07)61242-2.
4. Patel V, **Flisher AJ**, McGorry P. The mental health of young people: A global public health challenge. *Lancet* 2007; 369: 1302-1313.

5. Breen A, Swartz L, **Flisher AJ**, Joska J, Corrigan J, Plaatjies L, McDonald DA. Experience of mental disorder in the context of basic service reforms: The impact on care-giving environments in South Africa. International Journal of Environmental Health Research 2007; **17**: 327 – 334.
6. Corrigan, J., **Lund, C.**, Patel, V., Plagerson S., **Funk, M.** (2008). Poverty and mental illness: fact or fiction? A commentary on Das, Do, Friedman, McKenzie & Scott (65:3, 2007, 467-480). Social Science and Medicine 66:2061-2063.
7. **Flisher AJ**, Myer L, Marais A, Lombard C, Reddy P. Prevalence and correlates of partner violence among South African adolescents. Journal of Child Psychology and Psychiatry 2007; **48**: 619 – 627.
8. Jaspan H, **Flisher AJ**, Mathews C, Seebregts C, Berwick JR, Wood R, Bekker L-G. Methods for collecting sexual behaviour information from South African adolescents - a comparison of paper versus personal digital assistant questionnaires. Journal of Adolescence 2007; **30**: 353-359.
9. Joska J, **Flisher AJ**. Needs and services at an in-patient psychotherapy unit. African Journal of Psychiatry, 2007; **10**: 149-156.
10. Liang H, **Flisher AJ**, Lombard C. Bullying, violence and risk behaviour in South African adolescents. Child Abuse and Neglect 2007; **31**: 161-171.
11. Mertens JR, **Flisher AJ**, Fleming MF, Weisner C. Medical conditions of adolescents in alcohol and drug treatment: Comparison with matched controls. Journal of Adolescent Health 2007; **40**: 173-179.
12. Palen L-A, Smith EA, Caldwell LL, **Flisher AJ**, Wegner L, Vergnani T. Inconsistent Reports of Sexual Intercourse Among South African High School Students. Journal of Adolescent Health 2008; **42**: 221 – 227.
13. Patel V, **Flisher AJ**, Nikapota A, Malhotra S. Promoting child and adolescent mental health in low and middle income countries. Journal of Child Psychology and Psychiatry 2008; **49**: 313-334.
14. Ward CL, Mertens JR, **Flisher AJ**, Bresick GF, Sterling SA, Little F, Weisner CM. Prevalence and correlates of substance use among South African primary care clinic patients. Substance Use and Misuse 2008; **43**: 1-16.
15. Peltzer, K; **Kleintjes, S**; Van Wyk, B; Thompson, EA; Mashego, TA. Correlates of suicide risk among secondary school students in Cape Town. Social Behavior & Personality: An International Journal, 2008, Vol. 36 Issue 4, p493-502,
16. Kareithi R, **Flisher AJ**. Location of development NGOs providing HIV/AIDS services to young people in Cape Town, South Africa. Journal of Social Development in Africa (in press).
17. Chopra M, Lawn JE, Sanders D, Barron P, Karim S, Bradshaw D, Jewkes R, Karim Q, **Flisher AJ**, Mayosi B, Tollman S, Churchyard G, Coovadia H, for *The Lancet* South Africa team. Achieving the health MDGs for South Africa: challenges and priorities. Lancet DOI:10.1016/S0140-6736(09)61122-3.
18. **Lund C**, Oosthuizen P, **Flisher AJ**, Emsley R, Stein DJ, Botha U, Koen L, Joska J. Pathways to specialist inpatient mental health care among high and low frequency service users in the Western Cape, South Africa. Psychiatric Services 61:235-240.
19. Onya H, **Flisher AJ**, Distiller G, Mashamba JT. Prevalence of substance use among rural high school students in Limpopo Province, South Africa. African Journal of Drug and Alcohol Studies 2007; **7**: 71-80.
20. Sorsdahl K, **Flisher AJ**, Stein DJ. Traditional healer attitudes and beliefs regarding referral of mentally ill adult and adolescent patients to Western doctors in the Eastern Cape, South Africa. Transcultural Psychiatry (in press).
21. Mayosi BM, **Flisher AJ**, Lalloo UG, Sitas F, Tollman S, Bradshaw D. The rising tide of non-communicable diseases in South Africa. Lancet. DOI:10.1016/S0140-6736(09)61087-4

22. Helleve A, **Flisher AJ**, Onya H, Mukoma W, Klepp K-I. Can any teacher teach sexuality and HIV/AIDS? Perspectives of South African Life Orientation teachers. Sex Education (in press).
23. Wegner L, **Flisher AJ**. Leisure boredom and adolescent risk behaviour: a systematic literature review. Journal of Child and Adolescent Mental Health 2009; **21**: 1-28.
24. Soka NF, Jaspan HB, Mathews C, **Flisher AJ**, Mark D, Middelkoop K, Wood R, Bekker LG. "A qualitative assessment of perspectives on the inclusion of adolescents in HIV vaccine trials in South Africa. International Journal of STD & AIDS (in press).
25. Selikow T-A, Ahmed N, **Flisher AJ**, Mathews C, Mukoma W. I am not "umqwayito": A qualitative study of peer pressure and sexual risk behaviour amongst young adolescents in Cape Town, South Africa. Scandinavian Journal of Public Health 2009; **37 (suppl. 1)**: 107-112.
26. Mukoma W, **Flisher AJ**, Kaaya S, Onya H, Wubs A, Mathews C, Helleve A, Klepp K-I: Development, reliability and validity of a research instrument designed to evaluate school-based HIV/AIDS interventions in South Africa and Tanzania. Scandinavian Journal of Public Health 2009; **37 (suppl. 1)**: 7-15.
27. Ammon LN, Mertens JR, Ward CL, **Flisher AJ**, Bresick GF, Weisner CM. Stress, Substance Use and Sexual Risk Behaviors Among Primary Care Patients in Cape Town, South Africa. Aids and Behavior (in press)(DOI 10.1007/s10461-009-9525-2)
28. Aarø LE, **Flisher AJ**, Kaaya S, Onya H, Namisi FS, Wubs A: Parental education as an indicator of socioeconomic status: Improving quality of data by requiring consistency across measurement occasions. Scandinavian Journal of Public Health 2009; **37 (suppl. 1)**: 16-27.
29. Ahmed N, **Flisher AJ**, Mathews C, Mukoma W, Jansen S. HIV education in South African schools: The dilemma and conflicts of educators. Scandinavian Journal of Public Health 2009; **37 (suppl. 1)**: 48-54.
30. Chikobvu P, Lombard C, **Flisher AJ**, King G, Townsend L, Muller M. Evaluating the bias in a binary risk behaviour model subject to inconsistent reports and drop-out: South African high school cohort study. Statistics in Medicine (in press).
31. **Flisher AJ**, Townsend L, Chikobvu P, Lombard C, King G. A longitudinal analysis of substance use and high school attrition in Cape Town, South Africa. Journal of Research on Adolescence (in press).
32. Gilreath T, King G, Graham JW, **Flisher AJ**, Lombard CF. Associations between maternal closeness, suicidal ideation and risk behaviours in Cape Town. European Child and Adolescent Psychiatry (in press).
33. Hatherill S, **Flisher AJ**, Nassen R. Delirium in children with HIV/AIDS. Journal of Child Neurology (in press).
34. Helleve A, **Flisher AJ**, Onya H, Mukoma W, KleppK-I. South African Life Orientation teachers' reflections on the impact of culture on their teaching of sexuality and HIV/AIDS. Culture, Health and Sexuality (in press).
35. Helleve A, **Flisher AJ**, Onya H, Kaaya S, Mukoma W, Swai C, Klepp K-I. Teachers' confidence in teaching HIV/AIDS and sexuality in South African and Tanzanian schools. Scandinavian Journal of Public Health 2009; **37 (suppl. 1)**: 55-64.
36. **Lund C**, Boyce G, **Flisher AJ**, Kafaar Z, Dawes A. Scaling up child and adolescent mental health services in South Africa: Human resource requirements and costs. Journal of child Psychology and Psychiatry 2009; **50**:1121-1130.
37. Mathews C, Guttmacher S, **Flisher AJ**, Mtshizana YY, Nelson T, McCarthy J, Daries V. The quality of HIV testing services for adolescents in Cape Town, South Africa: Do adolescent-friendly services make a difference? Journal of Adolescent Health 2009; **44**: 188 - 190.

38. Mertens J, **Flisher AJ**, Ward C, Bresick G, Sterling S, Weisner C. Medical Conditions of Risky Drinkers and Drug Users in Primary Care Clinics in Cape Town, South Africa. Journal of Drug Issues (in press).
39. Meyers P, Keet N, Winckler G, **Flisher AJ**. Mental health service users' perceptions and experiences of sedation, seclusion and restraint. International Journal of Social Psychiatry (in press).
40. Mükoma W, **Flisher AJ**, Ahmed N, Jansen S, Mathews C, Klepp K-I, Schaalma H: Process evaluation of a school-based HIV/AIDS intervention in South Africa. Scandinavian Journal of Public Health 2009; **37 (suppl. 1)**: 37-47.
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43. Patrick ME, Collins LM, Smith E, Caldwell L, **Flisher AJ**, Wegner L. A prospective longitudinal model of substance use onset among South African adolescents. Substance Use and Misuse 2009; **44**: 647-662.
44. Schaalma H, Aarø LE, **Flisher AJ**, Mathews C, Kaaya S, Onya H, Ragnarson A, Klepp K-I: Condom use among Sub-Saharan African youth: The applicability of the Theory of Planned Behaviour. Scandinavian Journal of Public Health 2009; **37 (suppl. 1)**: 87-91.
45. Seebregts C, Zwarenstein M, Mathews C, Fairall L, **Flisher AJ**, Seebregts C, Mukoma W, Klepp K-I, for the PDACT Working Group. Handheld Computers For Survey and Trial Data Collection in Resource-Poor Settings: Development and Evaluation of PDACT, a Palm® Pilot Interviewing System. International Journal of Medical Informatics (in press).
46. Sorsdahl K, Stein DJ, **Flisher AJ**. Explanatory models of mental disorders and treatment practices among traditional healers in Mpumalanga, South Africa. Culture, Medicine and Psychiatry (in press).
47. Sorsdahl K, Stein D, Grimsrud A, Seedat S, **Flisher AJ**, Williams DR, Myer L. Traditional healers in the treatment of common mental disorders in South Africa. Journal of Nervous and Mental Disease (in press).
48. Wubs AG; Aarø LE, **Flisher AJ**, Bastien S, Mathews C, Onya HE. Intimate partner violence among young adolescents in Tanzania and South Africa: prevalence and socio-demographic variations. Scandinavian Journal of Public Health 2009; **37 (suppl. 1)**: 75-86.
49. Yitayew Y, **Flisher AJ**, Alem A, Bahiretebeb Y. Pathways to psychiatric care in Ethiopia. Psychological Medicine (in press).
50. Mathews C, Aarø LE, **Flisher AJ**, Mukoma W, Wubs A, Schaalma H, Ahmed N, Klepp K-I. Predictors of first sexual intercourse among adolescents in Cape Town, South Africa. Health Education Research 2009; **24**: 1 - 10.
51. Caldwell LL, Younker AS, Wegner L, Patrick P, Vergnani T, Smith EA, **Flisher AJ**. Understanding Leisure-related Program Effects by Using Process Data in the HealthWise South Africa Project. Journal of Park and Recreation Administration 2008; **26**: 146-162.
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53. Mertens JR, **Flisher AJ**, Satre D, Weisner C. The role of health conditions and services in 5-year outcome among HMO chemical dependency treatment patients. Drug and Alcohol Dependence 2008; **98**: 5-53.

54. Mlisa LN, Ward C, **Flisher AJ**, Lombard C. Bullying at rural high schools in the Eastern Cape Province, South Africa: Prevalence, and risk and protective factors at school and in the family. Journal of Psychology in Africa 2008; **18**: 261 – 268.
55. Palen L, Graham JG, Smith EA, Caldwell LL, Mathews C, **Flisher AJ**. Rates of missing responses in PDA versus paper assessments. Evaluation Review 2008; **32**: 257 - 272.
56. Plüddemann A, **Flisher AJ**, Mathews C, Carney T, Lombard C. Adolescent methamphetamine use and sexual risk behaviour in secondary school students in Cape Town, South Africa. Drug and Alcohol Review 2008; **29**: 1-6.
57. Plüddemann A, Parry CDH, **Flisher AJ**, Jordaan E. Heroin users in Cape Town, South Africa: Injecting practices, HIV-related risk behavior, and other health consequences. Journal of Psychoactive Drugs 2008; **40**: 273-279.
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60. Wegner L, **Flisher AJ**, Chikobvu P, Lombard C, King G. Leisure boredom and high school dropout in Cape Town, South Africa. Journal of Adolescence 2008; **31**: 421 – 431.
61. Wegner L, **Flisher AJ**, Caldwell L, Vergnani T, Smith E. HealthWise South Africa: Cultural Adaptation of a School-Based Risk Prevention Programme. Health Education Research 2008; **23**: 1085-1096.
62. Corrigan, J., Plagerson, S., **Lund, C.**, Myers, J. (2008). Global trade and mental health. Global Social Policy **8**: 335-358.
63. **Petersen, I.**, Swartz, L., **Bhana, A & Flisher, A.J.** (2010). Mental health promotion initiatives for children and youth in contexts of poverty. The case of South Africa. Health Promotion International. doi:10.1093/heapro/daq026
64. **Petersen, I.**, **Bhana, A.**, Myeza, N., Alicea, S., John, S., Holst, H., McKay, M., Mellins, C. (2010). Psychosocial challenges and protective influences for socio-emotional coping of HIV+ adolescents in South Africa. A qualitative investigation. AIDS Care. doi:10.1080/09540121003623693.
65. **Ofori-Atta A.L.** (in press). Clinical Psychology in Ghana. Clinical Psychology Forum
66. **Lund, C.**, Kagee, A., & Wood, N. (in press). Clinical psychology training in South Africa. Clinical Psychology Forum.

PEER REVIEWED PUBLICATIONS IN PRESS OR SUBMITTED

The following direct MHaPP publications, which report findings from the Phase 1 situation analysis and/or Phase 2 interventions, are 'in press' or have been submitted

1. Doku, V., Ofori-Atta, A., Akpalu, B., Osei, A., Read, U., Cooper, S., and the MHaPP Research Programme Consortium (In press). Stakeholders' perceptions of the main challenges facing Ghana's mental health care system: A qualitative analysis. **International Journal of Culture and Mental Health**.
2. Lund, C., Kleintjes, S., Cooper, S., Petersen, I., Bhana, A., Flisher, A. and the MHaPP Research Programme Consortium (In press). Challenges facing South Africa's mental health care system: stakeholders' perceptions of causes and potential solutions. **International Journal of Culture and Mental Health**.
3. Mwanza, J., Cooper, S., Kapungwe, A., Sikwese, A., Mwape, L. and the MHaPP Research Programme Consortium. Stakeholders' perceptions of the main challenges facing Zambia's mental health care system: A qualitative analysis. **International Journal of Culture and Mental Health**.

4. Ssebunnya, J., Kigozi, F., Ndyabangi, S., Cooper, S and the MHaPP Research Programme Consortium (In press). Stakeholders' perceptions of the main challenges facing Uganda's mental health care system: A qualitative analysis. **International Journal of Culture and Mental Health.**
5. Mwape, L., Sikwese, A., Kapungwe, A., Mwanza, J., Flisher, A., Lund, C., Cooper, S and the MHaPP Research Programme Consortium (In press). Integrating mental health into primary health care in Zambia: A care provider's perspective. **International Journal of Mental Health Systems.**
6. Campbell-Hall, V., Petersen, I., Bhana, A., Mjadu, N., Hosegood, V., & Flisher, A.J. (in press). Collaboration between traditional practitioners and primary health care staff within one rural sub-district in South Africa: Developing a workable partnership for community mental health services. **Transcultural Psychiatry.**
7. Kapungwe, A., Cooper, S., Mayeya, J., Mwanza, J., Mwape, L., Sikwese, A., Lund, C. and the MHaPP Research Programme Consortium (Submitted). Attitudes of primary health care providers towards people with mental illness: Evidence from two districts in Zambia. **African Journal of Psychiatry.**
8. Osei, A., Cooper, S., Lamensdorf Ofori-Atta, A., Akpalu, B., Doku, V., Flisher, A. and the MHaPP Research Programme Consortium. (Submitted). Viewing Ghana's Mental Health System through a Human Rights Lens. **BMC International Health and Human Rights.**
9. Omar M, et al (submitted) Mental health policy processes in four African countries. **International Journal of Mental Health Systems.**
10. Petersen, I., Bhana, A., Baillie, K. Adapting Interpersonal Therapy (IPT) for the treatment of depression by community health workers within the context of task shifting in South Africa. A feasibility study. Submitted to **Journal of Affective Disorders.**
11. Petersen, I., Lund, C., Bhana, A., & Flisher, A.J. A task shifting approach to primary mental health care for adults in South Africa. Human resource requirements and costs. Submitted to **Health Policy and Planning.**
12. Faydi, E., Funk, M., Kleintjies, S., Ofori-Atta, A., Ssebunnya, J., Mwanza, J., Kim, C., Flisher, A. (submitted). A comparison of mental health policy in four African countries. **Health Research Policy and Systems.**
13. Baillie, K., Petersen, I., Bhana, A., Ofori-Atta, A., Cooper, S. and MHaPP research programme consortium. Perceptions of the causes of mental illness in women in Africa. A qualitative investigation in four countries. Submitted to **Women's Health Issues.**

The following direct MHaPP publications are in press, in a special issue of the International Review of Psychiatry, devoted to the MHaPP Phase 1 findings:

1. Sikwese, A., Mwape, L., Mwanza, J., Kapungwe, A., Kakuma, R., Imasiku, M., Lund, C., Cooper, S. and the MHaPP Research Programme Consortium (In press). Human resource challenges and constraints facing Zambia's mental health care system: Results from a combined quantitative and qualitative study. **International Review of Psychiatry.**
2. Ae-Ngibise, K., Cooper, S., Adibokah, E., Lund, C., Doku, V. and the MHaPP Research Programme Consortium (In Press). *"Whether you like it or not people with mental problems are going to go to them...":* A qualitative exploration into the widespread use of, and collaboration with, traditional and faith healers in the provision of mental health care Ghana. **International Review of Psychiatry.**
3. Ofori-Atta, A., Cooper, S., Akpalu, B., Osei, A., Doku, V., Lund, C., Flisher, A. and the MHaPP Research Programme Consortium. (In press). Common Understandings of Women's Mental Illness in Ghana: Results from a Qualitative Study. **International Review of Psychiatry.**

4. Cooper, S., Ssebunnya, J., Kigozi, F., Lund, C., Flisher, A. and the MHaPP Research Programme Consortium (In press). Viewing Uganda's Mental Health System through a Human Rights Lens. **International Review of Psychiatry.**
5. Bhana, A., Petersen, I., Baillie, K., Flisher, A. and the MHaPP Research Programme Consortium (In press). Meeting the Minimum Actions Required for Integrated Primary Mental Health Care. A Situational Analysis of Three African Countries: Ghana, South and Uganda. **International Review of Psychiatry.**
6. Skeen, S., Lund, C., Kleintjes, S., Flisher, A. and the MHaPP Research Programme Consortium (In press). Meeting the Millennium Development Goals in Sub-Saharan Africa: the role of mental health. **International Review of Psychiatry.**
7. Skeen, S., Kleintjes, S., Lund, C., Petersen, I., Bhana, A., Flisher, A. and the MHaPP Research Programme Consortium (In press). Inter-sectoral collaboration for mental health in South Africa. **International Review of Psychiatry.**
8. Kleintjes, S., Lund, C., Swartz, L., Flisher, A. and the MHaPP Research Programme Consortium (In press). Barriers and opportunities for mental health care user participation in mental health policy development and implementation in South Africa. **International Review of Psychiatry.**

IN-HOUSE PUBLICATIONS

The following country-specific reports were published in-house (not externally peer-reviewed), which provide detailed findings from the phase 1 situation analysis:

1. Doku, V., Ofori-Atta, A., Akpalu, B., Read, U., Osei, A., Ae-Ngebise, K., Awenva, D., Lund, C., Flisher, A.J., Petersen, I., Bhana, A., Bird, P., Drew, N., Faydi, E., Funk, M., Green, A., & Omar, M. (2008). **A situation analysis of mental health policy development and implementation in Ghana.** Accra: Mental Health and Poverty Project.
2. Kigozi, F., Ssebunnya, J., Kizza, D., Ndyabangi, S., Green, A., Omar, M., Bird, P., Funk, M., Faydi, E., Drew, N., Lund, C., & Flisher, A.J. (2008). **A situation analysis of the mental health system in Uganda. Phase 1 Country Report.** Kampala: Mental Health and Poverty Project.
3. Lund C, Kleintjes S, Campbell-Hall V, Mjadu S, Petersen I, Bhana A, Kakuma R, Mlanjeni B, Bird P, Drew N, Faydi E, Funk M, Green A, Omar M, & Flisher AJ. (2008). **Mental health policy development and implementation in South Africa: a situation analysis. Phase 1 Country report.** Cape Town: Mental Health and Poverty Project.
4. Mwanza, J., Sikwese, A., Banda, M., Mayeya, J., Lund, C., Bird, P., Drew, N., Faydi, E., Funk, M., Green, A., Omar, M., & Flisher, A. J. (2008). **Mental health policy development and implementation in Zambia: a situation analysis. Phase 1 Country Report.** Lusaka: Mental Health and Poverty Project.

BOOKS OR BOOK CHAPTERS

The following books or book chapters are direct products of MHaPP data:

1. WHO. (2007). Monitoring and evaluation of mental health policies and plans. **Mental Health Policy and Service Guidance Package.** Geneva: WHO.
2. Lund C, Sutcliffe T, Flisher AJ, Stein DJ (in press). Protecting the rights of the mentally ill in poorly resourced countries. In Dudley M, Silove D, Gale F (eds). **Mental health and human rights.** Oxford University Press.
3. Kakuma R, Bird P, Omar M, Lund C, Flisher AJ and the MHaPP Research Programme Consortium. (2008). Mental Health Research in Africa: Lessons learned. In Reading J, Marsden N, Link R, Kurbanova D & Kelly M. (Eds.), **Global Indigenous Health Research Symposium Report Papers and**

Presentations: Directions and Themes in International Indigenous Health Research 2008. University of Victoria, Victoria, British Columbia, Canada.

4. Cooper, S., Bhana, A., Drew, N., Faydi, E., Flisher, A., Kakuma, R., Kleintjes, S., Lund, C., Ofori-Atta, A., Skeen, S. and the MHaPP Research Programme Consortium. (In press). Recommendations for Improving Mental Health Care Systems in Africa: Lessons from Ghana, Uganda, South Africa and Zambia. In **Africa Focus**. Pretoria: HSRC Press.
5. WHO and MHaPP (in press). **Mental Health and Development: Treating people with Mental Health Conditions as a Vulnerable Group**. Geneva: WHO.

The following books or book chapters are not direct products of MHaPP data, but have been authored or co-authored by partners in the consortium (in bold), and the findings support the overall objectives of MHaPP:

1. Moutrie, A & **Kleintjes, SR**. Women's Mental Health in South Africa. In: Ijumba P, Padarath A (eds). South African Health Review 2006. Durban: Health Systems Trust, 2006.
2. Corrigan, J., Ward, C., Stinson, K., Struthers, P., Frantz, J., **Lund, C., Flisher, A.J.**, & Joska, J. (2007). Burden of Disease Project: Decreasing the burden of mental illness in the Western Cape. Cape Town: Department of Health, Provincial Government of the Western Cape.
3. **Flisher AJ**, Hatherill S, Dhansay Y. Child and adolescent psychiatric disorders. In: Heggenhogen HK (Ed-in chief). Encyclopedia of Public Health. San Diego, CA: Elsevier Inc., 2008.
4. Patel V, **Flisher AJ**, Cohen A. Social and cultural determinants of mental health. In: Murray R, Kendler K, McGuffin P, Wessely S, Castle D (Eds.) Essential Psychiatry (4th edition). Cambridge: Cambridge University Press, 2008.
5. **Petersen I, Bhana A**, Swartz L, **Flisher AJ**, Richter L (Eds.). Promoting mental health in scarce resource contexts: Emerging evidence and practice. Human Sciences Research Council Press, 2010.
6. **Flisher AJ**, Gevers A. Adolescence. In: Petersen I, Bhana A, Swartz L, Flisher AJ, Richter L (Eds.). People First: Promoting Mental Health and Preventing Mental and Behavioural Problems in Low-income Contexts. Human Sciences Research Council Press, 2010.
7. **Flisher AJ**, Gurein N. Adolescence. In: Heggenhogen HK (Ed-in chief). Encyclopedia of Public Health. San Diego, CA: Elsevier Inc., 2008.
8. Palen L-A, Smith EA, Caldwell LL, **Flisher AJ**. Longitudinal Patterns of Cigarette Use Among Girls in Cape Town, South Africa. In Tolson KP, Veksler EB (Eds.), Research Focus on Smoking and Women's Health. Hauppauge, NY, USA: Nova Publishers, 2008. Also published in Wesley JK, Sternbach IA (Eds.), Smoking and Women's Health, Hauppauge, NY, USA: Nova Publishers, 2008.
9. Patel V, **Lund C**, Hatherill S, Plagerson S, Corrigan J, Funk M, **Flisher AJ**. Mental disorders: equity and social determinants. In WHO (ed) Social determinants of priority public health conditions. Geneva: WHO Commission on Social Determinants of Health report (in press).
10. Gevers A, **Flisher AJ**. School-based youth violence prevention interventions. In Ward C, Dawes A (Eds.), Youth Crime and Violence. Cape Town: HSRC press (in press).
11. Tomlinson M, Dawes A, **Flisher AJ**. "Intervene early, intervene intensively and intervene everywhere": Preventing the development of youth violence in the early years. In Ward C, Dawes A (Eds.), Youth Crime and Violence. Cape Town: HSRC press (in press).
12. **Flisher AJ**, Riordan G. Psychiatric problems. In Motala C (Ed.), Handbook of Paediatrics. Cape Town, Oxford University Press (in press).

POLICY BRIEFS

1. Breaking the vicious cycle of mental ill-health and poverty. Policy Brief 1. Mental Health and Poverty Project, University of Cape Town.
2. The prioritisation of mental health as a public health issue in South Africa. Policy Brief 2. Mental Health and Poverty Project, University of Cape Town.
3. Challenges of implementing mental health policy and legislation in South Africa. Policy Brief 3. Mental Health and Poverty Project, University of Cape Town.
4. Promoting community-based services for mental health in South Africa. Policy Brief 4. Mental Health and Poverty Project, University of Cape Town.
5. Inter-sectoral collaboration for mental health in South Africa. Policy Brief 5. Mental Health and Poverty Project, University of Cape Town.
6. Integrating mental health into maternal care in South Africa. Policy Brief 6. Mental Health and Poverty Project, University of Cape Town.
7. Developing effective Mental Health Laws in Africa. MHaPP Policy Brief 7.
8. Developing effective Mental Health Policies and Plans in Africa: 7 key lessons. MHaPP Policy Brief 8.
9. Key elements of a situational analysis to inform mental health policy. MHaPP Policy Brief 9.
10. Developing and adopting mental health policies and plans in Africa: Lessons from South Africa, Uganda and Zambia. Policy Brief 10. Mental Health and Poverty Project, University of Cape Town.
11. Developing and adopting mental health laws in Africa: Lessons from Ghana, Zambia and Uganda. Policy Brief 11. Mental Health and Poverty Project, University of Cape Town.
12. Better information for better mental health: Developing Mental Health Information Systems in Africa. Policy Brief 12. Mental Health and Poverty Project, University of Cape Town.
13. Scaling up mental health services at district level: Lessons from district care systems in Ghana, South Africa and Uganda. Policy Brief 13. Mental Health and Poverty Project, University of Cape Town.
14. Mental health and development. Policy Brief 14. Mental Health and Poverty Project, University of Cape Town.
15. Issues & interventions for vulnerable women in the perinatal period. Policy Brief 15. Mental Health and Poverty Project, University of Cape Town.

PUBLICITY MATERIAL

The following general publicity materials have been produced:

Posters and brochures

- MHaPP brochure
- Summary booklet of MHaPP findings in Uganda.
- MHaPP poster: Mental health services in South Africa
- MHaPP poster: Mental health policy development and implementation in four African countries: Ghana, South Africa, Uganda and Zambia
- MHaPP poster: Planning district mental health services for resource constrained settings. A case study in South Africa.
- MHaPP poster: Planning for maternal mental health care at primary care level in resource constrained districts in South Africa. A Case Study.

Press releases

- World Mental Health Day (October 10, 2008) press release – focusing on mental health policy and services in SA
- World Mental Health Day (October 10, 2009) press release – focusing on the integration of mental health into primary health care.
- Cape Mental Health Society Conference (October 21, 2008) press release – focusing on mental health and poverty
- South African Depression and Anxiety Group (January, 2009) press release, using MHaPP country report

Magazine and newspaper articles

- Article on mental health care system in Uganda in the New Vision, June, 2006: *"Mental health worries experts"*
- Article on health, including mental health care system in Zambia in the Voanews, June, 2007: *"Lack of financing, skilled personnel challenge health care in Zambia"*
- Article on mental health care system in South Africa in All Africa, April 2008: *"South Africa: Where Have the Piglets Gone?"*
- Article on mental health care bill in Ghana in the Daily Graphic, August 2008: *"Pass the Mental Health Bill Now"*
- Article on mental health care system in Uganda in the Daily Monitor, August 2008: *"Big gaps in mental health care system"*
- Article on mental health care system in Ghana in the Ghanaian Times, October 2008: *"Experts Analyse Mental Health System In Ghana"*
- Article on the Perinatal Mental Health Project in 'O' Magazine, May 2009: *"When pregnancy hurts"*
- Article on mental health care system in South Africa in Health24.com, May 2009: *"SA's sad state of mental health care"*.
- Article on mental health in South Africa in Sowetan, April 2009: *"Nearly 1 in 5 South Africans suffer from mental illnesses"*.
- Article on mental health in Africa in Psychiatric News, April 2010: *"Long Overlooked in Africa, MH Now Getting Attention"*
- Article on child and adolescent mental health in Daily Dispatch, May 2010: *"Protecting our future"*
- Short newspaper articles on MHaPP and mental health policy/services in South Africa in 2009 in: the Argus, Mail & Guardian, Sunday Times, Cape Times, The Natal Witness, Health-E news, Daily Dispatch

Radio coverage

- Interviews with SAFM, 2007, 2008
- Interviews with BBC World Service, 2007
- Interviews with Radio 702, 2009
- News item on CCFM, 2009
- News item on Heart FM, 2009

Television coverage

- News interview (SABC) – World Mental Health Day, 10 Oct 2008
- Voice of America Interview, April 2009
- TV Africa and Metro TV, Ghana – reports on launch of Ghana's situation analysis report, late 2008.

Documentaries

- The Perinatal Mental Health Project has produced a DVD for advocacy, training, promotional and fundraising purposes. This can be downloaded from the PMHP website: www.psychiatry.uct.ac.za/pmhp/
- Web-based media documentary in Uganda:
www.monitor.co.ug/artman/publish/features/Big_gaps_in_mental_healthcare_system_69345.shtml
- Documentary on mental health advocacy in Ghana, available from the Ghana PI, Dr Doku.

WEBSITE LINKS

- MHAPP website: www.psychiatry.uct.ac.za/mhapp/
- WHO Mental health, poverty and development website:
www.who.int/mental_health/policy/development/index.html
- Perinatal Mental Health Project: www.psychiatry.uct.ac.za/pmhp/

Links from the MHAPP website to:

- Department for International Development (DFID) UK, Central Research Department: <http://www.dfid.gov.uk/research/>
- WHO Mental health policy and services:
http://www.who.int/mental_health/policy/en/
- WHO Mental Health Policy Web board: <http://www.mayeticvillage.com/who-mh-policy-and-development>
- Health Systems Trust: <http://www.hst.org.za/>
- Ministry of Health/Dept of Health websites in each study country

RESEARCH PROGRAMME REPORTS

- Inception Phase Report, submitted to DFID, February 2006
- Annual report, August 2006
- Mid-term review report, August 2007
- Annual report, August 2007
- Annual report, August 2008
- Examples of innovative communication strategies being used by MHAPP, May 2009
- Annual report, August 2009
- Final report, July 2010

DISSEMINATION EVENTS

- Launch of the MHAPP and establishment of the MHAC in South Africa, Uganda, Ghana and Zambia, 2006
- Attendance at the meeting of the African Psychiatric Association and Allied Professions, Addis Ababa, Ethiopia, April 2006.
- Presentation of the MHAPP at public lectures at the Department of Psychiatry and Mental Health, and the Children's Institute, University of Cape Town, 2006
- Presentation of the MHAPP at the International Mental Health conference, Institute of Psychiatry, London in August 2006.
- Ugandan dissemination workshop, April 2008, at which findings of the situation analysis were disseminated to various stakeholders.

- Presentation to South African Human Rights Commission: Public Hearings on the Millennium Development Goals and the realisation of Economic and Social Rights in South Africa, 2009.
- SAHRC presentation: Achieving the Millennium Development Goals: Addressing mental health, 2009
- Presentation on climate change and mental health at the South African Parliament Public Hearings on the Political, Economic, Legal, Gender and Social Impacts of Climate Change, November 2009.
- Presentation on education and mental health at the South African Parliament Public Hearings on Education Access and Delivery Challenges, hosted by the Parliamentary Committee on Education, May 2010.

The following papers were presented at local or international conferences

1. Flisher AJ, Lund C, Agoussou T, Banda M, Bhana A, Doku V, Drew N, Funk M, Green A, Kigozi F, Knapp M, Mayeya J, Ndyanabangi SZ, Omar M, Osei A, Petersen I, Phakathi S, Saraceno B. Mental health policy development in four African countries. 3rd International Mental Health Conference, London, UK, 30 August - 1 September 2006.
2. Petersen I, Bhana A, Govender K. The individual and beyond: promoting mental health in developing contexts. 4th International Conference of Promotion of Mental Health and Prevention of Mental and Behavioural Disorders, Oslo, Norway, 11-13 October, 2006.
3. Kakuma R, Goering P, Flisher A, Stuart H, Lund C. International comparison of mental health policy and service delivery: how do different countries deal with stigma? Poster presentation: Canadian Academy of Psychiatric Epidemiology Annual Scientific Symposium, Toronto, Canada, 9 November 2006.
4. Banda M, Mayeya J, Sikwese A. (2007) WHO AIMS data – presented for a Ministry of Health meeting on the Strategic plan for the mental health system, cresta Golf View Hotel, Lusaka 18-22 December 2006.
5. Lund C, Flisher AJ, Banda M, Doku V, Kigozi F, AkpaluB, Campbell-Hall V, Kaoma K, Kleintjes S, Sebunya J, Saxena S. Use of the WHO AIMS to assess mental health systems in four African countries. International Centre for Mental Health Policy and Economics 8th Workshop on Costs and Assessment in Psychiatry, Venice, Italy 9-11 March 2007.
6. Lund C, Breen A, Flisher AJ, Swartz L, Joska J, Corrigan J, Kleintjes S, Patel V. Mental health and poverty: a systematic review of the research in low and middle income countries. International Centre for Mental Health Policy and Economics 8th Workshop on Costs and Assessment in Psychiatry, Venice, Italy 9-11 March 2007.
7. Flisher AJ, Lund C, Funk M, Banda M, Bhana A, Doku V, Drew N, Kigozi F, Knapp M, Omar M, Petersen I, Green A. A new initiative to develop and implement mental health policy in Africa. WPA Regional Conference, Nairobi, Kenya, 21-23 March 2007.
8. Lund C, Petersen I, Bhana A, Kleintjes S, Campbell-Hall V, Bird P, Drew N, Faydi E, Funk M, Green A, Omar M; Flisher AJ. The Mental Health and Poverty Project (MHAPP): Part II. Preliminary results of the situation analysis from South Africa. WPA Regional Conference, Nairobi, Kenya, 21-23 March 2007.
9. Lund C, Muller L, Flisher AJ, Swartz L, Kagee A, Naidoo A, Kleintjes S. Public mental health capacity development in Africa: Proposal for a Centre for Public Mental Health. Presentation at Afrihealth Public Health Education conference, Pretoria, 14 June 2007.

10. Banda M. MHAPP preliminary results of the situational analysis on Neuroscience Retreat workshop on the Infection and Brain Diseases Burden, InterContinental Hotel, Lusaka 13-15 June 2007.
11. Lund C, Muller L, Flisher AJ, Swartz L, Kagee A, Naidoo A, Kleintjes S. Public mental health capacity development in Africa: Proposal for a Centre for Public Mental Health. Presentation at Afrihealth Public Health Education conference, Pretoria, 14 June 2007.
12. Kleintjes, S, Campbell, V, Flisher, AJ, Lund, C, Bhana, A, Bird, P, Omah, M, Petersen, I. Green, A. A situational analysis of child and adolescent mental health policy development and implementation in South Africa. 16th Congress of the South African Association for Child and Adolescent Psychiatry and Allied Professions, Included and Visible: Development for a New Millennium. Tuesday 11 – Friday 14 September 2007, University of Cape Town, Cape Town, South Africa.
13. Ofori-Atta A, Akpalu B, Osei A, Doku V. Witches' Camps, Faith Healers and Psychiatric Hospitals? A critical study of available options in mental health services around Ghana. Annual General Conference of the College of Health Sciences, Accra, Ghana, 26th to 28th Sept 2007.
14. Doku V, Ofori-Atta A, Akpalu B, Osei A. The use of the WHO AIMS to assess the mental health system in Ghana. Annual General Conference of the College of Health Sciences, Accra, Ghana, 26th to 28th Sept 2007.
15. Akpalu B, Doku V, Ofori-Atta A, Osei A. Why not evidence based policies in mental health? Preliminary findings from the Mental Health and Poverty Project in Ghana. Annual General Conference of the College of Health Sciences, Accra, Ghana, 26th to 28th Sept 2007.
16. Osei A, Ofori-Atta A, Akpalu B, Doku V. Mental Health and Human Rights in Ghana. Annual General Conference of the College of Health Sciences, Accra, Ghana, 26th to 28th Sept 2007.
17. Kigozi F, Ssebunnya, J, Flisher AJ, Lund C, Funk M, Omar M, Doku V, Petersen I, Bhana A. The Mental Health and Poverty Project (MHAPP): Assessment of the mental health systems and mental health policy evaluation in four African countries using WHO-AIMS and Policy Checklist. WPA Regional Conference/CSP Annual Congress, Shanghai, China, 20th -23rd Sept. 2007.
18. Kakuma R, Kleintjes S, Lund C, Bird P, Drew N, Faydi E, Funk M, Green A, Omar M, Flisher AJ. Mental Health Stigma - What is being done to raise awareness and reduce stigma in South Africa? Symposium on Evidence-To-Action in Disability: Tygerberg, 27 - 28 November 2007. The Centre for Rehabilitation Studies, Stellenbosch University, Tygerberg, Cape Town, South Africa. Poster presentation.
19. Kleintjes, S, Flisher, AJ, Lund, C, Bhana, A, Bird, P, Drew, N, Faydi, E, Funk, M, Green, A, Omah, M, Petersen, I. Opportunities for and barriers to improving mental health care user participation in mental health related policy development and implementation in South Africa: Preliminary findings. Symposium on Evidence-To-Action in Disability: Tygerberg, 27 - 28 November 2007, The Centre for Rehabilitation Studies, Stellenbosch University, Tygerberg, Cape Town, South Africa.
20. Ssebunnya J, Kigozi F & Ndyabangi S. Integration of Mental Health into Primary Health Care: a case of one rural district in Uganda. Uganda Psychiatric Association Annual Scientific Conference. 28th – 29th February 2008, Kampala, Uganda.
21. Lund C, Kleintjes S, Kakuma R, Flisher A.J. and the MHaPP Research Programme Consortium Public mental health services in South Africa: inter-provincial comparisons and policy implications. 4th Public Health Association of South Africa Conference, Cape Town, South Africa, 2-4 June 2008.

22. Ofori-Atta A, Read U & the MHaPP Research Programme Consortium. Transforming mental health services in Ghana. Paper presented at the annual conference of the African Association of Psychiatrists and Allied Professions, June 26 -28, 2008, Accra, Ghana.
23. Akpalu B, Doku V, Ofori-Attah A, Osei A, Awenva D & the MHaPP Research Programme Consortium. Is this a mental disorder? Diagnostic practices of traditional healers in the diagnosis of mental illness in a rural district in Ghana. Paper presented at the annual conference of the African Association of Psychiatrists and Allied Professions, June 26 -28, 2008, Accra, Ghana.
24. Awenva D, Read U, Doku V, Akpalu B, Ofori-Attah A, Osei A, & the MHaPP Research Programme Consortium. Mental health policy implementation in Ghana: the challenges. Paper presented at the annual conference of the African Association of Psychiatrists and Allied Professions, June 26 -28, 2008, Accra, Ghana.
25. Lund C, Flisher AJ, Kleintjes S, Kakuma R and the MHaPP Research Programme Consortium. Mental health policy or legislation: which comes first? Lessons from South Africa. 15th Biennial National Congress of the South African Society of Psychiatrists: 10-14 August 2008. George, South Africa. Poster presentation.
26. Kakuma R, Flisher AJ, Lund C, Omar M, Drew N, Faydi E, Funk M and the MHaPP Research Programme Consortium. National health plans in four African countries - Is mental health adequately addressed? 15th Biennial National Congress of the South African Society of Psychiatrists: 10-14 August 2008. George, South Africa. Poster presentation.
27. Kleintjes,S, Campbell, V, Flisher, AJ, Funk, M, Lund, C, Bhana, A, Bird, Doku, V, Kigozi, F, Ofori-Atta, A, Omah, M, Petersen, I. Green, A and the Mental Health and Poverty Research Programme Consortium. A situational analysis of child and adolescent (CA) mental health policy development and implementation in 4 African countries, South African Society of Psychiatrists, George, South Africa, August 2008.
28. Kakuma R, Kleintjes S, Lund C, Flisher AJ, Goering P and the MHaPP Research Programme Consortium. Development and implementation of mental health policy and law in South Africa: What is the impact of stigma? 15th Biennial National Congress of the South African Society of Psychiatrists. 10-14 August 2008, George, South Africa.
29. Lund C, Breen A, Flisher AJ, Kakuma R, Swartz L, Joska J, Corrigan J, Patel V. Poverty and Mental Health in Low and Middle Income Countries: a systematic review. 15th Biennial National Congress of the South African Society of Psychiatrists. 10-14 August 2008, George, South Africa.
30. Honikman S, Field S. The Perinatal Mental Health Project: a summative evaluation of a pilot implementation programme. 4th International Mental Health Conference, 26-28 August 2008, Institute of Psychiatry, London. Poster presentation.
31. Bhana A, Petersen I, Flisher A, Doku V, Mwanza J, and the MHaPP Research Programme Consortium . Comparison of district mental health models and structures across four African countries: Ghana, South Africa, Uganda & Zambia. World Congress of the World Federation for Mental Health, 2-6th September 2009, Athens, Greece.
32. Kakuma R, Kleintjes S, Lund C, Flisher AJ, Goering P, and the MHaPP Research Programme Consortium. Development and implementation of mental health policy and law in South Africa: what is the impact of stigma? Poster Presentation at the Fourth International Stigma Conference. Together Against Stigma: Stigma & Discrimination: Evidence for Action , 20-23 January 2009, London, UK

33. Ssebunnya J, et al. Social Stigma: the link between poverty and mental illness. Presentation at the 4th International Stigma Conference, London, U.K 21st - 23rd January 2009.
34. Honikman S and Field S. The “secret history” method: Training maternity staff for mental health promotion in Cape Town. “Expanding our Horizons: Moving Mental Health and Wellness Promotion into the Mainstream Conference”. Convened by the Clifford Beers Foundation in conjunction with the Mental Health Commission of Canada, Toronto, Canada, 4-6 March 2009.
35. Honikman S and Field S. Maternal antenatal distress: risk factors and service utilisation in a South African setting. “Expanding our Horizons: Moving Mental Health and Wellness Promotion into the Mainstream Conference”. Convened by the Clifford Beers Foundation in conjunction with the Mental Health Commission of Canada, Toronto, Canada, 4-6 March 2009.
36. Kigozi F, Ssebunnya J, Ndyanabangi S and Kizza D. The media and mental health in Uganda. Presentation at the 3rd Uganda Psychiatric Association annual scientific conference: Gulu, Uganda, 14th – 17th April 2009.
37. Kigozi F, Ssebunnya J, Ndyanabangi S and Kizza D. Current Initiatives to improve Management of mental disorders in rural communities in sub-Saharan Africa through integrated health service provision under PHC. Presentation at the 3rd Uganda Psychiatric Association annual scientific conference: Gulu, Uganda, 14th – 17th April 2009.
38. Ssebunnya J, Kigozi F, Ndyanabangi S and Kizza D. Use of WHO-AIMS in the assessment of the mental health system in Uganda. Presentation at the 3rd Uganda Psychiatric Association annual scientific conference: Gulu, Uganda, 14th – 17th April 2009.
39. Ssebunnya J, et al. Social Stigma: the link between poverty and mental illness. Presentation at the 3rd Uganda Psychiatric Association annual scientific conference: Gulu, Uganda, 14th – 17th April 2009.
40. Osei A. Responding to the challenges of mental health care delivery in Ghana. Health summit of the Ghana Health Services, Accra, 20-24 April, 2009.
41. Skeen S, Lund C, Kleintjes S, Flisher AJ. Mental health and the Millennium Development Goals in South Africa. Presentation to the South African Human Rights Commission Public Hearings on the Millennium Development Goals and the realisation of Economic and Social Rights in South Africa. Johannesburg: South African Human Rights Commission, 10 June 2009.
42. Skeen, S. *Maximising the Movement for Global Mental Health website*. First Summit for the Movement for Global Mental Health, Athens, October 2009.
43. Kleintjes, S, Flisher, AJ, Lund, C, Swartz, L. Improving mental health care user participation in policy development and implementation in South Africa. AFRINEAD Symposium November-December 2009, The Centre for Rehabilitation Studies, Stellenbosch University, Tygerberg, Cape Town, South Africa
44. Skeen, S. Kleintjes, S., Lund, C., Petersen, I., Bhana, A. & Flisher A. “Mental health is everyone’s business”: defining roles for an intersectoral approach to implementing the CRPD in South Africa. AFRINEAD Symposium November-December 2009, The Centre for Rehabilitation Studies, Stellenbosch University, Tygerberg, Cape Town, South Africa.
45. Skeen, S. Lund, C., Kleintjes, S., Flisher, A. *Mental health and climate change*. Public hearings on the Public Hearings on the Political, Economic, Legal, Gender and Social Impacts of Climate Change. Parliament of South Africa, November 2009.
46. Lund C. 10 reasons to include Mental Health on the Public Health Agenda. Public Health Association of South Africa Conference, 1-2 December 2009, Durban, South Africa.

47. Petersen, I. Improving mental health through community participation. Presentation at the Global Mental Health symposium. London School of Economics, University of London, 28 June 2010.
48. Kleintjes, S. Organising for self-advocacy in mental health: Lessons from 5 African countries. Presentation at the Global Mental Health symposium. London School of Economics, University of London, 28 June 2010.

OTHER RELEVANT OUTPUTS

The following training materials were produced:

- Mental Health Information System Training Manual for Northern Cape and KwaZulu-Natal provinces.
- Perinatal Mental Health Training Manual, 3rd edition. Cape Town: Perinatal Mental Health Project.
- Inter-personal therapy (IPT) manual for training community health workers in IPT group therapy for depression and maternal depression. (English and isiZulu), KwaZulu-Natal.

The following case studies, which document the impact of MHaPP interventions on policy and practice in the four countries, were produced:

1. Capacity development for public mental health research and policy in Africa
2. A new mental health information system for Ghana
3. The development and evaluation of a pilot community-based intervention for common mental disorders (CMDs) in a rural district in South Africa
4. Developing information systems to monitor mental health care in South Africa
5. Developing a Mental Health Plan for the Northern Cape Province, South Africa
6. Development of the National Mental Health Policy and Strategic plan in Uganda
7. Transforming Mental Health Legislation: The Case of Zambia
8. The Perinatal Mental Health Project: Integrating mental health into maternal care
9. The Perinatal Mental Health Project: Training maternity staff for mental health promotion – the “Secret History” method
10. The Perinatal Mental Health Project: Advocacy – raising the profile of a neglected issue

Annex 6. Capacity development

In our annual reports we outlined the overall approach to capacity development that this consortium has undertaken. As part of the second phase of the consortium's work, it was necessary to modify this approach, with particular reference to the interventions identified for this phase. The following document was developed by our Leeds partners (who are leading the capacity development aspect of our work) to address capacity development needs during the intervention phase. It also provided guidance for study country teams on completing a capacity assessment matrix in the country-specific intervention protocols. The document was circulated for comment within the consortium, and country partners have since used this as a basis for assessing and planning for their capacity development needs during the intervention phase. This capacity development aspect was written into the intervention protocols for each country, which are available on request.

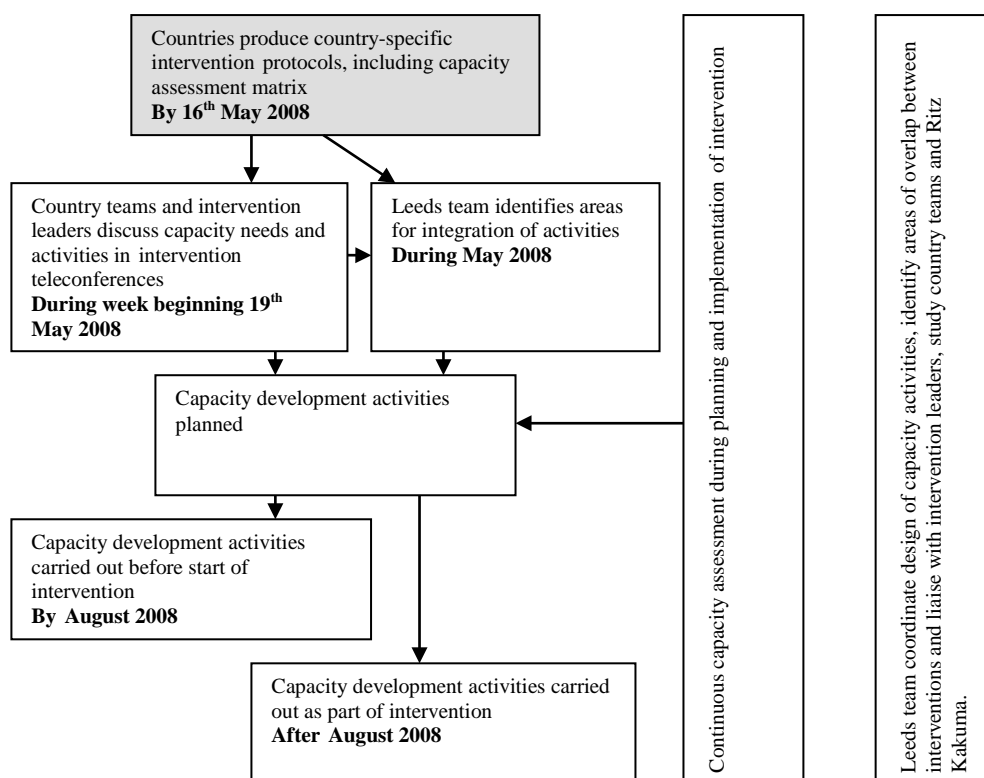
6.6.1 Process of capacity assessment and design of capacity development activities

6.6.1.1 Suggested approach

The Leeds team and UCT team conducted a teleconference on capacity development. The following approach to assessing capacity and designing capacity development activities was agreed:

- Country study teams will identify capacity needs in their country-specific intervention protocols. This document can be used as a guide for developing a capacity assessment matrix.
- Capacity development will be added to the agenda of the intervention protocol teleconferences for more in-depth discussion of the capacity needs and suggested activities.
- Country study teams and intervention leaders will ensure that the capacity needs for their intervention are met.
- The Leeds team will coordinate the process of assessing and designing capacity development activities and will work with intervention leaders and Ritz Kakuma (Post-Doctoral Research Fellow at UCT). The Leeds team will identify areas where activities can be integrated across interventions.
- Further capacity needs may be identified during planning and implementing the intervention and further activities may need to be planned in accordance with these.

6.6.1.2 Timeline for intervention capacity development



6.6.1.3 Budget

Capacity development activities were designed and prioritised within the constraints of the budget for the intervention stage. There was no specific budget for capacity development activities, although capacity development activities could be funded as part of the intervention, eg., training of district health managers in mental health information systems. Budget for capacity development was built into staff salaries, including some lead partners' staff time.

The Leeds team identified potential for integration of capacity development activities between interventions. This enabled more efficient use of project time and financial resources. For example, it was possible to hold a workshop on research methods for all three interventions at the same time, with joint sessions where the same research methods were used (eg Participatory Action Research (PAR)).

During budget allocation country study teams were advised to take into account the possibility that further capacity needs and activities may be identified during planning and implementation stages of the intervention.

6.6.2 Guidance for intervention capacity assessment

6.6.2.1 Matrix for intervention capacity assessment

Country study teams were required to assess their capacity needs and suggest activities in the country-specific intervention protocols.

It was suggested that country teams use the matrix below to guide this assessment.

Intervention title:

<i>What</i> are the capacity needs?	<i>Who</i> has capacity need?	<i>How</i> could capacity be developed?	<i>When</i> should capacity be developed?

6.6.2.2 Guidance notes on completing the capacity assessment matrix

***What* are the capacity needs?**

In this column fill in the types of capacity required for the intervention. Try to think about the needs as thoroughly as possible. Try to suggest specific needs based on the tasks identified in the intervention proposal.

The list of potential capacity needs below provides food for thought for filling in this column. The list is not exhaustive and you are likely to identify different needs according to your context.

The capacity needs you identify may include e.g.

- Knowledge and skills in the intervention topic, e.g. knowledge on MHIS
- Knowledge and skills in research methods proposed for the intervention topic
- Knowledge and skills in disseminating research
- Resources and infrastructure e.g. equipment, books, internet access
- Research management within the team and institution, e.g.
 - Team management/mentoring
 - Financial management
- Communication and networking
 - Internal communication
 - Networking
- Research capacity evaluation

Also, identify needs for other stakeholders in the intervention, e.g.

- Knowledge and skills in the intervention topic, e.g. knowledge on MHIS
- Skills in the use of evidence for policy, planning or management

***Who* has capacity need?**

In this column identify the groups that have the capacity need, for example:

- Your institution
- The MHaPP country team
- Individuals in the MHaPP country team
- Stakeholders in the intervention e.g.
 - Policy makers
 - Health managers
 - MHIS administrators

The matrix should be completed by country teams to assess the capacity needs of the team as a whole as well as individuals within the teams.

How could capacity be developed?

In this column suggest some activities or processes to meet each of the capacity needs. Use the following list of potential activities as food for thought to help your team identify appropriate processes and activities. This list is not exhaustive, so don't be restricted by the activities in this list – try to think outside the box to identify feasible and useful activities.

- Training
 - In-country training
 - MHaPP training workshops
- Support visits by intervention leaders
- Support by members of the country study team
- Exchange visits
 - Between country study teams and intervention leaders
 - Between country study teams
- Enhancing relationships between partners, e.g.
 - Pairing country study teams
 - Mentoring
- Improving access to resources, e.g. through
 - Purchase of resources (books, equipment etc.)
 - Sharing of resources
- Online learning e.g. blogging
- Email
- Telephone
- Written handbooks
- Technical guidance, e.g. support from the Health Metrics Network

When should capacity be developed?

In this column suggest a date for the activity or process and where it fits in with the schedule for planning and implementing the intervention.

Annex 7. Final Report Summary Sheet for R4D

1. Background Information

Title of research programme:	The Mental Health and Poverty Project: Mental health policy development and implementation in four African countries
Reference number:	HD6
Period covered by report:	1 August 2005 – 31 July 2010
Name of lead institution and Director:	University of Cape Town (UCT), Prof Alan Flisher*
Key partners:	World Health Organization
	University of Leeds
	London School of Economics
	University of KwaZulu-Natal, South Africa
	Human Sciences Research Council, South Africa
	Makerere University, Uganda
	Kintampo Health Research Centre, Ghana
	University of Zambia
	Department of Health, South Africa
	Ministry of Health, Uganda
	Ministry of Health, Ghana
	Ministry of Health, Zambia
Countries covered by research:	Ghana
	South Africa
	Uganda
	Zambia

	Planned	Actual
Start date:	1 August 2005	1 August 2005
End date:	31 July 2010	31 July 2010**
Total programme budget:	£ 2,198,552	

* Note: Prof Flisher died tragically of leukemia in April 2010. In the final months of the RPC, Prof Crick Lund (former MHaPP Project Coordinator) has served as Director.

** Note: MHaPP has been granted a no-cost extension to 31 January 2011.

2. One page summary

• How far have intended outputs as listed in the logframe been achieved?

Knowledge has been generated regarding the factors necessary for the development and effective implementation of mental health policy in Ghana, South Africa, Uganda and Zambia. In Phase 1 (2006-2008) a large scale situation analysis of mental health policy development and implementation was conducted in each country. The situation analysis provided new knowledge regarding the countries' mental health systems, through the administration of the WHO Assessment Instrument for Mental health Systems (WHO AIMS); new knowledge regarding current mental health policy, plans and legislation, through the administration of the WHO Checklists for Mental Health Policy and Plans and for Mental Health Legislation; and new knowledge regarding the opinions of a large number of mental health stakeholders about mental health policy development and implementation in each country, through semi-structured interviews and focus groups. In Phase 2 (2008-2010), on the basis of these situation analyses, several policy, planning, legislation, information systems and district primary health care interventions were undertaken in the countries. Lessons have been generated from these interventions, which are now available to a wider range of low and middle-income countries. In addition to these country-specific outputs, MHaPP engaged in extensive secondary research regarding the relationship between poverty and mental health in low and middle-income countries (LMIC). This has led to key outputs, such as the first systematic review of poverty and common mental disorders in low and middle-income countries, the WHO/MHaPP Mental Health and Development Report (to be launched jointly with UN DESA in September 2010), and contributions to the WHO Commission on the Social Determinants of Health. MHaPP researchers have also partnered with a number of international colleagues to contribute to key milestones in the development of global mental health, including authorship in the landmark Lancet series on Global Mental Health 2007 "Call for Action" paper, active membership in the subsequently established Movement for Global Mental Health, and contributions to the development of the WHO mhGAP programme. Furthermore, we have used the MHaPP platform to generate or partner with other projects, through multiplier funding, including the Perinatal Mental Health Project (Cape Town), the BasicNeeds Outcome study (rural Kenya), the development of Adolescent Health Policy Guidelines for South Africa, and the evaluation of the WHO AFRO Regional Strategy for Africa (2001-2010).

There are a small number of evaluation studies from the Phase 2 interventions which need to be submitted to peer reviewed journals, and we have received commitment from all MHaPP partners to complete this task in the months ahead. Research, policy and communications capacity have been substantially increased in all participating institutions. We have established a Centre for Public Mental Health at UCT, as an output of the RPC, which includes a distance learning curriculum (including a Post-graduate Diploma in Public Mental Health and a MPhil in Public Mental Health), which will be offered from 2011. This Centre provides the infrastructure for ongoing capacity development in public mental health in Africa.

• What impact has the research programme had?

The research programme has had a major impact in the study countries, through the development of new mental health policy in Uganda and South Africa, reform of mental health legislation in Ghana, Uganda and Zambia, development of mental health information systems in Ghana and South Africa, and district demonstration projects which have integrated mental health into primary health care in all four study countries. These intervention studies have generated lessons that may be used for mental health policy development and implementation in a range of other low and middle-income countries. We have not yet been able to assess the extent to which the work of the RPC has had an impact on other developing countries. Secondary data analysis has provided compelling evidence for the inclusion of mental health on international development targets, such as the MDGs, and given prominence to the key role of mental health in international development targets beyond 2015.

3. Products and Publications

PEER REVIEWED PUBLICATIONS

The following papers are direct MHaPP publications on findings from the Phase 1 situation analysis:

1. Flisher, A.J., Lund, C., Funk, M., Banda, M., Bhana, A., Doku, V., Drew, N., Kigozi, F., Knapp, M., Omar, M., Petersen, I., & Green A. (2007). Mental health policy development and implementation in four African countries. **Journal of Health Psychology** 12: 505-516.
2. Lund, C., Stein, D.J., Flisher A.J., Mehtar, S. (2007). Challenges faced by South African health services in implementing the Mental Health Care Act. Editorial. **South African Medical Journal** 97:352-353.
3. Lund, C., Stein, D.J. Corrigan, J., Bradshaw D., Schneider M., Flisher, A.J. (2008). Mental health is integral to public health: a call to scale up evidence-based services and develop mental health research. Editorial. **South African Medical Journal** 98: 444-446.
4. Flisher, A. J., & Lund, C. (2009). The Mental Health and Poverty Project: Some preliminary findings. **Mental Health Reforms**, 1, 11-13.
5. Petersen, I., Bhana, A., Campbell-Hall, V., Mjadu, S., Lund, C., Kleintjes, S., Hosegood, V., & Flisher, A.J. (2009) Planning for district mental health services in South Africa. A situational analysis of a rural district site. **Health Policy and Planning**, doi:10.1093/heapol/czn044
6. Draper, C., Lund, C., Kleintjes, S., Funk, M., Omar, M., Flisher, A.J., and the MHaPP Research Programme Consortium (2009). Mental health policy in South Africa: development process and content. **Health Policy and Planning**. doi:10.1093/heapol/czp027.
7. Lund, C., Kleintjes, S., Kakuma, R., Flisher, A.J., and the MHaPP Research Programme Consortium (2009). Public sector mental health systems in South Africa. **Social Psychiatry and Psychiatric Epidemiology**. DOI 10.1007/s00127-009-0078-5.
8. Ssebunnya, J., Kigozi, F., Lund, C., Kizza, D., & Okello E.S., (2009). Stakeholder Perceptions of Mental Health Stigma and Poverty in Uganda. **BMC International Health and Human Rights** 9:5 doi:10.1186/1472-698X-9-5.
9. Kigozi, F., & Ssebunnya, J. (2009). Chronic Poverty, wars and mental health: the East African perspective. **International Psychiatry** 6(2): 31-32.
10. Ssebunnya, J., Kigozi, F. (2009). Integration of mental health into primary health care in Uganda: opportunities and challenges. **Mental Health in Family Medicine**. 6:37-42.
11. Lund C, Flisher AJ. (2009). A model for community mental health services in South Africa. **Tropical Medicine and International Health**,14: 1040-1047.
12. Kigozi, F. Ssebunnya, J., Kizza, D. Cooper, S. Ndyabangi, S. (2010). An overview of Uganda's mental health care system: results from an assessment using the world health organization's assessment instrument for mental health systems (WHO-AIMS). **International Journal of Mental Health Systems**, 4(1).
13. Lund, C., Breen, A., Flisher, A., Kakuma, R., Corrigan, J., Joska, J., Swartz, L., Patel, V. (2010). Poverty and common mental disorders in low and middle income countries: A systematic review. **Social Science and Medicine**. 71: 517-528.

The following direct MHaPP publications have been published in a special issue of the African Journal of Psychiatry, devoted to the MHaPP Phase 1 findings:

1. Flisher, A.J., Lund, C. and the MHaPP Research Programme Consortium (2010) Mental health policy in Africa. Guest Editorial. **African Journal of Psychiatry**. 13:81-83.
2. Akpalu, B., Lund, C., Doku, V., Ofori-Atta, A., Osei, A., Ae-Ngibise, K., Awenwa, D., Cooper, S., Flisher, A.J. and the MHaPP Research Programme Consortium (2010). Scaling up community-based services and improving quality of care in the state psychiatric hospitals: the way forward for Ghana. **African Journal of Psychiatry**. 13: 109-115.
3. Kakuma, R., Kleintjes, S., Lund, C., Drew, N., Green, A., Flisher, A.J., and the MHaPP Research Programme Consortium (2010). Mental health stigma: what is being done to raise awareness and reduce stigma in South Africa? **African Journal of Psychiatry** 13: 116-124.
4. Kigozi, F., Ssebunnya, J., Kizza, D., & Ndyabangi, S. (2010). Media and mental health in Uganda. **African Journal of Psychiatry**. 13:125-127
5. Kleintjes, S., Lund, C., Flisher, A.J., and the MHaPP Research Programme Consortium (2010). A situational analysis of child and adolescent mental health services in Ghana, Uganda, South Africa and Zambia. **African Journal of Psychiatry**. 13:132-139.
6. Ofori-Atta, A., Read, U.M., Lund, C., and the MHaPP Research Programme Consortium (2010). A situation analysis of mental health services and legislation in Ghana: challenges for transformation. **African Journal of Psychiatry**. 13:99-108.
7. Ssebunnya, J., Kigozi, F., Kizza, D., & Ndyabangi, S. (2010). Integration of mental health into primary health care: a case of one rural district in Uganda. **African Journal of Psychiatry**. 13:128-131.
8. Awenwa AD, Read UM, Ofori-Atta AL, Doku VCK, Akpalu B, Osei A, Flisher AJ and the MHaPP Research Programme Consortium (2010). From Mental Health Policy Development in Ghana to Implementation: What are the Barriers? **African Journal of Psychiatry**. 13: (in press)
9. Kapungwe, A., Cooper, S., Mwanza, J., Mwape, L., Sikwese, A., Kakuma, R., Lund, C., Flisher, A.J., and the MHaPP Research Programme Consortium (2010). "*I hope that one day a person like me could walk head up into a psychiatry unit and not feel afraid ...*": Mental illness stigma in Zambia. **African Journal of Psychiatry**. 13: (in press).
10. Lund, C., and the MHaPP Research Programme Consortium (2010). Mental health policy implementation in Ghana and Zambia. Guest Editorial. **African Journal of Psychiatry**. 13: (in press).

The following publications are not direct products of MHaPP data, but have been authored or co-authored by partners in the consortium (in bold), and the findings support the overall objectives of MHaPP:

1. **Kleintjes, S, Flisher, AJ**, Fick, M., Railoun, A, **Lund, C**, Molteno, C., Robertson, B.A. The prevalence of mental disorders among children, adolescents and adults in the Western Cape, South Africa, *South African Psychiatry Review*, Vol 9, Issue 3, August 2006, p.157-160.
2. Chisholm, D., **Lund, C.**, Saxena, S. (2007). The cost of scaling up mental health care in low- and middle-income countries. *British Journal of Psychiatry*. 191, 528-535.
3. The Lancet Global Mental Health Group. (2007). (Writing group in alphabetical order: Chisholm D, **Flisher AJ, Lund C**, Patel V, Saxena S, Thornicroft G, Tomlinson M). Scale up services for mental disorders: a call for action. *The Lancet* Published online September 4, 2007 DOI:10.1016/S0140-6736(07)61242-2.
4. Patel V, **Flisher AJ**, McGorry P. The mental health of young people: A global public health challenge. *Lancet* 2007; 369: 1302-1313.

5. Breen A, Swartz L, **Flisher AJ**, Joska J, Corrigan J, Plaatjies L, McDonald DA. Experience of mental disorder in the context of basic service reforms: The impact on care-giving environments in South Africa. International Journal of Environmental Health Research 2007; **17**: 327 – 334.
6. Corrigan, J., **Lund, C.**, Patel, V., Plagerson S., **Funk, M.** (2008). Poverty and mental illness: fact or fiction? A commentary on Das, Do, Friedman, McKenzie & Scott (65:3, 2007, 467-480). Social Science and Medicine 66:2061-2063.
7. **Flisher AJ**, Myer L, Marais A, Lombard C, Reddy P. Prevalence and correlates of partner violence among South African adolescents. Journal of Child Psychology and Psychiatry 2007; **48**: 619 – 627.
8. Jaspan H, **Flisher AJ**, Mathews C, Seebregts C, Berwick JR, Wood R, Bekker L-G. Methods for collecting sexual behaviour information from South African adolescents - a comparison of paper versus personal digital assistant questionnaires. Journal of Adolescence 2007; **30**: 353-359.
9. Joska J, **Flisher AJ**. Needs and services at an in-patient psychotherapy unit. African Journal of Psychiatry, 2007; **10**: 149-156.
10. Liang H, **Flisher AJ**, Lombard C. Bullying, violence and risk behaviour in South African adolescents. Child Abuse and Neglect 2007; **31**: 161-171.
11. Mertens JR, **Flisher AJ**, Fleming MF, Weisner C. Medical conditions of adolescents in alcohol and drug treatment: Comparison with matched controls. Journal of Adolescent Health 2007; **40**: 173-179.
12. Palen L-A, Smith EA, Caldwell LL, **Flisher AJ**, Wegner L, Vergnani T. Inconsistent Reports of Sexual Intercourse Among South African High School Students. Journal of Adolescent Health 2008; **42**: 221 – 227.
13. Patel V, **Flisher AJ**, Nikapota A, Malhotra S. Promoting child and adolescent mental health in low and middle income countries. Journal of Child Psychology and Psychiatry 2008; **49**: 313-334.
14. Ward CL, Mertens JR, **Flisher AJ**, Bresick GF, Sterling SA, Little F, Weisner CM. Prevalence and correlates of substance use among South African primary care clinic patients. Substance Use and Misuse 2008; **43**: 1-16.
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20. Sorsdahl K, **Flisher AJ**, Stein DJ. Traditional healer attitudes and beliefs regarding referral of mentally ill adult and adolescent patients to Western doctors in the Eastern Cape, South Africa. Transcultural Psychiatry (in press).
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62. Corrigan, J., Plagerson, S., **Lund, C.**, Myers, J. (2008). Global trade and mental health. Global Social Policy **8**: 335-358.
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65. **Ofori-Atta A.L.** (in press). Clinical Psychology in Ghana. Clinical Psychology Forum
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PEER REVIEWED PUBLICATIONS IN PRESS OR SUBMITTED

The following direct MHaPP publications, which report findings from the Phase 1 situation analysis and/or Phase 2 interventions, are 'in press' or have been submitted

1. Doku, V., Ofori-Atta, A., Akpalu, B., Osei, A., Read, U., Cooper, S., and the MHaPP Research Programme Consortium (In press). Stakeholders' perceptions of the main challenges facing Ghana's mental health care system: A qualitative analysis. **International Journal of Culture and Mental Health**.
2. Lund, C., Kleintjes, S., Cooper, S., Petersen, I., Bhana, A., Flisher, A. and the MHaPP Research Programme Consortium (In press). Challenges facing South Africa's mental health care system: stakeholders' perceptions of causes and potential solutions. **International Journal of Culture and Mental Health**.
3. Mwanza, J., Cooper, S., Kapungwe, A., Sikwese, A., Mwape, L. and the MHaPP Research Programme Consortium. Stakeholders' perceptions of the main challenges facing Zambia's mental health care system: A qualitative analysis. **International Journal of Culture and Mental Health**.

4. Ssebunnya, J., Kigozi, F., Ndyabangi, S., Cooper, S and the MHaPP Research Programme Consortium (In press). Stakeholders' perceptions of the main challenges facing Uganda's mental health care system: A qualitative analysis. **International Journal of Culture and Mental Health.**
5. Mwape, L., Sikwese, A., Kapungwe, A., Mwanza, J., Flisher, A., Lund, C., Cooper, S and the MHaPP Research Programme Consortium (In press). Integrating mental health into primary health care in Zambia: A care provider's perspective. **International Journal of Mental Health Systems.**
6. Campbell-Hall, V., Petersen, I., Bhana, A., Mjadu, N., Hosegood, V., & Flisher, A.J. (in press). Collaboration between traditional practitioners and primary health care staff within one rural sub-district in South Africa: Developing a workable partnership for community mental health services. **Transcultural Psychiatry.**
7. Kapungwe, A., Cooper, S., Mayeya, J., Mwanza, J., Mwape, L., Sikwese, A., Lund, C. and the MHaPP Research Programme Consortium (Submitted). Attitudes of primary health care providers towards people with mental illness: Evidence from two districts in Zambia. **African Journal of Psychiatry.**
8. Osei, A., Cooper, S., Lamensdorf Ofori-Atta, A., Akpalu, B., Doku, V., Flisher, A. and the MHaPP Research Programme Consortium. (Submitted). Viewing Ghana's Mental Health System through a Human Rights Lens. **BMC International Health and Human Rights.**
9. Omar M, et al (submitted) Mental health policy processes in four African countries. **International Journal of Mental Health Systems.**
10. Petersen, I., Bhana, A., Baillie, K. Adapting Interpersonal Therapy (IPT) for the treatment of depression by community health workers within the context of task shifting in South Africa. A feasibility study. Submitted to **Journal of Affective Disorders.**
11. Petersen, I., Lund, C., Bhana, A., & Flisher, A.J. A task shifting approach to primary mental health care for adults in South Africa. Human resource requirements and costs. Submitted to **Health Policy and Planning.**
12. Faydi, E., Funk, M., Kleintjies, S., Ofori-Atta, A., Ssebunnya, J., Mwanza, J., Kim, C., Flisher, A. (submitted). A comparison of mental health policy in four African countries. **Health Research Policy and Systems.**
13. Baillie, K., Petersen, I., Bhana, A., Ofori-Atta, A., Cooper, S. and MHaPP research programme consortium. Perceptions of the causes of mental illness in women in Africa. A qualitative investigation in four countries. Submitted to **Women's Health Issues.**

The following direct MHaPP publications are in press, in a special issue of the International Review of Psychiatry, devoted to the MHaPP Phase 1 findings:

1. Sikwese, A., Mwape, L., Mwanza, J., Kapungwe, A., Kakuma, R., Imasiku, M., Lund, C., Cooper, S. and the MHaPP Research Programme Consortium (In press). Human resource challenges and constraints facing Zambia's mental health care system: Results from a combined quantitative and qualitative study. **International Review of Psychiatry.**
2. Ae-Ngibise, K., Cooper, S., Adibokah, E., Lund, C., Doku, V. and the MHaPP Research Programme Consortium (In Press). *"Whether you like it or not people with mental problems are going to go to them...":* A qualitative exploration into the widespread use of, and collaboration with, traditional and faith healers in the provision of mental health care Ghana. **International Review of Psychiatry.**
3. Ofori-Atta, A., Cooper, S., Akpalu, B., Osei, A., Doku, V., Lund, C., Flisher, A. and the MHaPP Research Programme Consortium. (In press). Common Understandings of Women's Mental Illness in Ghana: Results from a Qualitative Study. **International Review of Psychiatry.**

4. Cooper, S., Ssebunnya, J., Kigozi, F., Lund, C., Flisher, A. and the MHaPP Research Programme Consortium (In press). Viewing Uganda's Mental Health System through a Human Rights Lens. **International Review of Psychiatry.**
5. Bhana, A., Petersen, I., Baillie, K., Flisher, A. and the MHaPP Research Programme Consortium (In press). Meeting the Minimum Actions Required for Integrated Primary Mental Health Care. A Situational Analysis of Three African Countries: Ghana, South and Uganda. **International Review of Psychiatry.**
6. Skeen, S., Lund, C., Kleintjes, S., Flisher, A. and the MHaPP Research Programme Consortium (In press). Meeting the Millennium Development Goals in Sub-Saharan Africa: the role of mental health. **International Review of Psychiatry.**
7. Skeen, S., Kleintjes, S., Lund, C., Petersen, I., Bhana, A., Flisher, A. and the MHaPP Research Programme Consortium (In press). Inter-sectoral collaboration for mental health in South Africa. **International Review of Psychiatry.**
8. Kleintjes, S., Lund, C., Swartz, L., Flisher, A. and the MHaPP Research Programme Consortium (In press). Barriers and opportunities for mental health care user participation in mental health policy development and implementation in South Africa. **International Review of Psychiatry.**

IN-HOUSE PUBLICATIONS

The following country-specific reports were published in-house (not externally peer-reviewed), which provide detailed findings from the phase 1 situation analysis:

1. Doku, V., Ofori-Atta, A., Akpalu, B., Read, U., Osei, A., Ae-Ngebise, K., Awenwa, D., Lund, C., Flisher, A.J., Petersen, I., Bhana, A., Bird, P., Drew, N., Faydi, E., Funk, M., Green, A., & Omar, M. (2008). **A situation analysis of mental health policy development and implementation in Ghana.** Accra: Mental Health and Poverty Project.
2. Kigozi, F., Ssebunnya, J., Kizza, D., Ndyabangi, S., Green, A., Omar, M., Bird, P., Funk, M., Faydi, E., Drew, N., Lund, C., & Flisher, A.J. (2008). **A situation analysis of the mental health system in Uganda. Phase 1 Country Report.** Kampala: Mental Health and Poverty Project.
3. Lund C, Kleintjes S, Campbell-Hall V, Mjadu S, Petersen I, Bhana A, Kakuma R, Mlanjeni B, Bird P, Drew N, Faydi E, Funk M, Green A, Omar M, & Flisher AJ. (2008). **Mental health policy development and implementation in South Africa: a situation analysis. Phase 1 Country report.** Cape Town: Mental Health and Poverty Project.
4. Mwanza, J., Sikwese, A., Banda, M., Mayeya, J., Lund, C., Bird, P., Drew, N., Faydi, E., Funk, M., Green, A., Omar, M., & Flisher, A. J. (2008). **Mental health policy development and implementation in Zambia: a situation analysis. Phase 1 Country Report.** Lusaka: Mental Health and Poverty Project.

BOOKS OR BOOK CHAPTERS

The following books or book chapters are direct products of MHaPP data:

1. WHO. (2007). Monitoring and evaluation of mental health policies and plans. **Mental Health Policy and Service Guidance Package.** Geneva: WHO.
2. Lund C, Sutcliffe T, Flisher AJ, Stein DJ (in press). Protecting the rights of the mentally ill in poorly resourced countries. In Dudley M, Silove D, Gale F (eds). **Mental health and human rights.** Oxford University Press.
3. Kakuma R, Bird P, Omar M, Lund C, Flisher AJ and the MHaPP Research Programme Consortium. (2008). Mental Health Research in Africa: Lessons learned. In Reading J, Marsden N, Link R, Kurbanova D & Kelly M. (Eds.), **Global Indigenous Health Research Symposium Report Papers and**

Presentations: Directions and Themes in International Indigenous Health Research 2008. University of Victoria, Victoria, British Columbia, Canada.

4. Cooper, S., Bhana, A., Drew, N., Faydi, E., Flisher, A., Kakuma, R., Kleintjes, S., Lund, C., Ofori-Atta, A., Skeen, S. and the MHaPP Research Programme Consortium. (In press). Recommendations for Improving Mental Health Care Systems in Africa: Lessons from Ghana, Uganda, South Africa and Zambia. In **Africa Focus**. Pretoria: HSRC Press.
5. WHO and MHaPP (in press). **Mental Health and Development: Treating people with Mental Health Conditions as a Vulnerable Group**. Geneva: WHO.

The following books or book chapters are not direct products of MHaPP data, but have been authored or co-authored by partners in the consortium (in bold), and the findings support the overall objectives of MHaPP:

1. Moutrie, A & **Kleintjes, SR**. Women's Mental Health in South Africa. In: Ijumba P, Padarath A (eds). South African Health Review 2006. Durban: Health Systems Trust, 2006.
2. Corrigan, J., Ward, C., Stinson, K., Struthers, P., Frantz, J., **Lund, C., Flisher, A.J.**, & Joska, J. (2007). Burden of Disease Project: Decreasing the burden of mental illness in the Western Cape. Cape Town: Department of Health, Provincial Government of the Western Cape.
3. **Flisher AJ**, Hatherill S, Dhansay Y. Child and adolescent psychiatric disorders. In: Heggenhogen HK (Ed-in chief). Encyclopedia of Public Health. San Diego, CA: Elsevier Inc., 2008.
4. Patel V, **Flisher AJ**, Cohen A. Social and cultural determinants of mental health. In: Murray R, Kendler K, McGuffin P, Wessely S, Castle D (Eds.) Essential Psychiatry (4th edition). Cambridge: Cambridge University Press, 2008.
5. **Petersen I, Bhana A**, Swartz L, **Flisher AJ**, Richter L (Eds.). Promoting mental health in scarce resource contexts: Emerging evidence and practice. Human Sciences Research Council Press, 2010.
6. **Flisher AJ**, Gevers A. Adolescence. In: Petersen I, Bhana A, Swartz L, Flisher AJ, Richter L (Eds.). People First: Promoting Mental Health and Preventing Mental and Behavioural Problems in Low-income Contexts. Human Sciences Research Council Press, 2010.
7. **Flisher AJ**, Gurein N. Adolescence. In: Heggenhogen HK (Ed-in chief). Encyclopedia of Public Health. San Diego, CA: Elsevier Inc., 2008.
8. Palen L-A, Smith EA, Caldwell LL, **Flisher AJ**. Longitudinal Patterns of Cigarette Use Among Girls in Cape Town, South Africa. In Tolson KP, Veksler EB (Eds.), Research Focus on Smoking and Women's Health. Hauppauge, NY, USA: Nova Publishers, 2008. Also published in Wesley JK, Sternbach IA (Eds.), Smoking and Women's Health, Hauppauge, NY, USA: Nova Publishers, 2008.
9. Patel V, **Lund C**, Hatherill S, Plagerson S, Corrigan J, Funk M, **Flisher AJ**. Mental disorders: equity and social determinants. In WHO (ed) Social determinants of priority public health conditions. Geneva: WHO Commission on Social Determinants of Health report (in press).
10. Gevers A, **Flisher AJ**. School-based youth violence prevention interventions. In Ward C, Dawes A (Eds.), Youth Crime and Violence. Cape Town: HSRC press (in press).
11. Tomlinson M, Dawes A, **Flisher AJ**. "Intervene early, intervene intensively and intervene everywhere": Preventing the development of youth violence in the early years. In Ward C, Dawes A (Eds.), Youth Crime and Violence. Cape Town: HSRC press (in press).
12. **Flisher AJ**, Riordan G. Psychiatric problems. In Motala C (Ed.), Handbook of Paediatrics. Cape Town, Oxford University Press (in press).

POLICY BRIEFS

1. Breaking the vicious cycle of mental ill-health and poverty. Policy Brief 1. Mental Health and Poverty Project, University of Cape Town.
2. The prioritisation of mental health as a public health issue in South Africa. Policy Brief 2. Mental Health and Poverty Project, University of Cape Town.
3. Challenges of implementing mental health policy and legislation in South Africa. Policy Brief 3. Mental Health and Poverty Project, University of Cape Town.
4. Promoting community-based services for mental health in South Africa. Policy Brief 4. Mental Health and Poverty Project, University of Cape Town.
5. Inter-sectoral collaboration for mental health in South Africa. Policy Brief 5. Mental Health and Poverty Project, University of Cape Town.
6. Integrating mental health into maternal care in South Africa. Policy Brief 6. Mental Health and Poverty Project, University of Cape Town.
7. Developing effective Mental Health Laws in Africa. MHaPP Policy Brief 7.
8. Developing effective Mental Health Policies and Plans in Africa: 7 key lessons. MHaPP Policy Brief 8.
9. Key elements of a situational analysis to inform mental health policy. MHaPP Policy Brief 9.
10. Developing and adopting mental health policies and plans in Africa: Lessons from South Africa, Uganda and Zambia. Policy Brief 10. Mental Health and Poverty Project, University of Cape Town.
11. Developing and adopting mental health laws in Africa: Lessons from Ghana, Zambia and Uganda. Policy Brief 11. Mental Health and Poverty Project, University of Cape Town.
12. Better information for better mental health: Developing Mental Health Information Systems in Africa. Policy Brief 12. Mental Health and Poverty Project, University of Cape Town.
13. Scaling up mental health services at district level: Lessons from district care systems in Ghana, South Africa and Uganda. Policy Brief 13. Mental Health and Poverty Project, University of Cape Town.
14. Mental health and development. Policy Brief 14. Mental Health and Poverty Project, University of Cape Town.
15. Issues & interventions for vulnerable women in the perinatal period. Policy Brief 15. Mental Health and Poverty Project, University of Cape Town.

PUBLICITY MATERIAL

The following general publicity materials have been produced:

Posters and brochures

- MHaPP brochure
- Summary booklet of MHaPP findings in Uganda.
- MHaPP poster: Mental health services in South Africa
- MHaPP poster: Mental health policy development and implementation in four African countries: Ghana, South Africa, Uganda and Zambia
- MHaPP poster: Planning district mental health services for resource constrained settings. A case study in South Africa.
- MHaPP poster: Planning for maternal mental health care at primary care level in resource constrained districts in South Africa. A Case Study.

Press releases

- World Mental Health Day (October 10, 2008) press release – focusing on mental health policy and services in SA
- World Mental Health Day (October 10, 2009) press release – focusing on the integration of mental health into primary health care.
- Cape Mental Health Society Conference (October 21, 2008) press release – focusing on mental health and poverty
- South African Depression and Anxiety Group (January, 2009) press release, using MHaPP country report

Magazine and newspaper articles

- Article on mental health care system in Uganda in the New Vision, June, 2006: *"Mental health worries experts"*
- Article on health, including mental health care system in Zambia in the Voanews, June, 2007: *"Lack of financing, skilled personnel challenge health care in Zambia"*
- Article on mental health care system in South Africa in All Africa, April 2008: *"South Africa: Where Have the Piglets Gone?"*
- Article on mental health care bill in Ghana in the Daily Graphic, August 2008: *"Pass the Mental Health Bill Now"*
- Article on mental health care system in Uganda in the Daily Monitor, August 2008: *"Big gaps in mental health care system"*
- Article on mental health care system in Ghana in the Ghanaian Times, October 2008: *"Experts Analyse Mental Health System In Ghana"*
- Article on the Perinatal Mental Health Project in 'O' Magazine, May 2009: *"When pregnancy hurts"*
- Article on mental health care system in South Africa in Health24.com, May 2009: *"SA's sad state of mental health care"*.
- Article on mental health in South Africa in Sowetan, April 2009: *"Nearly 1 in 5 South Africans suffer from mental illnesses"*.
- Article on mental health in Africa in Psychiatric News, April 2010: *"Long Overlooked in Africa, MH Now Getting Attention"*
- Article on child and adolescent mental health in Daily Dispatch, May 2010: *"Protecting our future"*
- Short newspaper articles on MHaPP and mental health policy/services in South Africa in 2009 in: the Argus, Mail & Guardian, Sunday Times, Cape Times, The Natal Witness, Health-E news, Daily Dispatch

Radio coverage

- Interviews with SAFM, 2007, 2008
- Interviews with BBC World Service, 2007
- Interviews with Radio 702, 2009
- News item on CCFM, 2009
- News item on Heart FM, 2009

Television coverage

- News interview (SABC) – World Mental Health Day, 10 Oct 2008
- Voice of America Interview, April 2009
- TV Africa and Metro TV, Ghana – reports on launch of Ghana's situation analysis report, late 2008.

Documentaries

- The Perinatal Mental Health Project has produced a DVD for advocacy, training, promotional and fundraising purposes. This can be downloaded from the PMHP website: www.psychiatry.uct.ac.za/pmhp/
- Web-based media documentary in Uganda: www.monitor.co.ug/artman/publish/features/Big_gaps_in_mental_healthcare_system_69345.shtml
- Documentary on mental health advocacy in Ghana, available from the Ghana PI, Dr Doku.

WEBSITE LINKS

- MHAPP website: www.psychiatry.uct.ac.za/mhapp/
- WHO Mental health, poverty and development website: www.who.int/mental_health/policy/development/index.html
- Perinatal Mental Health Project: www.psychiatry.uct.ac.za/pmhp/

Links from the MHAPP website to:

- Department for International Development (DFID) UK, Central Research Department: <http://www.dfid.gov.uk/research/>
- WHO Mental health policy and services: http://www.who.int/mental_health/policy/en/
- WHO Mental Health Policy Web board: <http://www.mayeticvillage.com/who-mh-policy-and-development>
- Health Systems Trust: <http://www.hst.org.za/>
- Ministry of Health/Dept of Health websites in each study country

RESEARCH PROGRAMME REPORTS

- Inception Phase Report, submitted to DFID, February 2006
- Annual report, August 2006
- Mid-term review report, August 2007
- Annual report, August 2007
- Annual report, August 2008
- Examples of innovative communication strategies being used by MHAPP, May 2009
- Annual report, August 2009
- Final report, July 2010

DISSEMINATION EVENTS

- Launch of the MHAPP and establishment of the MHAC in South Africa, Uganda, Ghana and Zambia, 2006
- Attendance at the meeting of the African Psychiatric Association and Allied Professions, Addis Ababa, Ethiopia, April 2006.
- Presentation of the MHAPP at public lectures at the Department of Psychiatry and Mental Health, and the Children's Institute, University of Cape Town, 2006
- Presentation of the MHAPP at the International Mental Health conference, Institute of Psychiatry, London in August 2006.
- Ugandan dissemination workshop, April 2008, at which findings of the situation analysis were disseminated to various stakeholders.

- Presentation to South African Human Rights Commission: Public Hearings on the Millennium Development Goals and the realisation of Economic and Social Rights in South Africa, 2009.
- SAHRC presentation: Achieving the Millennium Development Goals: Addressing mental health, 2009
- Presentation on climate change and mental health at the South African Parliament Public Hearings on the Political, Economic, Legal, Gender and Social Impacts of Climate Change, November 2009.
- Presentation on education and mental health at the South African Parliament Public Hearings on Education Access and Delivery Challenges, hosted by the Parliamentary Committee on Education, May 2010.

The following papers were presented at local or international conferences

1. Flisher AJ, Lund C, Agoussou T, Banda M, Bhana A, Doku V, Drew N, Funk M, Green A, Kigozi F, Knapp M, Mayeya J, Ndyanabangi SZ, Omar M, Osei A, Petersen I, Phakathi S, Saraceno B. Mental health policy development in four African countries. 3rd International Mental Health Conference, London, UK, 30 August - 1 September 2006.
2. Petersen I, Bhana A, Govender K. The individual and beyond: promoting mental health in developing contexts. 4th International Conference of Promotion of Mental Health and Prevention of Mental and Behavioural Disorders, Oslo, Norway, 11-13 October, 2006.
3. Kakuma R, Goering P, Flisher A, Stuart H, Lund C. International comparison of mental health policy and service delivery: how do different countries deal with stigma? Poster presentation: Canadian Academy of Psychiatric Epidemiology Annual Scientific Symposium, Toronto, Canada, 9 November 2006.
4. Banda M, Mayeya J, Sikwese A. (2007) WHO AIMS data – presented for a Ministry of Health meeting on the Strategic plan for the mental health system, cresta Golf View Hotel, Lusaka 18-22 December 2006.
5. Lund C, Flisher AJ, Banda M, Doku V, Kigozi F, AkpaluB, Campbell-Hall V, Kaoma K, Kleintjes S, Sebunya J, Saxena S. Use of the WHO AIMS to assess mental health systems in four African countries. International Centre for Mental Health Policy and Economics 8th Workshop on Costs and Assessment in Psychiatry, Venice, Italy 9-11 March 2007.
6. Lund C, Breen A, Flisher AJ, Swartz L, Joska J, Corrigan J, Kleintjes S, Patel V. Mental health and poverty: a systematic review of the research in low and middle income countries. International Centre for Mental Health Policy and Economics 8th Workshop on Costs and Assessment in Psychiatry, Venice, Italy 9-11 March 2007.
7. Flisher AJ, Lund C, Funk M, Banda M, Bhana A, Doku V, Drew N, Kigozi F, Knapp M, Omar M, Petersen I, Green A. A new initiative to develop and implement mental health policy in Africa. WPA Regional Conference, Nairobi, Kenya, 21-23 March 2007.
8. Lund C, Petersen I, Bhana A, Kleintjes S, Campbell-Hall V, Bird P, Drew N, Faydi E, Funk M, Green A, Omar M; Flisher AJ. The Mental Health and Poverty Project (MHAPP): Part II. Preliminary results of the situation analysis from South Africa. WPA Regional Conference, Nairobi, Kenya, 21-23 March 2007.
9. Lund C, Muller L, Flisher AJ, Swartz L, Kagee A, Naidoo A, Kleintjes S. Public mental health capacity development in Africa: Proposal for a Centre for Public Mental Health. Presentation at Afrihealth Public Health Education conference, Pretoria, 14 June 2007.

10. Banda M. MHAPP preliminary results of the situational analysis on Neuroscience Retreat workshop on the Infection and Brain Diseases Burden, InterContinental Hotel, Lusaka 13-15 June 2007.
11. Lund C, Muller L, Flisher AJ, Swartz L, Kagee A, Naidoo A, Kleintjes S. Public mental health capacity development in Africa: Proposal for a Centre for Public Mental Health. Presentation at Afrihealth Public Health Education conference, Pretoria, 14 June 2007.
12. Kleintjes, S, Campbell, V, Flisher, AJ, Lund, C, Bhana, A, Bird, P, Omah, M, Petersen, I. Green, A. A situational analysis of child and adolescent mental health policy development and implementation in South Africa. 16th Congress of the South African Association for Child and Adolescent Psychiatry and Allied Professions, Included and Visible: Development for a New Millennium. Tuesday 11 – Friday 14 September 2007, University of Cape Town, Cape Town, South Africa.
13. Ofori-Atta A, Akpalu B, Osei A, Doku V. Witches' Camps, Faith Healers and Psychiatric Hospitals? A critical study of available options in mental health services around Ghana. Annual General Conference of the College of Health Sciences, Accra, Ghana, 26th to 28th Sept 2007.
14. Doku V, Ofori-Atta A, Akpalu B, Osei A. The use of the WHO AIMS to assess the mental health system in Ghana. Annual General Conference of the College of Health Sciences, Accra, Ghana, 26th to 28th Sept 2007.
15. Akpalu B, Doku V, Ofori-Atta A, Osei A. Why not evidence based policies in mental health? Preliminary findings from the Mental Health and Poverty Project in Ghana. Annual General Conference of the College of Health Sciences, Accra, Ghana, 26th to 28th Sept 2007.
16. Osei A, Ofori-Atta A, Akpalu B, Doku V. Mental Health and Human Rights in Ghana. Annual General Conference of the College of Health Sciences, Accra, Ghana, 26th to 28th Sept 2007.
17. Kigozi F, Ssebunnya, J, Flisher AJ, Lund C, Funk M, Omar M, Doku V, Petersen I, Bhana A. The Mental Health and Poverty Project (MHAPP): Assessment of the mental health systems and mental health policy evaluation in four African countries using WHO-AIMS and Policy Checklist. WPA Regional Conference/CSP Annual Congress, Shanghai, China, 20th -23rd Sept. 2007.
18. Kakuma R, Kleintjes S, Lund C, Bird P, Drew N, Faydi E, Funk M, Green A, Omar M, Flisher AJ. Mental Health Stigma - What is being done to raise awareness and reduce stigma in South Africa? Symposium on Evidence-To-Action in Disability: Tygerberg, 27 - 28 November 2007. The Centre for Rehabilitation Studies, Stellenbosch University, Tygerberg, Cape Town, South Africa. Poster presentation.
19. Kleintjes, S, Flisher, AJ, Lund, C, Bhana, A, Bird, P, Drew, N, Faydi, E, Funk, M, Green, A, Omah, M, Petersen, I. Opportunities for and barriers to improving mental health care user participation in mental health related policy development and implementation in South Africa: Preliminary findings. Symposium on Evidence-To-Action in Disability: Tygerberg, 27 - 28 November 2007, The Centre for Rehabilitation Studies, Stellenbosch University, Tygerberg, Cape Town, South Africa.
20. Ssebunnya J, Kigozi F & Ndyabangi S. Integration of Mental Health into Primary Health Care: a case of one rural district in Uganda. Uganda Psychiatric Association Annual Scientific Conference. 28th – 29th February 2008, Kampala, Uganda.
21. Lund C, Kleintjes S, Kakuma R, Flisher A.J. and the MHaPP Research Programme Consortium Public mental health services in South Africa: inter-provincial comparisons and policy implications. 4th Public Health Association of South Africa Conference, Cape Town, South Africa, 2-4 June 2008.

22. Ofori-Atta A, Read U & the MHaPP Research Programme Consortium. Transforming mental health services in Ghana. Paper presented at the annual conference of the African Association of Psychiatrists and Allied Professions, June 26 -28, 2008, Accra, Ghana.
23. Akpalu B, Doku V, Ofori-Attah A, Osei A, Awenva D & the MHaPP Research Programme Consortium. Is this a mental disorder? Diagnostic practices of traditional healers in the diagnosis of mental illness in a rural district in Ghana. Paper presented at the annual conference of the African Association of Psychiatrists and Allied Professions, June 26 -28, 2008, Accra, Ghana.
24. Awenva D, Read U, Doku V, Akpalu B, Ofori-Attah A, Osei A, & the MHaPP Research Programme Consortium. Mental health policy implementation in Ghana: the challenges. Paper presented at the annual conference of the African Association of Psychiatrists and Allied Professions, June 26 -28, 2008, Accra, Ghana.
25. Lund C, Flisher AJ, Kleintjes S, Kakuma R and the MHaPP Research Programme Consortium. Mental health policy or legislation: which comes first? Lessons from South Africa. 15th Biennial National Congress of the South African Society of Psychiatrists: 10-14 August 2008. George, South Africa. Poster presentation.
26. Kakuma R, Flisher AJ, Lund C, Omar M, Drew N, Faydi E, Funk M and the MHaPP Research Programme Consortium. National health plans in four African countries - Is mental health adequately addressed? 15th Biennial National Congress of the South African Society of Psychiatrists: 10-14 August 2008. George, South Africa. Poster presentation.
27. Kleintjes,S, Campbell, V, Flisher, AJ, Funk, M, Lund, C, Bhana, A, Bird, Doku, V, Kigozi, F, Ofori-Atta, A, Omah, M, Petersen, I. Green, A and the Mental Health and Poverty Research Programme Consortium. A situational analysis of child and adolescent (CA) mental health policy development and implementation in 4 African countries, South African Society of Psychiatrists, George, South Africa, August 2008.
28. Kakuma R, Kleintjes S, Lund C, Flisher AJ, Goering P and the MHaPP Research Programme Consortium. Development and implementation of mental health policy and law in South Africa: What is the impact of stigma? 15th Biennial National Congress of the South African Society of Psychiatrists. 10-14 August 2008, George, South Africa.
29. Lund C, Breen A, Flisher AJ, Kakuma R, Swartz L, Joska J, Corrigan J, Patel V. Poverty and Mental Health in Low and Middle Income Countries: a systematic review. 15th Biennial National Congress of the South African Society of Psychiatrists. 10-14 August 2008, George, South Africa.
30. Honikman S, Field S. The Perinatal Mental Health Project: a summative evaluation of a pilot implementation programme. 4th International Mental Health Conference, 26-28 August 2008, Institute of Psychiatry, London. Poster presentation.
31. Bhana A, Petersen I, Flisher A, Doku V, Mwanza J, and the MHaPP Research Programme Consortium . Comparison of district mental health models and structures across four African countries: Ghana, South Africa, Uganda & Zambia. World Congress of the World Federation for Mental Health, 2-6th September 2009, Athens, Greece.
32. Kakuma R, Kleintjes S, Lund C, Flisher AJ, Goering P, and the MHaPP Research Programme Consortium. Development and implementation of mental health policy and law in South Africa: what is the impact of stigma? Poster Presentation at the Fourth International Stigma Conference. Together Against Stigma: Stigma & Discrimination: Evidence for Action , 20-23 January 2009, London, UK

33. Ssebunnya J, et al. Social Stigma: the link between poverty and mental illness. Presentation at the 4th International Stigma Conference, London, U.K 21st - 23rd January 2009.
34. Honikman S and Field S. The “secret history” method: Training maternity staff for mental health promotion in Cape Town. “Expanding our Horizons: Moving Mental Health and Wellness Promotion into the Mainstream Conference”. Convened by the Clifford Beers Foundation in conjunction with the Mental Health Commission of Canada, Toronto, Canada, 4-6 March 2009.
35. Honikman S and Field S. Maternal antenatal distress: risk factors and service utilisation in a South African setting. “Expanding our Horizons: Moving Mental Health and Wellness Promotion into the Mainstream Conference”. Convened by the Clifford Beers Foundation in conjunction with the Mental Health Commission of Canada, Toronto, Canada, 4-6 March 2009.
36. Kigozi F, Ssebunnya J, Ndyanabangi S and Kizza D. The media and mental health in Uganda. Presentation at the 3rd Uganda Psychiatric Association annual scientific conference: Gulu, Uganda, 14th – 17th April 2009.
37. Kigozi F, Ssebunnya J, Ndyanabangi S and Kizza D. Current Initiatives to improve Management of mental disorders in rural communities in sub-Saharan Africa through integrated health service provision under PHC. Presentation at the 3rd Uganda Psychiatric Association annual scientific conference: Gulu, Uganda, 14th – 17th April 2009.
38. Ssebunnya J, Kigozi F, Ndyanabangi S and Kizza D. Use of WHO-AIMS in the assessment of the mental health system in Uganda. Presentation at the 3rd Uganda Psychiatric Association annual scientific conference: Gulu, Uganda, 14th – 17th April 2009.
39. Ssebunnya J, et al. Social Stigma: the link between poverty and mental illness. Presentation at the 3rd Uganda Psychiatric Association annual scientific conference: Gulu, Uganda, 14th – 17th April 2009.
40. Osei A. Responding to the challenges of mental health care delivery in Ghana. Health summit of the Ghana Health Services, Accra, 20-24 April, 2009.
41. Skeen S, Lund C, Kleintjes S, Flisher AJ. Mental health and the Millennium Development Goals in South Africa. Presentation to the South African Human Rights Commission Public Hearings on the Millennium Development Goals and the realisation of Economic and Social Rights in South Africa. Johannesburg: South African Human Rights Commission, 10 June 2009.
42. Skeen, S. *Maximising the Movement for Global Mental Health website*. First Summit for the Movement for Global Mental Health, Athens, October 2009.
43. Kleintjes, S, Flisher, AJ, Lund, C, Swartz, L. Improving mental health care user participation in policy development and implementation in South Africa. AFRINEAD Symposium November-December 2009, The Centre for Rehabilitation Studies, Stellenbosch University, Tygerberg, Cape Town, South Africa
44. Skeen, S. Kleintjes, S., Lund, C., Petersen, I., Bhana, A. & Flisher A. “Mental health is everyone’s business”: defining roles for an intersectoral approach to implementing the CRPD in South Africa. AFRINEAD Symposium November-December 2009, The Centre for Rehabilitation Studies, Stellenbosch University, Tygerberg, Cape Town, South Africa.
45. Skeen, S. Lund, C., Kleintjes, S., Flisher, A. *Mental health and climate change*. Public hearings on the Public Hearings on the Political, Economic, Legal, Gender and Social Impacts of Climate Change. Parliament of South Africa, November 2009.
46. Lund C. 10 reasons to include Mental Health on the Public Health Agenda. Public Health Association of South Africa Conference, 1-2 December 2009, Durban, South Africa.

47. Petersen, I. Improving mental health through community participation. Presentation at the Global Mental Health symposium. London School of Economics, University of London, 28 June 2010.
48. Kleintjes, S. Organising for self-advocacy in mental health: Lessons from 5 African countries. Presentation at the Global Mental Health symposium. London School of Economics, University of London, 28 June 2010.

OTHER RELEVANT OUTPUTS

The following training materials were produced:

- Mental Health Information System Training Manual for Northern Cape and KwaZulu-Natal provinces.
- Perinatal Mental Health Training Manual, 3rd edition. Cape Town: Perinatal Mental Health Project.
- Inter-personal therapy (IPT) manual for training community health workers in IPT group therapy for depression and maternal depression. (English and isiZulu), KwaZulu-Natal.

The following case studies, which document the impact of MHaPP interventions on policy and practice in the four countries, were produced:

1. Capacity development for public mental health research and policy in Africa
2. A new mental health information system for Ghana
3. The development and evaluation of a pilot community-based intervention for common mental disorders (CMDs) in a rural district in South Africa
4. Developing information systems to monitor mental health care in South Africa
5. Developing a Mental Health Plan for the Northern Cape Province, South Africa
6. Development of the National Mental Health Policy and Strategic plan in Uganda
7. Transforming Mental Health Legislation: The Case of Zambia
8. The Perinatal Mental Health Project: Integrating mental health into maternal care
9. The Perinatal Mental Health Project: Training maternity staff for mental health promotion – the “Secret History” method
10. The Perinatal Mental Health Project: Advocacy – raising the profile of a neglected issue

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- (2) Kigozi, F., Ssebunnya, S., Kizza, D., Ndyabangi, S., Green, A., Omar, M., Bird, P., Funk, M., Faydi, E., Drew, N., Lund, C., and Flisher, A. J. A situation analysis of the mental health system in Uganda. Phase 1 Country Report. Kampala: Mental Health and Poverty Project, Makerere University; 2008.
- (3) Banda, M., Mwanza, J., Sikwese, A., and Mayeya, J. A situation analysis of mental health policy development and implementation in Zambia. Phase 1 Country Report. Lusaka: Mental Health and Poverty Project, University of Zambia; 2008.
- (4) Lund, C., Kleintjes, S., Campbell-Hall, V., Mjadu, S., Petersen, I., Bhana, A., Kakuma, R., Mlanjeni, B., Bird, P., Drew, N., Faydi, E., Funk, M., Green, A., Omar, M., and Flisher, A. J. Mental health policy development and implementation in South Africa. Phase 1 Country Report. Cape Town: Mental Health and Poverty Project, University of Cape Town; 2008.
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- (7) Kigozi F, Ssebunnya J, Kizza D, Cooper S, Ndyabangi S, the Mental Health and Poverty Project. An overview of Uganda's mental health care system: results from an assessment using the world health organization's assessment instrument for mental health systems (WHO-AIMS). *International Journal of Mental Health Systems* 2010;4(1):1.
- (8) Kleintjes S, Lund C, Flisher AJ, the MHaPP Research Programme Consortium. A situational analysis of child and adolescent mental health services in Ghana, Uganda, South Africa and Zambia. *African Journal of Psychiatry* 2010;13:132-9.
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- (19) Lund C, Kleintjies S, Cooper S, Petersen I, Bhana A, Flisher AJ et al. Challenges facing South Africa's mental health care system: stakeholders' perceptions of causes and potential solutions. *International Journal of Culture and Mental Health* 2010;In press.
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