Stories of Change

from the Global Mental Health Innovator Community

Grand Challenges Canada®
Grands Défis Canada
BOLD IDEAS WITH BIG IMPACT®

Mental Health
Innovation Network

Acknowledgements

This report was prepared by the Mental Health Innovation Network for Grand Challenges Canada. The Mental Health Innovation Network is a partnership between the Centre for Global Mental Health at the London School of Hygiene and Tropical Medicine (LSHTM) and the Department of Mental Health and Substance Abuse at the World Health Organization (WHO). Grand Challenges Canada funds activities of the Mental Health Innovation Network, including the stakeholder engagement visits described in this report.

The Mental Health Innovation Network would like to thank members of our core team and partners for the key role they played in preparing this report, particularly Josephine Tsui at the Overseas Development Institute and Lucy Lee and Agnes Becker at LSHTM, as well as the GCC grantees who participated in key informant interviews and played a substantial role in shaping their Stories of Change.

Thanks also to Jessica Mackenzie and Josephine Tsui from the Overseas Development Institute, Agnes Becker from LSHTM and Dr Daniel Chisholm and Dr Fahmy Hanna from WHO for conducting the stakeholder engagement visits highlighted in three of these Stories of Change.

Contents

Introduction 04

How the Human Development Research Foundation gained ministerial attention in Pakistan 07

Engaging funders and decision makers to scale up the Friendship Bench in Zimbabwe 10

How a collaborative approach aided decision-makers to support QualityRights Gujarat in India 15

Advocating for budget allocation in Kenya 18

Engaging the right people at the right time to scale up Vietnam's Enhanced Primary Mental Health Care Study 21

How Farm Radio International and TeenMentalHealth.org engaged decision-makers to support and promote youth mental health in Malawi and Tanzania 23

Discussion 28

Conclusion 30

Introduction

Participants identify solutions to barriers at a mental health workshop in Zimbabwe © Bongani Kumbula for ODI

Background

Since 2012, Grand Challenges Canada (GCC) has provided funding to over 50 innovations in global mental health. This funding portfolio aims to improve treatments and expand access to care for people living with mental, neurological and substance use (MNS) disorders in low- and middle-income countries (LMICs). GCC funds both seed grants to develop proof of concept for innovative ideas, and transition-to-scale grants that help innovations which have already demonstrated proof of concept to significantly expand their reach and achieve sustainable impact at scale. Many of these transition-to-scale initiatives aim to work directly with government partners and seek to engage with policy at the local or national level.

It has been observed that, globally, efforts by mental health researchers to effect policy change are often confounded by common challenges such as stigmatization, heterogeneity, low financial investment and limited data. However, examples of positive engagement with policy makers and paths to sustainable policy change do exist. This report presents a series of case studies chronicling the efforts of six GCC transition-to-scale projects to effect policy change. It is hoped that these stories, and the approaches used by the projects to engage with policy, may serve to inform similar efforts by mental health stakeholders in LMICs.

Analysing policy engagement

Better use of evidence in development policy and practice can help to reduce poverty and improve the quality of people's lives. Decades of research on policy processes and policy engagement have asked why some evidence-based innovations are taken up into policy, while others are ignored and disappear. A number of theoretical frameworks and checklists have been developed to assist in analyzing policy change processes. For example, Stachowiak (2014) documents ten different pathways to policy change. The theories are taken from various disciplines including political science, psychology, communication and sociology. Five of the theories focus on tactical approaches to make policy change occur, including, for example, grassroots community organizing and crafting a carefully framed message.

Research on how to create policy change has shown there are at least four factors to consider when trying to determine how evidence might be adopted by policymakers and practitioners (Crewe, 2002):

- **Look at the political context: Consider how political strategies and power relations influence what type of evidence is used.**
- **Consider the links between research and policymaking: Research has shown that credibility and communication are important factors in determining policy engagement.**

- **Type of evidence: Policy engagement is affected by topical relevance but also operational usefulness of the idea and knowledge.**
- **External influences: Consider the key external factors affecting how evidence is used.**

What is apparent through this research is that there is no single approach to policy engagement. Every effort is unique and as a result requires its own particular combination of the above factors to achieve success. For this reason, it is often difficult to implement an impact evaluation of policy engagement to tease apart the mechanisms for success, and other methods of tracking policy engagement are required.

Stories of Change

Stories of Change provide a way to describe the key factors to achieving policy change through the use of detailed narratives of key policy engagement efforts undertaken by a specific program or initiative. They can be particularly useful in communicating changes in knowledge, behaviors and attitudes, and provide an additional, qualitative perspective to complement quantitative indicators of impact.

Developing a Story of Change follows a process of data gathering, reflection and writing, and is often driven by a researcher independent to the change being investigated. The data gathering focuses on document review and semi-structured interviews with key stakeholders involved in the implementation of the actions leading to policy change. During interviews, the researcher and the stakeholder focus first on the policy change, and work backwards to identify and describe the mechanisms that contributed to the policy change. The mechanisms are unpicked to determine the contextual factors related to the actions.

The knowledge gained through reflection is then captured and presented as a succinct report, outlining the background to the Story, the political processes that took place, the results of these actions and a summary of conclusions and lessons learned about how and why change occurred in this context. Stories of Change are designed to provide an accessible account of how policy change can be achieved within development programs. While they are specific to a single program, Stories of Change are intended to inspire those hoping to influence policy through their work, by describing why and how strategies worked in a particular context, and providing a set of conclusions that may help those working in similar contexts or hoping to apply similar strategies.

It is important to note that research into the processes of evidence-based policy making has emphasized that context is the most important factor in determining policy engagement, and that every opportunity to engage with policy will be unique. Case studies offer a way to look at the contextual factors that have led to success and may serve to inspire other researchers and practitioners to identify strategies for policy engagement.

About this report

This report presents six Stories of Change in LMICs as examples of successful mental health policy engagement. Case studies were selected from a sample of recipients of GCC transition-to-scale funding, including:

1. Friendship Bench, Zimbabwe: A program delivering Problem Solving Therapy for common mental disorders in primary care, to a population with a high HIV prevalence.
2. FaNs for Kids, Pakistan: A network that organizes, trains and empowers family members of children with developmental disorders alongside primary healthcare specialist and voluntary workers.
3. Quality Rights Gujarat, India: A program using the WHO's innovative QualityRights framework and toolkit to promote human rights and establish new standards of care within mental health facilities.
4. Farm Radio International, Malawi and Tanzania: A model for decreasing stigma and improving identification and treatment of depression in young people through youth radio programing, school-based mental health literacy, and community health provider training.
5. Africa Mental Health Foundation, Kenya: A program building referral networks and integrating mental health into existing public and community health services by training formal and informal healthcare providers.
6. Enhanced Primary Mental Health Care Study, Vietnam: An approach to improving the capacity and quality of primary healthcare services for the identification and treatment of depression in adults.

Usman Hamdani pitches Family Networks for Kids to decision-makers at a meeting hosted by the World Bank and World Health Organisation in Washington, D.C.
© Jeff Martin, 2016.

How the Human Development Research Foundation gained ministerial attention to the needs of children with developmental disorders and their families in Pakistan

Introduction

The Human Development Research Foundation (HDRF) is a research institute focusing on health, educational, social and biological aspects of maternal and child health, with an emphasis on turning research into action. One of its projects, The Family Network (FaNs) for Kids project, has recently captured the attention of the government's Benazir Income Support Program, and HDRF is currently engaging in talks on how to collaborate. The FaNs project uses an integrated, task-sharing approach to improve treatment access for children with developmental delays in low-income settings. This Story of Change illustrates how HDRF gained the government's attention to consider the longer-term sustainability of FaNs.

In many low-income countries, such as Pakistan, the treatment gap for children with developmental disorders in rural areas is significant. More than three quarters of Pakistan's population live in these rural areas, with one in five people living on less than US$1.25 a day. In Pakistan, the prevalence of developmental disorders is greater than 7%.

There are many barriers to providing care in rural areas for children with developmental delays: a lack of mental health professionals; weak specialist services and healthcare systems; and stigma. Children with developmental delays and their families often need substantial state-led support, for instance, in accessing appropriate screening, services to help with caregiving or training, and social support networks. The lack of coordinated mechanisms among public sector specialists makes it difficult for children and families to access special education, health and social welfare services.

HDRF is committed to addressing this treatment gap in Pakistan through the FaNs project, led by Principal Investigator and Deputy Director, Dr. Usman Hamdani, and his mentor, Professor Atif Rahman. The FaNs project aims to improve access to treatment through the following innovations:

1. Families of children with developmental disorders are identified through a mobile phone-based interactive voice response (IVR) system. The system has been able to identify 84.4% of children with developmental disorders at one hundredth of the price of a house-to-house survey.
2. Using the World Health Organization Mental Health Gap Action Program Intervention Guide (mhGAP-IG), HDRF has developed diagnostic and management guidelines to help support task-shifting of social care from health care providers to families. The guidelines are incorporated into training scenarios in the form of graphic images in a mobile phone application ('app'). The images depict characters that facilitate real-life discussion among families about their own situations and assist the development of individualized management plans for their children, as well as allowing families to practice parent-management skills and discuss ways to participate in communal life.
3. FaNs organizes families into clusters of ten networks within villages, each with a champion. These networks provide strong psychosocial support to allow families to work through the training programs together.

Action

The project's outcomes were positive, as families found the app useful in developing parent-management skills. Families were organizing together and advocating for public services for their children. As a result, FaNs was awarded extra funding from Grand Challenges Canada and Autism Speaks to transition to scale – from working with a population of 30,000 to a population of 1 million.

To help plan for their next phase, HDRF invited the Mental Health Innovation Network (MHIN) to Pakistan to build capacity in research communication, stakeholder engagement, and work together on a policy engagement plan to find partners for FaNs. The invited team included MHIN's Knowledge Exchange Officer based at WHO and Targeted Communications Officer from CGMH, alongside a research Fellow from ODI's RAPID team. This team brought expertise in global mental health, communications and capacity building for policy engagement. The Overseas Development Institute's RAPID Outcome Mapping Approach (ROMA) was applied in a workshop setting. The workshop helped the FaNs research team to prioritize their policy objectives and map their stakeholders, in order to strategize. The team separated out the various strands of their policy problem, and from this point, were able to prioritize the long-term sustainability of the program as their main objective.

A separate, dedicated workshop was held to bring together other organizations that HDRF worked closely with, to seek alliances, search for new partnerships and identify new ways of working together. Participants including the Canadian High Commissioner, and representatives from the Pakistani Government's Benazir Income Support Programme (BISP), the Aga Khan Foundation, the UK Department for International Development, Federal Ministry of National Health Services Regulation & Coordination, Heartfile Health Policy Think Tank, the Institute of Psychiatry (a WHO Collaborating Centre), and the Institute Centre of Social Franchising were invited.

MHIN's presence at the workshop helped to lend HDRF

Minister of State & Chairperson, Benazir Income Support Program (BISP), Government of Pakistan, Ms Marvi Memon meets with Usman Hamdani of the Family Networks for Kids project. © Rabia Rauf, Graphic Artist, 2016.

A separate, dedicated workshop was held to bring together other organizations that HDRF worked closely with, to seek alliances, search for new partnerships and identify new ways of working together.

convening power and provided a hook for HDRF to capitalize on their existing and long-standing connections to request an audience with the Minister of State and Chair of BISP, Marvi Memon. Though the visit from MHIN helped to spur the team on, it had taken years of hard work, network-building and convincing evidence from a pilot study to secure this meeting.

Results, conclusions and lessons learned

Hamdani and Rahman— together with MHIN— made a pitch to the Minister using data from the pilot study and stories of evidence-based care of children. Discussions revealed there was significant overlap between BISP and the work of FaNs – both, for example, worked in similarly socioeconomically deprived settings where the population had many unmet needs. FaNs' work was helping BISP to fulfil their mandate, and the Minister had confidence in the program because it was run by a Pakistani organization, for Pakistani people.

With a little help from MHIN, Hamdani and Rahman clearly communicated FaNs' strengths and the ways in which it could improve BISP's service delivery to underprivileged rural populations. The Minister was particularly interested in the IVR system, as it could identify families of children with developmental disorders at a cheaper and faster rate. The meeting concluded with the Minister promising to visit the FaNs families and further investigate possible collaboration and draft memorandums of understanding.

HDRF was able to get the Minister to consider integrating FaNs into BISP. The main components underlying this success were:

- **HDRF's high-quality research that provided the data to communicate to the Ministry. The Minister was particularly interested in the data collected about the IVR system's capabilities and cost-effectiveness.**
- **HDRF is a Pakistani organization, which contributed to the Minister's confidence in their work, because it meant a local organization would be accountable for the welfare of Pakistani people.**
- **After the ROMA workshop with MHIN, HDRF was able to clarify their objectives for the program and what they were seeking from their partners.**
- **HDRF's credibility has been built over decades of work in mental health. Their credibility allows them to work with diverse partners around the country to build a coordinated approach to support children with developmental disorders.**

Sources

- Key informant interviews with Dr. Hamdani and Professor Rahman
- Becker, A. (2016). Communication is key to scale up. MHIN; London, UK. http://mhinnovation.net/blog/2016/mar/16/communication-key-scale#.WAJNyfkrKUn
- Hamdani, S., Atif, N., Tariq, M., Minhas, F., Igbal, Z., & Rahman, A. Family networks to improve outcomes in children with intellectual and developmental disorders; a qualitative study. International Journal of Mental Health Systems. 2014. Feb 1; 8 (1):7: doi: 10.1186/1752-4458-8-7.

Engaging funders and decision-makers to scale up the Friendship Bench in Zimbabwe

Introduction

The Friendship Bench started in 2006 as an effort to reduce the treatment gap for common mental disorders (CMDs) in Zimbabwe, one of the countries hit hardest by the global HIV/AIDS pandemic. Led by Dr. Dixon Chibanda, with the clinical team under the leadership of Ruth Verhey, the Friendship Bench is named after a wooden bench that is stationed outside primary healthcare facilities and staffed by supervised lay health workers trained to deliver problem-solving therapy. The innovation focusses on:

1. Training lay health workers known as community "grandmothers", who typically visit communities to address HIV/AIDS and other health issues, to offer a brief psychological intervention called problem-solving therapy.
2. Dedicating a bench on the grounds of a primary healthcare facility where these lay workers can offer services; when someone sits on the bench, a lay worker approaches and initiates a conversation.
3. Integrating a screening questionnaire into the primary health clinic to detect and refer people with CMDs to the bench.
4. Delivering six 45-minute sessions of psychological intervention through the lay workers.
5. Initiating an economic empowerment component that service users can be referred to.

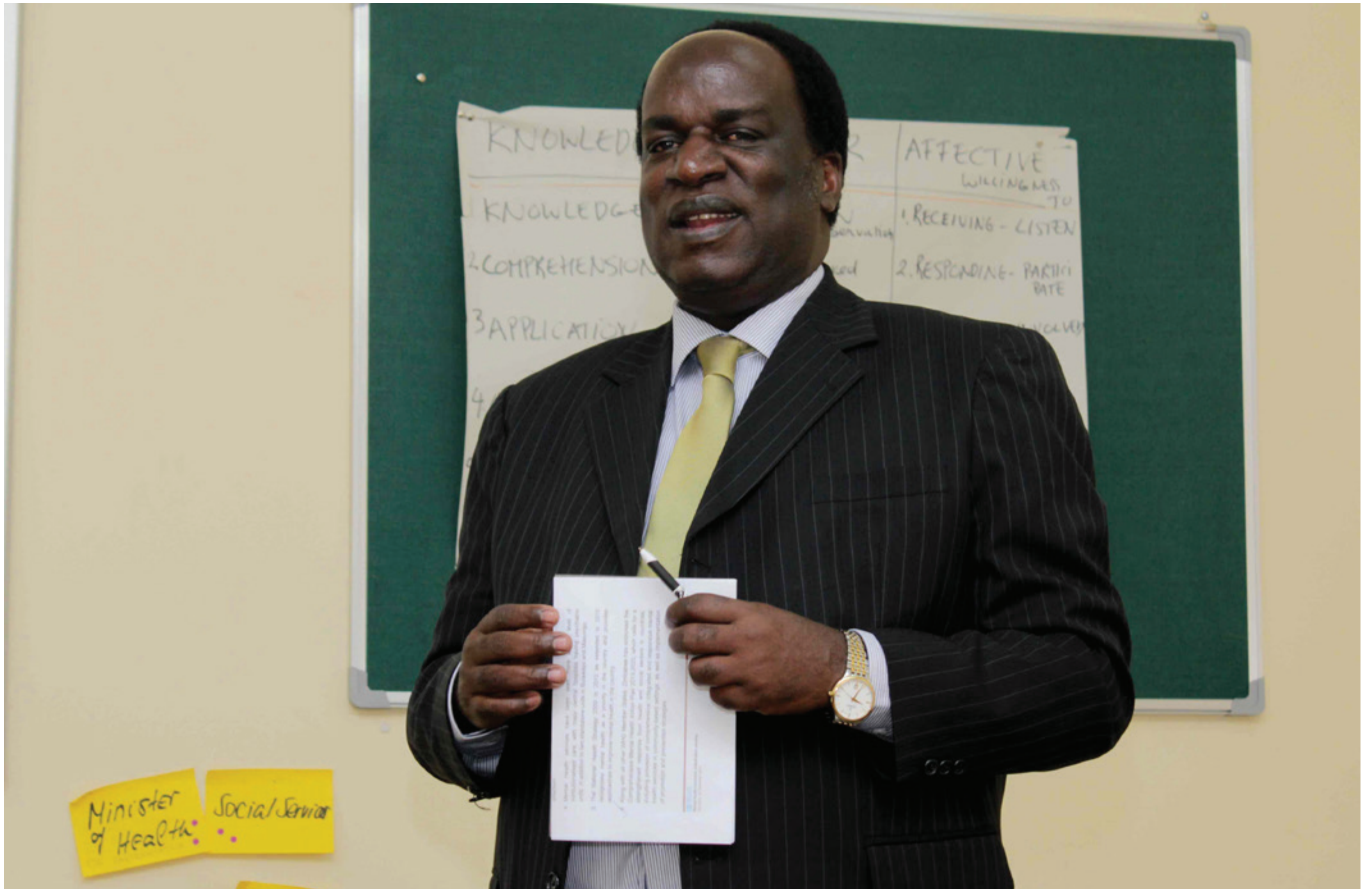
Before the Friendship Bench started, the Zimbabwean government's limited resources for mental health were focused almost entirely on delivering tertiary care in hospitals to people living with severe mental disorders such as schizophrenia. People struggling with CMDs at the community-level were not accessing care. Even people diagnosed with HIV, who are at particularly high risk of developing CMDs like depression, were receiving only one group therapy session before and one session after starting HIV therapy.

With help from the National Ministry of Health officials and the Harare City Health Department officials, Friendship Bench has expanded to 72 clinics in Harare. The results are impressive, as the team expanded their approach to mental health service provision from one focused on high-cost, intensive tertiary care to one encompassing low-cost mental health services at the community level. The team also partnered with a prominent international non-governmental organization (NGO), Médecins Sans Frontières Holland (MSF), to work with Dr. Chibanda in Harare Central Hospital's psychiatric unit as well as invest in the Friendship Bench's scale-up. By engaging Zimbabwe's World Health Organization Representative (WR) in the country's mental health care, the team facilitated the training of Zimbabwe's primary health workers (nurses) in WHO's Mental Health Gap Action Programme (mhGAP).

Action

The Friendship Bench team achieved this new focus on low-cost community services for CMDs by engaging with each stakeholder in a number of ways, outlined below.

The team secured early buy-in from the City Health Department (along with other key stakeholders such as the Ministry of Health, NGOs, user groups, nurses, doctors and researchers) by presenting the Friendship Bench concept in 2006 before implementing the innovation in Mbare clinic, Harare, Zimbabwe. The objective of the meeting was to reach consensus and establish how and where to implement the innovation. The initial selling point was a survey carried out in



Dr Okello presents at the mental health workshop in Zimbabwe © Bongani Kumbula for ODI

Harare to establish the prevalence of CMDs in the clinics. The survey revealed a prevalence of over 30%. Mbare was identified as the community most affected, and therefore the decision was made to start the first Friendship Bench in Mbare. At this point, City Health Department officials were willing to listen, but they weren't actively engaged.

Through regular formal and informal meetings and progress updates, the City Health Department started to take an interest, particularly when early quantitative results showed the Friendship Bench's lay health workers were treating many more people for CMDs than the health specialists at the tertiary facility could. The team also framed their success as a success for the Department—and National—priority health areas, such as HIV and maternal and child health. After hearing from the nurse-in-charge at Mbare that personal stories were convincing the nursing staff that the innovation was working, the team shared stories from the Mbare clinic with the City Health Department to demonstrate how Friendship Bench was also benefiting priority health areas. For example, mothers who had been diagnosed with CMDs could now take their children to appointments, resulting in more children getting vaccinated. People who had taken part in the Friendship Bench began to adhere better to treatments for chronic diseases such as HIV and diabetes. These meetings convinced the City Health Department Director that the innovation worked, and he became a champion for the Friendship Bench within the Zimbabwean government.

Dr. Chibanda started to build a working partnership with MSF staff, following a joint effort to curb a cholera outbreak in 2008. Following the outbreak, Dr. Chibanda and MSF staff continued to support each other's work, particularly within the corrective system, where many prisoners are affected by mental health issues. During the cholera outbreak, Dr. Chibanda managed to secure vital medicines and accessories worth over $40,000 from Mandela and Graça Machel in South Africa, winning him the respect of the Ministry of Health in Zimbabwe. It led to the Ministry of Health requesting his support to put together the National Mental Health Policy. This respect for Dr. Chibanda's work and opinion—coupled with a strong recommendation from Friendship Bench's champion, the City Health Department Director—convinced Ministry of Health officials to engage with the Friendship Bench. Eventually, the Ministry of Health and City Health Department requested the team undertake a randomized controlled trial and stated that if it showed positive results, they would support the innovation.

Through funding from Grand Challenges Canada, the trial has demonstrated significant impact. Over 15,000 people have utilized the Friendship Bench, and it is estimated that once integration into all clinics in the three cities is complete, up to 50,000 people will have access to the Friendship Bench. Data is currently being analyzed, but early results suggest that the intervention is cost-effective. These results cemented buy-in from the City Health Department, the Ministry of Health and MSF. It led to Grand Challenges Canada and MSF both supporting the scale-up of the innovation to 72 clinics in Harare. The Friendship Bench implemented this scale-up in collaboration with the City Health Department and the Ministry of Health, who offered support through community outreach activities as well as sustainability strategies for medication and staff retention.

Shortly after the scale-up funding announcement, a team from the Mental Health Innovation Network (MHIN), including representatives from CGMH, WHO and ODI travelled to Harare in December 2015. They visited the Friendship Bench programme to build the capacity of the local research team on policy engagement and strategic communication through a stakeholder engagement workshop. As MHIN includes staff members from the WHO in Geneva, the visit resulted in the Zimbabwean WR being invited to meet the City Health Department Director and hear stories from Friendship Bench service users. The WR's engagement reinforced the Ministry of Health's desire to address mental health issues at a national level and led to preparations for WHO Mental Health Gap Action Program (mhGAP) training to be rolled out nationally.

The Friendship Bench has now been scaled-up to 72 clinics in Harare and is due to present results in December 2016.

Results

The success of the innovation, credible evidence from the study, and the team's efforts to convince Ministry of Health officials, have resulted in the Friendship Bench being integrated into Zimbabwe's standard packages of care for HIV treatment and Prevention-of-Mother-To-Child-Transmission (PMTCT) of HIV. These initiatives have been fully integrated into the City Health Department and the Ministry of Health programs and no longer require external funding. They will be implemented with technical support (developing training materials, training, supervision strategy etc.) from a newly established Friendship Bench Trust, which will over the next five years gradually hand over technical expertise to the Department so that the innovation becomes sustainable. Becoming an independent Trust has helped them leverage funds from other partners. An adolescent mental health component will be added in January 2017 with funding from the UK Medical Research Council.

Further, the Ministry of Health, MSF and the WR requested staff from WHO Geneva and the WHO regional office to train 36 trainers in mhGAP who will in turn roll out the training to nurses in all of Zimbabwe's provinces. By training nurses at the primary care level in mhGAP, the government is supporting the work of the Friendship Bench as well as scaling up mental health care in the country on various levels. For example, when a lay health worker refers service users who need more support to a primary healthcare facility, nurses will now be able to deliver care thanks to their mhGAP training. So far, 45 nurses have been trained in mhGAP with another 50 to receive training in November 2016. The Friendship Bench is currently delivering treatment to around 24,000 people with CMDs per month in Zimbabwe. Improving training of primary healthcare workers via mhGAP will help to deliver care to 6-8,000 people with mental, neurological and substance use disorders, including more severe disorders.

Conclusion and lessons learned

Scale-up of the Friendship Bench was achieved through persistent efforts to demonstrate the potential and effectiveness of the innovation to policy-makers and donors. Lessons learned from the program's success suggest that a number of factors were important in ensuring buy-in from these partners:

- **Engaging policy-makers early at proof-of-concept stage.**
- **Providing regular updates on progress, framing results to match policy-maker's priority areas.**
- **Sharing personal success stories and rigorous science to secure funding for scale-up.**
- **Finding a champion in the Harare City Health Department.**
- **Capitalizing on Dr. Chibanda's position of respect and trust with the Ministry, garnered through his work obtaining funds for the cholera outbreak and putting together the National Mental Health Plan.**
- **Forging alliances with MSF, a donor, by supporting their work as well as requesting support.**
- **As a result of the stakeholder engagement visit, a new partnership was facilitated between WHO, MSF and the Ministry of Health to scale up mental health care at Primary Health Centres in the country.**

Sources

- Key informant interview and correspondence with Dr. Dixon Chibanda, 13 September 2016
- 'The Friendship Bench'. Web page on mhinnovation.net (accessed 17 October 2016) http://mhinnovation.net/innovations/friendship-bench
- MHIN Friendship Bench Stakeholder Engagement Country Visit Report (report submitted to GCC February 2016)
- Chibanda, D., Cowan, F., Gibson, L., Weiss, H. A. & Lund, C. 2016a. Prevalence and correlates of probable common mental disorders in a population with high prevalence of HIV in Zimbabwe. BMC Psychiatry, 16, 55.
- Chibanda, D., Verhey, R., Munetsi, E., Cowan, F. M. & Lund, C. 2016b. Using a theory driven approach to develop and evaluate a complex mental health intervention: the friendship bench project in Zimbabwe. Int J Ment Health Syst, 10, 16.
- Chibanda, D., Verhey, R., Munetsi, E., Rusakaniko, S., Cowan, F. & Lund, C. 2016c. Scaling up interventions for depression in sub-Saharan Africa: lessons from Zimbabwe. Global Mental Health, 3, e13 (9 pages).
- Todd, C., Patel, V., Simunyu, E., Gwanzura, F., Acuda, W., Winston, M. & Mann, A. 1999. The onset of common mental disorders in primary care attenders in Harare, Zimbabwe. Psychological Medicine, 29, 97-104.

Janaki Patel, Peer Support Volunteer, Hospital for Mental Health, Vadodara. © QualityRights Gujarat

How a collaborative approach aided decision-makers to support QualityRights Gujarat in India

Introduction

Poor quality of care and human rights violations in inpatient and outpatient facilities are a common feature of mental health services in many LMICs in the world including India. Many people with mental illness are exposed to inhumane and degrading treatment, restraints, seclusion and physical, sexual, and emotional abuse and neglect. To address these concerns, QualityRights Gujarat (QRG) has been implemented since 2014 at public mental health facilities in the Indian state of Gujarat with funding from GCC.

QRG uses the WHO QualityRights Toolkit and capacity building tools to promote human rights and establish new standards of care to bring about a positive impact on the quality of services and promote respect for human rights. Led by Dr. Soumitra Pathare at the Centre for Mental Health, Law & Policy, Indian Law Society, Pune, QRG has been delivered in six public mental health facilities in Gujarat State, India, and focuses on four areas of intervention:

1. Improvements to the facility environment, emphasizing quality of interactions.
2. Training of health workers, service users and families on human rights and changes in attitudes and practice required to move towards a recovery approach.
3. Introducing facility-level policies to protect against inhuman, degrading treatment, violence and abuse (including reducing or eliminating the use of seclusion and restraints).
4. Building peer and family volunteer groups.

The innovation has influenced the heads of the participating mental health facilities and State Government to support the continuation and expansion of the program within Gujarat State, through training key workers and ring-fencing budgets for psychotropic medicines. The innovation has also inspired and empowered service users to become active participants in their own care and treatment and to become advocates for change, with their personal stories having a powerful influence on decision makers at the State Government.

Action

The team took a collaborative and participatory approach to build a working relationship with stakeholders at the local and state level that secured their buy-in and ownership of QRG.

Following the National Human Rights Commission report in 2000, the State Government sought to improve their national ranking and obtained funding in 2005-2006 from the Netherlands to create a State Mental Health Policy. The policy included a general statement on protecting human rights and making services human rights- oriented. During this period, the State Government made sustained efforts to bring about change within the mental health sector. The QRG team recognized that there was a willingness from the State Government to improve the quality of Gujarat's mental health services and that the QRG innovation might be of interest to them.

The Government also had a pre-existing Nodal Mental Health Officer, Dr. Chauhan, who was keen to implement QR principles. Dr. Pathare had met Dr. Chauhan at various meetings and conferences around five years before implementing QRG. During these meetings, they held repeated discussions on their shared vision for rights-based mental health services and how and what reform was necessary to achieve this goal. The proposal of implementing QR in Gujarat was first discussed with the State Nodal Officer, who further helped organize meetings with the Government officials.

There was a shared desire to bring about change, which was further enhanced through a trusting relationship developed over time through informal discussions Dr. Pathare was holding as part of his policy- and law-related work. Dr. Pathare had previously worked with the Government of India on drafting the new national Mental Health Care Bill and was also a member of the policy group appointed by the Government of India to draft India's first National Mental Health Policy, which was an added advantage for the collaboration. Through these meetings, Dr. Pathare learned that the State Health Department identified quality improvement as a priority for the health sector and, unusually for India, had set up a Quality Assurance Department. The team pitched the QRG project to the State Health Department and the Quality Assurance Officer as a quality improvement project. Thus, the innovation was seen as an important contribution to achieving the State Government's aims. The team made a sustained effort to include the State Government throughout the project's implementation via Advisory Team Meetings, held at least once a year.

In February 2016, an international conference was held at the Hospital for Mental Health in Ahmedabad, Gujarat. The conference was attended by delegates from across the country as well as from four other countries. Service users and caregivers presented their experiences to policy makers and politicians, including the Hon Minister of Health, Government of Gujarat. As well as presenting evidence from their baseline assessment, the QRG team gave space for peer support volunteers (PSVs) to speak of their journey in the project on a personal and community level which left an impression on the officials, later facilitating advocacy for financial funding for PSVs by the State authorities. The peer and family support group meetings are a strong source of building participation and empowerment, which initiated newfound discussions with heads of facilities to advocate for rights of service users and caregivers. The State Minister for Health, along with other national and international dignitaries, attended the conference and was particularly interested in the beneficiaries' stories. The QRG team felt this interaction helped in including funding for the PSVs in the State Health Budget from May 2016.

The quality improvement measures taken by the facilities focus on eliciting feedback from service users and caregivers about their satisfaction, ways of increasing awareness of support groups, and reducing the drop-out rate of service users. The interaction with service users and caregivers has shifted from a purely medically-centered interaction to discussions on psychosocial aspects of recovery aided by the recovery plans.

To secure buy-in from the heads of facilities, Dr. Pathare and Dr. Chauhan personally invited them to become partners in the innovation. A 'management team' of heads of the facilities was established, which was responsible for managing the overall implementation and evaluation of the innovation and for troubleshooting along the way. The management team meetings also ensured buy-in from and sustained participation of the main actors throughout implementation.

The team placed a researcher at each facility site to implement the innovation on a day-to-day basis. For the first three months, the researcher worked to understand and observe the system of mental health care and treatment and to build relationships with staff at the facilities. To implement changes within the facility, a core team developed a set of improvement plans with concrete, achievable goals. These plans were based on priority areas identified through a democratic and participatory approach, to be achieved over a period of one year.

This participatory approach meant that all stakeholders felt the innovation belonged to them – they had a shared interest in making it work.

Results

The innovation has already had an impact at the local and state level.

Engaging service users from the beginning to become active participants in their own care and treatment is an ongoing key element of the innovation. This empowerment has led to service users becoming advocates for change, with their personal stories having a powerful influence on decision-makers at the State Department of Health and Family Welfare.

Even after the project funding from GCC ends on 30th November 2016, the State Government is going to expand QR to three additional sites using staff from the original six facilities. Further, the peer and family support groups, which have been running successfully across all six intervention sites, will continue to be supported by mental health facilities. In the past year, the Department of Health and

Family Welfare, Government of Gujarat State, has expanded this peer support initiative by funding 50 'peer support volunteers' in the State of Gujarat along with a commitment to increase this funding in coming years. Moreover, the State has also introduced ring-fenced budgets for psychotropic medication in all public health facilities.

The State plans to also introduce cafes run by NGOs and employ people with mental illness at the public mental health facilities, to address financial independence and reduce stigma towards mental illness.

The QR team is working on a quality accreditation process using the WHO QualityRights Toolkit for all mental health facilities within the State of Gujarat in order to reward achievements and provide an incentive. The innovation has already led to facilities achieving prestigious awards: In 2016, one of the nurses trained through the QR innovation received the nation's prestigious National Florence Nightingale Nurses Award— the first mental health nurse to have won the award.

The QR innovation is also now spreading to other Indian States. Recently, the QR team was contracted by the Tata Trust to implement the QR innovation in Nagpur Mental Hospital in the neighboring state of Maharashtra.

In the long-term, the QR innovation aims to cover all public and private mental health care facilities in the State of Gujarat and also expand to other states in India.

Conclusion and lessons learned

The success of QR in promoting change in behaviors, attitudes, knowledge, practice and policies was due to multiple factors:

- **Engaging and collaborating with key stakeholders at all stages of the innovation's implementation to build ownership of the innovation.**
- **Empowering service users to be at the forefront of mental health care and treatment and advocate for change.**
- **Capitalizing on Dr. Pathare's position of respect and trust garnered through his work with the Government of India on drafting the new Mental Health Care Bill of the country and his membership of the policy group appointed by the Government of India to draft India's first National Mental Health Policy.**
- **Aligning with the priorities and aims of the Heads of public mental health facilities and State Government.**
- **Building a trusting relationship with the Nodal Mental Health Officer who could champion the project within the State Government.**
- **Building rationale and relevance for the innovation to fit with the State Government's needs.**
- **Breaking through hierarchies by demonstrating that a democratic process of decision making and implementation of the innovation helped to increase buy-in from policy makers and public mental health staff, as they felt they were part of the solution.**
- **Sustaining motivation among the mental health care professionals through regular management meetings and generating ownership. Again, this approach meant mental health staff felt they owned the project and were part of the solution.**
- **The success of QRG has meant that the team has been able to build on their relationship with the government in developing additional programmes, such as Atmiyata, which uses mobile technology to guide community mobilizers in promoting wellbeing, and detecting common mental disorders. Atmiyata was visited by MHIN in the summer of 2016 to support and build capacity in stakeholder engagement and strategic communications. MHIN's visit further strengthened the team's connections with the government.**

Sources

- Key informant interview and correspondence with Dr. Soumitra Pathare, 15 September 2016
- Presentations from 7th International Conference on Schizophrenia by SCARF, Chennai, 8-10 September 2016
- Significant input from Jasmine Kahla, Researchers, Quality Rights Gujarat

Advocating for budget allocation in Kenya

Introduction

The Africa Mental Health Foundation (AMHF) is a not-for-profit research organization based in Nairobi, Kenya. In 2015, following several years of networking and lobbying, AMHF was able to secure dedicated government funding to improve mental health services in Makueni County, one of the 47 counties in Kenya. AMHF achieved policy change through the provision of clear, reputable data, trust-building in the community, and capitalizing on a policy window.

AMHF is a Kenyan research organization that conducts and shares mental health research for the improvement of mental health services nationally and across Africa. In 2007 it started to analyze the barriers faced by the Kenyan population in accessing adequate mental health services. As well as undertaking research, AMHF generates evidence to inform multiple approaches to service development, including working within the school education system and with formal and informal healthcare providers. AMHF has a rich portfolio of projects, many of which build on the World Health Organization Mental Health Gap Action Programme (mhGAP) and the mhGAP Intervention Guide (mhGAP-IG), including: the 'Dialogue to Empower, Supervise, Support and Include the Informal Traditional and Faith Healers to Deliver Evidence-Based MhGAP-IG Adapted Psychosocial Interventions to Reduce Treatment Gap in Kenya' project (DIALOGUE); 'mHealth', which focuses on evaluating the applicability of using mobile technology to train, supervise, monitor and support non-specialist health workers in the implementation of the mhGAP-IG depression module; 'the e-DATA K Project', which provides training to clinical and non-clinical health workers in mhGAP; and 'the Kenya Integrated Intervention Model for Dialogue and Screening to Promote Children's Mental Wellbeing' project (KIDS), among others.

In Kenya, psychiatrists are concentrated in urban areas, with the majority working in private practice or in academic institutions. The high cost of traveling to urban areas to access these services is a significant barrier to care for the majority of the population. In addition, as less than 0.01% of the health budget is allocated to mental health, often clinics in the counties do not have the material or human resources to support mental health care— such as mental health specialists, medical supplies, or physical infrastructure. In many counties, there are no available psychiatrists. AMHF is the only organization working outside Nairobi that focusses on developing approaches to improving access to mental health services.

Action

Acknowledging the scarcity of resources available for mental health— particularly outside the capital—AMHF lobbied the national Ministry of Health for several years for a budget to be allocated to mental health. It proved difficult to obtain meetings with key health officials to make the case for this. In 2010, however, a policy window presented itself: the devolution of Kenya's public institutions that year marked a significant change in national administration, and created new county governments. Through this process, 47 new county governors and county assemblies were elected and began setting up new institutions. New county health services were set up across the 47 counties. This provided an opportunity for AMHF to focus its lobbying activities on counties as they set up their new institutions.

AMHF has had a research presence in Makueni County since 2008. Over the past eight years it has been able to collect data that challenges local perceptions about the prevalence of mental illness in the region. Partly, this has been through its 'DIALOGUE' project, which was also working in Makueni County. The 'DIALOGUE' project brought together traditional and faith healers with nurses and clinical officers at the primary care level to support the identification and treatment of

The Makueni County Governor, senior Ministry of Health Officials and County Cabinet Secretary affirm the country's support for mental health in a meeting with the Grand Challenges Canada CEO © 2016 Africa Mental Health Foundation

people living with mental health problems. The project saw a significant increase in the numbers of people accessing clinics and requiring treatment for mental health conditions. In one clinic alone, more than 1,050 cases were documented in a year. The data collected demonstrated not only that the need for mental health services in the county was far greater than previously thought, but that linking traditional and formal health services could improve support for people living with mental health conditions in the community.

Armed with this information, AMHF honed their policy message and approached Makueni County's Health Ministry to advocate for a portion of the total health budget to be allocated to mental health care. AMHF applied stakeholder engagement strategies inspired by a stakeholder engagement workshop supported by Grand Challenges Canada (GCC) and facilitated by the Overseas Development Institute in collaboration with the Mental Health Innovation Network, and succeeded in securing an audience with the key people defining the health budget at the county's rural health level.

AMHF began by writing to county health officials who agreed to meet with them. At this meeting, they asked for a bigger audience, and were later introduced to the Chief of Health, and subsequently to three more directors in the Department of Health Services. Finally, they were granted an audience with the Minister of the Department of Health Services. It took several meetings to convince the Minister of Health, but this ensured he understood the complexity of the issue before bringing it to the County Governor, who needed to authorize the budget allocation.

The Minister of Health needed to present the idea to the County Governor, and AMHF worked closely with the Ministry to craft the message. The policy brief hinged on two key pieces of information: need and return on investment. First, although the Ministry had little understanding of the prevalence of mental health issues in rural areas, AMHF was able to provide data to give a

clear understanding of the need. Second, the policy brief informed the Governor that by investing in mental health, it was possible to support citizens to return to work. As poverty reduction is a priority for the government, the understanding that investment in mental health may in turn increase workers' productivity provided an incentive to pay attention to AMHF's call for action.

Results

The Governor of Makueni was convinced, as was the County Assembly through lobbying from the Department of Health, and so authorization of the reallocation of a portion of the health budget for mental health was approved. Direct positive impact was soon observed. Makueni County now offers training scholarships for doctors to study psychiatry, and postgraduate diplomas for clinical officers wishing to pursue clinical psychiatry and psychiatric nursing. This year, the first trainee beneficiary started studying for a Masters of Medicine at a public university in Kenya. The reallocated budget has also allowed for psychotropic medicine to be distributed to the primary healthcare facilities and administered to patients who are unable to travel to Nairobi.

Co-funding provided by GCC has been instrumental in ensuring the sustainability of the intervention. The GCC funding was used to hire research assistants for the duration of the transition-to-scale grant to carry out symptom-specific assessments at the point of care in primary healthcare centers. The research assistants use paper and pencil questionnaires to collect the data and then enter it into an online system, so that the data are received by AMHF's central data processing platform in real time. The matched funding from GCC has also helped to bridge the gaps that the mental health budget is unable to fulfil, and demonstrates by example to the County Government the benefit of investing. Through this funding, AMHF are able to collect disaggregated mental health data that can be used by the County for health planning. Through GCC's transition-to-scale funding, AMHF is looking to replicate this success in two more counties.

Conclusion and lessons learned

Lessons learned from AMHF's success demonstrated that a combination of factors were instrumental in leveraging funding for mental health in rural Kenyan counties:

- **AMHF had a long-standing presence within Makueni County which provided credibility and trust with the ministry.**
- **The devolution of Kenyan government services to the local level provided a policy window within Makueni County. This provided an opportunity to influence the assignment of health budgets at the county level.**
- **Through other projects, AMHF had been collecting data on patient access to mental health services. AMHF therefore acted as a knowledge broker, demonstrating the treatment gap to decision-makers.**
- **Using stakeholder analysis, AMHF was strategic with their engagement, targeting the information to the right county health officials.**
- **Through lobbying of multiple Health Directors, AMHF realized that highlighting the economic rationale of returning citizens back to work was key to persuading decision-makers to consider committing funds to improve mental health services.**

Sources

- Africa Mental Health Foundation website: http://www.africamentalhealthfoundation.org/ (Accessed March 2016)
- MHIN Africa Mental Health Foundation innovation case study: http://mhinnovation.net/organisations/africa-mental-health-foundation (accessed 17 October 2016)
- University of Toronto, Psychiatry Unit article. Kenya Integrated Intervention Model for Dialogue and Screening to Promote Children's Mental Wellbeing http://www.psychiatry.utoronto.ca/news-announcements/kenya-integrated-intervention-model-for-dialogue-and-screening-to-promote-childrens-mental-wellbeing-kids/ (accessed 17 October 2016
- Key informant interviews conducted with Dr. Victoria Mutiso, March 2016

Engaging the right people at the right time to scale up Vietnam's Enhanced Primary Mental Health Care Study

Introduction

The Mental Health in Adults and Children- Frugal Innovations (MAC-FI) study is a research project based in Vietnam that aims to improve the capacity and availability of community-based healthcare services for better depression care among adults. After an initial pilot in one province, the project expanded its aims to address an identified gap in services for children.

Vietnam has a high prevalence of depression. But, while primary healthcare services are available to the general population, the capacity of primary healthcare staff to identify and treat depression is low. Mental health services are offered at the tertiary level, with little community-based care. And because the attention of tertiary healthcare workers such as doctors is in demand across so many unmet needs, they often have little time to devote to common mental health disorders such as depression.

The MAC-FI study aims to address this service gap by improving the capacity and availability of community-based healthcare services for depression among adults ('supported self-management'), which is offered by primary care providers and social workers. MAC-FI aims to achieve this by developing a new cadre of social workers, trained by Vietnamese Ministry of Labour, Invalids and Social Affairs (MOLISA), to deliver community-based services for mental health. These social workers collaborate with primary healthcare providers to screen for depression and to deliver supported self-management (SSM) interventions.

The study is comprised of multiple partners including the Institute of Population, Health and Development (PHAD), the Centre for Applied Research in Mental Health and Addictions at Simon Fraser University (SFU) and the Vietnamese Ministry of Labour, Invalids and Social Affairs (MOLISA). Following the receipt of additional funding from Grand Challenges Canada, the project has since been expanded to include the Strongest Families Institute into the consortia and other partners including Vietnam's Ministry of Health, UNICEF, WHO, the Global and Cultural Mental Health Unit at the University of Melbourne, BasicNeeds Vietnam, and the Vietnam Veterans of America Foundation.

Action

Researchers from PHAD had contacts within MOLISA and, fortunately, MOLISA was eager to improve their support to people with mental health disorders. With PHAD and SFU offering to pilot a mental health program, MOLISA immediately took a very active role in the partnership. MOLISA's proactive role was rewarded by the Prime Minister, who in turn provided substantial support. The coalition of study partners mentioned above were eager to include the expertise of Simon Fraser University, because they wanted strong academic, institutional backing. Vietnam generally is heavily supportive of evidence-based policy-making and values the role of universities and research. MOLISA thus saw the benefits of collaborating with PHAD and SFU in the project, and the government then allocated their own funding to expand the project in the transition to scale phase, matching the funding from GCC.

The goal of the pilot was to test the feasibility of (1) training primary care providers to screen for depression and support patients using SSM intervention, and (2) implementing a full-scale randomized control trial to test the effectiveness of the intervention in Vietnam. It offered training to primary care providers to detect and treat adult depression using a SSM intervention. This meant task shifting the delivery of depression treatment from a mental health specialist to primary healthcare staff. This allows for greater access, as there are more primary healthcare staff available than mental health specialists.

Results

Through the pilot study, it became evident that children's mental health services were lacking in Vietnam which spurred the introduction of the second component. The second component was the service delivery mechanism for children. The telephone-based Strongest Families intervention is delivered to parents by trained coaches. This helps to address the lack of child psychologists in the country, and also helps parents to gain access to more family-friendly services, as they are often busy working during the day, and treatment can be provided in the evening or on weekends. The pilot component of the project has received high praise from MOLISA and will transition into a randomized controlled trial to further test the effectiveness of the intervention over the next two years.

A combination of four different elements led to the scale up of the intervention:

- **PHAD and SFU were able to build the right government partnership from the beginning of the study. As MOLISA was in charge of providing social services to those who are most vulnerable, they were well placed delivery partners. Working together from the beginning built MOLISA's trust in the intervention, which was instrumental in convincing more senior officials. MOLISA was one of the co-applicants for the transition-to- scale funding.**

- **Together with MOLISA, the project partners were able to build a strong coalition. The coalition includes UNICEF and the World Health Organization, local Vietnamese NGOs, government ministries, and universities. By engaging a diverse group, the project has built the trust of senior policy-makers and also ensured the research addresses key issues relating to common mental disorders in adults and children.**

- **SFU and PHAD's role as research institutes mitigated some of the risk surrounding the project. Governments can be risk adverse because they are concerned about their constituents and public opinion. Given that Vietnam is already geared toward evidence-based policy-making, it is difficult to achieve policy change without the support of research institutions. The involvement of SFU and PHAD satisfied this requirement and added gravitas.**

- **The project had enough flexibility to pivot when necessary. For example, the project was originally designed to address mental health services for adults, but a contextual analysis showed there were no services available for children. The project was able to adapt and expand in the transition-to-scale phase to meet these needs, which were highlighted through implementation and partnership with government. The project was able to adapt when needed which enabled it to remain relevant and address the most pressing needs.**

Conclusion and lessons learned

In summary, SFU and PHAD had engaged the right partners at the right time; MOLISA was eager to make mental health a policy priority to improve community-based health services. The positive culture in Vietnam of evidence-based policy-making places a strong emphasis on research, which elevated the legitimacy of SFU's presence. Moreover, existing respect for PHAD's work also ensured it was noticed by senior officials at MOLISA, giving it the attention it needed to secure further funding.

Sources

- MHIN Enhanced Primary Mental Health Care Study innovation case study: http://mhinnovation.net/innovations/enhanced-primary-mental-health-care-study#.VvMi6uKLSUk (accessed 17 October 2016)
- Meadahl, M., Expanding mental health care for adults, children in Vietnam. Simon Fraser University News Story www.sfu.ca/sfunews/stories/2016/expanding-mental-health-care-for-adults-children-in-vietnam.html 27 January 2016. (Accessed 17 October 2016)
- Key informant interview with Jill Murphy, March 2016

How Farm Radio International and TeenMentalHealth.org engaged decision-makers to support and promote youth mental health in Malawi and Tanzania

Introduction

A collaboration between Farm Radio International (FRI) and Teenmentalhealth.org (TMH) has produced a novel, three-part model for addressing youth depression called Pathways Through Care, which has obtained support from Ministries of Health in Malawi and Tanzania. This model integrates mental health awareness, mental health literacy, improved access to care and enhanced mental health care capacity and quality in community health settings.

Young people regularly face mental health problems, and most mental disorders onset before the age of 25. But in LMICs, where young people make up the majority of the population, the resources available for identification and treatment of mental disorders among young people are often inadequate. When treated, young people are often prescribed psychotherapies or medications intended primarily for adults, as youth-appropriate treatments are not known or readily available.

In countries such as Malawi and Tanzania, there are very few psychiatrists or other mental health care providers who have been trained in the diagnosis and treatment of young people, and there is little or no effort to address youth mental health in schools or in communities. The stigma related to mental disorders is also significant. As a result, young people often suffer in silence and do not receive the care they need. This leads to significant negative social, academic, vocational, health and personal outcomes.

Action

Since 2012, a collaboration between FRI (led by Executive Director Kevin Perkins) and TMH (led by Canadian psychiatrist Dr. Stan Kutcher), has been working to adapt, implement and scale-up an innovative approach to improve mental health and access to effective mental health care for young people affected by depression. It aims to: raise youth and community awareness of common mental disorders (with a focus on depression); improve mental health literacy; increase demand for and access to adolescent mental health care; develop and embed an integrated pathway to mental health care across health and education sectors; and build the capacity of community-based health providers to assess, diagnose and effectively treat adolescent depression.

FRI builds the capacity of African radio stations to produce informative and entertaining radio programs for farmers. This approach was adapted to produce engaging, participatory weekly radio programs for teens. Dr. Kutcher worked with local mental health experts in each country to adapt training programs he had developed for use in Canada to help primary care providers diagnose and treat depression in young people, and to help teachers deliver mental health literacy interventions in schools. Along with TMH's existing educational materials, the project team created an integrated Pathway Through Care model adapted for implementation in Malawi and Tanzania, in collaboration with local experts. This consisted of three components:

1. **A national radio campaign combined a weekly soap opera with music, celebrity interviews, and discussions. The serialized soap featured key topics relevant to teenagers, including pregnancy, depression, suicide and rape. The radio program also hosted a weekly phone call with different local experts. Young people could call in to ask questions or anonymously discuss personal problems, and these Q&As were also aired over the radio.**

2. **Teachers were trained in a school-based mental health literacy curriculum and used this to in turn teach students about mental health and mental disorders. The program also encouraged schools to set up mental health clubs to listen to the radio program together and discuss the**

topics presented afterward. Teachers were taught how to identify young people with probable depression and how to facilitate referrals to local health care providers who were trained to address this need.

3. **To tackle the demand for services created by these awareness campaigns, the program also trained primary healthcare providers in community clinics to identify, diagnose and effectively treat adolescent depression using a specifically designed psychological intervention called Effective Helping and to correctly use appropriate medications if necessary.**

The support of government was critical to the success of the program. Fortuitously, when the project team began working in Malawi, the Non-Communicable Diseases Unit (NCDU) within the Ministry of Health was in the process of revising their Mental Health Action Plan. A good fit between the goals of the Canadian intervention and those of the NCDU enabled close government involvement in all aspects of the development and implementation of the program. Concurrently, the government's plan – which had not previously addressed young people as a demographic – harnessed Canadian expertise in policy development, and was modified and expanded to address the mental health needs of adolescents.

The mental health lead within the Ministry of Health, Michael Udedi, quickly became an effective champion for the program and took on a national leadership role. Udedi not only provided a link to the Ministry but also maintained a key 'hands-on' role: he led the development of a National Training Team; provided expertise for the adaptation of Canadian training programs and educational materials; assisted in establishing collaborations with community-based health care providers; oversaw the delivery of training programs in clinics and schools; led the embedding of training programs into nursing institutions; oversaw regulatory and ethics applications; and helped write relevant papers for academic publication.

Students at a secondary school in Meru,Tanzania explain their hopes and fears to radio drama writers. © 2014 Heather Gilberds, Farm Radio International.

With Udedi's help, and with local expertise and support provided by Farm Radio Trust Malawi and World University Services Canada (Malawi), the project team worked hard to meet regularly with policy-makers and make necessary and ongoing adjustments to the project plan. Farm Radio Trust Malawi played a key role in developing and maintaining this work. This collaboration even included the National Training Team members reviewing the radio drama scripts and school curricula, as well as meetings with key program staff and radio program developers.

"With Udedi's help, and local expertise and support provided by Farm Radio Trust Malawi and World University Services Canada (Malawi), the project team worked hard to meet regularly with policy-makers, and make necessary and on-going adjustments to the project plan."

In Tanzania, the work took a different approach. Knowing that Tanzania's mental health plan was also under revision, Tanzania Farm Radio Program Manager, Godlove Nderingo, attempted to set up a meeting with the Director of Mental Health Services. After numerous phone calls and multiple cancelled meetings, Nderingo travelled to Dar es Salaam and waited outside the Director of Mental Health Services' office until he would be seen. He did this for 22 hours across three consecutive days before he was invited in for a meeting.

The senior bureaucrat who met with Nderingo was near retirement, but saw collaborating with the Tanzanian FRI office and the Canadian team as an opportunity to leave a legacy before his departure. He agreed to help implement the intervention with the support of the Ministry of Health. Again, as in Malawi, key government officials became part of a National Training Team, co-led by a psychiatrist and psychologist who took on essential roles in the program's development, application and evaluation – including helping to write manuscripts for academic publication. Similar to Malawi, the Ministry of Health in Tanzania was preparing to update their mental health policy, and as a result of this intervention, there was an invitation to bring Canadian expertise to assist in the process of formulating policy change. Numerous components of the intervention are now being considered for inclusion in the updated policy.

Result

In both countries, key policy-makers not only supported the work, but also played crucial roles in promoting and enabling the implementation of the program. They also played key roles in changing existing regulatory processes to allow for the use of more appropriate treatments.

For example, the medication Fluoxetine is an effective treatment for depression in adolescents and is listed on the WHO's Model List of Essential Medicines. Despite this, the medicine was not available in either country and young people were being treated with other medications that lacked evidence to support their use. In Malawi, the project team worked with Udedi and the Ministry of Health to revise existing treatment guidelines to allow for the use of appropriate medications in the treatment of adolescents with depression. With this change in treatment guidelines, primary health clinics were obliged to procure the medicine, creating an accessible and effective treatment option for adolescents that was previously unavailable.

Similarly, in Tanzania, after working with the Director of Mental Health Services to champion the cause, and following the project team's state-of-the-art scientific review of the treatment of depression in adolescents, Fluoxetine's addition to the new Essential Medicine List is now moving forward. Including this medicine in the Essential Medicine List at the district-level is a vital step to ensure it is available free of charge to those who need it, thus reducing the burden of paying for effective treatment on local households.

The Canadian team and its local partners also acted as knowledge brokers for both the Malawi and Tanzania Ministries of Health at national,

local and district levels. By collecting data on multiple program activities as part of the research and evaluation of the various Pathway Through Care components, the program was able to inform the ministries of health about facilitators and barriers to youth mental health care provision at the community level, including but not limited to: mental health knowledge and stigma in youth and teachers; clinical competencies of community health care providers; number of referrals; number of young people screened and treated for depression at community clinics; health outcomes of youth treated; and changes in knowledge and attitudes resulting from exposure to the radio program. This data provided information about the treatment gap for adolescent mental health care and the effectiveness of the program, thus allowing the Ministries to decide which approaches to prioritize within their national mental health plans.

With consistent communication and management of activities by Heather Gilberds, and arising from the collaboration between the Canadian team and the ministries, Dr. Kutcher was appointed as a technical consultant to both ministries and is now assisting them in the further development of their national mental health plans. Another key and unexpected outcome was the identification of the need to provide training on adolescent depression to nursing students (who, when qualified, will provide the majority of community-based healthcare). At this time, initial application and evaluation of this intervention in select nursing colleges is underway.

Conclusions and lessons learned

Data analyzed to date (and some already published in peer-reviewed journals) indicates significant and substantial success at every level of the program – the radio intervention, the school intervention and the community clinic intervention. A number of factors were instrumental to achieving the support and involvement of the Ministry of Health in Malawi and Tanzania:

- **The project teams in each country were able to find champions within the respective ministries of health. These champions were instrumental in ensuring, first, the development, application and evaluation of the program, and, second, that country mental health plans and policies were informed and shaped by the work conducted as a result of the project.**
- **The project teams in each country were able to meaningfully involve key decision-makers as implementing partners from the beginning, collaborating with them to create plans and materials instead of directing how these were to be done.**
- **Serendipitously, in both countries, policy windows related to the development of national mental health plans were open, thus affording a unique opportunity to impact ongoing activities.**
- **The project had a strong foundation in evidence, and provided research and analyzed information in a way that was useful for government decision-makers.**
- **The ongoing collaboration between the project team and key government decision-makers led to the identification, development and implementation of program components that had not been considered in the original plan – for example, the training of nursing students, which is enriching the initial program and allows it to better fit country-specific needs.**

Sources

- 'How Farm Radio & Dr. Stan Kutcher Increased the Availability of an Essential Medicine in Malawi and Tanzania': Blog by Heather Gilberds. 11 January 2016. (accessed on 17th October 2016) www.grandchallenges.ca/2016/farm-radio
- 'Integrated mental health in Malawi and Tanzania': Web page on farmradio.org (accessed on 17th October 2016): www.farmradio.org/portfolio/integrated-mental-health-in-malawi
- 'An Integrated Approach to Addressing the Issue of Youth Depression'.Web page on mhinnovation.net (accessed on 17th October 2016) http://mhinnovation.net/innovations/integrated-approach-addressing-issue-youth-depression#.VtdbkPmLTIV
- Key informant interview and correspondence with Heather Gilberds, April and September 2016
- Correspondence with Stan Kutcher, September and November 2016

An actress records an episode of a radio drama in Malawi. © 2013 Stephen Sherman, Farm Radio International

Discussion

The six Stories of Change included in this report present a number of different pathways to success in policy engagement. While each Story is unique and takes place in a different context, it's useful to recognize the common attributes shared among them:

1. **The six Stories feature established organizations working in the development and delivery of low-cost, innovative mental health programs in low- and middle-income countries, where mental health policy is generally underdeveloped.**
2. **These organizations have all received Grand Challenges Canada transition-to-scale funding, which could affect the likelihood of successful policy engagement.**
3. **All of these organizations have received some technical assistance in stakeholder engagement, including face-to-face training and online resources offered by the Mental Health Innovation Network and the Overseas Development Institute.**
4. **Three of the six organizations have further hosted on-site stakeholder engagement workshops, providing more intensive stakeholder engagement support by the Mental Health Innovation Network and the Overseas Development Institute.**

The examples presented in this report do not describe policy engagement as a lucky coincidence. Rather, organizations were prepared and able to find opportunities for policy engagement based on knowledge and experience of the local political economy.

Through a review of these Stories of Change, eight themes have been identified that may help to describe factors of success in policy engagement achieved by one or more of the organizations included in this report. Further research would be needed to determine how the factors work together to achieve different pathways to success. These are (in no specific order): aligning with government priorities; involving key decision- makers early; providing high quality research; being a knowledge broker; making friends; finding champions; being flexible with your messaging; and finding policy windows.

1. Aligning with government priorities

All six Stories of Change involved policy engagement efforts that aligned with government priorities and were tailored specifically to the appropriate government level (municipal, county, or federal). For example, the Friendship Bench has worked closely with the Harare City Health Department since 2006 and has now succeeded in scaling up Friendship Bench services to 72 clinics in the city. Africa Mental Health Foundation first focused their advocacy for mental health service budget allocation at the national level. However, they realized that processes of government devolution required they instead work at the county level and tailor their ask for a single county's unique context. Similarly, the Quality Rights Gujarat program knew the State Government of Gujarat was seeking to improve quality of care in their hospitals and was able to demonstrate how their program would meet the needs of the government.

2. Involving key decision-makers early

Involving key decision-makers early was common to all the Stories of Change presented in this report. Farm Radio International sought the involvement of key Ministry of Health representatives at an early stage of development of their program in Tanzania. Their team was already working with the Non-Communicable Diseases Unit within the Ministry of Health to provide technical assistance for the revision of the National Mental Health Action Plan. Seeking out and involving key decision-makers requires persistence, as evidenced by Farm Radio International's Program Manager who waited in the Ministry of Health for more than 22 hours over three consecutive days before he was invited in for a meeting with the Director of Mental Health Services.

In other Stories, relationships with key decision-makers had been built over time. The Friendship Bench and Quality Rights Gujarat had long-standing relationships with their respective Ministries of Health and were able to tailor their policy engagement efforts by drawing on their understanding of the decision-makers' needs.

3. Providing high quality research

These Stories of Change describe the actions undertaken by research organizations, and public sector institutions may look to these organizations to provide the evidence for implementing new interventions. For example, the Human Development Research Foundation's high-quality research provided the data needed to

convince the Minister of State and Chair of BISP that their intervention was able to identify children with developmental disorders faster and more economically than the standard approach at the time. The MAC-FI research project, based in Vietnam, benefited from a local culture of evidence-based policy-making. The researchers understood that the coalition of stakeholders were eager to partner with the expertise of Simon Fraser University because the government preferred working with coalitions supported by strong academic institutions.

4. Being the knowledge broker

Organizations can leverage their knowledge to better support government partners. Key to this is the ability to transform that knowledge into something usable for the government. The African Mental Health Foundation and Farm Radio International acted as knowledge brokers for their respective Health Ministries. In Malawi and Tanzania, the Health Ministries did not have any mechanisms to collect monitoring data on training competencies, number of mental health referrals, number of young people screened for depression at community clinics, or health outcomes. Through their program, Farm Radio International were able to provide this information to inform the Health Ministries about facilitators and barriers to youth mental health provision at the community level. Similarly, the African Mental Health Foundation collected data on patient access to mental health services and used this to strategically communicate the treatment gap present in the county in which they were working.

5. Making friends

There are multiple examples within the Stories of Change presented in this report where building friendly relationships has been instrumental in gaining access to decision-makers. As a member of the policy group appointed by the Government of India to draft the new Mental Health Care Bill, the lead of Quality Rights Gujarat met Gujarat State's Nodal Mental Health Officer, who was keen on implementing quality improvements as a priority for the health sector. It was through this connection that they were able to develop a "management team" to ensure buy-in from hospitals for the Quality Rights innovation. Similarly, the lead of the Friendship Bench was able to leverage his position of respect and trust with the Ministry of Health built through previous work—for example, on the National Mental Health Plan— to gain buy-in to scale up the Friendship Bench to 72 clinics in Harare.

6. Finding champions

In the context of policy engagement, a champion is defined as someone who understands how the internal system works and who supports the progress of a particular program or initiative. There have been several instances in the Stories of Change presented, where organizations have either proactively or unexpectedly found a champion. Farm Radio International demonstrates how an insider champion can help to promote an enabling environment for the implementation of a program. In Malawi, Farm Radio International created a relationship with the Ministry of Health's mental health lead, who took on a national leadership role. This was a young bureaucrat who was determined to leave a lasting impact. He assisted in establishing collaborations with community-based health care providers, oversaw the delivery of training programs and led the embedding of training programs into nursing institutions, oversaw regulatory and ethics application, and wrote relevant papers for academic publications. Likewise, in Gujarat, a champion was identified who was keen to implement human rights principles within the State's hospitals and championed the project with senior officials.

7. Being flexible with your messaging

Innovation in mental health often requires multi-sectoral approaches, requiring that messages be tailored to decision-makers with very different priorities. For example, the Africa Mental Health Foundation worked hard to gain an audience with Makueni County's Health Ministry to advocate for a portion of the health budget to be allocated to mental health care. AMHF had a series of meetings with county health officials, first starting with directors before progressing with the Minister of Health. Working with the Minister of Health, they were able to get the message across that, by investing in mental health, it is possible to support citizens to return to work. As poverty reduction was a priority of the government, it was important to link investment in mental health

with an increase in workers' productivity. Similarly, the Foundation sought to capitalize on their existing and long-standing connections to scale up the FaNs for KIDS program, and considered how they might package the program to different potential partners. Initially planning to package it as a women's empowerment program, they reconsidered this approach after an audience with the Minister of State and Chair of the Benazir Income Support Programme, focusing instead on the ways in which FaNs' could improve service delivery to underprivileged rural populations.

8. Looking for policy windows

Policy windows are opportunities for policy change that occur when a potential policy solution and problem are aligned. It takes a skilled policy entrepreneur to be able to spot oncoming trends and prepare for future policy windows, but they can also occur spontaneously. For example, Africa Mental Health Foundation had been advocating for a national mental health care budget for years. A policy window opened up when the country's governance system was devolved to 47 counties. As a result, 47 Health Ministries around the country needed to redefine their health budgets. Using the Foundation's old contacts in Makueni County, they were able to gain an audience with decision-makers at the county level and successfully lobbied for the allocation of funds to mental health at the county level, an ask which had previously been ignored at the national level.

Farm Radio International intentionally chose to implement their program in countries that were in the process of revising their national mental health plans. By pursuing this policy window, they were able to implement their intervention "Pathway Through Care" with the support of the Ministry of Health.

Conclusion

Mental health remains one of the most underdeveloped areas of research and policy in low- and middle-income countries. In recent years, researchers from low- and middle-income countries have contributed only 5% of the international research literature on mental health . As of 2014, 10% of the world's countries had no national mental health policy or plan at all .

Researchers and policy-makers must work together to ensure that the scarce resources available for mental health are leveraged effectively—first to develop practical, evidence-based innovations that address the most pressing needs in the local context, and then to take these innovations to scale in order to maximize their impact. But policy engagement can be a daunting exercise, and mental health researchers may not know where to begin or how to strengthen existing efforts.

This report aims to inspire those who are hoping to inform policy through their work, by presenting six recent Stories of Change that illustrate a variety of different strategies which have proven successful in low-resource settings. There is no one-size-fits-all solution, but readers should be heartened to learn that there is a global community of like-minded innovators struggling—and often succeeding—to change policy, who are willing to share their experiences and learning. As the Hema proverb states: Wisdom is like fire—people take it from others.

Sources

- Global mental health from a policy perspective: a context analysis. Jessica McKenzie. Overseas Development Institute. 2014
- Barriers to improvement of mental health services in low-income and middle-income countrie. Saraceno, Benedetto et al. (2007). The Lancet, Volume 370 , Issue 9593 , 1164 – 1174
- The 10/90 divide in mental health research: Trends over a 10-year period. Saxena S, et al. (2006). British Journal of Psychiatry 188, 81-82
- World Health Organization. WHO mental health atlas. WHO, 2014

Mental Health Innovation Network

The Mental Health Innovation Network is a community of mental health innovators-researchers, practitioners, policy-makers, advocates, and funders from around the world - sharing innovative resources and ideas to promote mental health and improve the lives of people with mental, neurological and substance use disorders.

mhinnovation.net

(Cover photo) Jamila, a 10 year-old girl with Down Syndrome, lies on a floormat in East Java, Indonesia.
© 2013 Jefri Tarigan, Courtesy of Photoshare