Mental Health Service Scale Up in Nigeria – mhSUN

3 YEAR PROJECT PLAN

a.1 *Provide a short description of the (proposed) project*

This project is designed specifically to provide credible evidence and impetus for scaling up mental health services in Nigeria, particularly through Government structures. The project aims to both have an impact on poverty arising from mental illness in the two intervention States (by improving access to mental health services), but also to build on this experience by creating a strong case for scaling up services based on the results. It is hoped that this will provide the FMOH with the tools it needs to defend budgetary allocation to scale up services more widely. This is particularly timely as the Federal Ministry of Health recently adopted an updated and progressive Mental Health Services Policy, and a Plan for mhGAP implementation.

The first aspect will be achieved through a participative process at State level to develop a practical model of service provision based on current best-practice guidelines and local experience. Almost all the current expertise in the country lies in the tertiary institutions. However, according to the Mental Health Policy (2014), services should be at PHC level, so State and Local Government are essential partners in this process. A steering committee in State will ensure smooth roll-out of the service model that is developed, as has been done in other State programmes.
The evaluation of the two State model programmes will look both at process indicators (how the service works and why some aspects may need adjustment) and costed outcomes. This will result in conclusions that can be clearly communicated to Federal Government, and professionals in other States contemplating mental health reform.
Several key components are therefore included to achieve this; participation of key decision-makers at all stages, use of current international evidence-base in model design, research-standard evaluation of models, dissemination of outcomes with practical policy briefs.

a.2 *Name, office address, phone, fax, e-mail of the partner organisation legally responsible for the (proposed) project as well as contact person.*

WHO Collaborating Centre for Research and Training in Mental Health, Neurosciences and Substance Abuse, Department of Psychiatry, University College Hospital, Ibadan, Nigeria.

Contact Person: Professor Oye Gureje
Email: ogureje@comui.edu.ng
Phone: +234 80 33 464 284

a.3 Name, designation, role of the person in charge of the project.

Oye Gureje. Professor at University of Ibadan

SECTION B: Partner Organisation, Project Management and Structure

Please answer the following questions about the management of the project, in particular previous experiences and available capacities.

b.1 *Describe the management structure of the (proposed) project and indicate how the project is embedded in the overall organisational structure (include an organisational chart, Annex 1).*

Department of Psychiatry, University of Ibadan will co-ordinate the project, build capacity of the leaders and train the trainers for mhGAP and will also participate in research M&E and model development. They will also liaise with international academic partners such as London School of Hygiene and Tropical Medicine and King's College London, who will provide technical support in research and M&E.

The Federal Neuropsychiatric Hospitals Kaduna and Calabar are the implementing institutions. They will lead the model development and integration into State and LGA structures and will be responsible for M&E data collection.
The Federal Neuropsychiatric Hospital, Aro will be advise on model development and M&E.
The Federal Ministry of Health (FMoH) will be the target for advocacy for scaling up of services and host the 6 monthly National Mental Health Action Committee meetings.

CBM mental health advisors will provide technical support in model development, research, M&E, advocacy and inclusion.
The CBM Global Advisor Dr Julian Eaton will be the lead on the research aspects of the project.

The CBM Nigeria Country Co-ordination Office will support University of Ibadan in co-ordination of the programme. It will be responsible for capacity building, receipt and disbursement of funds for activities to UI, and receipt of report from the partners, verification of same and transmitting to CBM Australia.

b.2 *Describe the partner organisation's mandate, including current programmes and key activities*

The University of Ibadan (UI) is a tertiary institution, owned by the Federal Government of Nigeria, with the mandate to provide training at both undergraduate and postgraduate levels, conduct research, and provide public service. The first University in the country, UI has faculties in Medicine, Arts, Social Science, Science, Engineering, and Law as well as several Institutes. The WHO Collaborating Centre of the Department of Psychiatry has a long record of multi-site programs of research and collaborations. In partnership with the WHO and the Federal Ministry of Health, it has recently conducted a 3-year program of mental health service development in the State of Osun, funded by the European Commission, in which the mhGAP related activities

were implemented. Since 2010, in partnership with the CBM and other institutions, it has implemented the Mental Health Leadership and Advocacy Programme consisting of capacity building and mobilization of the civil society in the five Anglophone countries of Ghana, Liberia, Nigeria, Sierra Leone and The Gambia.

The Federal Neuro-Psychiatric Hospital, Kaduna was established as a tertiary mental health institution in 1996. The core mandate of the institution is provision of Tertiary Mental Health services; Training of Doctors, Nurses, Community Health Officers, Community Health Extension Workers and other personnel in Mental Health related fields; Conducting research in mental health related fields.
FNPH is strategically located in Kaduna metropolis, and has the eight states (Kaduna, Kano, Kogi, Katsina, Niger, Benue, Nasarawa, and Jigawa) and the Federal Capital Territory, Abuja, as its catchment area for the execution of its mandate.
The hospital is a 200 Bed capacity hospital with 10 consultant psychiatrists, 40 resident doctors, nurses, psychologists, social welfare officers, counselors, occupational therapists and other mental health personnel. Treatment services include Out-patient and In-patient facilities, and Outreach mental health services that extend to neighboring states. As well as General Psychiatry, the hospital offers Geriatric Psychiatry, Forensic Psychiatry, Child and Adolescent psychiatry, Alcohol and Substance use treatment and rehabilitation (in collaboration with UNODC and the Society for Famil t Health), and Emergency Psychiatry. Community Psychiatry is an area the hospital is keen to expand through an existing collaboration with Kaduna State Government with the aim of integration into Primary and Secondary Health systems. Other collaborations include with the Society for Family Health (SFH) on provision of Specialized Substance abuse management services for Most At Risk Persons (MARPs), Training of Community Health workers on detoxification. The hospital has been designated a model treatment center for the country and a training hub for alcohol and substance use treatment as well by the UNODC, and collaborated with the Meriden Family Programme of Birmingham and Solihull Mental Health NHS Foundation Trust/Commonwealth Scholarship Scheme, UK.

Federal Neuro-Psychiatric Hospital, Calabar was founded in 1903 to provide mental health services under the old Southern Protectorate of Nigeria. Now designated as a Federal specialist hospital, services are provided for the South-South Region. In addition to providing tertiary inpatient and outpatient care, the hospital trains psychiatry residents, and provides clerkships for medical and nursing students.

In recent years, there has been an increased focus on innovative community mental health approaches in collaboration with the Cross River State Government. This includes supporting decentralised outposts (integrating mental healthcare in general hospital settings to improve access to care), prison mental health, school-based mental health literacy programmes (with the School of Psychiatric Nursing), and research related to these fields.

b.3 *What is the organisation's professional and administrative capacity (total number of staff, position and professional qualifications of project staff members) related to the (proposed) project?*

Project Co-ordinator /MH Specialist at Ibadan - 0.5 FTE
Project Supervisor - Ibadan: Full time
Project Supervisor - FNH Kaduna: Full time*
Project Supervisor - FPH Calabar: Full time*
Research/M&E Officer - FNH Kaduna: Full time*
Research/M&E Officer - FPH Calabar: Full time*
Project Administrator/Finance Officer - Coord Office Kaduna Full time*
Project Administrator/Finance Officer - Coord Office Calabar Full time*
Consultant Psychiatrist - Uni Ibadan: Project oversight*
Consultant Psychiatrist - FNH Kaduna: Pilot oversight*
Consultant Psychiatrist - FPH Calabar: Pilot oversight*
Driver for Calabar model implementation - Full time*
Driver for Kaduna model implementation- Full time*
* These staff are seconded by their respective hospitals and paid a monthly allowance by the project

b.4 Which additional managerial and technical capacities need to be built to ensure a successful implementation of the (proposed) project?

- Leadership skills – through the mhLAP course and support of CBM Advisors and mhLAP Director
- Reporting skills – for CBM CO and partners, through Project Research Lead/PI and CBM Country Co-ordination Office

Section C: Project Context[1]

Information on the Catchment Area:

c.1 What is the catchment area (geographical scope).

The catchment area consists of:
Ibadan, Oyo State (South West zone) is the base for the project co-ordination and lead research partner.

Kaduna, Kaduna State (North West Zone); and Calabar, Cross River State (South-South zone). These are the areas where we expect to see (and measure) impact in terms of our service user target group. These two were deliberately chosen to reflect the (North/South) diversity in Nigeria.

[1] Reference CBM Project Cycle Management Handbook, Chapter 1 "Pre-Project Analysis"

Abuja (The Federal Capital Territory) is the main catchment area for our advocacy aims towards increasing political commitment and financing for wider scaling up

c.2 *What are the conditions in the project area? Please specify the geographic characteristics and other relevant influencing factors like transport, influencing cultural and political issues as well as existing services, relevant for the (proposed) project*

Nigeria's huge population, high levels of poverty and illiteracy, and weak health, education and social sector infrastructure, present a big challenge for provision of health care generally, and mental health care in particular. Despite the official national policy of delivery through primary health care, this level of health service is very weak, and there is almost no mental health human resource capacity or provision of essential medication at the level of care. Modern mental health services at present are only available at specialist hospitals (Federal Neuropsychiatric Hospitals, University Hospitals, and a few Federal Medical Centres). These number around 30 in total (for a population of 174 million people), and are all based in large cities. This is reflected in the fact that currently all the small resources (About 3.3% of the health budget for Nigeria) is distributed through Federal Government institutions. This lack of local availability of care compounds the fact that people with mental health problems often do not access services as they are socially marginalised, have high rates of poverty, and tend to use traditional or religious options first due to popular beliefs about causation of mental illness.

Mental illness, principally through lost income from unemployment and health care costs, exposes people to poverty[2]. There is also evidence that carer burden leads families and wider communities to be exposed to poverty through this route. Compounding this, poverty is a strong risk factor for mental illness.

There has been a significant increase in interest in mental health in Nigeria, both by NGOs and Government sectors, over the last 10 years. This is why we have identified this time as providing an exciting opportunity to advocate for substantial extra investment by the Government of Nigeria and external donors;
- The WHO has identified Nigeria as a priority country for roll-out of its flagship mhGAP programme in Africa,
- the result has been increased prioritisation of MH by the Government, with several new programmes now under way, most integrated with Government services.
- Partly through successful advocacy by the partners in this proposal, and the work of MHAC, a Policy and Strategic Plan for mhGAP implementation was launched in 2013
- FMOH now encourages Federal tertiary hospitals to support decentralised services, and there has been significant new investment
- A dedicated desk officer for mental health was recently appointed for the first time in many years

[2] Patel V & Kleinman A. Poverty and common mental disorders in developing countries. *Bull World Health Organ* 2003; 81(8), 609-615

This strong bi-directional relationship is well demonstrated in research in Africa[3]. This research is also starting to show that mental health interventions are associated with improved economic outcomes and improved economic status is associated with reduced clinical symptoms, creating a virtuous cycle of increasing returns[4]. Enabling better access to psychiatric services will lead to a reduction in days out of role and in catastrophic health care costs, both of which will reduce the risk of poverty, and the likelihood of benefitting from means of escaping from poverty.
It is a crucial time for MH work in Nigeria, and this programme will help ensure that sound evidence and best practice are integrated into the emerging services.

The target States have been chosen because the leadership of their specialist hospitals have already demonstrated a commitment to scale up services by supporting secondary and primary care initiatives. In fact, the specialist hospitals provide quality care, but are limited in their scope to in- and out-patient services in large cities. The partners in this project have started to extend their historic role to close some of the treatment access gaps using innovative approaches. At present, only around 10% of people with mental illness currently receive the treatment they need. These hospitals do this despite little official central budgetary support. This project will develop advocacy tools for increased resources to support this direction of service reform, by providing a strong example of proven impact with a generalisable model.

c.3 *Please specify the relevant socio demographic data including 1) total population in the area, 2) gender and age distribution, 3) population growth rate, 4) percentage of population below the poverty line (<1 US Dollar per day), 5) life expectancy, 6) prevalence of impairments and disabilities and 7) major forms of income, 8) for education projects provide net. primary school enrolment/attendance.*
See attached table.

Nigeria, under the Economic Community of West African States (ECOWAS), covers a total area of 923,768 sq. km (land 910,768sq. km, water 13,000sq. km) and has a total population of is 174,507,539 (2013 est.) with population annual growth rate of 2.5%. At present; 44% of the population is 15 or under[5].

Kaduna State has a population of 6.1 million while Cross River State has a population of 2.91 million.

Nigeria has a life expectancy at birth of 52.46 years (males 49.35 years and females 55.77 years). 63% per cent of the entire population live below poverty

[3] Lund C, De Silva M, Plagerson S, Cooper S, Chisholm D, Das J, Knapp M, Patel V. (2011) Poverty and mental disorders: breaking the cycle in low-income and middle-income countries. Lancet 378:1502–14
[4] www.PRIME.uct.ac.za
[5] World Population Data Sheet, 2012. Population Reference Bureau

line of USD1 per day (DFID). Health expenditure is 5.31% of GDP (2011) 3.3% of this goes to mental health.

c.4 *What are the main governmental policies and strategies (including Poverty Reduction Strategies and Debt Relief programmes) relevant for the project? What is their impact on the project?*

Through the work of the national Mental Health Action Committee (MHAC over several years, the government has been reviewing the 1991 mental health policy responsible for regulating the practice and management of mental health in Nigeria. In August 2013 the National Council on Health adopted the updated Policy. The new policy is progressive and practical, drawing heavily on WHO guidelines and recommendations. In fact, accompanying the updated Policy, there is a national Implementation Plan for mhGAP (both are attached as annexes to this document). These developments should enhance the provision of access and appropriate care for people with psychosocial disability and make adequate provisions for its implementation in the health budget.
The policy stipulates that treatment of mental disorder should be at the Primary Health level. It seeks to reduce the disability associated with mental illness through the bridging of the treatment gap, promotion of the human rights of patients with mental disorders, and reduction in the level of stigmatization of mental illness. All these aspects are in line with the content of this proposal.

SECTION D: Situation Analysis

Problems and Needs in the Catchment Area

d.1 *What specific problems does the proposed project plan to address? What are the root causes? Please specify the magnitude of the need using statistical information.*

Mental disorders are among the most disabling health conditions in the world. Mental and substance use disorders constitute the single largest burden of Years Lived with Disability of any condition (22.9% of the total, compared to 2.8% for cardiovascular and circulatory diseases) and are the leading cause of Disability Adjusted Life Years (DALYs) worldwide, accounting for 37% of healthy life years lost from Non Communicable Diseases (NCDs)[6].
Among factors contributing to this high level of disability attributable to mental ill health are; high prevalence rates of many mental illnesses, their long-term nature (chronicity) with onset at an early age, and high mortality (people with schizophrenia die on average 15 years earlier than contemporaries).

[6] Whiteford H, Degenhardt L, Rehm J, Baxter AJ, Ferrari AJ, Erskine HE, Charlson FJ, Norman FE, Flaxman AD, Johns N, Burstein R, Murray CJL, Vos T. Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *Lancet* 2013. 10.1016/S0140-6736(13)61611-6

Compounding this in lower income countries is the huge treatment gap that exists, the often poor quality of services that persons with mental disorders receive, social exclusion and discrimination, and the abuse of the human rights of such persons. While poor access to services is a problem worldwide, it is particularly large in low and middle income countries. For example, 80% of persons with severe mental disorders in Nigeria do not receive any treatment. Among the few who receive any treatment, only about 10% get what can be described as minimally adequate care and it takes about 6 years on average between onset of illness and the receipt of care[7].

Direct Stakeholders (Target Group)

d.2 *Which specific groups will benefit directly and indirectly through the proposed project activities? Please specify their socio demographic and economical characteristics and location*

Direct Stakeholder:

40 mental health leaders (mental health professionals, Ministry planners, senior health service management staff) will have improved public mental health and research knowledge and skills

10 master trainers who will gain skills to train mhGAP (within and beyond this programme) – in association with the mhLAP programme

100 district and PHC health service personnel who will receive training in delivery of evidence-based mhGAP package of care (followed by regular refresher training and supervision).

Indirect Stakeholders:

- Leaders and planners in the Federal Ministry of Health (and in Ministries of Health in Kaduna, and Cross River States) will be recipients of targeted advocacy for service reform and increased prioritisation for scale up.

- Persons with mental conditions will receive evidence based care in centres closest to their places of abode in the two intervention states. Ultimately (after this specific project time-frame) this will also apply to people requiring services in other parts of the country.

Please specify whether the project specifically targets women and children and why.

Women are more likely than men to develop mental health problems (for example the rates are twice as high for depression in women), but they are much less likely to access services, especially when these services are far away and expensive. As well as some biological risk factors, women are at higher

[7] Gureje O. Psychological disorders and symptoms in primary care. Association with disability and service use after 12 months. Soc Psychiatry Psychiatr Epidemiol 2002; 37(5):220-224.

risk due to disproportionate unpaid workload, greater exposure to violence and coercion, and less access to the protective factors of education, paid work and political decision-making. One focus of the project will be increasing awareness around mental health of women (particularly through services for mothers during pregnancy and after childbirth), and finding innovative ways of increasing their access to services.
The specific needs of children (eg focus on mental health promotion, school-based activities, epilepsy) and young men (high risk of alcohol and drug use, drug induced psychosis, and suicide) will also be considered in the model service development.
People with other disabilities are also often excluded from services. During this programme, CBM will support the implementation of disability inclusive approach to ensure that people with other forms of disability (physical or sensory, who are also at a higher risk of mental health problems) can also gain access to mainstream services that can meet their particular needs.

d.3 *Has the target group been involved in the identification, planning and implementation of the project? If so, in which way? In which way does the target group contribute towards the project[8]?*

In keeping with the procedures that flow from CBM's partnership principles, the local partners have participated throughout the project design process, as well as having had a long-term relationship with CBM over many years. The conception of the idea came from discussions around identified gaps in the overall process of scaling up mental health services in Nigeria, namely, the barrier presented by lack of financial resources having reached a point of improved understanding of ways to address the mental health treatment gap in Nigeria. The partners represent organisations charged with providing mental health services, but where the professionals recognised the need to move beyond historical models of large institutions providing care to only a tiny minority of those in need. This realisation came in part from significant shifts in international guidelines and evidence-base, advice from the WHO (who have been working with the Federal Government and leading Nigerian experts for several years now), and the result of several years of gradual education of mental health leaders in Nigeria (including through the Leadership course of one of the partners; University of Ibadan). The overall reform process, with several pilots already under way, therefore started about 5-6 years ago, with this particular idea being formalised about 3 years ago.
The process was co-ordinated by the CBM Country Office in Nigeria, mainly by the Regional Mental Health Advisor, and the Nigeria Mental Health Advisor. This was initially through individual visits to partners (with whom CBM already has existing projects) and email, but later with joint meetings of partners to finalise technical and organisational details. The end beneficiaries (people with mental health problems, and those participating in mental health services)

[8] A contribution of the target group towards the project could e.g. be the provision of service fees, involvement in a CBR project as volunteers, etc.

have been important stakeholders in related projects that have preceded this proposal development, for example a current project at the University of Ibadan has developed a national stakeholder council who participated in national policy and legislation reform, and Kaduna Neuropsychiatric Hospital has been training nurses who now deliver services in Benue State through a separate CBM-partnered programme.

Involvement of other Stakeholders

d.4 *What skills, resources and capacities will the local community bring to the project? How will the local community be involved in the design and implementation of the (proposed) project?*

In the two sites for practical implementation, a mental health stakeholder committee will be established, with membership including important representatives of the local communities (existing service users, family members/carers, community leaders, as well as professionals). They bring relevant knowledge of the local communities, including the context in which mental health care service is delivered or absent. The knowledge and skills are important in delivering the project in a culturally sensitive manner. These stakeholders will be active partners in the planned workshops that will precede the project implementation during which detailed project design will be developed and strategies for implementation drawn up.

d.5 *Who are key stakeholders relevant for the project (national and international partners, local authorities, DPOs, other (I)NGOs or specialized organisations and service providers active in related areas).*

- Federal Government of Nigeria through the Federal Ministry of Health (and its agencies such as the National Primary Health Care Development Agency, Department of NCDs etc)
- Federal Neuropsychiatric Hospitals; Calabar and Kaduna (and Aro in an advisory role)
- University of Ibadan Department of Psychiatry and WHO Collaborating Centre
- Cross River and Kaduna States Governments and Local Government areas in the two states
- Ministries of Health, Women affairs and Justice in the implementation states.
- Local Government Service Commissions in the implementation states
- Joint National Association of Persons with Disability

d.6 *What do they do to address the situation or need? How do they complement the activities of the partner organisation See stakeholder analysis Appendix 1.*

The three tiers of government and the health system leaders are the main duty-bearers for provision of first-line care. However, there are many gaps in

the care they provide, particularly at the lower tiers of the system. The recognition that there is such a dominance of expertise and resources at the specialist hospitals is the reason for the proposition to allow the Federal Hospitals to become hubs for supporting the secondary and primary structures local to them. This principle has been accepted at the NMAC level (including by the Federal Hospitals Management Board) and is the basis for this proposal.

There will be particular engagement with the two psychiatric hospitals in the states where we seek to reform services, to build on their existing efforts to reach out to a wider constituency than just providing inpatient care for a small proportion of those in need. Specifically, we will aim to channel their expertise and desire to have a wider impact by strategically designing and implementing (then measuring) outreach activities in the surrounding state and local government health systems.

d.7 *How will the project be integrated into / coordinated with government activities in the project area?*

The integration of the service development into the Government structures in the two pilot States mean that from the start, the design will be based on a service model that relies on existing human, financial, and infrastructure resources. One of Nigeria's great strengths is the quantity and quality of personnel in its civil service, and more efficient utilisation of this resource means that for relatively little investment, the outputs can be substantial. In our experience, government leaders are very willing to utilise staff in more effective ways. Our partners have committed staff time to this programme as their in-kind contribution. Similarly, buildings will be used with no cost to the programme.

In general, efficiency is one of the major benefits of the kind of service reform being proposed here. This is particularly the case at the point of use, i.e. community-based, decentralised services are much cheaper for service users and families – a major factor in increased service utilisation and improved outcomes. Task sharing to increase use of less highly qualified professionals is also an efficient way to deliver services.

Finally, the fact that this service is largely focused on advocacy for increased government resources for service scaling up, the DFAT funds are essentially priming a system for far larger potential release of funds than those invested here (both from traditional government budgetary allocation, and from external sources).

SECTION E: The Project Plan[9]

Existing Activities related to the Proposed Project

[9] Reference CBM Project Cycle Management Handbook, Chapter 2 "Project Planning"

e.1 *Describe the current activities of the partner organisation[10] to address the need and provide qualitative and quantitative information*

CBM and University of Ibadan run a leadership course in mental health (mhLAP – www.mhlap.org). The main thrusts of the mhLAP project since its inception have been 1) to build local capacity in mental health leadership and advocacy, and 2) to develop local groups with the knowledge and interest to champion country-specific goals of mental health development. The project has made remarkable success in both of these areas.
University of Ibadan Department of Psychiatry is a WHO Collaborating Centre, and runs a large number of research programmes, including multi-site international collaborations. They have a strong international reputation in this field, as well as being seen as a source of expertise by the Nigeria Government and local State Governments, particularly in mhGAP implementation.

Federal Neuropsychiatric Hospitals (such as in Aro, Calabar and Kaduna) are mandated to provide specialist tertiary psychiatic care, but the three in this partnership have already moved well beyond this in providing outreach services to local communities, practical training courses, and support for district and primary care services.

The Federal Ministry of Health both supervises the work of these tertiary Hospitals, and oversees overall policy and development in secondary and primary care (through the National PHC Development Agency). Recent years have seen a significant increase in interest in mental health which has resulted not only in the national Policy being adopted, but in official launch of the mhGAP implementation plan, and an increase in resource allocation and commencement of several mental health projects at this level.

e.2 *What lessons related to these activities have been drawn from past experiences? How are they incorporated in the design of the proposed project?*

The proposed project follows current established international best practice for achieving greater coverage of mental health care and reducing the treatment gap by scaling up services. CBM and University of Ibadan have both contributed significantly to this literature (including through other CBM Australia and DFAT-funded programmes)[11], as well as running and evaluating successful mental health programmes at State level in Nigeria (in Osun[12] and

[10] e.g. services in quantity and quality, ongoing community development / rehabilitation initiatives, prevention programmes, advocacy

[11] A: Jibril Abdulmalik, Lola Kola, Woye Fadahunsi, Emeka Nwefoh, Julian Eaton, Harry Minas, Oye Gureje. Mental Health Care in Anglophone West Africa. *Psychiatric Services* 2014

B. Abdulmalik J, Fadahunsi W, Kola L, Nwefoh E, Minas H, Eaton J and Gureje O. The Mental Health Leadership and Advocacy Program (mhLAP): a pioneering response to the neglect of mental health in Anglophone West Africa. *International Journal of Mental Health Systems* 2014, 8:5

[12] Abdulmalik J, Kola L, Fadahunsi W, Adebayo K, Yasamy MT, et al. (2013) Country Contextualization of the Mental Health Gap Action Programme Intervention Guide: A Case Study from Nigeria. PLoS Med 10(8): e1001501. doi:10.1371/journal.pmed.1001501

Benue States), which follow a similar model of integration into Government services as proposed here. The mhLAP has close links with leading international research centers (King's College London, LSHTM, Melbourne University). MH is a rapidly growing field of work for CBM internationally. Experience accumulated in Africa and Asia over the past decade strongly indicates that CMH services are successful in terms of increased economic participation by stabilized service recipients. CBM Community Mental Health Policy, Reference Plan, and practical Implementation Guidelines have been developed based on these experiences and taking into account WHO evidence-based guidelines and policies (which CBM has advised on since its inception). The National MH Action Committee has been at the centre of significant recent progress in Policy and Legislation development.
It is this success that we wish to capitalize on by strengthening their capacity to fulfill their mandate to translate policy into practice.

Project Plan for the Proposed Project

Overall Objective

e.3 *What is the overall objective (such as sectoral, regional, national or organisational strategies) to which the proposed project contributes? How does the (proposed) project relate to CBM supported global programmes*

To provide a strong evidence-base for the scale-up of accessible mental health services in Nigeria.

This is directly in line with the principles and recommendations of Nigeria Mental Health Policy, and the mhGAP guidelines to which it is aligned. The project specifically aims to generate the evidence for the successful implementation of this policy.
The project is also aligned with CBM CMH Policy, Strategic Framework and Guidelines, and is supported by the CBM Advisory structure. In addition, the key research questions in line with the priorities systematically identified in Grand Challenges for Mental Health process designed to guide investment in implementation science in global mental health[13].

e.4 *Which qualitative and quantitative indicators will measure the successful contribution of the proposed project towards the achievement of the overall objective?*[14]

Indicators
1. Population coverage by mental health services in 2 target states by 2016. Includes population coverage and quality domains.

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[13] Collins PY, Patel V, Joestl SS, March D, Insel TR, Daar AS. Grand Challenges in Global Mental Health. *Nature* 2011; 475(7354): 27–30
[14] Reference CBM Project Cycle Management Handbook, Chapter 2, sub chapter 2.5 "Defining and Setting Indicators"

2. % Fidelity to developed model for service provision (degree to which model design is implemented in practice)
3. Cost-effectiveness of services delivered in 2 pilot sites
4. Client satisfaction with services

Please see logical framework for details.

e.5 *Specific objective: Describe the specific problem to be addressed by the project and tangible benefits that can be expected by the implementation of the specific objective.*

The specific objectives are:

1) **To improve access to mental health services in two intervention states**
2) **To provide credible evidence and impetus for scaling up mental health services in Nigeria, particularly through Government structures, and communicate this clearly with advocacy targets.**

e.6 *Which qualitative and quantitative indicators will measure the successful achievement of the specific objectives?*

1. Population coverage by mental health services in 2 target states by 2016 (WHO Mental Health Observatory Method). Includes population coverage and quality domains.
2. a. Production of Policy Briefs and an advocacy plan targeting Federal Ministry of Health and State Ministries of Health.
   b. Regular Mental Health Advocacy Meeting minutes (6-monthly)

Project Results

e.7 *Describe the results needed to obtain the specific objective*

Result 1: Training of Mental Health Leaders; 40 mental health leaders (mental health professionals, Ministry planners, senior health service management staff) who have completed training that includes the recent developments in global mental health, skills for implementation of mental health services in Low income country contexts, and improved research capacity

Result 2: **Implementation of model services in 2 intervention states;** 2 pilot programmes complete (one in the North, and one in the South). These will be based on the preferred FMOH model, carefully designed in a participatory process.

Result 3: **Model outcome evaluation, reporting and dissemination of lessons learnt;** Rigorous model evaluation based on recognised methods for

evaluation of complex interventions. Generation of evidence for scaling up based on the results, and advocacy materials (Policy Briefs).

Result 4: Building research capacity in Nigeria and international collaborative networks; Improved alliances between Nigerian academic and clinical professionals with Global Mental Health Community, better capacity of Nigerian researchers, and improved quality of research

Result 5: Support of National Mental Health Action Committee at FMOH; Reinforcement of recently developed National Mental Health Policy with development of 5 year strategy based on pilot outcome through support of National Mental Health Action Committee.

Results 6: Provide a strong organisational infrastructure for successful implementation, financial management and reporting.

e.8 *How many people of the target group will directly benefit from the proposed project? Please specify the estimated maximum / minimum number of beneficiaries (men, women, boys, girls) per year during the lifespan of the project.*

We expect the number who will directly benefit to be between 10,000 and 30,000 (expected 20,000) previously untreated persons and between 20,000 and 60,000 care givers (expected 40,000) in the 2 intervention states over the lifespan of the project.

e.9 *Which quantitative and qualitative indicators measure the achievement of the project results*

See Logical Framework for indicators

A **cross-cutting** indicator is the number of women involved in each of the activities, especially in activities that involve planning and implementation.

e.10 *All services supported by CBM need to adhere to the CBM Quality Criteria of Success/Reference Guides.*

This project is closely aligned to both the CBM Community Mental Health Strategy and Reference Guide

Project Activities

e.11 *Describe in short the main activities of the project for the envisaged project period. Please take into account the cross cutting issues (e.18 - e.24).*

Result 1: Training of Mental Health Leaders;

1.1.1 Internal review of curriculum for relevance to Nigeria. Plan how will be delivered in course
1.2.1 Identification of appropriate attendees for course (from NGO partners, State and Federal Government). Invite through relevant structures. Aim is to identify people who will have an impact with the knowledge they gain (including in our project in our intervention states)
1.3.1 Liaise with mhLAP course organisers to facilitate logistics. Payment of fees, ensure space is available and that they communicate with attendees.
1.3.2 Conduct course for first 20 participants at University of Ibadan. Review relevance of course for first tranche of participants.
1.3.3 Conduct second course for 2nd 20 participants, incorporating lessons learnt from first course.

Result 2: **Implementation of model services in 2 intervention states;**
2.1.1 National workshop conducted with key stakeholders resulting in documented model for service implementation. Review of planned models by independent expert. 2 day event (combined with research protocol development meeting) held in first three months of project. Participation from all project partners, FMOH, and external experts.
2.1.2 Establish 2 State MH Stakeholder Committees to oversee implementation, evaluation and reporting of model. Steering committees regularly meet (minimum quarterly). Key stakeholders in each State briefed about project, and participate in model development and implementation. Committee also serves to engage with State officials and advocate for greater buy-in.
2.1.3 Liaison/advocacy with State and LGA governments, hospitals etc. Regular visits to State MOH and LGA Chairmen. Aim is to establish relationship and support for integration.
2.1.4 Print Nigerian contextualised mhGAP intervention guides. 200 copies of Guide that has been adapted and approved by FMOH (signed by Minister of Health)
2.2.1 Training of Trainers conducted (national) for 10 persons using mhGAP ToT materials and experience of University of Ibadan from their Osum State programme. Participants will be mainly from our 2 intervention States, who will carry out subsequent mhGAP training in this project.
2.2.2 Capacity building for task shifting model. 5-day standard mhGAP training CHO/nurses etc, details depending on exact model designed in Activity 2.1.1) – 50 persons trained per State (2)
2.2.3 Regular supervision from Federal Hospitals. Consultant and Resident Psychiatrists initially, and later trained senior psych nurses, will travel to identified sites for supervision, and support for challenging cases.
2.2.4 Regular 1-day refresher training (6 monthly) for trained PHC staff (ie those who attended the first mhGAP training). This is part of the routine mhGAP training process, and will help to maintain motivation.
2.3.1 Planning and advocacy for integration of MH into health management information system. This will involved developing forms that improve on the current recording of mental health in State systems and piloting them, while advocating for formal integration.

2.3.2 Planning and advocacy for ensuring access to medication. Medication is essential for quality services, but often not available. The model will probably start by using Fed Hospital structures, but in a fully integrated system, State and LGA structures should have meds available through routine medication procurement systems.
2.4.1 Awareness-raising in communities receiving services. It is well recognised that awareness-raising increases access to services. This will therefore be an essential component to these new services. Materials will be developed, and (probably by CHOs and nurses trained at LGA level) used in community awareness activities.

Result 3: **Model outcome evaluation, reporting and dissemination of lessons learnt;**
3.1.1 Research protocol finalised in advance of model implementation starting. This activity is carried out alongside the model development workshop, as it is necessary to have data collected from the very start of the pilot implementation.
3.1.2 Ethics approval agreed. This will be through University of Ibadan ethics review board, based on the protocol in 3.1.1.
3.1.3 Measures/tools identified and validated. Fidelity testing measure developed. This measures the extent to which implementation matches with designed ideal model.
3.1.4 Regular M&E and research visits conducted, collecting relevant data. Models modified if necessary based on feedback
3.2.1 Data management, cleaning, and analysis. Participation of a statistician is essential from the start of the research process. Proper design of statistical needs, and regular monitoring and management ensures that any gaps are quickly resolved.
3.2.2 Preparation of paper(s) for publication in peer reviewed journal
3.3.1 Results used for advocacy materials development/policy briefs, for use in planning for scaling up of services in Nigeria and other similar settings.
3.3.2 Presentation at MHAC, and relevant global forums at a special MHAC meeting at the end of the project (Act 5.3.4). Also presentation at international conference for dissemination purposes.
3.4.1 Initial M&E Planning meeting (2 days) facilitated by CBM, explaining and training partner project staff on reporting needs.
3.4.2 Joint M&E plan annual review meeting. This would ideally rotate between partners, and allow comparison of results and shared lessons
3.4.3 M&E Materials printing
3.4.5 Final independent evaluation by external consultant. Includes M&E results and monitoring of progress against activity schedule, and financial aspects, recommendations for improvement.
3.4.5 Technical and M&E visits by experts. Includes travel within Nigeria to visit projects for M&E by staff from the Ibadan Office; travel from CBM Regional Office to visit project; travel by CBM MH Advisor for Nigeria, and annual visit from international research collaborating partners

Result 4: Building research capacity in Nigeria and international collaborative networks;

4.1.1 Terms of Reference prepared for systematic review of current status of research in Nigeria. Report commissioned from competent researcher knowledgeable in systematic review methodology. Once complete, report shared with MH Action Committee, and once approved, disseminated further (Act 4.2.2). Maybe possible to publish this.

4.2.1 Terms of Reference prepared for analysis of views of experts (Delphi survey method). Survey format trialled and survey conducted by email.

4.2.2 Results of survey analysed and combined with systematic review to make recommendations for research capacity building in this project and beyond (this is a replication of a global exercise called 'Grand Challenges in MH Research', carried out in relation to Nigeria)

4.3.1 Development of workshop and workshop conducted by University of Ibadan with international resource persons, with clear plan documented for strengthening networks established at the workshop.

4.3.2 Networks strengthened through linking to online resources and email community (probably not development of new website as many exist).

Result 5: Support of National Mental Health Action Committee at FMOH;

5.1.1 Initial special MHAC meeting held within first three months of project. Report produced outlining current situation in Nigeria. Includes WHO, FMOH and civil society. Report findings and recommendations will form baseline for review in mid-term and final evaluations.

Meetings will be hosted by FMOH, but managed by University of Ibadan.

5.2.1 Organisation of logistics of regular (6 monthly) MH Action Committee meetings by FMOH/UOI team. Meetings held, minutes, and action points recorded.

5.3.1 Policy Briefs finalised and printed, distributed during enlarged meeting at end of project period (Costed under 3.3.1)

5.3.2 Travel for advocacy (National) for participation in specific meetings. ToRs written and reports submitted when specific meetings arise where there is benefit for project partners to attend to raise awareness about the programme, or further advocacy agenda.

5.3.3 Dissemination meeting for results of pilot site evaluations. To be held at end of project. Main opportunity to share findings and key messages of results and lessons learnt.

Results 6: Provide a strong organisational infrastructure for successful implementation, financial management and reporting.

6.1.1 Regular Steering Committee meetings held following up on recommendations of MH Action Committee and oversee project implementation. Members are all three major partners, plus CBM and invited others

6.2 Office running costs. Materials, travel and communication on three sites.

6.3 Recruitment and personnel development. Building capacity for good management and reporting.

6.4 Staff salaries and allowances. Most staff will be given allowances only which will establish norms for integration. Consultants have allowance for local technical support. 1 additional staff at Co-ordination office in Ibadan, plus 50% of MH Specialist (shared with mhLAP programme).
6.5 CBM Technical and Administrative support including work of Regional and National Mental Health Advisors, admin/finance support at Country Office

e.12 *Describe in short which steps and measures are taken to reach the poor by the proposed project.*

The activities to reduce treatment gap by bringing quality services closer to communities will significantly improve the opportunities for the poor to access them (compared to the need to travel to capital cities). There is evidence that mental health interventions can break the cycle of psychosocial disability and poverty (see footnotes 3,4 above).

e.13 *Are any research, studies or legal and/or technical preparations necessary before the planned project can be started? If so, will there be associated costs?*

- A significant amount of systematic review and Delphi research will be carried out in the initial stages of the project.
- There is a structured planning process to refine and adopt a consensus model for evaluation.
- The research component will have a development process for the research protocol.
- In addition, there are several opportunities for planning workshops with stakeholders to develop and refine the project proposal.

Risk Assessment and Assumptions[15]

e.14 *What are the potential risks that could jeopardize the success of the (proposed) project and how will that be managed?*

Explanation of Risk	***Potential impact*** High/Medium/Low	***Probability*** High/Medium/Low	***Mitigation measures***
External 1. Insecurity in Nigeria makes travel (eg for M&E) difficult. This is particularly true over the election period (Feb 2015)	Medium	Medium	Local partners involved in implementation will be less affected by this than international partners and outside monitors. Local partners are very capable of giving estimates of risk at any time visits are due, and can provide safety advice and support for visits. Can work around periods of short-term insecurity. Some aspects (especially those involving multiple partners and external input) can be done in Abuja

[15] Reference CBM Project Cycle Management Handbook, Chapter 2, 2.4 "Carrying out a Risk Analysis"

External 2. Increase in costs of basic goods/inflation (particularly fuel and can influence other products)	High	Medium	Fuel costs budgeted according to expected increase in fuel price. Average inflation in the previous 5 years has been 8%
External 3. Influential personnel in partners (all Government institutions) may be changed, and those replacing them may be less committed to the project.	Medium	Low	Involve as many relevant people in each partner as possible so that ownership is beyond individuals. Invest time with any new key staff in partners to ensure buy-in. Write Memorandums of Understanding committing partner institutions (rather than individuals) to collaboration for full project term. Project term is relatively short
Internal 1. Co-ordination across five partners who are widely geographically spaced.	Medium	Low	Clear reporting schedule Budget for routine M&E visits Regular joint activities throughout project period Mitigated by regular visits due to string evaluation/research component
Internal 2. Bureaucracy within partner institutions			There is a risk of delay in certain processes (eg ethics approval) within Federal Government institutions. Mitigated by involvement in this project of Federal Government at central level as well as leadership of Fed Hospitals Risk of unforeseen charges by institutions. We are already paying University of Ibadan, and will argue that it is not possible to charge twice for the same funds.

Expected Outcomes and Impacts

e.15 *What are the possible positive and negative economic and social implications of the (proposed) project for the target group or the project partner?*

Mainly through benefits of access to treatment and subsequent symptom reduction, leading to improved social integration and participation in economic life of communities. This will improve the economic opportunities of persons with mental health conditions as well as their social wellbeing and status.
There are no potential negative economic impacts that we can identify.
Self-identification as a person with psychosocial disability in self-help groups may carries a risk of subsequent stigmatisation, but this is also the only way of challenging such stigma.

e.16 *Describe the partner's strategies to reduce or minimise these negative economic and social impacts.*

All participants engaging in advocacy and anti-stigma activities, particularly as self-advocates, will be doing so with full informed consent. Persons with psychosocial disabilities will be encouraged to speak for themselves, they are the only people who can decide whether they want to disclose their status. Full confidentiality will apply to personal medical data in conformity with standard medical practice, and higher expectations of research ethics committees. All data communicated outside of medical setting will have personal identifying features removed.

e.17 *Which aspects / activities of the initiative will last beyond the end of the funding period of the project? Describe who will carry them out beyond the project. Which organisational capacities and processes (human resources, work processes, procurement, etc.) are being developed to carry them out?*

It is expected that the result of this scale up exercise will be used by the Federal Ministry of Health to scale up services in other zones in the country. The ministry is also expected to continue to fund the National Mental Health Action Committee meeting.

Generation of strong evidence is also attractive to external non-Governmental, multilateral and bilateral funders, increasing the opportunities for partners (and CBM) to raise funds from such sources for future work.

Mental Health Steering Committee in each state and Local Government area will be encouraged and supported to become autonomous bodies with full registration a non-governmental organizations.

Consideration of Cross Cutting Issues in the Project Design

Where relevant, describe how the design of the project addresses the following:

e.18 *Comprehensive approach towards disability:* What measures does the partner take to ensure a comprehensive (quality of life improving) approach towards disability?[16]

The objectives of reduction in treatment gap (translating to improved access to care) and improvement in quality of service (including promotion of human rights and autonomy of patients) provides a comprehensive approach to disability aimed at enhancing quality of life as well as promoting social and economic wellbeing. Many of the hospitals already include self-help structures in their services.

[16] The comprehensive approach to service delivery aims at the active establishment of service delivery networks in order to provide all necessary elements of care and rehabilitation according to the identified multiple needs of an individual.

e.19 *Accessibility of services:* Which measures does the partner take that the project services are accessible and affordable to the poor?

The objective of reducing treatment gap is to be implemented by building the capacity of primary care providers to deliver evidence-based service. Primary care constitutes the most accessible and affordable point of receiving mental health service.

e.20 *Advocacy for the inclusion / rights of persons with disabilities:* How does the project intend to advocate and raise awareness of the rights of persons with disabilities? Will any specific measures be taken to promote the inclusion of persons with disabilities into society?

The proposed project seeks to include users of mental health service and their caregivers in advocating for the protection of patients' human rights and reduction in stigma and discrimination. They will be members of the local MH Steering Committees.

e.21 *Gender:* How will the project create new opportunities for women and girls to expand their roles in the social and economic life of the local community? How will the project enable women to their status in the community?

Each Mental Health Steering Committee will be encouraged to have at least 3 women members and to develop a specific activity aimed at advocating for improved social and economic life for women with mental health conditions. Women and girls are identified as a specific target group in the new Nigeria Mental Health Policy which is the basis of much of the service design work. Also, mhGAP includes specific focus on meeting specific mental health needs of women and girls, as well as high-risk male groups.

e.22 *Child Protection*: How does the project address the vulnerability of children in the community and partner organisation? How are children protected from abuse, exploitation and neglect by the partner organisation?

It is anticipated that staff and other major participants in the project may interact with children (especially indirectly through interaction with their mothers). For this reason, such staff will be given specific training about the special vulnerabilities of children, including those with mental health conditions or have parents with mental illness. How to recognize and respond appropriately to children at risk of abuse and other problems will be an important component of the training.

e.23 *Appropriate Technology*: How are the technologies introduced in the project maintained in the local context? What are the strategies of the organisations to ensure that the necessary financial, technical (spare parts,

supplies, etc) and human resources are in place to maintain the technology in the long term?

The project does not include use of specific technologies. One of the advantages of mental health care is that interventions are low-tech (even medications used are well established), with time and skills of clinicians as paramount.

e.24 *Environmental Sustainability:* How will the project impact on the local environment? Where applicable: What steps are taken to enhance environmental sustainability in the project area?

No specific impact on the environment expected. We will minimise use of vehicles and existing buildings are used.

Financial and Organisational Sustainability[17]

e.25 *What are the strategies and means to strengthen the organisational and local capacity during the project implementation (e.g. training, retention of qualified staff, etc.) to ensure a successful long term implementation of activities?*

The programme is designed to transfer skills and expertise to local staff and researchers already in the employ of the local government. Steps will be taken to reduce reposting of trained staff especially those involved in service provision.

e.26 *What is the cost recovery strategy of the organisation with regard to the project? Does the partner organisation plan that funding of the project activities will continue? Please specify how, if applicable.*

Financial aspects of service delivery will be considered in design of the new services. This routinely includes cost recovery in Nigeria (fee for seeing doctor/nurse and payment for medications) but we will ensure that this is balanced with making access to services relatively easy.

Section F: Project Management

Monitoring and Reporting

f.1 *Indicate how often monitoring and assessment will be done and how often narrative and financial reporting will be provided to CBM.*

The overall monitoring and research for the programme is designed to ensure continued attention to and achievement of the project's intended outcome and outputs. This will mainly be carried out as part of the overall project design by

[17] Reference CBM Project Cycle Management Handbook, Chapter 3, 3.10 "Sustainability"

the co-ordination team. During the project initialisation phase, a workshop will be held with all partners to detail practicalities of how the expected outputs in this proposal will be measured using the indicators in the log-frame. There is a designated M&E budget. This will include some funds for collation of detailed baseline information, and there will be regular monitoring visits (transport and accommodation).

In addition to these standard M&E systems however, this project will collect extensive high-quality data for a research-level evaluation as part of a multi-site project evaluating integration of mental health into PHC settings in sub-Saharan Africa, run by the London School of Hygiene and Tropical medicine (subject to grant approval). Even without this, there will be support for this research through CBM as part of a PhD being carried out by JE (CBM Regional MH Advisor)

f.2 *Reporting of approved project plans should be done against 1) the indicators identified in the logical frame work 2) project milestones outlined in the Project Activity Schedule and 3) project expenses against the annual project budget*

Evaluation

f.3 *When do you plan to do an evaluation of the project? What type of evaluation do you plan to conduct (external, mixed or self-evaluation)?*

Since this project is built around the principle of translating international evidence (much of it from LAMICs) to a specific country context, evaluating the outcomes of these pilot initiatives will be an essential component of the activities. The subsequent presentation of the results in an accessible format is a major outcome, which is hoped will provide professionals and advocates with tools to affect change at the highest level. It will therefore be built around the principles of evaluation of complex MH interventions (using the experience of LSHTM as a collaborating partner, and Ibadan University). Ibadan University and CBM Advisors and the co-ordination office will oversee this through engagement with the professionals in the two service implementing partners, using standardised outcome measures, locally adapted as appropriate. These will focus on functional and social outcomes, but will also include symptom outcomes in specific cases to allow international comparisons to be made.

Relevant skills will be taught and supervised as part of the research skills building component of the project. The logical framework matrix for the project will provide a time-bound structure for minimum expectations, but the details of the evaluation will depend on the intervention service model design, with fidelity to the chosen model being an essential factor in evaluation to ensure that practical, replicable models ready for scale-up in Nigeria result.

We will use several general dissemination methods including publication in relevant peer review journals, writing a formal report, and presentation at academic conferences (Activity 3.3.2). There will also be targeted communication with key decision makers in Nigeria at Federal and State level. Many of the targets of this advocacy will have been involved in the project from an early stage, they should be receptive to, and interested in hearing the results of the work. There will also be a special national meeting to disseminate results at the end of the project in the form of an extended ½ day MHAC meeting (Activity 5.3.3).
On-going internal monitoring with mid-term internal evaluation of results will be conducted. This will involve collation of reports and completion of evaluation questionnaire.

Appendices

Please use these supportive Appendices for the completion of the project proposal.

Appendix 1: Stakeholder Involvement Matrix

Stakeholders List all current and potential external and internal stakeholders including beneficiaries that contribute or influence the success of the proposed project(s)[18]	What is their interest and contributions in the proposed project?	What is their power and influence in the project (1-5 rating, 1=low, 5=high)	How does the project involve / plan to involve these stakeholders?
Primary Stakeholders			
Project staff	Fulfilment of employment contract. Will Contribute in the day-to-day project implementation.	5	Direct employment, training, and involvement in project planning and implementation. Will have specific roles within the project.
Federal Ministry of Health	Provision of quality mental health care for the citizenry.	5	Will co-ordinate the programme with the plans to carry on the activities at the end of the project cycle
Federal Neuropsychiatric Hospitals in Aro, Calabar and Kaduna	Train the trainers and research	4	Will be involved in model development activities.

18 Relevant stakeholders can be e.g. beneficiary groups (primary stakeholders), national and international partners, local authorities, DPOs, (I)NGOs or specialised organisations and service providers active in related areas (secondary stakeholders)

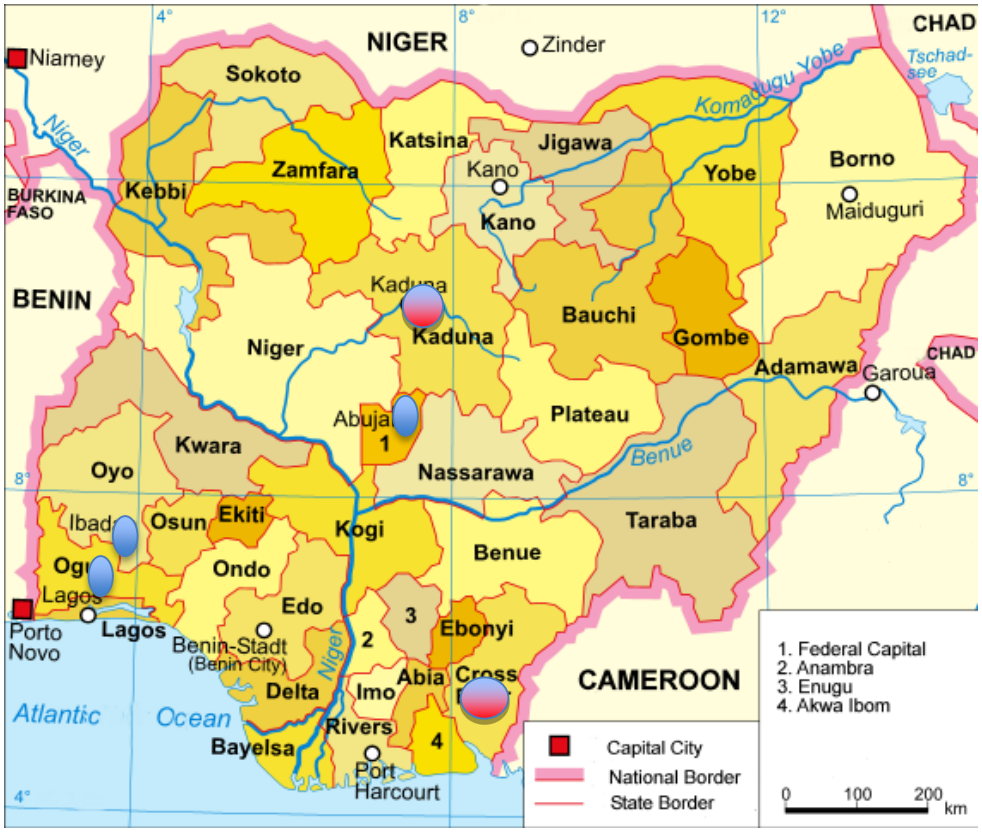
and the University of Ibadan			
PHC workers	Acquiring capacity to diagnose and treat disorders.	5	will participate in training the service providers and in quality service delivery.
National Mental Health Action Committee members	Advisor to the programme	4	Advocacy for National service improvement
Mental Health Steering Committee	Stigma reduction	4	Advocacy for service improvement in the states and local government areas
Secondary Stakeholders			
Ministry of Justice	Up-holding the human rights of persons with mental disorder	3	Working to reduce "civil lunatics"
Civil Society Organisations / NGOs Human Rights Commission	Up-holding the human rights of persons with mental disorder	4	Can help in building capacity and awareness Supportive. Advocacy
Media Houses	Advocacy in improved MH services and attitudes of the general populace towards persons with psychosocial disabilities	4	Sensitisation on MH issues
Donor agencies	Possible opportunities for funding	4	Funding M&E Technical support
Complimentary Alternative Providers	First point of contact for many patients	3	Need to respect human rights Improved methods for serving PW PSD
Ministry of women affairs and Social Welfare	Promote and protect PWPSD. Inclusion	4	Improved care and facilities
National Disability Federation	Promote wellbeing of PW disability	4	Advocacy. Include psychosocial disabilities in their work

Appendix 2: Logical Framework – see separate document
Appendix 3: Budget and Activity Schedule – see separate document

Annex 1; Organisational Chart - see separate document
Annex 2; Partner Organisation annual reports
Annex 3; Partner organisation registration documents (University is formal partner with CBM and as is existing partner, this is waived)

Annex 4; Map of Nigeria showing the location of the catchment areas (see below)
Annex 5; Relevant government policies; Nigeria MH Policy and Strategy
Annex 6; Relevant research on needs (Nigeria, and 5-country situation analysis)

Annex 4; Map of Nigeria showing the location of the catchment areas



= Field Implementation Sites
= Evaluation/research co-ordination