AFRICA MENTAL HEALTH FORUM: “Continental Alliance for Integrated Mental Health Care in Africa”
during the WPA International Congress in Cape Town,
18-22 November 2016

Roof Terrace CTICC, Friday, 18 November 2016
08h15-15h00

DOCUMENTATION

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EXECUTIVE SUMMARY

The WPA-WHO Africa Mental Health Forum was organized as a round table discussion on the 18th November 2016 in Cape Town, with plenary presentations, as well as four break away panel discussions.

The panels were set up in terms of the four objectives of the WHO MENTAL HEALTH ACTION PLAN 2013-2020: (1) PANEL I. Leadership and governance; (2) PANEL II. Health and social services; (3) PANEL III. Prevention and promotion; and (4) PANEL IV. Information, evidence and research.

The participants in this round table discussion included WPA Executive Committee and Board Members, Psychiatric Associations in Africa and elsewhere, National Directors of Mental Health Programs and Mental Health Advocacy Groups.

The three background policy documents for the Forum were: (1) The WHO MH Care Action Plan 2013-2020; (2) The Africa Health Transformation Program 2015-2020; and (3) WPA Action Plan 2014-2017. Chairs and Panel Leaders were encouraged to liaise with the proposed panel members beforehand, but also to consider and advise on any other participants which they thought would be able to contribute to these discussions. Panel Leaders were invited to coordinate and prepare in advance a brief background section on each subtheme of about 1-2 pages, including 2-3 potential recommendations. They were also invited to forward any documentation for the meeting that should be considered as context. (Both the leaders' background documents and submitted documents are included/listed in the Addenda to the “Documentation” document for the forum.)

The round table program consisted of three plenary sessions and four breakaway sessions. The session on the report back session by the four breakaway panels was audio-recorded and transcribed. (The transcription has been included as an Addendum to the “Documentation” document for the forum.)

Presentations. The plenary presentations were delivered under the program headings of: (1) “Overview of Mental Health Care Policy in Africa”; (2) “Service delivery, training and research”; and (3) “Alliance of stake holders for integrated care”

The different presentations were either included in the Addenda to the “Documentation” document for the forum, or a short summary was included in the text of the document:

(1) Dr Shekhar Saxena – “The Global Mental Health Action Plan”

1 http://www.who.int/mental_health/publications/action_plan/en/
The outcome of the meeting was foreseen to be a report on the four panels’ inputs with particular recommendations on the identified four areas, while also to incorporate and consolidate a position statement on a continental alliance for integrated mental health care in Africa.

**Recommendations by four panels.** The following 25 recommendations were made by the four panels:

1. **PANEL I. Leadership and governance**
   1) To involve all stakeholders in all (planning) meetings at all levels, including patients, while enabling and supporting consumers to participate meaningfully
   2) To achieve a systematized approach in mental health leadership and governance, so that not all effort and support depends on one individual in a particular Ministry – the approach should include different departmental officials from the chief medical officer to administrative staff, but also reach beyond and across departments and governments
   3) To obtain comprehensive data on all aspects in order to have information and provide evidence for the financing required for different mental health programs
   4) To retain the “bigger picture” with regard to CRPD, namely to achieve humane mental health care, and not to be side-tracked in the debate while considering applicable options for mental health in a step-by-step way
   5) To mobilize resources for training in public mental health from national to district level; in order to have understanding that resources must be identified and systems created beyond hospital care, e.g. not only to advocate for hospitals, but for systems of care It is important to have national standards but local action and delivery
   6) To utilize “Mental Health Innovations – Africa” as a platform for role players to continue discussion and communication between role players in Africa

2. **PANEL II. Health and social services**
   7) To reorganize and reform the whole mental health care system by integrating available resources (e.g. psychiatrists in private practice with other role players), while clearly identifying the roles of mental health care workers involved
   8) To achieve integration and role identity through training of current and future practitioners and students - all need to know more about each other; an

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4 Convention on the Rights of Persons with Disabilities
integrated model of practice must be promoted e.g. Psychiatry and other disciplines, mental and physical health care.

9) To broaden the treatment pyramid base through self-care and getting people to be able to care for themselves - at least, with regard to minor problems, while people with severe neuropsychiatric problems *per se* should have easy access to specialized services.

10) To clarify the roles of the different role players in the field in a specific catchment area, while people in a certain catchment area must also be aware of what the referral route is for emergencies, or the correct way to address problems.

11) To address this communication and logistical aspects will require leadership, while these basics may have to be addressed to achieve a reorganization and reformation of the mental health care system.

3. **PANEL III. Prevention and promotion**

12) To incorporate the interests of patients, which must be at the heart of all mental health care, including promotion and prevention - their voice must be recognized in order to bring the richness and strength of their experience to the table; particular areas of concern include:
   - that a holistic approach is adopted when addressing comorbid physical illnesses of patients in view of the known increased risk of morbidity and mortality associated with being a psychiatric patient
   - involvement in the evaluation of service provision in order to achieve services that care and support, rather than stigmatize.

13) To achieve different competencies, such as cultural, (health) educational, service delivery and policy competency.

14) To work with the media to address stigma while also addressing cultural aspects of stigma and constantly recognizing the voice of patients and their families and carers.

15) To revise training curricula of undergraduate and post graduate programs to ensure inclusion of the minimum required content on mental health, including on promotion and prevention.

4. **PANEL IV. Information, evidence and research**

16) To acknowledge the critical importance of collaboration and networks.

17) To share information and experiences.

18) To address stigma, including stigma in mental health workers and the systems in which they work.

19) To incorporate the use of technology in screening and intervention delivery.

20) To consider cultural idioms of distress and appropriate interventions.

21) To accommodate the qualification of new cadres of mental health workers through creating posts and career paths.

22) To teach research methods and dispel myths about research, while refocusing the emphasis on scientific curiosity to answer questions.

23) To embrace a range of research methods in mental health from quantitative, systems, mixed to qualitative; from basic neuroscience to implementation research; also, to develop “clinician researchers”
24) To conduct further epidemiological research, as there are relatively few data for example on the prevalence and associations of mental disorders in primary care settings in the African context
25) To conduct research on the effectiveness and cost-efficiency of integrated care and collaborative care in the African context, as well for further work on moderating and mediating factors

Position statement on a continental alliance for integrated mental health care in Africa

In order to achieve the communicated vision, objectives and targets for achieving the potential of mental health for all and integrated mental health care in Africa, we will need to work together with collective strength and active collaboration. Such an alliance for integrated mental health care in Africa, with emphasis on public mental health, includes: individual and collective psychiatrists; as well as all members of the multidisciplinary mental health team (psychologists, nurses, social workers, occupational therapists); other health professionals in primary and specialist health care; community mental health workers and self-help resources; our patients and their families; the public at large through the media; training institutions; as well as governments’ Ministries of Health and private service providers of mental health care services. While different countries and groups may have different entry points, strengthening of this alliance must be sought within countries nationally, provincially and locally, but also on subcontinental and continental levels.
1. INTRODUCTION

Invitations to attend the **WPA-WHO Africa Mental Health Forum** by Prof Dinesh Bhugra, WPA President and Dr Shekhar Saxena, Director WPA Department of Mental Health and Substance Abuse, were forwarded to prospective participants during October 2016 (Addendum 1 – Invitation and Program).

The participants in this round table discussion included WPA Executive Committee and Board Members, Psychiatric Associations in Africa and elsewhere, National Directors of Mental Health Programs and Mental Health Advocacy Groups.

The Forum was organized as a round table discussion, with plenary presentations, as well as four break away panel discussions. The panels were set up in terms of the four objectives of the **WHO MENTAL HEALTH ACTION PLAN 2013-2020**, namely:

1. to strengthen effective leadership and governance for mental health
2. to provide comprehensive, integrated and responsive mental health and social care services in community-based settings
3. to implement strategies for promotion and prevention in mental health
4. to strengthen information systems, evidence and research for mental health

The four panels consisted of the following members:

**Panel I. Leadership and governance**
- **Chair**: Dr Shekhar Saxena (WHO) saxenas@who.int
- **Leader**: Dr Florence Baingana, University School of Public Health; WHO-AFRO, Uganda kamayonza@gmail.com
- **Members**: Dr Peter Dowd (UK); Prof Olayinka Omigbodun (Nigeria); Prof Melvyn Freeman (SA); Prof Sir Simon Wessely (UK); Dr Mvuyiso Talatala (SA); Dr Saul Levin (USA); Prof Solly Rataemane (SA) pcdowd@hotmail.com; olayinka.omigbodun@gmail.com; FreemM@health.gov.za; simon.wessely@kcl.ac.uk; mvuyiso@talatala.co.za; slevin@psych.org; srataema@gmail.com;

**Panel II. Health and social services**
- **Chair**: Prof Helen Herrman (WPA President-Elect, Australia) h.herrman@unimelb.edu.au
- **Leader**: Prof Wolfgang Gaebel, President of the European Psychiatric Association Wolfgang.Gaebel@uni-duesseldorf.de
- **Members**: Prof Vikram Patel (UK/India); Prof Nahla Nagy (Egypt); Dr Owoidoho Udofia (Nigeria); Prof David Ndetei (Kenya); Dr Lesley Robertson (South Africa): Dr John Parker (South Africa): Prof Jain Mari (Brazil); Prof Zuki Zingela (South Africa) vikram.patel@lshtm.ac.uk; nahlanag64@yahoo.com; drudofia@gmail.com; dmdndtei@uonbi.ac.ke; dmdndtei@amhf.or.ke; Lesley.Robertson@wits.ac.za; John.Parker@westerncape.gov.za; jamari17@gmail.com; zingelaz@telkomsa.net;

**Panel III. Prevention and promotion**
- **Chair**: Dr Matshidiso Moeti (Director WHO African Region - WHO-AFRO) moetim@who.int; moetim@afro.who.int; jirim@who.int

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Panel IV. Information, evidence and research

Chair Prof Dinesh Bhugra (UK) dinesh.bhugra@kcl.ac.uk
Leader Prof Dan Stein, Department of Psychiatry and Mental Health, University of Cape Town dan.stein@uct.ac.za
Members Prof Oje Gureje (Nigeria), Prof Soraya Seedat (SA), Prof Graeme Thornicroft (UK), Prof Seggane Musisi (Uganda), Prof Crick Lund (SA), Prof Lukoye Atwoli (Kenia), Prof Christopher Szabo (SA), Dr Tine van Bortel (UK) oye_gureje@yahoo.com; SSEEDAT@sun.ac.za; graham.thornicroft@kcl.ac.uk; segganemusisi@yahoo.ca; crick.lund@uct.ac.za; lukoye.atwoli@mu.ac.ke; lukoye@gmail.com; christopher.szabo@wits.ac.za; tv250@medschl.cam.ac.uk

The three background documents for the Forum were:
2. The Africa Health Transformation Program 2015-2020; 6 and
3. WPA Action Plan 2014-20177

As part of the preparation, Chairs and Panel Leaders were encouraged to liaise with the proposed panel members but also to consider and advise on any other participants which they may think will be able to contribute to these discussions.

- Panel Leaders were invited to coordinate and prepare in advance a brief background section on each subtheme of about 1-2 pages, including 2-3 potential recommendations.
- They were also invited to forward any documentation for the meeting that should be considered as context
- The session on the report back session by the four breakaway panels was audio-recorded and transcribed.

The outcome of the meeting was foreseen to be a report on the four panels’ inputs with particular recommendations on the identified four areas, while also to incorporate and consolidate a position statement on a continental alliance for integrated mental health care in Africa.

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2. PROGRAMME

2.1 PLENARY SESSIONS

2.1.1 ROUND TABLE SESSION 1. Overview of Mental Health Care Policy in Africa - Chair: Prof Dinesh Bhugra, President WPA

In this session, the following presentations were made (for summary or full text see Addendum 2 – Plenary Presentations):

(1) Dr Shekhar Saxena – “The Global Mental Health Action Plan”

2.1.2 ROUND TABLE SESSION 2. Service delivery, training and research - Chair: Dr Shekhar Saxena, Director WHO Department of Mental Health and Substance Abuse

(1) Prof Dinesh Bhugra – “Social contracting of Psychiatry and psychiatrists for mental Health in Africa”

The basic aim of Psychiatry’s contract derives from Medicine’s contract social contract with society and it refers to what is the society at large expecting from psychiatrists and vice versa. The concept dates back to the 17th century when the monarchies in Europe were not inherited, but appointed. The public then had certain expectations from the monarch and vice versa. It can also be traced to the guilds in Western Europe, who were controlling who were teachers, who were taught what and who graduated. This applied to all industrial guilds, from the building trades to surgery, which represent the original roots of the different Royal Colleges, including the Royal College of Psychiatrist. While emphasis in the UK might have been placed on risk management for the profession of Psychiatry, it should rather be psychiatrists’ expectations, e.g. to be autonomous, to speak for the patient, to receive remuneration and a level of respect. Society’s expectations include that the profession will uphold professional standards, will look after the needs of the vulnerable, and will give impartial advice. The social contract of Psychiatry is the fundamental reason for convening this meeting.

(2) WPA African Regions overview: Northern Africa – Zone 11: Central and Western Africa – Zone 13; Eastern and Southern Africa – Zone 14

Prof David Ndetei (Kenia) - Eastern & Southern Africa (Zone 14)

- The aim in Zone 14 was to improve membership through more societies, and by supporting psychiatrists in countries to form new associations. There are only a few professional societies with active membership, including Kenya, Uganda and South Africa. Mozambique has recently formed an association, while in Zambia, local psychiatrists are working with other professional groups. Zimbabwean and

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Tanzanian psychiatrists are in the process of establishing groups. Namibia only had two psychiatrists and Angola one.

- Mozambique Psychiatric Society representative noted that their society is member of WPA since 2014, with 13 psychiatrists of who 5 attended the Forum. They have also with the 5 Angolan psychiatrists form an Association for Portuguese speaking members. They are planning a meeting in 2017 in Cape Verde.
- The Ethiopian association has joined this region from the Mediterranean/North African (Zone 11). In Somali, the status remains problematic due to difficulties with El-Shabab.
- In Southern Sudan there are two psychiatrists, on who was trained in Nairobi, while the other were trained in Khartoum trained and externally examined by a Kenyan examiner. These two doctors find it difficult to stay though.
- Although there is a challenge to include French speaking countries, for historical and language reasons, it was agreed that more efforts must be include these societies as a group.
- A planned meeting in Mombasa, by the Kenyan Psychiatric Association will continue to strengthen intra and inter Zonal relations.
- It should be noted that of the six WPA collaborative centers, two are in Zone 14.

### 2.2 BREAKAWAY SESSIONS: Africa and the Global Mental Health Action Plan 2013-2020

In addition to the plenary presentations, the following breakaway sessions were conducted:

1. PANEL I. Leadership and governance - Roof Terrace, CTICC
2. PANEL II. Health and social services - Meeting Room 1.41, CTICC
3. PANEL III. Prevention and promotion - Meeting Room 1.42, CTICC
4. PANEL IV. Information, evidence and research - Meeting Room 1.43, CTICC

Documents submitted by Panel Leaders were included as Addendum 3 – Submitted Documents.

In addition to the report back on the discussion during the breakaway sessions, Panel Leaders were also invited to coordinate and prepare in advance a brief background section on each subtheme of about 1-2 pages, including 2-3 potential recommendations.

(Addendum 4 – Panel Leaders’ Background & Transcription of Proceedings)

#### 2.2.1 REPORTING BACK BY PANELS

The first group of plenary presentations were followed by the reporting back of the different panels:

- Dr Florence Baingana (Uganda) - Rapporteur: Panel I. Leadership and governance
- Prof Wolfgang Gaebel (Germany) - Rapporteur: Panel II. Health and social services
- Dr Albert Persaud (UK) - Rapporteur: Panel III. Prevention and promotion
- Prof Crick Lund (SA) Rapporteur: Panel IV. Information, evidence and research

(Addendum 4 – Panel Leaders’ Background & Transcription of Proceedings)
(1) **Dr Florence Baingana - Panel I. Leadership and governance**

- **Issues discussed include:**
  - Change of leadership, when policy and programs are e.g. supported by one political decision-maker and not the next;
  - Different “languages” must be used, e.g. when communicating with patients, with the hospital manager, the minister of finance; the department of social welfare; or the district level service managers;
  - Application of the Convention on the Rights of Persons with Disabilities (CRPD) to mental health care in the Sub-Saharan region, especially with regard to involuntary admissions;
  - Obstacles to the implementation of policy implements – adopted policy may not lead to implementation;
  - Training on Public Mental Health on all levels is required (health care students, service providers, managers), from an international to district level, everybody must understand language of Public Health;
  - Tensions between role players, e.g. between psychiatrists and the official in the Health Ministry; between providers and consumers, as well as within groups;
  - Regulation of task shifting, e.g. who would do training, who is trained to do what; how supervised;

(2) **Prof Wolfgang Gaebel - Panel II. Health and social services**

- **Comments:**
  - The problem in transforming mental health seems not only to be that of resources and of allocating the resources, but by identifying responsibilities and roles of those involved in mental health care;
  - A balanced model of care is required, e.g. mental health hospitals (or “asylums”) can't be closed altogether until something new is built up in the community; both components (facility and community based) must exist in a relationship with each other;
  - From the Indian experience, hospitals may be transforming themselves, by offering different types of services and expand the spectrum, e.g. day care services and developing integrated community services, in order to refer patients to community care where service is fully built-up; the hospital however remains an integral part of a community-based system;
  - Reconsideration of a disorder-based approach to also include milder disorders e.g. mild depression, which must be treated in the community. This will require a distinction of mild versus severe mental disorders, which would need specialist care. Therefore, a dimensional view on the problem of disorders may be appropriate where, referring to the (broadening of the) base of the treatment pyramid, starting with self-care to more professional levels. Psychiatrists may then be rather given the role of training and education of general practitioners, social workers, nurses and other;

(3) **Dr Albert Persaud – Panel III. Health Promotion and prevention**

- **Recommendations:**
  - To incorporate the interests of patients, which must be at the heart of all mental health care, including promotion and prevention - their voice must be recognized;
in order to bring the richness and strength of their experience to the table; particular areas of concern include:
- that a holistic approach is adopted when addressing comorbid physical illnesses of patients in view of the known increase risk of morbidity and mortality associated with being a mental health care user
- involvement in the evaluation of service provision in order to achieve services that care and support, rather than stigmatize
  - To achieve different competencies, such as cultural, (health) educational, service delivery and policy competency
  - To involve the media to address stigma, e.g. through advertisement, while also addressing cultural aspects of stigma and constantly recognizing the voice of patients
  - To revise training curricula of under and post graduate programs to ensure inclusion of the minimum required content on mental health, including on promotion and prevention

(4) Prof Crick Lund – Panel IV. Information, evidence and research

- Comments:
  - Examples of research and practice innovations include:
    (1) “The Teachable Moment” - A randomized controlled trial conducted in emergency departments in the Western Cape on screening and brief intervention of alcohol use disorders; this is now being taken up by the Health Department and rolled out; this is a very good example of research being translated into policy and practice
    (2) AMARI (African Mental Health Research Initiative) – led by Dr Dickson Shibanda from Zimbabwe; a Wellcome Trust capacity building grant providing fellowships for Masters, and PhD and post doc students; some 47 fellowships have been awarded across 4 countries (Ethiopia, Malawi, Zimbabwe, SA); a great example of how capacity building is being developed for the next generation of researchers
    (3) Mental Health Innovation Network (MHIN) – an online platform managed by the London School Hygiene and Tropical Hygiene, providing a way of sharing mental health innovations across the world, especially in low-income countries; on the basis of this, a MHIN-Africa has been started, which is really focused on African innovations and provide a platform for African innovators, policy-makers and researchers to interact with each other
    (4) Other examples of projects on: task sharing innovations, e.g. training community health workers to support adherence for people with severe psychiatric disorders in the Western Cape; working with traditional healers in the Gauteng Province; integrating mental health in non-communicable diseases care in Kenya with training of clinical officers in screening and providing basic mental health interventions; integrating mental health in HIV care in Gauteng Province; a lot of these projects are well evaluated and written-up or in the process of being reported on.
2.3 ROUND TABLE SESSION 3 – Alliance of stake holders for integrated care. Chair: Dr Mvuyiso Talatala, President SASOP

2.3.1 Dr Mvuyiso Talatala – WPA and an African Federation of Psychiatric Associations

The question about an alliance of role players will be addressed throughout the Cape Town congress. The African psychiatric leadership on a continental level, in particular the African Association of Psychiatrists and Allied Professions (AAPAP) has been in the process of reviewing its constitution. They may be in a position to share with delegates on how to take the process forward. This will be done to strengthen an African strategy and to share resources within Africa. While there are challenges to develop a sustainable professional body whose members are from different professions, there is a need to develop institutions which are not dependent on individuals, but rather with robust inherent governance and management systems through which it must sustain itself. Such an institution must be driven by its members, with good governance processes. Professional institutions must be driving the purpose it was designed for, while it is accountable to its members.

The South African Society of Psychiatrists (SASOP) is now more than 60 years old, while only in the past couple of years a more specific management approach was adopted to operate as a professional specialty group. This approach includes good governance, sustainability, reporting to members, set terms of office and the presidency. Without these, governance will otherwise be imploding. As part of its own project on Psychiatry’s and psychiatrists’ social contract, the SASOP has during the past year also approached the other professional societies in mental health care (e.g. the Occupations Therapy, Psychology and Nursing societies). Discussion with these groups has confirmed strong support locally for a national alliance for mental health, consisting of all the stake holders, including the professional groups, patients and their families, the media and general public, public and private employers, etc.

2.3.2 Prof Dinesh Bhugra and panel - Continental alliance for integrated mental health care in Africa - WHO, WPA, professional societies
[Panel included: Prof Kamaldeep Bhui, Prof Wolfgang Gaebel; Prof Solly Rataemane]

- Prof Bhugra requested Prof Kamaldeep Bhui to introduce the online available tool developed by CareIF: “Mental Health for all for Life”. He explained that it is an online open access resource. While it is recognized that we will not have enough trained clinicians and there will always be a treatment gap, emphasis should be on prevention, where each person is required to self-manage problems first. There are different modules, also for teachers and emergency workers. This resource being from the UK therefore needs to be adapted. Anybody interested can make contact, while the WPA has agreed to adopt this as one of its prevention management tools [To contact Prof Dinesh Bhugra, or visit the CareIF website http://mentalhealthforlife.org/]. Modules include: Mental health for life - The basics; Mental health with parents and infants; Mental health with children and young people; Mental health with working age people; Mental health with older people; Mental health with schools; Mental health with councils with employers; Mental health with health and emergency services; Creative arts and mental health; and E-Therapies.
Prof Bhugra requested Prof Wolfgang Gaebel to comment on the benefits and challenges of the European network of psychiatric associations. Prof Gaebel, current President of the European Psychiatric Association (EPA), alluded to the advantages of having the EPA, for the past more than 30 years, which started as a group of individual members. African societies may be considering something similar. The history of the EPA includes a name change and has currently 40 national societies members, as well as individual members, representing 80,000 psychiatrists in Europe. During his two years as President, he tried to get all national societies in action and to identify what are common topics. It may also be of interest from an African and global perspective. There are quite some differences in European systems, e.g. some systems are quite big (e.g. UK, Germany, Nordic), while South Eastern Europe may not be doing that well. Instruments have been developed by the EU for improving the transition from institutional to community mental health care. The EPA is trying to interest these members to participate, while it is an option that needs an ongoing effort. Success is subject to how willing and engaged member societies are to go in the same direction. If this makes sense, people may also be in favor of organizing societies in Africa more, to bring them on track for similar topics and priorities, to whom they can be brought forward and to develop and reach goals that they may have in common.

Prof Bhugra noted that other examples of federations of psychiatric associations are also operating in Asia – the Asian Federation of Psychiatric Associations (AFPA), as well as in Latin America – the Asociación Psiquiátrica de América Latina (APAL). An advantage is that there is strength in numbers and psychiatrists can speak with a single voice. As such the group can try to influence policy. A danger may be that smaller organizations may be feeling left out, with bigger organizations telling them what to do. He confirmed from attending psychiatric societies from the floor whether they may be interested is such alliances, including e.g. Mozambique and Kenya.

Prof Bhugra requested Prof Solomon Rataemane, current chair of the AAPAP to add some comments. He noted that such an idea can be supported. It is necessary to raise a few problems why this was not achieved earlier, e.g. there are different countries and different societies, with some with weak and some strong participation. As Prof Ndetei noted, some don’t have formal societies yet, but have some formations of stake holders, The AAPAP aimed to increase its numbers by the inclusion Psychologists and other. The AAPAP Board therefore includes psychologists and others. In some countries, there are also strong psychological associations. It may be of importance that the process is driven by psychiatrists, while affiliated status can be retained. He does however believe in strength to the WPA, with its current members being psychiatric societies. The WPA be guiding the development of liaison and alliances in the African region. He noted that there will be a joint AAPAP/Kenyan Psychiatric Association (KPA) meeting in Mombasa, in March 2017. The meeting will be hosted by the President of the KPA, Dr. Simon Njuguna, with the AAPAP group. He also noted that a MOU with the EPA was signed, agreeing on the sharing information, research in Addis Ababa in June 2016. Renewed efforts to re-establish an African psychiatric journal should also be considered. Support from the APA in this regard can perhaps also be explored, with reference to e.g. the existing NAPA (Nigerian-American Psychiatric Association - http://www.nigerianpsych.org/register.html).

Dr Simon Njuguna (KPA, Kenya) noted that the different African zones should be brought together, including Northern, Western-Central, and Eastern/Southern Zones. As these national societies are affiliated to WPA, the WPA may still have to strengthen these (and other) countries’ societies. If in Zone 14 there are currently only 5 societies, the leadership mentioned will be required to bring the different language groups (French.
Portuguese, Arabian) together as we. The seeds must be planted to grow and develop in a farm.

- Prof Bhugra concluded with the remark that the discussion in this session confirms that there is an interest and appetite to strengthen relations and form alliances and strengthening structures for that, while looking at both the advantages and disadvantages.

2.4 Conclusion - Towards agreement and practical resolutions (Dr Shekhar Saxena)

- Dr Saxena draw the round table discussions to close reminding that the recommendations from the four groups will be forwarded to the WHO Head Office, but also to the WHO Regional Office in Africa, for implementation as to what must be the most prioritized areas.
- Dr Saxena reminded again that substance use and abuse should be included in all considerations of mental health as an important element.
- He supported the idea to use the “Mental Health Innovations – Africa” for frequent networking. He encouraged delegates to visit their booth, to register and become active in sharing ideas and experiences (http://www.mhinnovation.net/organisations/mental-health-innovation-network-africa-mhin-africa).
- Dr Saxena reminded delegates of the annual Health Day in 2017, on the 7th April 2017 - after 16-years since its inception, will be devoted to depression, a mental health theme. All WHO officials are working on the theme of depression as the face of the WHO in 2017, in order for the message of depression to be known to the public. There is already and enormous amount of material that can be down loaded from the WHO website. http://www.who.int/campaigns/world-health-day/2017/event/en/
- Dr Saxena congratulated the SASOP for broadening the scope of collaboration outside that of psychiatrists only, as it is extremely important to join with other professions in common interests, as well as the ties with NGOs and user groups that must be strengthened. This will serve one well if you go outside your own group to have a mental health alliance, which is broader than just psychiatrists.
- He noted that since area of Mental Health is so deprived of adequate resources, one must look for entry points, e.g. in Africa, with the Ebola pandemic in West Africa, certain countries did a large amount of collaborative work. Other entry points are in fact regional conflicts and wars, on the basis of “build back better”. Each country will have a different entry point, such as Human rights, Suicide Prevention or Integration of Care. All such initiatives will be supported from WHO Regional Office and Head Office in Geneva.
- He thanked all and also the WPA and SASOP for bringing all these issues to light through the proceedings of the African Forum round table meeting.
- Prof Bhugra also thanked all, concluding with the “take home” message that we will need to work with colleagues, with health ministries and managers, with NGO for (and by) patients; with care givers to advocate for them, while they can do the same for us.
3. RECOMMENDATIONS

In summary, the following 25 recommendations were made by the four panels:

3.1 PANEL I. Leadership and governance - Roof Terrace, CTICC

1) To involve all stakeholders in all (planning) meetings at all levels, including consumers, while enabling and supporting consumers to participate meaningfully.
2) To achieve a systematized approach in mental health leadership and governance, so that not all effort and support depends on one individual in a particular Ministry – the approach should include different departmental officials from the chief medical officer to administrative staff, but also reach beyond and across departments and governments.
3) To obtain comprehensive data on all aspects in order to have information and provide evidence for the financing required for different mental health programs.
4) To retain the “bigger picture” with regard to CRPD, namely to achieve humane mental health care, and not to be side-tracked in the debate while considering applicable options for mental health in a step-by-step way.
5) To mobilize resources for training in public mental health from national to district level; in order to have understanding that resources must be identified and systems created beyond hospital care, e.g. not only to advocate for hospitals, but for systems of care.
6) To utilize “Mental Health Innovations – Africa” as a platform for role players to continue discussion and communication between role players in Africa.

3.2 PANEL II. Health and social services - Meeting Room 1.41, CTICC

7) To reorganize and reform the whole mental health care system by integrating available resources (e.g. psychiatrists in private practice with other role players), while clearly identifying the roles of mental health care workers involved.
8) To achieve integration and role identity through training of current and future practitioners and students - all need to know more about each other; an integrated model of practice must be promoted e.g. Psychiatry and other disciplines, mental and physical health care.
9) To broaden the treatment pyramid base through self-care and getting people to be able to care for themselves - at least, with regard to minor problems, while people with severe neuropsychiatric problems per se should still be further treated in specialized centers.
10) To clarify the roles of the different role players in the field in a specific catchment area, while people in a certain catchment area must also be aware of what the referral route is for emergencies, or the correct way to address problems.
11) To address this communication and logistical aspects will require leadership, while these basics may have to be addressed to achieve a reorganization and reformation of the mental health care system.

3.3 PANEL III. Prevention and promotion - Meeting Room 1.42, CTICC

12) To incorporate the interests of patients which must be at the heart of all mental health care, including promotion and prevention - their voice must be recognized in order to bring the richness and strength of their experience to the table; particular areas of concern include:

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9 Convention on the Rights of Persons with Disabilities
that a holistic approach is adopted when addressing comorbid physical illnesses of patients in view of the known increased risk of morbidity and mortality associated with being a mental health care user
- involvement in the evaluation of service provision in order to achieve services that care and support, rather than stigmatize

13) To achieve different competencies, such as cultural, (health) educational, service delivery and policy competency
14) To involve the media to address stigma, e.g. through advertisement, while also addressing cultural aspects of stigma and constantly recognizing the voice of patients
15) To revise training curricula of under and post graduate programs to ensure inclusion of the minimum required content on mental health, including on promotion and prevention

3.4 PANEL IV. Information, evidence and research - Meeting Room 1.43, CTICC

16) To acknowledge the critical importance of collaboration and networks
17) To share information and experiences
18) To address stigma, including stigma in mental health workers and the systems in which they work
19) To incorporate the use of technology in screening and intervention delivery
20) To consider cultural idioms of distress and appropriate interventions
21) To accommodate the qualification of new cadres of mental health workers through creating posts and career paths
22) To teach research methods and dispel myths about research, while refocusing the emphasis on scientific curiosity to answer questions
23) To embrace a range of research methods in mental health from quantitative, systems, mixed to qualitative; from basic neuroscience to implementation research; also, to develop “clinician researchers”
   [From the Panel leader’s summary – Addendum 4 – Panel Leaders’ Background & Transcription of Proceedings]
24) To conduct further epidemiological research, as there are relatively few data for example on the prevalence and associations of mental disorders in primary care settings in the African context
25) To conduct research on the effectiveness and cost-efficiency of integrated care and collaborative care in the African context, as well for further work on moderating and mediating factors
4. **Position statement on a continental alliance for integrated mental health care in Africa.**

From the vision stated by Dr Moeti in her plenary presentation and from the concluding remarks by Dr Saxena and Prof Bhugra on the proceedings of this first WPA-WHO African Forum - towards agreement and practical resolutions, the following position statement on a continental alliance for integrated mental health care in Africa:

In order to achieve the communicated vision, objectives and targets for achieving the potential of mental health for all and integrated mental health care in Africa, we will need to work together with collective strength and active collaboration. Such an alliance for integrated mental health care in Africa, with emphasis on public mental health, includes: individual and collective psychiatrists; as well as all members of the multidisciplinary mental health team (psychologists, nurses, social workers, occupational therapists); other health professionals in primary and specialist health care; community mental health workers and self-help resources; our patients and their families; the public at large through the media; training institutions; as well as governments’ Ministries of Health and private service providers of mental health care services. While different countries and groups may have different entry points, strengthening of this alliance must be sought within countries nationally, provincially and locally, but also on subcontinental and continental levels.

[Addendum 5 - Delegates]

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**Bernard Janse van Rensburg**  
Johannesburg  
April 2017
ADDENDA

Addendum 1. INVITATION AND PROGRAMME – p20

Addendum 2. PLENARY PRESENTATIONS – p24

Addendum 3. SUBMITTED DOCUMENTS – p32

Addendum 4. PANEL LEADERS’ BACKGROUND & TRANSCRIPTION OF PROCEEDINGS – p35

Addendum 5. DELEGATES – p41
ADDENDUM 1. INVITATION AND PROGRAMME

INVITATION

WORLD PSYCHIATRIC ASSOCIATION
AFRICA MENTAL HEALTH FORUM
Continental Alliance for Integrated Mental Health Care in Africa
during the WPA International Congress in Cape Town
Roof Terrace CTICC, Friday, 18 November 2016, 08h15-15h00

Dear Colleagues,

We are looking forward to the upcoming WPA International Congress in Cape Town, scheduled from 18 to 22 November in the CTICC, expecting it to be a significant meeting held in Africa, on how to achieve integrative psychiatric and mental health care for the community.

To introduce this business agenda and its particular African focus at the meeting, the World Psychiatric Association, in collaboration with the World Health Organization’s Department of Mental Health and Substance Abuse in Geneva, as well as with the South African Society of Psychiatrists (SASOP), is calling this pre-congress meeting on Friday, the 18th November 2016. Proposed participants include the WPA Executive Committee and Board, the SASOP and other psychiatric associations in Africa, national directors of mental health programs, as well as mental health advocacy groups.

The meeting has adopted the theme: “Continental Alliance for Integrated Mental Health Care in Africa”. It will be held in the format of a round table discussion, with the aim to develop a position statement on mental health issues in Africa with potential solutions. The meeting will consist of brief background presentations, as well as plenary and breakaway sessions. Four panels have been proposed to participate in terms of the four subthemes of the current WHO’s Global Mental Health Action Plan, namely: I. Leadership and governance; II. Health and social services; III. Prevention and promotion; and IV. Information, evidence and research.

Four theme chairs have been identified to coordinate the activities of each panel, while identified discussants (panel chairs) will be reporting back to the plenary meeting from the four break-away sessions on each of the subthemes:
Due to the very busy schedule of the day, in order to facilitate and focus the proceedings, each panel is invited to prepare in advance a brief background section on each subtheme of about 1-2 pages, including 2-3 potential recommendations. This framework will be used as the basis for the proposed joint position statement at the conclusion of the meeting.

Can you kindly forward any of this material to Bernard Janse van Rensburg (SASOP President-Elect and Chair of the LOC of the WPA IC 2016), at bernard.sasop@mweb.co.za, who will be able to coordinate all the inputs received for this meeting?

Thank you very much for your participation in this WPA roundtable meeting on integrative mental health care for Africa. Your participation and inputs are much appreciated.

With best regards

Prof Dinesh Bhugra CBE
President

Dr Shekhar Saxena
Director
WHO Department of Mental Health & Substance Abuse
## World Psychiatric Association
### Africa Mental Health Forum
Continental Alliance for Integrated Mental Health Care in Africa
during the WPA International Congress in Cape Town
Roof Terrace CTICC, Friday, 18 November 2016, 08h15-15h00

Proposed participants: WPA Executive Committee and Board Members, Psychiatric Associations in Africa, National Directors of Mental Health Programs, Mental Health Advocacy Groups

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<tr>
<th>Time</th>
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<tbody>
<tr>
<td>07:45 - 08:15</td>
<td>Registration</td>
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<tr>
<td>08:15 – 08h30</td>
<td>Welcome and introduction</td>
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<td>Prof Dinesh Bhugra, WPA President</td>
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<tr>
<td>08:30 – 08:45</td>
<td>Round Table Session 1. Overview of Mental Health Care Policy in Africa</td>
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<td>Chair: Prof Dinesh Bhugra, President WPA</td>
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<tr>
<td>08:30 - 08:45</td>
<td>Global Mental Health Action Plan</td>
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<td></td>
<td>Dr Shekhar Saxena (Switzerland) Director Department of Mental Health and Substance Abuse, World Health Organization</td>
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<td>08:45 - 09:00</td>
<td>The Transformation Agenda and the Global Mental Health Action Plan: Policies and targets for Africa</td>
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<td>Dr Matshidiso Moeti (Congo) African Regional Director World Health Organization</td>
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<td>09:00-09:15</td>
<td>WPA Action Plan 2014-2017</td>
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<td>Prof Dinesh Bhugra (UK) President World Psychiatric Association</td>
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### Breakaway Sessions: Africa and the Global Mental Health Action Plan 2013-2020

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<th>Time</th>
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<td>09:15 - 10:30</td>
<td>I. Leadership and governance</td>
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<td>Chair: Dr Shekhar Saxena (WHO)</td>
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<td>Prof Sir Simon Wessely (UK)</td>
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<td>Dr Mvuyiso Talatala (SA)</td>
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<td>Dr Saul Levin (USA)</td>
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<td>09:15 - 10:30</td>
<td>II. Health and social services</td>
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<td>Meeting Room 1.41</td>
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<td>Chair: Prof Helen Herrman (Australia)</td>
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<td>Prof Wolfgang Gaebel (Germany)</td>
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<td>Prof Vikram Patel (India)</td>
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<td>Prof Nahla Nagy (Egypt)</td>
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<td>Prof Owoidoho Udofia (Nigeria)</td>
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<td>Prof David Ndeitei (Kenia) Zone 14</td>
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<td>Dr Lesley Robertson (SA)</td>
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<td>Prof Jair Mari (Brazil)</td>
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<td>Dr Zuki Zingela (SA)</td>
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<td>III. Prevention and promotion</td>
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<td>Dr Albert Persaud (CareIF UK)</td>
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<td>Dr Julian Eaton (CBM, Togo), Dr Manaan Kar Ray (UK)</td>
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<td>Prof Bernard J/van Rensburg (National Alliance, SA)</td>
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<td>Prof Peter Jones (UK)</td>
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<td>Prof Maria Oquendo (USA)</td>
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<td>09:15 - 10:30</td>
<td>IV. Information, evidence and research</td>
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<td>Chair: Prof Dinesh Bhugra (UK)</td>
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<td>Prof Christopher Szabo (SA)</td>
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<td>Dr Tine van Bortel (UK)</td>
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Tea: 10:30 – 11:00
### ROUND TABLE SESSION 2. Service delivery, training and research

**Chair:** Dr Shekhar Saxena, Director WHO Department of Mental Health and Substance Abuse

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<th>Time</th>
<th>Session</th>
<th>Presenter/Chair(s)</th>
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<tbody>
<tr>
<td>11:00 - 11:15</td>
<td>Social contracting of Psychiatry and psychiatrists for mental Health in Africa</td>
<td>Prof Dinesh Bhugra, President WPA</td>
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<td>11:15 - 11:35</td>
<td>WPA African Regions overview</td>
<td>WPA Zonal Representatives for Africa:</td>
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<td>• Northern Africa – Zone 11</td>
<td>Prof Nahla Nagy (Egypt) - Zone 11</td>
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<td>• Central and Western Africa – Zone 13</td>
<td>Prof Owoidoho Udofia (Nigeria) - Zone 13</td>
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<td>• Eastern and Southern Africa – Zone 14</td>
<td>Prof David Ndetei (Kenia) - Zone 14</td>
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<tr>
<td>11:35 - 12:30</td>
<td>Leadership, services, advocacy and research for integrated mental health care in Africa</td>
<td>Dr Florence Baingana (Uganda)</td>
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<td>• Reports from breakaway sessions and discussion</td>
<td>Rapporteur: Leadership and governance breakaway</td>
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<td>Prof Wolfgang Gaebel (Germany)</td>
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<td>Rapporteur: Information, evidence and research break away</td>
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**Lunch:** 12:30 – 13:00

### ROUND TABLE SESSION 3 – Alliance of stake holders for integrated care

**Chair:** Prof Helen Herrman, WPA President-Elect

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<th>Time</th>
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<td>13:00 - 13:30</td>
<td>WPA and an African Federation of Psychiatric Associations</td>
<td>Prof Dinesh Bhugra</td>
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<td>Dr Mvuyiso Talatala, President SASOP</td>
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<td>13:30 - 14:30</td>
<td>Continental alliance for integrated mental health care in Africa - WHO, WPA, professional societies</td>
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<td>Dr Shekhar Saxena (WHO)</td>
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<td>Prof Dinesh Bhugra (WPA)</td>
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<td>14:30 -15:00</td>
<td>Conclusion: Towards agreement and practical resolutions</td>
<td>Prof Dinesh Bhugra</td>
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**Tea/coffee:** 15:00 – 15:30
2. Dr Shekhar Saxena – “The Global Mental Health Action Plan”

[The full Power Point presentation is available from Dr Saxena on request saxenas@who.int]

Keynote Address in Round Table Session 1: Overview of Mental Health Care Policy in Africa (15 minutes)

Other participants: Dr Shekhar Saxena, WHO HQ; Dr Olawale Maiyegun, Commissioner: Social Affairs, African Union

WHO/AFRO Transformation Agenda and the Global Mental Health Action Plan - Policies and targets for the African Region

Honorable President, Executive Committee and Board members of the World Psychiatric Association,
Esteemed Commissioner of Social Affairs from the African Union,
Distinguished directors of mental health programmes,
Partners in academia, mental health practice and advocacy groups,
Ladies and gentlemen

Global Mental Health situation

- There is no health without mental health. It is paramount to personal well-being, relationships and successful contributions to society, and is related to the development of societies and countries.
- This is why it is specifically included in Goal 3 of the Sustainable Development Agenda - “promoting mental health and well-being” - and includes a target on stronger prevention and treatment of substance abuse, narcotic drug abuse and harmful use of alcohol.
- Mental, neurological, and substance use disorders are prevalent in all regions of the world and are major contributors to morbidity and premature mortality. Globally, 1 out of 4 people suffer from a kind of mental health problem.

Mental health in the WHO African region

- In the African Region, data on these disorders are very scanty, but it is estimated that the burden is as huge as the global one. Studies in South Africa, Kenya and Nigeria have found that at least 1 in 5 people who present at the outpatient department of a health care facility has one mental health problem.
- At WHO AFRO, we recognize that the context of mental health and substance abuse is far broader than non-communicable diseases.
- Poverty is an over-arching cause of mental illness. People living in poverty are more vulnerable, while those with pre-existing mental illness are more likely to become trapped in poverty.
- The drivers of mental health disorders on our continent extend beyond communicable diseases such as HIV/AIDS and tuberculosis, to malnutrition, the harmful use of alcohol, substance abuse especially in adolescents, and violence against women and children.
- The African Region experiences myriad emergency situations, including armed conflict, natural disasters and epidemic outbreaks which lead to social disruption and displacement.
- We estimate that 50% of refugees have mental health problems, ranging from post-traumatic stress disorders to chronic mental illness.
• Social stigma has meant that in much of Africa, mental illness is a silent epidemic. The effect of the silence is further compounded by inadequate focus at policy level.

**Current policy and treatment gaps**

• **Ladies and gentlemen**, Mental Health is one of the most under-resourced areas of public health in the African Region, although mental health problems are on the rise.
• Many developing countries dedicate less than 2% of their health budgets to mental health care, and mental health services are inequitably distributed, concentrated in big cities, with high risks of abuse and human rights violation.
• In terms of costs, in 18 countries in the Region, the most common method of financing treatment involves out-of-pocket payments. In addition, only 20 of the countries provide disability benefits.

• The few resources are used inefficiently, leaving a large treatment gap of over 80% for mental disorders and substance abuse, and 95% for neurological disorders such as epilepsy.
• Most individuals with mental disorders do not receive any medical treatment at all, and rely on traditional and faith-based healers, despite the fact that effective therapies exists for many of these conditions.
• The region has a dearth of mental health professionals; only 0.04 psychiatrists per 100,000 people – the least of any other WHO region.
• Only 56% of African countries have community-based Mental Health facilities and only 37% of the countries have mental health programmes for children.

**WHO’s response: Global Mental Health Action Plan 2013-2020**

• **Ladies and gentlemen**, in May 2013, the 65th World Health Assembly adopted a resolution on the “Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level.”
• The Global Mental Health Action Plan was developed and adopted the following year. My colleague, Dr Shekhar Saxena from WHO’s headquarters will go into more detail around the plan’s four pillars and proposed actions.

• In terms of policies and targets for the African Region, we have tailored the Global Mental Health Action Plan for the African context because of the widespread emergencies and disasters our continent experiences, to reflect mental health in the context of emergencies.
• The Mental Health Strategy for the WHO African Region (2016-2026) is therefore highly relevant and responsive to the work of our health security team and the regional priorities.
• It will be presented to Member States for adoption at our Regional Committee meeting.

• Meanwhile, there are ongoing efforts in the Region to address mental health through policy programming. Sierra Leone, DRC, Uganda, Zambia and Ghana among others developed policies and are moving mental health up the health agenda.
• Most recently, we have supported countries to strengthen their capacity by training health professionals, including at primary care level, and community health workers.
• The training focused on how to respond to mental health issues during and after emergencies, and to identify and treat common mental disorders and refer the most complex cases using mental health gap action programme (mhGAP) intervention Guide.
• However, a lack of political will in some countries, resistance to decentralize services, and lack of mental health facilities both at central and district levels is hampering progress on several of the targets from the four major objectives.

• **Ladies and gentlemen**, we are nearly halfway through the term of the Global Mental Health Action Plan. It will require massive effort to achieve the targets, given the capacity gap in the region and the current pace of action.

**WHO /AFRO Transformation Agenda**

• In tandem with the SDG agenda, WHO in the African Region is accelerating a reform programme, the Transformation Agenda (TA), which aims to ensure that AFRO evolves into “the primary leader in health development in Africa and the reliable and effective protector of Africa’s health stock.”

• We are changing the way we do business, focusing on four areas:

  1) Through **Pro-Results Values**, we want to foster an organizational culture that is defined by the values of excellence, team work, accountability, integrity, innovation and openness;

  2) **Our Smart Technical Focus** aligns the technical areas of WHO’s work in the African region to the regional priorities and commitments. These are related to health security and emergencies, Universal Health Coverage, Social Determinants of Health, the Sustainable Development Goals, health system strengthening, and communicable and noncommunicable diseases;

  3) **With Responsive Strategic Operations**, we want to become an enabling organization that efficiently supports the delivery of programmes in our Member States; and

  4) Through **Effective Communications and Partnerships**, we are creating a more responsive, interactive organization, internally and externally with stakeholders.

• The key areas of the TA contribute to the achievement of the Global Mental Health Action Plan objectives. They respond to country needs and operations.

**Contribution of the TA to the GAP**

• The TA will contribute to the Global Action Plan’s (GAP) **Objective 1**: To strengthen effective leadership and governance for mental health, through its cross-cutting health focus on Health System strengthening, programme delivery and Universal Health Coverage.

• For the GAP’s **Objective 2**: To provide comprehensive, integrated and responsive mental health and social care services in community-based settings, the TA help to drive progress towards equity, UHC, communicable and noncommunicable diseases.

• In terms of **Objective 3**: To implement strategies for promotion of mental health and prevention of mental disorders, our transformation agenda will contribute by tackling the social and economic determinants of health and strengthening human resources capacity.

• Finally, with **Objective 4**’s aim “to strengthen information systems, evidence and research for Mental Health”, the TA will support this through its cross cutting health system approach to facilitate delivery of programmes towards UHC.

**Way forward**

• The impetus of the new SDG Agenda and our WHO Transformation Agenda creates a powerful surge for reaching a number of the objectives of the Global Mental Health Action Plan 2013-2020, and the proposed Mental Health Strategy for the WHO African Region which will take us to 2026.
• We will continue to advocate for governments to develop or revise their national policies, plans, programmes and laws related to mental, neurological and substance use disorders.
• Specifically, we will urge countries to incorporate Mental Health into emergency management and build the capacity for the response before, during and after emergencies.
• We will continue to encourage countries to allocate domestic funds to support mental health activities.
• As part of our drive to improve partnerships and communication, we will include mental health in our resource mobilization efforts with partners. We have already implemented new systems to improve donor reporting, which will assist in coordinating donor and partner efforts and avoid duplication and competition.

The vision is there, the targets are there and we also know what it will take to achieve these targets. What we need is to work together, to harness our unique strengths and to collaborate actively to improve the mental health situation in the region. Mental health leaders and professionals, like you, can play a large role in this. We need you to work within your country, to take the next step in this direction. Psychiatrists need to not only treat patients, but help in planning for mental health services, in training primary care providers in basic mental health care and in increasing public awareness on mental health. We, in WHO are there to support you in these tasks for promoting mental health for the people of the African region.

[The full Power Point presentation is available from Prof Bhugra on request dinesh.bhugra@kcl.ac.uk]  

**WPA 2014 - 2017 ACTION PLAN**

November 2014

This WPA Action Plan for the period 2014 – 2017 has been produced by the WPA Planning Committee, and reviewed and approved by the WPA Executive Committee and is submitted for the approval of the General Assembly. Input from the WPA Council and WPA Board was also secured. As constructed, this 2014 – 2017 WPA Action Plan respected all the goals and objectives of the WPA By-Laws and WPA Statues. It also maintained the experiences and achievements acquired during the last triennium which has one of the most successful triennium in the history of the WPA. This WPA 2014 – 2017 Action Plan seeks the involvement and participation of all of the components of the WPA.

The Action Plan focuses on some general and two specific issues. The general aims and goals are:

**GOAL 1:** To enhance the image and respect of the WPA and the field of psychiatry and mental health worldwide, with specific emphasis on the general public, health care professionals, governments, policy makers, and society at large. **This is also described under Goals 10 & 11**

**ACTIONS**

**1.1:** Conduct ongoing press releases and reports when needed with focus on the most important advances in the field of psychiatry and mental health. The WPA scientific sections will be deeply involved in these activities. The WPA website will be completely reorganized. In addition other social media will be used more often such as Twitter and Facebook to disseminate information.

**1.2:** Produce written tools (books, articles, etc.) directed to enhance the public image of psychiatry across the world and, certainly, in all WPA regions. It is proposed that translations from other languages to English be also conducted so that we can learn from each other.

**1.3:** Collaborate with mental health advocacy, patients & carers organizations to eliminate stigma, discrimination practices and negative attitudes vis-à-vis mental illness across the world. Collaborating centres and virtual hubs will be developed. These will act as repositories of information, policy documents and research opportunities.

**1.4:** Collaborate with the appropriate health/mental health organizations and governmental agencies for the purposes of developing and implementing worldwide prevention programs vis-à-vis mental illness and conditions. These are illustrated later in detail. It is essential that the WPA works closely with the WHO and deliver effective leadership for mental health for all and comprehensive care.

**1.5:** Create special presentations and forums in all major WPA Conferences and Congresses directed to promote mental health initiatives across the world. This approach is about sharing vision and good practice.

**GOAL 2:** Plan and implement, in collaboration with all WPA Zone Representatives and local WPA Member Societies, educational programs and scientific publications directed to early career psychiatrists and primary care specialists along the lines of clinical and investigative areas of relevance to the fields of psychiatry and mental health in all WPA regions.

**ACTIONS**

**2.1:** Seek appropriate funding for these highly relevant educational initiatives.
2.2: Select the appropriate teachers/faculty to conduct these highly relevant educational activities. **Ensure that these are easily available and accessible. Educational activities will take priority and ways of exploring delivery and assessments will be explored.**

2.3: Select the most appropriate early career psychiatrists to **participate in these educational activities, support and mentor them**

2.4: Select and design the curriculum to be covered in these **educational activities at undergraduate, postgraduate and continuing learning modules.**

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**GOAL 3: Seek appropriate and high quality of educational materials** for circulation worldwide via the WPA website.

**ACTIONS**

3.1: The WPA Secretary for Education to select the appropriate and relevant educational curriculum to be included in this project. **These will be developed delivered and assessed by creating different methods and structures.**

3.2: Prepare the educational materials to be included in the WPA website.

3.3: Assess in an ongoing basis the outcome of this educational project in order to keep it up-to-date from a scientific point of view. **Create different modes of assessment and delivery. Closer liaison with interested high reputation educational bodies to be developed. Explore formally recognizing training being provided by the WPA.**

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**GOAL 4: Promote and disseminate worldwide relevant psychiatric and mental health information directed to improve the quality of psychiatric care across the world.**

**ACTIONS**

4.1: To maintain the high standards of excellence of "World Psychiatry" Journal.

4.2: Stimulate, carefully select the books to be published by the WPA leadership.

4.3: Promote the dissemination of evidence-based scientific information via all appropriate WPA media channels.

4.4: Make patient, carer/family educational materials accessible and available through the WPA web site and other resources.

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**GOAL 5: Operate the WPA under the highest organizational ethical standards.**

**ACTIONS**

5.1: Maintain the highest standards of fiscal accountability, transparency and openness.

5.2: Disseminate periodically full fiscal reports of all WPA activities via the WPA media channels (website, newsletters, etc.).

5.: Develop and maintain an open disclosure among the high leadership of all WPA insofar as potential areas of conflicts. Use the WPA website for this purpose.

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**GOAL 6: Conduct WPA Scientific Meetings with the highest standards of quality.**

**ACTIONS**

6.1: Select the best possible speakers and presentations in all of the WPA Sponsored Scientific Meetings.

6.2: Conduct WPA Scientific Meetings in regions and areas of the world where the scientific needs are very high (e.g., **poor countries** and/or areas of the world in poverty).

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**GOAL 7: Promote the highest quality of research activities in the fields of psychiatry and mental health. In collaboration with the WHO and member organizations to help develop information systems, evidence and research.**
ACTIONS
7.1: Promote the highest quality of leadership in all WPA Scientific Sections.
7.2: Seek financial support for the WPA Scientific Sections.
7.3: Stimulate the WPA Scientific Sections to present and actively collaborate in all WPA Scientific Meetings.

GOAL 8: Fully advocate for the rights of the mentally ill across the world.

ACTIONS
8.1: Join forces with as many as possible advocacy, patients & carers organizations. Develop closer links with high reputation organizations.
8.2: Provide appropriate leadership vis-à-vis the rights of the mentally ill worldwide.
8.3: Advocate for full access and quality of psychiatric care worldwide, with emphasis on the poorest regions of the world, in collaboration with international health/mental health organizations. To develop international standards of care for specific conditions and general principles -this will be at BOTH realistic and aspirational levels.
8.4: Assist governmental agencies across the world to protect the rights of the mentally ill and the highest standards of care for mental patients worldwide.

GOAL 9: Participate and collaborate with all worldwide organizations in the development and implementation of appropriate diagnostic and nomenclature systems across the world.

ACTIONS
9.1: Collaborate with the World Health Organization (WHO) in the revision and implementation of the International Classification and Diagnosis Diseases (ICD).
9.2: Collaborate in the Harmonization of all Diagnostic Manuals across the world.

GOAL 10: Prevent mental disorders. Four themes will be pursued and a member of the EC will take on coordinating responsibility using Task forces. The output for each theme will be development and delivery of undergraduate, post-graduate and continuing education curricula and a policy document.

ACTIONS
10.1: FOCUS ON GENDER BASED interpersonal and domestic violence
10.2: FOCUS ON CHILDREN AND ADOLESCENT MENTAL HEALTH ESPECIALLY ON emotional, physical and sexual abuse.
10.3: FOCUS ON PRISONER MENTAL HEALTH CARE-looking at improvement using education and policy changes and appropriate court diversion and assessment policy development
10.4: FOCUS ON MINORITY/ EXCLUDED/ VULNERABLE GROUPS MENTAL HEALTH: groups such as migrants, asylum seekers, LGBT, learning/intellectually disabled and the elderly.

GOAL 11: Mental health promotion

ACTIONS
11.1: Create materials and work closely with other organizations whose goals and aims are in harmony with the WPA in promoting well-being and good mental health using a number of strategies such as social media and web based learning.

As mentioned above the outcome of all these five themes will be at 4 levels, policy and curricula development at undergraduate, postgraduate and Continuing Medical Education levels. Provision of comprehensive services which are evidence-based and strategies for delivery of care in community settings will be a major part of the Action Plan. These will be monitored closely with clearly sign-posted details through the Executive Committee.


Addendum 3. SUBMITTED DOCUMENTS

3.1 PANEL I. Leadership and governance

(1) Republic Of Mozambique Ministry Of Health Public Health National Directorate Mental Health Department. Presentation: Integration Of Mental Health In Primary Health Care - Task-Shifting In Mozambique.


3.2 PANEL II. Health and social services

(1) Vikram Patel, Dan Chisholm, Rachana Parikh, Fiona J Charlson, Louisa Degenhardt, Tarun Dua, Alize J Ferrari, Steve Hyman, Ramanan Laxminarayan, Carol Levin, Crick Lund, María Elena Medina Mora, Inge Petersen, James Scott, Rahul Shidhaye, Lakshmi Vijayakumar, Graham Thornicroft, Harvey Whiteford, on behalf of the DCP MNS Author Group. Addressing the burden of mental, neurological, and substance use disorders: key messages from Disease Control Priorities, 3rd edition. Lancet. www.thelancet.com Published online October 8, 2015 http://dx.doi.org/10.1016/ S0140-6736(15)00390-6

(2) EPA Guidance Papers

Context


Topics


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- EPA Statement on the EPA Position Paper on Psychiatric Care of Refugees in Europe. [For any inquiries please contact the EPA administrative office: katie.luck@europsy.net]

### 3.3 PANEL III. Prevention and promotion

2. CareIF. Global Position Statement: Mental Health, Human Rights and Human Dignity: “Magna Carta for people living with Mental Illness”
3. European Union, 2011. David McDaid (Under the IMPACT contract to support the European Pact for Mental Health and Well-being.) Making the Long-Term Economic Case for Investing in Mental Health to Contribute to Sustainability.
4. CareIF Position Statement on Stigma
5. CareIF Newsletter 10th Anniversary
6. Submission - South African Federation for Mental Health. (Charlene Sunkel - Programme Manager: Advocacy & Development) charlene@safmh.org
7. Submission – SADAG (Zane Wilson – Founder)

### 3.4 PANEL IV. Information, evidence and research

Addendum 4. PANEL LEADERS’ BACKGROUND & TRANSCRIPTION OF PROCEEDINGS

1. PANEL LEADERS’ BACKGROUND

1.1 PANEL I Leadership and Governance

Summary of minutes of the meeting on the 2nd November 2016 with the South African National Department of Health’s official responsible for Mental Health, Civitas Building, Pretoria.

Present: Prof Melvyn Freeman (Chief Director Non-Communicable Diseases); Mr Sifiso Phakati (Director: National Directorate of Mental Health and Substance Abuse); Dr Mvuyiso Talatala (President SASOP 2014-2016); Prof Bernard Janse van Rensburg (President-Elect SASOP 2014-2016)

- The existing national policy document on mental health will be the context of the South African inputs to the Forum: National Mental Health Policy Framework and Strategic Plan 2013-2020.10

- The question remains of how to do these things, i.e. the resourcing of policy and programs, as well as for dedicated participants to meet and clarify their roles.

- It must be clarified between the WPA and the WHO how it may be best for the WPA to contribute to mental health in Africa, with particular reference to the different WPA regions in Africa. E.g. how the grouping can contribute towards the mental health of victims of regional conflicts and wars, as well as other trauma and violence.

- The possibilities for cooperation between the WPA’s three African Regions (Zones 11, 13 and 14) and the office of the WHO-African Region must in particular be explored.

- It may also be important to identify the correct connection with the African Union’s Social Desk.

- It may be important to identify what exists in the continent to energize everybody for this task and to attract and mobilize them towards the vision for the potential for mental health for all.

- The specific goal (Goal 3) of the Sustainable Development Goals Program must also be taken as a point of departure.

- The potential for collaboration and for all to share information may be developed through possible bi- and multilateral agreements

- Finally, the correct protocol for receiving the WHO Regional Director for Africa, Dr Moeti, on the 18th November 2016 at the proposed Forum, was discussed.

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The WHO Atlas documents that Africa has a growing portion of the world’s population, but that it has relatively few trained mental health clinicians. Nationally representative surveys of mental disorders have been undertaken by Nigeria and South Africa, and these indicate that there is significant under-diagnosis and under-treatment of these conditions. The WHO and other organizations have addressed this issue in a number of ways, including development of the Mental Health Action Plan 2013-2020, development of mHGAP guidelines, and encouraging work on task-shifting.

In terms of information, evidence, and research, it is important to acknowledge the 10:90 gap; 90% of global research emerges from high income countries where only 10% of the world’s population lives. Funding for work in the area of clinical neuroscience dramatically outweighs funding for work that is more directly relevant to the concerns of global mental health. Nevertheless, recent attention has been paid to addressing this gap; for example, the NIH has a number of mechanisms focused on global mental health issues, and the Canadian Grand Challenges has made monies available for low income countries in Africa.

Throughout the globe, one important approach to scaling up evidence-based mental health care has been a focus on integrated mental health care and collaborative care. Relatively little research has been undertaken on integrated mental health care and collaborative care in the African context. A number of research efforts are however currently under way, with funding from DFID, the EU, CDC, the Wellcome, and other science agencies. The development of an evidence-base on what works in the African context, and how, is paramount.

Recommendations:

1. There is a need for further epidemiological research; there are relatively few data for example on the prevalence and associations of mental disorders in primary care settings in the African context.
2. There is a need for further work to demonstrate the effectiveness and cost-efficiency of integrated care and collaborative care in the African context, as well for further work on moderating and mediating factors.
3. As recommended in a recent priority setting exercise, there is a need for a broad range of research methods to employed in mental health, and for a broad range of capacity building to be done; ranging from basic neuroscience through to implementation research.
2. TRANSCRIPTION OF PROCEEDINGS

2.1 Reporting back by Panels

(1) Florence Baingana - Panel I. Leadership and governance

Issues discussed include:

- Change of leaders; sometimes you have the support in a minister but then programs move and the minister changes
- The languages that are spoke – not only the language when communication with patients, but also hospital administrator, the minister of finance or of social welfare, on the district level a different level; there are different languages for different people you speak to
- CRPG (Convention on the Rights of Persons with Disabilities) – most of the discussion on this; many issues were discussed of how this will apply to mental health services in the Sub Saharan Region; especially with regard to involuntary admission; there is a recent paper out on this by Dr Melvyn Freeman; we also discussed a bunch of other things, in particular, inclusion of involuntary admission enforced or included in our laws
- Policy implementation does not always follow having good policy – having good mental health acts (or policy) in place does not always mean that having this indicator in itself, does not mean the policy is implemented
- Education on Public Health is required on all levels - all levels of people must be trained, form international to local; everybody needs to understand the language of public health
- Tensions, working with partners – even working within ourselves, e.g. psychiatrists working of (the official) in the Ministry; ourselves and consumers; ourselves (mental health stake holders) with others outside of mental health; between the central/national and lower levels
- Regulation of task shifting – it was talked about elegantly this morning by Dr Moeti, but there is a lot of issues about who would do training, who is trained to do what; and how is it supervised

Recommendations:

- Involvement of all stake holders in all meetings at all levels; if you have planning meetings on district level, you have to have all the stake holders at the table; that would also mean for consumers to be there; and you have to enable them to participate and not only sit there, they may require training and support; e.g. meetings should be for a length in order for them to participate
- We need to systematize the mental health approach the (in the) Ministry of Health and not to put all efforts in the Minister, as Ministers change; also the CMO, permanent secretary, technical officials, all must be talking mental health (on our behalf) on all levels – in the ministry, the district, also across ministries (finance, education, social welfare); we must systematize mental health across all these areas
- Data, data, data, in order to get the financing we need in order to do all the things we need to do
- CRDP – need to focus on the big picture; not to focus too much on the detail, as it may take away from all the gains are trying to make; the big picture is that we want human mental health service; we can get there step by step; may also have to think about a CRPD that is orientated for mental health; it may not e the same as others, it could be feasible, but it will take time to get there
- Need to mobilize resources to training people in public mental health at national and district level, in order to have as many as possible people understand public mental health; so if we have somebody in a Ministry that they not only advocate for psychiatric hospitals, but are looking for systems and resources and putting into place systems that are beyond hospital based care
Mental Health Innovations Africa – they are a platform that we can use to continue to discuss and debate issues and also hear what work; we can work them to see how to do that

(2) Wolfgang Gaebel - Panel II. Health and social services
This was a small group as a couple of members did not show up; it consisted of Prof Gaebel, Prof David Ndeitei, Prof Vikram Patel, Dr Parker, Dr Robertson, Prof Jair Mari. Prof G also took the role of chair and panel coordinator and gave an introductory presentation on Objective 2 on Health and social service, namely: to provide comprehensive, integrated and responsive mental health and social care services in community-based settings.

I was a little surprised to hear that the problem in transforming the mental health care system towards this objective, is not (only) the problem of resources, but of the allocation of these resources, as well as the question of responsibility and the role identity of those responsible for doing the mental health care in the country; at least in this country but also other African countries.

The balanced care model plays a role, with several votes that of course the mental hospital (“asylums”) can’t be closed altogether or reduce their beds until something new has been built up in the community; both of these systems/components – outpatients, community-based and hospital services must exist in a relationship and in cooperation with each other.

Prof Patel, in particular from his Indian perspective and experience, meant that hospitals should transform themselves and should also offer services on an outpatient and day care basis; they should expand their spectrum of activities not only to have people in a bed and then afterwards being referred to a community service which is not fully built; this was an important perspective; hospitals should be and remain an integral part of the community-based service system.

A question arose again also from Prof Patel if we really need a disorders-based model of care or whether since most of them who are of a milder character should be treated in the community; and not in a specialist setting, of whether it is important to make this distinction of these milder disorders, e.g. mild depression; people who do have other needs than those with severe disorders - who need the specialist care; in this regard, he mentioned the dimensional view on the problem of disorders and severity of disorders, which might be important, meaning that this refers to the base of the WHO treatment pyramid, so that this base (which was a continuing comment) should strengthening and broadened; meaning that the mental health work force besides the psychiatrists need to take over the roles which may have been traditionally that of the psychiatrists; this would need education, of GPs, social workers other health care workers; the question is, who is doing this, could it be done by the more equipped other members themselves, e.g. experiences mental health nurse could give education to nurse who has been working in the somatic field; here Prof Gaebel also tried to get the panel on track with regard to concrete recommendations, as the whole document needs to be a position paper; it was the panel’s part to contribute in this regard, it was tried to make these recommendation clear enough so that it could form part of this whole endeavor of writing this position paper.

Dr Ndeitei for instance has also commented on that Africa is not lacking resources, but e.g. has too many psychiatrists working in private practice and are not available for a connected and integrated work with the other players in the field; therefore he meant that families, teachers, policy makers and opinion leaders are all there and might be involved in this ask of transforming the system.

It came up several times that doctors, psychiatrists do want in private sector, or the academic field and not in the community; this raises the question of how the identity of psychiatrists and other workers need to be transformed and developed so that there is a broader picture that
there is not specialist here and other there; that all of them do need to know about the other part in this field, which led to the recommendation that in all educational materials and textbooks that mental should not be a separate part, but should be integrated in somatic material and the other way around; so we all need to be knowing more about the other, about health and mental health

- So, broadening the pyramid base by selfcare; getting people able to get care for themselves, where others with neuropsychiatric disorders should be of course be further treated in specialized centered, but it should only be for these severe disorders

- Prof Mari mentioned that in a catchment area the role must be clear between the different players in that field; also for the people living in a catchment area, should be assured that in case of an emergency, the right places can be addressed here; so it seems to be a problem of communication logistics, allocation, which is something that will need leadership to address; it is if the basics is lacking here, it is a reorganization and a reformation of the system that has to be done here.

(3) **Albert Persaud – Panel III. Health Promotion and prevention**

The group had a very lively discussion and was chaired by Dr Moeti. Albert will forward a full summary to be placed on website. Discussion can be summarized in 4 key headings: (1) Service user (2) Competency (3) Stigma (4) Training/ Education programs.

- The service user is at the heart of it; you need to recognize the voice of the service user and the richness and depth they bring to the table; particularly patients want a holistic approach when they are tackling some of the physical illnesses that Shekhar referred to in the morning when he spoke about mortality and deaths, where people with mental illness often die 15-20 years younger than others

- Patients must be involved in the monitoring and evaluation of services; create services that care and support rather than service which stigmatize people even more

- Competence - cultural, educational, service and policy competencies; examples were considered of community-based programs, especially in the rural areas; “speaking the language”, organizing mental health days, getting policy makers involved, looking for supporters and champions

- Another key component is undergraduate and post graduate training; in some parts of Africa only 4 weeks of training in mental health are included in undergraduate programs; if awareness of mental health has to be increase, this must be improved, as a lot of symptoms in primary care has a mental health link which needs to be understood

- Stigma a key issue that came up over and over again; but there are good examples of using the media to address this; someone mentioned an amount of R19 million worth of advertising space; cultural aspects of stigma was addressed as it presents itself in various groups of different ethnic backgrounds; Dr Moeti mentioned the example of her own family, where her mother commented on the fact of having only seven daughters and no boy and what that meant to her and the community

- The health system e.g. PHS, NGO that recognize the voices of the service user are the progressive ones

(4) **Crick Lund – Panel IV. Information, evidence and research**

Interesting discussion; low mean age of the group with a lot of young people interested in research and evidence; chaired by Dan Stein and Dinesh Bhugra; the group was basically asked for examples of research and practice innovations, from which lessons can be drawn. These include:
• “The Teachable Moment” - A randomized controlled trial conducted in emergency departments in the Western Cape on screening and brief intervention of alcohol use disorders; this is now being taken up by the Health Department and rolled out; this is a very good example of research being translated into policy and practice

• AMARI (African Mental Health Research Initiative) – led by Dr Dickson Shibanda from Zimbabwe; A Wellcome Trust capacity building grant providing fellowships for Masters, PhD and post doc students; some 47 fellowships have been awarded across 4 countries (Ethiopia, Malawi, Zimbabwe, SA); a great example of how capacity building is being developed for the next generation of researchers

• Mental Health Innovation Network (MHIN) – an online platform managed by the London School Hygiene and Tropical Hygiene, providing a way of sharing mental health innovations across the world, especially in low-income countries; on the basis of this, a MHIN-Africa has been started, which is really focused on African innovations and provide a platform for African innovators, policy-makers and researchers to interact with each other

• Other examples of projects on: task sharing innovations, e.g. training community health workers to support adherence for people with severe psychiatric disorders in the Western Cape; working with traditional healers in the Gauteng Province; integrating mental health in non-communicable diseases care in Kenya with training of clinical officers in screening and providing basic mental health interventions; integrating mental health in HIV care in Gauteng Province; a lot of these projects are well evaluated and written-up or in the process of being reported on.

Lessons and recommendations
(1) The critical importance of collaboration and network and generating evidence is very much a team effort; the more we can build networks especially for people who isolated in their countries, the better
(2) The sharing of information and experiences
(3) To address stigma – when we do task shifting or task sharing interventions to rain specialist, we also have to address stigma in these workers and the systems in which they operate
(4) To make use of technology in screening and intervention delivery, but noting e.g. the limitations of the use of cell phones in such interventions in communities which is marked by poverty and criminality has many challenges
(5) The importance of cultural idioms of distress and adapting interventions to be culturally appropriate in different setting
(6) The risk of training or identifying new cadres who can deliver mental health if the Ministry of health does not provide the posts for them to take up and practice what they have learned; so it is an important part of research to work closely with policy makers to make sure that there is readiness to take up findings and scale up services
(7) Very important message to teach undergraduates about the different types of research and to dispel myths about research (e.g. common myths such as the “Frankenstein” myth of the researcher developing evil technology, or the “Einstein” myth of the “genius couch potato”’) while research is really about curiosity and stimulating clinicians to chase and pursue questions they may have in their practice
(8) The embrace a range of research methods from quantitative to qualitative methods and to develop a new group of clinician researchers – not people who only do research, but people who integrate research with clinical practice and also the importance of translational research
### ADDENDUM 5. DELEGATES

*To note that this list is not the attendance list, but only those who RSVPed to the invitation*

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**Apologies**

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