Semi-Annual Report:

An Integrated Approach to Addressing the Challenge of Depression Among the Youth in Malawi and Zambia

March, 2013

Submitted To:
Grand Challenges Canada

Submitted By:
Farm Radio International
Detailed Report

1. **Describe the anticipated impact of your project. How will your project improve the health and well-being of those affected by mental health conditions in low- or middle-income countries within the context of your project? Please indicate how this will be measured.**

   - We anticipate our project will: 1) Enable youth better to understand Depression as an illness and where to get help when needed; 2) Equip teachers to identify Depression in young people and to be “go-to” people for youth who may be suffering from Depression; 3) Build the capacity of the health system to effectively understand Depression as a mental illness, and to identify and treat Depression; 4) Improve mental health literacy, increase mental health-seeking practices, and reduce stigma surrounding mental illness and Depression.

   - The anticipated impact will be measured in a number of ways. Through a baseline survey and a follow-up survey we will measure mental health KAP prior to and following our school-based peer educator interventions and our comprehensive communication strategy to identify positive changes in knowledge and attitudes about Depression. We will also work with district-level health centers and schools to measure whether there is an increase in the number of youth seeking help during the program. Qualitatively, we will work with in-school and out-of-school youth clubs to determine whether their attitudes and perceptions of Depression have changed as a result of the interventions

   - We anticipate empirically demonstrated outcomes in the following areas: Improved access to mental health services and treatments; positive change in knowledge, attitudes or behaviours of youth, teachers and health care providers; positive change in practices and policies of service providers through increased training or skills to improve the lives of those affected by Depression; improved sustainability of mental health programs through integration of curriculum within the school system.

2. **To date, has your project led to positive changes in one or more of the following outcomes? Describe the positive change and how you have evaluated the success of this change. If you are in the process of achieving positive change in one or more outcomes, please indicate your current progress. Where possible quantify the number of people that have been impacted (or will be impacted) by these changes?**
• We are currently in the process of laying the groundwork for interventions that will achieve positive changes in our anticipated outcomes. We have currently worked to engage the relevant government ministries as stakeholders to ensure political buy-in and long-term sustainability of the project. Early efforts are contributing to recognition that mental health is a priority across sectors. The ministries of youth, health and education have all expressed their interest, commitment and support for the program. We had a very successful stakeholder meeting in January, 2013 where we worked with federal and district level stakeholders, as well as academic and youth representatives to establish a set of shared aims and priorities. Successes are evidenced by the identification of knowledge partners across sectors, and memoranda of understanding signed by representatives from relevant government ministries.

• Through mental health and Depression sensitization and awareness sessions, we have also developed a common understanding of Depression among stakeholders across sectors.

3. Has your project produced any outputs (e.g. prototypes, service delivery models, peer-reviewed publications, policy recommendations, and/or patents, etc.) to report on?

• We have completed a baseline survey of mental health literacy in the three impact districts where we will carry out our work in Malawi. As detailed in the baseline survey report (Annex A), we identified gaps and inconsistencies in the knowledge, attitudes and health practices of respondents. This data will help us to identify areas of focus for our peer-educator and radio-based intervention strategies, and provides a baseline against which to measure changes in MH literacy and attitudes about Depression.

• We have completed the development and adaptation of peer educator and mental health curriculum materials to use for teacher training and peer educator training, commencing in May. These documents will be translated into Chichewa by the end of March. In both Malawi and Zambia, we will train 260 teachers, school administrators and youth leaders to run mental health literacy sessions, and 150 peer educators in each country. We have produced mental health curriculum and peer educator training materials to use within the school system, adapted and translated from Dr. Stan Kutcher’s curriculum for mental health education in Canada.
• We have created a tool for assessing MH and Depression literacy levels. This tool will be administered before and after each training and MH literacy session to measure change in knowledge and attitudes.

• A situational assessment and mapping exercise was completed in Malawi, providing data on schools, health centers, and youth clubs and mapping the distances between them. The situational assessment allowed us to determine the extent to which school teachers, counselors, and administrators have previously been exposed to mental health education, and provided a self-assessment of their level of mental health literacy.

• We have created a module specifically about youth Depression to add to Dr. Kutcher’s school-based curriculum.

• We are in the process of creating a training manual for radio broadcasters about mental health, mental illness, and Depression.

Challenges and Lessons Learned

Grand Challenges Canada believes in the importance of identifying challenges and documenting lessons learned to improve on future activities. Please describe the top 3 challenges or lessons learned to date.

1) Translation of the word/concept Depression

In implementing the baseline survey, we realized that the word Depression does not easily translate to the local language Chichewa. This difficulty was compounded by the fact that Depression is not recognized as a mental illness in Malawi, which made attempts to describe it to respondents challenging. We held a number of team meetings to determine the best term to use, and the best way for enumerators to describe it to respondents. Overall, the Chichewa word that was agreed upon directly translates to “disease of worries”. This challenge delayed our timeline for implementing the baseline survey as we drastically underestimated the time it would take to complete a single survey.

We mitigated this challenge in a number of ways. We held a one-day training session on mental health Depression for all staff and partners in Malawi in January. This ensured that all implementing staff have the same basic understanding of the overall aims and objectives of the program and a common understanding of mental health, mental illness, and Depression. We intend to run a similar training with our radio broadcasting partners in April. In addition to the training sessions on mental health and Depression, we have decided to convene an advisory panel of knowledge partners who...
will ensure that the mental health messages are coherent across languages. We will conduct focus groups with youth clubs who will provide feedback and input on the development of messages about Depression that will be used in the communication strategy. As a result, our project has taken on a participatory element that was not in the original proposal.

In future scales-up activities, we have learned that we will need to allocate greater resources—finances, time and human resources—to facilitate extensive consultation with knowledge partners prior to conducting baseline research or adapting and translating training materials.

2) Stakeholder Engagement

We recognized from the inception of the project how important it is to engage stakeholders across sectors to work with us as supporters and partners. We did not anticipate the level of disconnect, mistrust and competition that exists between different sectors. We engaged the ministry of Education as the primary stakeholder given that the majority of our interventions use the school system as the entry point. However, the Ministry of Education was reluctant to help us engage the ministries of youth and health, preferring to see itself as the “patron” of the project. At our stakeholder meeting, representatives from the Ministry of Health were clearly concerned that they had not been engaged more fully to that point. In order to mitigate this challenge, we added a second day to our stakeholder meeting that was solely for health sector representatives. We used that time to discuss ways to engage the health sector more fully, and created relationships with key people in the Ministry of Health, as well engaged the lead psychiatrist working out of Malawi’s only mental hospital as a knowledge partner. We still found that, in many cases, stakeholders had their own motivations for championing the program. Some representatives within the Ministry of Health wanted to add psychosis and epilepsy as targets, rather than just focusing on Depression. Representatives within the Ministry of Education feel it is important to use the funds for this program to establish sports leagues in secondary schools. Given that we feel it is exceedingly important to, at one and the same time, take the motivations of our key stakeholders into account while staying true to the overall aims and objectives of our program, we have invested a lot of energy in stakeholder relationships. This extra effort has delayed the engagement of the ministries of youth and health, as we underestimated the time it would take to nurture these relationships and to navigate varying motivations among stakeholders. It would be valuable for Grand Challenges Canada to consider adding a session on navigating stakeholder engagement in projects that are “integrated” within and across a number of sectors.
This challenge also delayed the development of a theory of change that incorporated feedback from key stakeholders. We will hold a theory of change workshop with all project partners and staff in mid-April to draft our theory of change for the project. We will incorporate the feedback we received from stakeholders to date, but without asking them for direct input into the theory of change.

3) Impact vs Control Communities

In the early stages of the project, we faced challenges in selecting impact and control communities that would allow us to gather statistically valid data to demonstrate the contribution of our interventions to changes in knowledge, attitudes and practices within target communities. We chose the three impact districts based on relationships previously fostered in those communities by one of our implementing partners—the Guidance, Counseling and Youth Development Centre of Africa. Given those relationships, we are able to build on work previously done there. Control districts were selected given their similarity to the impact districts in terms of language, socioeconomic factors and school system. However, our radio listening preference survey shows that youth have a strong preference for listening to stations that broadcast across both impact and control communities. For this reason, even our control community will have access to messaging about mental health and Depression, compromising the ability for these districts to act as strict controls. In order to mitigate this difficulty, we will develop a monitoring system that will allow us to determine whether or not people in control districts have heard the radio programs, and we will account for this factor in our follow-up survey. We will be able to generate data that compares changes in MH literacy and attitudes among: a) individuals that listened to the radio program AND were exposed to the school and youth-club based intervention with; a) individuals that listened to program but were NOT exposed to the school/youth club intervention (listeners in control communities), with individuals that neither listened to the radio program NOR were exposed to the school/youth club intervention.

Next steps (1/2 page)

- Mental Health Literacy Training: Stan Kutcher will conduct 5 days of training (Aril 15 – 19) for those who will be responsible for implementing mental health literacy training to 260 teachers, school administrators and youth club leaders, which will take place between May - June, 2013.
- Teachers, administrators and youth leaders will deliver 600 hours of mental health literacy sessions in schools and youth clubs between Aug 2013 and Aug 2014.
- 150 peer educators will be selected and trained between May - Sept. 2013.
Radio partners will sign contracts by then end of April 2013, and will undergo in-station training on youth radio, mental health training, and technical training on Integrated Voice Response systems between April – July, 2013.

Storyboards for 60 3-5 minute mini-drama episodes will be completed by June 2013, and production of mini-dramas will be completed by August 2013.

3 radio stations in Malawi will commence mental health program broadcasts in August 2013

Youth clubs will form listener groups, and will contribute content to the radio programs from Sept – June 2013.

Training program for Mental Health Identification and Mitigation Trainers developed by August 2013

10 days of training for Mental Health Identification and Mitigation Trainers will take place in Sept, 2013.

Our team will present our project at a mental health conference in Malawi taking place April 24 - 26, 2013, and we are also submitting an abstract to participate in Sustainable development through global action: The case for investing in mental health conference taking place at the Institute of Psychiatry, King’s College London in Sept, 2013.

Other accomplishments (1/2 page)
Has support from Grand Challenges Canada enabled you or your team beyond the scope of the project? If so, please describe. Examples could include leveraging additional funding, career/professional progression etc.

The partners were able to design a promising new tool for measuring knowledge and attitudes about mental health and Depression. The tool can be used on a mobile device (cell phone) or on a pad of paper, enabling quick and reliable measurement and analysis of changes in MH literacy and attitude before and after various interventions.

Support from Grand Challenges has enabled us to understand Theory of Change as an evaluation tool, and we are working to incorporate it into our other projects.
<table>
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<tr>
<th>Objectives</th>
<th>Activities</th>
<th>Critical milestones / Metrics of success</th>
<th>Estimated Dates</th>
<th>PROGRESS</th>
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</table>
| Objective 1: Create multi-stakeholder commitment | Activity 1.1: Convene project partners and key stakeholders | Project partners meeting conducted | Month 3 | 1. **Project Implementation Partners’ Inception Meeting:**

In October 2012, together with FRM, co-organized an inception meeting for all project implementation partners at Capital Hotel, Lilongwe – Malawi. Key results/resolutions of this meeting were:
- Agreement made on MoUs
- Development of a specific collaboration roadmap
- Signing of the grant agreement between FRI and local partners FRM and GCYDCA

- Inception meeting conducted with key stakeholders (12 of stakeholders, senior officials at Ministries of Health, Youth Development and Sports, Education Science and Technology, Information and Civic Education in Malawi and Zambia)
- 3 MoUs signed with key ministries in each country
  - **Malawi (MW):** Ministries of Health, Education Science and Technology, and one or both of Youth Development and Sports, and Information and Civic Education.
  - **Zambia (ZB):** Ministry of Education, Science, Vocational Training and Early Education; Ministry of Health and one or both of Ministry of Sport Youth and Child Development, and Ministry of Information and Broadcasting Services

1st Qtr – by Month 3
- MW: By Month 3
- ZB: By Month 12

1. **Partnership Discussions with Stakeholders:**

   i. Conducted preliminary partnership discussions with the key Malawi Ministries namely; Ministry of Education, Ministry of Health and ministry of Youth between October to March 2013. Key resolutions/results of the discussions were:
   - Signing partnership agreement letter with the key Malawi Ministries (see Annex G)
   - Facilitated the acquisition of an Ethical Clearance from the Malawi Ministry of Education as legal requirements to safeguard the rights, dignity and welfare of people participating in research-related activities of the project (see Annex F)
   - Conducted preliminary partnership discussions with key Malawi Ministry of Education officials on school-based programme – including representatives from the Directorate of School Health & Nutrition & HIV/Aids; Education Division Managers, District Education Managers, Primary Education Advisors, and head-teachers from selected schools from the participating schools
   - Conducted preliminary partnership discussions with the Zambia High
Commission to Malawi, Zambia Ministry of Education (gatekeeper) and the Zambia Open University (possible Knowledge Consultancy) for sensitization about the programme

2. Malawi Stakeholder Meeting
All partners co-facilitated the organization of and participated in the February 2013 Malawi inception meeting with stakeholders from the Ministry of Education, Ministry of Health, Zambia High Commission, African Union (SARO offices), Malawi Institute of Education, Kamuzu College of Nursing, School of Health Sciences, St. John of God School of Mental Health, Zomba Mental Hospital, Youth representatives from impact districts, GCYDCA, FRI, FRM, and Media houses namely: National Media Institute Of Southern Africa (NAMISA), The Nation, The Daily Times, Zodiak Broadcasting Station, Malawi Broadcasting Cooperation (MBC TV), Galaxy FM Radio, and Mudzi Wathu Community Radio Station (see Annex E for meeting report). The meeting was 2 days, with the first day for all invited participants and a second day for health stakeholders only.

| Activity 1.2: Path to scale and integrated innovation approach for program | - Develop path to scale and refined integrated innovation approach for discussion with Grand Challenges Canada by Month 6  
- Develop a draft theory of change map for your project with support and guidance provided by Grand Challenges Canada and experts (6 months) and be actively engaged in Theory of Change-related portfolio activities. | By Month 6 (and duration of project) | We have had preliminary discussions about the Path to Scale and Theory of Change, but have not yet completed them. We would like to ensure all partners—including management and program staff—to have the opportunity to give feedback before submitting to Grand Challenges. We have planned a theory of change/path to scale workshop in April led by Heather Gilberds for all program staff in Malawi to attend. We will submit the theory of change and path to scale by April 30, 2013. |
| Objective 2: Mental health literacy among adolescents in Malawi and Zambia increased | Activity 2.1: Baseline survey & needs assessment related to MH literacy (knowledge, attitudes, practices). | MH literacy/KAP survey conducted in MW 1250 surveyed; in ZB 1250 surveyed | MW Month 4-6 ZB: Month 13-15 | Baseline Activities:
1) Situation analysis (Malawi):
The situation analysis was conducted in order for teachers in the participating schools to self-assess their mental health literacy in the participating schools in the three participating districts between November 2012 to February 2013
- Developed a situation analysis tool
- Trained GCYDCA staff in conducting the situation analysis
- Conducted the situation analysis in the impact districts
- Conducted data entry and analysis
- Wrote a situation analysis report (Annex B)

2. KAP and audience listening baseline survey
We altered the numbers from the original proposal and are now surveying 3000 people in Malawi to oversample given the inevitable difficulties in locating respondents for a follow-up survey. The survey includes sections on knowledge, attitudes and practices as well as radio listening habits and preferences. We have currently completed the survey in the 3 impact districts, and will complete the 2 control districts by the beginning of May. See Annex A.1 for a detailed report of the survey findings and a copy of the survey itself. See Annex A.2 for enumerator reflections.

3. Mapping:
Developed mapping tools
- Trained GCYDCA staff in use of mapping tools and mapping process
- Conducted a desk mapping exercise of the impact districts namely: Salima, Lilongwe, Mchinji – November 2012. The desk mapping served two purposes as follows:
- Paid courtesy calls and sensitized Education Division Managers and District Education Managers on the inception of the project
- Documented an infrastructure scan of each impact district to include number of schools in each district, and identification of schools
- Conducted a physical mapping exercise of the impact districts namely; Salima, Lilongwe, Mchinji – November 2012 to February 2013 to document basic infrastructure scan, including information about the schools, health centres nearest to schools, nearest NGOs/CBOs/FBOs, school feeder villages, out-of-school youth clubs near each school in each district; distance between schools, barriers between schools and nearest health centres/NGO/CBO/FBO, number learners in each school, and number of teachers and teachers' names.
- Hired a consultant to design GPS for the infrastructure scan of each impact district schools and nearest infrastructures (See Consultant’s report in Annex C). The GPS is under on-going construction (http://mhii.org)

| Baseline and needs assessment report written for MW and ZB | MW: Month 4-6 ZB: Month 13-15 | See Annex A for the first draft report of the baseline survey. The report will be shared with the head teachers and of participating schools and the district level education managers in each district. We have not yet completed the needs assessment for primary health care providers, which will be completed by June 2013 in advance of the primary health care training sessions in Sept, 2013 |
| Consolidated research report shared/disseminated | Month 19-21 | |
| Activity 2.2: Mental Health Curriculum Development and Training for Schools and Youth Clubs | MH literacy curriculum modified and contextualized for use in MW and ZB | Month 4-6 | Adaptation of materials is done, yet GCYDCA will conduct a review meeting with selected knowledge partners before completing the translation. |

   - Development of TORs for Knowledge Consultant and identification of a Knowledge Consultant
   - Conducted a review of the Canadian High School Mental Health Curriculum
   - Identified areas for adaptation
- Compiled a localised version of the Curriculum which is titled ‘African School Mental Health Curriculum (yet to be finalized. Will be finalized and printed by April 1, 2013)

<table>
<thead>
<tr>
<th>Activity 2.3: Peer mental health educator training in youth depression.</th>
<th>Peer Educator Training Program in Youth Depression developed</th>
<th>Month 4-6</th>
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</thead>
</table>
| 50 schools selected for participation in MW; and 50 schools selected in ZB | MW: Month 7-9  
ZB: Month 13-15 | Identified thirty-five participating schools and started the process of identifying in-school and out-of-school youth clubs for the project in the impact districts (the process is yet to be finalized) |
| 10 days MH literacy education provided to 260 people from 50 schools, including teachers, administrators and youth leaders from selected schools in MW; and 260 trained from 50 schools in ZB | MW: Month 7-12  
ZB: Month 13-18 | |
| MH literacy sessions delivered by teachers/student leaders in selected schools in: MW (total of 1200 hours of sessions in 50 schools – estimate ~600 hours of sessions by month 20); in ZB (total of 1200 hours of sessions - ~600 hours by month 26) | MW: Month 10-30  
ZB: Month 16-36 | |
| - Together with the Knowledge Consultant, reviewed Prof. Hamwaka’s book on Peer Health Education in African Schools and Communities  
- Identified areas for adaptation and considered proposals  
- Compiled an adapted version as a Learners’ Handbook entitled ‘Training Manual for Peer Mental Health Education in African Schools and Communities’ (yet to be finalized. Will be finalized and printed by April 1, 2013) |  |
| 2. Facilitators’ Guide for Peer Mental Health Education (up to Mar. 2013) |  |
| - Together with the Knowledge Consultant, reviewed Dr. Stan Kutcher’s Mental Health for Peer Educators  
- Identified areas for adaptation and considered proposals |  |
## Objective 3: Youth-friendly, interactive communication strategy raises MH literacy among young adult population.

### Activity 3.1: Conduct formative audience research

**MW:** Conduct 12 focus group discussions and 18 key informant interviews

- Evaluation and analysis of research completed (by month 6)
- Formative research report completed (by month 6)

**ZB:** Conduct 8 focus group discussions and 12 key informant interviews

- Data captured on audience preferences and information needs (by month 12)
- Evaluation and analysis of research completed (by month 12)
- Formative research report completed (by month 15)

### Activity 2.4: Peer educators run sessions with youth members of youth clubs with backstopping from GCYDCA specialists

- 360 sessions with 7200 youth club members in MW; 240 sessions with 4800 youth club members in ZB

### To date, we have completed the following formative research activities:

- Conducted Rapid Assessment on radio listenership and mobile phone network coverage, preferred mobile phone service providers and mobile phone usage by youth in Lilongwe, Mchinji and Salima districts on the 30th and 31st December 2012. It has to be noted that the actual formative research will be rolled out in the next quarter.

- A report on Rapid Assessment on radio listenership and ICT usage has been attached. *(See Annex D)*

- Assessments yet to be finalized and will be analyzed in line with the results of the baseline survey in terms so that the choice is based on youth preference.

- Conducted the MH literacy and KAP survey

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### To date, we have completed the following formative research activities:

- Interim assessment of the impact of literacy program
  - 90% of attendees (6480 youth club members) have significantly higher MH literacy than control cohort in MW;
  - 90% (4320 youth club members in ZB have higher MH literacy than control.

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**To finalize and print by April 1, 2013**

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| Peer Educators in MW identified by school administrators and youth club leaders and selected by GCYDCA; and 150 peer educators in ZB selected by GCYDCA | MW: Month 7-9  
|---|---|
| MW: Month 7-9  
ZB: Month 19-21 | ZB: Month 22-24 |

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| 150 Peer educators trained for a total of 5 days (3 initial) in MW; 150 peer educators trained in ZB | MW: Month 10-12  
|---|---|
| MW: Month 10-12  
ZB: Month 22-24 | ZB: Month 22-24 |

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| Activity 2.4: Peer educators run sessions with youth members of youth clubs with backstopping from GCYDCA specialists | MW: Month 13-30  
|---|---|
| MW: Month 13-30  
ZB: Month 22-33 | ZB: Month 22-33 |

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| Activity 3.1: Conduct formative audience research | MW: Month 4-6  
|---|---|
| MW: Month 4-6  
ZB: by month 10-15 | ZB: by month 10-15 |
as part of baseline in Salima, Mchinji and Lilongwe between 28th January to 26th February 2013. At present 15 sites have been done covering 40 in school youth, 40 out of school youth and 10 opinion leaders that include parents and teachers.

We have yet to conduct focus group discussions and key informant interviews as part of the formative research for our radio-based communication strategy due to delays with the baseline survey. Focus group discussions and key informant interviews will take place in April and May, 2013.

| Activity 3.2: Build capacity of radio stations to deliver mental health programming | MW:  
- 3 Radio stations selected (Month 1-3)  
- MOUs signed with 3 stations (month 3)  
- Station capacity assessments completed (Month 4-6)  
- 60 days of in-station training delivered (month 4-6)  
- Stations' programs meet VOICE standards (Month 7-9) | Month 1-9 | • Started the process of recruiting radio stations to work with under the MHII program in line with Deliverable 3.3.  
• An Expression Of Interest (EOI) was prepared and publicized for interested radio stations to apply in the media  
• 7 radio stations have submitted their EOIs  
• Station selection will be completed by March 30, 2013 |
| --- | --- | --- | --- |
| ZB:  
- 2 Radio stations selected (Month 10-12)  
- 2 MOUs signed with stations (Month 12)  
- Station capacity assessments completed (Month 13-15)  
- 40 days of in-station training delivered (Month 13-15)  
- Stations’ programs meet VOICE standards (Month 16-18) | Month 10-18 |
| Activity 3.3: Design a radio-based communication strategy | MW:  
- Multi-stakeholder planning workshop held (Month 4-6)  
- Comprehensive radio-based strategy designed (Month 7-9) | Month 4-9 | See Deliverable 1.1 |
| ZB:  
- Multi-stakeholder planning workshop held (Month 13-15)  
- Comprehensive radio-based strategy designed (Month 16-18) | Month 13-18 |
**Activity 3.4:** Develop, install, maintain and promote an Interactive Voice Response (IVR) System.

<table>
<thead>
<tr>
<th>MW:</th>
<th>Month 4-21</th>
<th>• IVR installation and training will take place April 11 – April 15, 2013 in Malawi</th>
</tr>
</thead>
<tbody>
<tr>
<td>- IVR system installed in MW (Month 4-5)</td>
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<tr>
<td>- 3 staff trained to utilize and update FVR content and tools (Month 5-6)</td>
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<tr>
<td>- IVR hotline promotions developed (Month 7-9)</td>
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<tr>
<td>- 10 IVR content and tools developed (Month 10-21; by month 15 an estimated 4 content items and tools are developed)</td>
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<table>
<thead>
<tr>
<th>ZB:</th>
<th>Month 13-30</th>
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</thead>
<tbody>
<tr>
<td>- IVR system installed (Month 13-14)</td>
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<tr>
<td>- 3 staff trained to utilize and update FVR content and tools (Month 14-15)</td>
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<tr>
<td>- IVR hotline promotions developed (Month 16-18)</td>
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<td>- IVR content and tools developed (Month 19-30)</td>
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- Regular monitoring of IVR usage (monthly) to be assessed at mid-point of implementation in MW and ZB
- Conduct survey with a sample of approx. 2000 (TO BE CONFIRMED in month 4) youth in radio listening areas
- An estimated 30% of surveyed adolescents know the hotline number; and a target of 5% of those surveyed have called the hotline at least once

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<thead>
<tr>
<th></th>
<th>Month 4-30</th>
<th>Ongoing</th>
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<tbody>
<tr>
<td>MW:</td>
<td>Month 10-21; 24 mini-dramas available by month 15 ZB: 19-30; 24 mini-dramas available by month 24</td>
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<td>ZB:</td>
<td>Month 19-30</td>
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**Activity 3.5:** Design and produce a series of very short interactive audio dramas on mental health issues to be broadcast on radio and hosted on an IVR in both MW and ZB

<table>
<thead>
<tr>
<th>Storyboard for a 60-episode 2-5 minute mini-dramas designed</th>
<th>Month 7-9</th>
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<tbody>
<tr>
<td>• A radio drama expert and producer have been hired and will commence storyboarding after the completion of the formative research (May, 2013)</td>
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<table>
<thead>
<tr>
<th>Series of 60 mini-dramas produced (an estimated 48 mini-dramas by month 12)</th>
<th>Month 7-15</th>
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<table>
<thead>
<tr>
<th>Series of 60 mini-dramas made available on IVR in MW and ZB</th>
<th>MW:</th>
<th>ZB:</th>
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<tbody>
<tr>
<td></td>
<td>MW: Month 10-21; 24 mini-dramas available by month 15 ZB: 19-30; 24 mini-dramas available by month 24</td>
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<td></td>
<td>ZB: Month 19-30</td>
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<p>| - Series of 60 mini-dramas broadcast by partner stations as part of weekly program in MW and ZB (see 3.6) (MW: | | |
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<table>
<thead>
<tr>
<th>Activity 3.6: Design, produce and broadcast weekly radio show featuring mini-dramas from IVR, phone-in show with forums, radio diaries, etc building on mini dramas.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 3 MW radio stations produce &amp; broadcast 90 hours of MH programming (2 hours/month for 15 Month)</td>
</tr>
<tr>
<td>- 2 ZB radio stations produce &amp; broadcast 60 hours MH programming (2 stations, 2 hours/month for 15 Month)</td>
</tr>
<tr>
<td><strong>MW:</strong> Month 13-27</td>
</tr>
<tr>
<td><strong>ZB:</strong> Month 22-35</td>
</tr>
<tr>
<td><strong>MW:</strong></td>
</tr>
<tr>
<td>- MH literacy/KAP survey in listening areas and non-listening control areas</td>
</tr>
<tr>
<td>- 1250 minimum number of survey respondents. The following are targets for MW as measured by survey (month 21 and 27)</td>
</tr>
<tr>
<td>- 20% of youth in listening areas of 3 MW radio stations hear min 5 hours of MH programming (By month 27)</td>
</tr>
<tr>
<td>- Mental health literacy levels significantly higher among listeners than non-listeners (by month 27)</td>
</tr>
<tr>
<td>- Stigmatizing attitudes are significantly lower among listeners than non-listeners (by month 27)</td>
</tr>
<tr>
<td><strong>ZB:</strong></td>
</tr>
<tr>
<td>- MH literacy/KAP survey in ZB listening areas and non-listening control areas.</td>
</tr>
<tr>
<td>- 1250 minimum number of survey respondents (by month 35). The following are targets for MW as measured by survey (month 30 and month 35):</td>
</tr>
<tr>
<td>- Mental health literacy levels significantly higher among listeners than non-listeners (by month 36)</td>
</tr>
<tr>
<td>- 20% of youth in listening areas of 2 ZB radio stations hear min 5 hours of MH programming</td>
</tr>
<tr>
<td><strong>Month 21-27</strong></td>
</tr>
<tr>
<td><strong>Month 30-35</strong></td>
</tr>
<tr>
<td>Objective 4: Upgraded capacity of health systems for identifying depression for young people</td>
</tr>
<tr>
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<tr>
<td>Activity 4.2: Training for Mental Health Identification and Mitigation (MHIM) Trainers</td>
</tr>
<tr>
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<td></td>
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<tr>
<td>Activity 4.3: Training and capacity development for Primary Care providers and “Go To” Teachers</td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Measure: Numbers of youth to be screened, diagnosed, and provided care/treatment for depression in MW over the period between Month 16-33. <strong>Target number of youth provided care will be determined in month 13.</strong></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>MHIM Trainers in ZB provide training to 800 primary care providers, &quot;Go to&quot; teachers and youth leaders (10 days of training). Assume 80% will be successfully trained (640 trained). Month 22-33</td>
</tr>
<tr>
<td>16 Health facilities introduce new or modified diagnostic, measurement, and care tools for youth depression in ZB</td>
</tr>
<tr>
<td><strong>Objective 5:</strong> To share, evaluate, and provide recommendations for policy makers on how to continue to support and scale up this and other MH initiatives</td>
</tr>
<tr>
<td><strong>Activity 5.1:</strong> Participate in GCC community meetings</td>
</tr>
<tr>
<td>Participate in bi-annual GCC Community of Practice meetings (2 per year) Month 3 – ongoing throughout the project every 6 months</td>
</tr>
<tr>
<td><strong>Activity 5.2:</strong> Development of recommendations for policy-makers and dissemination</td>
</tr>
<tr>
<td>Develop a dissemination plan (by month 9). This might include:</td>
</tr>
<tr>
<td>- Capture and share case studies (Month 12, 24, 33)</td>
</tr>
<tr>
<td>- MH symposium conducted for key stakeholders and policy makers from Zambia and Malawi (by month 33)</td>
</tr>
<tr>
<td>Report on upgrading health system capacity for identifying and responding to depression for young people to be published/shared (by month 24)</td>
</tr>
<tr>
<td>Report on youth-friendly, interactive communication strategies to be</td>
</tr>
<tr>
<td>Month 9 - 36</td>
</tr>
<tr>
<td>• PIs Stan Kutcher, Co-I Kenneth Hamwaka, and Program Manager Heather Gilberds attended the GCC meeting in Ottawa in Dec, 2012. PI Rex Chapota and Program Manager Heather Gilberds will attend the GMH side meeting in Calagay in June, 2013.</td>
</tr>
</tbody>
</table>
published/shared (by month 27)
Annex A:

Baseline Survey

- A.1 Preliminary Report
- A.2 Enumerator Feedback

Prepared by: Farm Radio International and Farm Radio Malawi
**Baseline Survey**

One of the key milestones for the first 6 month period was the completion of a baseline survey. The survey had the following components: Mental Health literacy including knowledge and attitudes about mental health, mental illness and Depression; health-seeking practices; and a radio listening audience survey. The baseline survey had the following objectives:

- Assess the overall mental health literacy of youth, teachers, school counselors and other community members who interact with youth
- Assess mental health seeking practices
- Determine stigmatizing attitudes, fears and taboos
- Determine the radio listening preferences of youth, including the popular stations, formats and themes as well as the availability of radios and mobile phones

We surveyed 3000 youth (12-25 years), teachers, youth club leaders, parents, service providers and community leaders in three impact districts and two control communities using mobile phones (Mobenzi). The information acquired through the survey will be used to identify the stigmatizing attitudes, taboos, fears, practices and awareness of mental health issues and Depression as an illness. These gaps and stigmatizing attitudes will inform the content for the peer educator and teacher training as well as the radio-based communication strategy. The radio listening survey will allow us to create a radio program that youth will find entertaining and engaging.

**Methodology**

The mental health literacy component of the survey was designed by Dr. Stan Kutcher, and the audience listening component of the survey was designed by Farm Radio International and Farm Radio Malawi. The MH Literacy survey is comprised of three parts: knowledge about mental health, mental illness and Depression, attitudes and stigmas, and health-seeking practices. The audience listening component of the survey identified youth radio preferences, including favourite times to listen, platforms for listening to the radio, and favourite formats and genres. The survey was implemented using a mobile phone application called Mobenzi. Mobenzi is a useful research tool as it allows ongoing monitoring of fieldworkers and enumerators, allows for geocoding of submissions through GPS, does not require data connectivity to conduct surveys, and it manages data uploaded to the web in real time. See Annex A for the complete survey questionnaire. Enumerators attended a 1 ½ day training session on Mobenzi, and the survey was pilot-tested at a secondary school in Lilongwe to identify confusions or errors in survey logic. Enumerators provided feedback on the pilot test and questions were refined by the program manager.

**Sampling Strategy**

The survey was carried out in the three impact districts—Lilongwe, Salima and Mchinji in February, 2013. Due to delays resulting from school closures and exams, the survey will also be carried out in two control communities—Nkhotakota and Dedza—in early April. Impact districts are areas where one of the implementing partners—the Guidance, Counseling, Youth and Development Centre of Africa—has
previously had in-school programs on counseling, mental health facilitation and peer health education. As such, we were able to leverage the relationships previously established and build on work already done within the school system in the central region of Malawi. Control districts were selected based on a number of factors: proximity to the intervention sites, cultural, socio-economic and linguistic similarity to impact districts, and facility of travel. Nkhotakhota and Dedza were selected as they are culturally, socio-economically and linguistically similar to the impact districts, but they are far enough away to limit the diffusion effect of the mental health literacy training to provide statistically valid evaluation of impact.

A total of 3000 respondents will complete the questionnaire—1800 in impact districts and 1200 in control districts—within schools, youth clubs and at the village level in each district. Schools and youth clubs were randomly selected and disaggregated according to major characteristics: urban and rural, all-boys and all-girls, and faith-based, private and public. Due to the difficulty of finding respondents a year later for a post-intervention follow-up survey, we deliberately oversampled out-of-school youth and avoided administering the questionnaire to students in Standard 8, who will move from a primary school to a secondary school within the intervention period.

The team of enumerators encountered some difficulties in carrying out the survey, including identifying out-of-school youth who were willing to participate in the survey, translation of the word “Depression” in Chichewa, and underestimating the time it would take to complete the survey in each district. See Annex B for enumerator reflections, collected as part of the team’s effort to engage in reflexive practice throughout the duration of the program.
The average score for the Mental Health Literacy knowledge component of the survey is 52.7%. There is little statistical difference between men’s and women’s knowledge of mental health, mental illness and Depression. As expected, the group that scored the highest are those who have completed tertiary education, and are between ages 26-35. The group that scored the lowest are those who have not completed primary or secondary education, and those who have only completed primary education. As detailed in Annex C, very few respondents chose to answer “I don’t know”, pointing to a reluctance to admit not knowing, despite attempts on the part of the research team to mitigate this risk by explaining that “I don’t know” is a reasonable and correct response.

**Attitudes**

As shown in detail in Annex C, in the attitudes section of the survey, respondents were given a statement about mental illness and Depression and were asked to rate their response according to a Likert scale—strongly agree, agree, neutral, disagree, strongly disagree. Most respondents strongly agreed with most statements, with a few statements having near equal responses of strongly agree and strongly disagree. Very few respondents had agree, disagree or neutral attitudes. Similar to the
reluctance to choose “I don’t know” for the knowledge component, this could potentially suggest a desire on the part of surveyed people to choose the “correct” response. The attitudes component of the survey was useful in terms of identifying common stigmatizing beliefs. In general, the survey indicates that people equate mental illness with severe psychosis, and powerful stigmas are present, especially in terms of seeing mentally ill people as threats to themselves and the community. Generally, respondents feel that mental illness is very debilitating. However, the attitudes survey also suggests that people feel a fair bit of empathy and compassion for mentally ill people, and a desire to help them get well. Respondents had an overwhelmingly positive attitude toward the potential for treatment, and felt that with appropriate interventions, people will recover from a mental illness.

**Practices**

As demonstrated in Annex C, mental health-seeking practices are relatively uncommon among respondents. This may be due to any combination of the following factors: low mental health literacy and awareness of mental health issues, stigma and embarrassment about revealing mental health issues, or a lack of awareness of where to seek help within the health sector.

**Discussion**

Overall, we found some very interesting trends in mental health knowledge, attitudes and practices. In the knowledge section, respondents often replied in contradictory or inconsistent ways. For instance, approximately 60% of respondents believe that mental illnesses including Depression are caused by evil spirits or witchcraft, yet 90% also believe that mental illnesses result from problems with brain functioning. Also, while the majority of respondents believe that smoking hemp causes most mental illnesses, an overwhelming number believe that useful treatments include counselling and medications. However, a significant majority (almost 75%) also believe that Depression is the result of weakness, that depressed people cannot be successful, and that depressed people do not need medicine or therapy, but rather need to develop a more positive attitude and work harder. Generally speaking, respondents appear to hold multiple perspectives and worldviews on mental health at one and the same time: mental illness is the result of problems with brain functioning, yet can also be caused by evil spirits. The team attributes these consistencies to a number of different factors: 1) It appears as though there is a cultural overlap in traditional belief systems and scientific worldviews where people are “double-bookkeeping”—i.e. holding two opposing worldviews at the same time; 2) Respondents appear to have a much greater understanding of the symptoms and treatments for Depression than the causes; 3) Respondents tend to view mental illness as psychosis, and don’t believe that depressive emotional states and mood disorders are mental illnesses. In terms of attitudes, the anticipated stigmas are present, which likely affects health-seeking practices—i.e. willingness to ask for help with mental health issues. Generally, the results of the baseline indicate that our project is well-positioned to address gaps in knowledge and to reduce the stigmatizing perceptions and resultant practices that prevent youth from admitting they have a problem, asking for help, and knowing where to go to get help when needed.
Section 2: About the Respondent

Among the students whom we interviewed, it was found that a number of them had no mobile phones. I observed that this made some of them to feel out of place. The confusion was whether to take the contact details of their parents which they offered or not. It was easy for girls’ sec schools which has a rule of “no mobile phones allowed at school” but this question still lingered its ugly head.

Age

This was a contentious issue in that most of the Youth Clubs were observably run by people who are aged more than 25 years. The good news is that these were already catered for in the adult section.

Section 3: Knowledge

3.2: Mental illness is translated as “matenda a misala”. From experience and observations from this research many people know the advanced and violent type of mental illness “madness” (wozungulira mutu”) literally translated as “the one with a turned head”. This term is negative and associated with a lot of stigma. As such, it sounds disrespectful to ask somebody whether is “wozungulira mutu” or not. Besides this is something many people wouldn’t like to associate themselves with.

As such, we had to find a way of ensuring they know that by asking this question we are not being rude to them. It might have tempted some to hide real information on these questions.

Another observation is that many people here who consider themselves modern consider accepting the existence of evil spirits as negative and superstitious. This view extends to witchcraft where it is not about their knowledge about its existence but trying to portray an image of not being seen as believing in witchcraft. Believing in witchcraft in educated and exposed communities of Malawi exposes a person to stigma, or being seen as uncivilized and villagish.

Furthermore, mixing evil spirits and God’s intervention was confusing to respondents. They accept one and deny the other. **Terminology and challenges in translation**

Depression was translated at first as “matenda a nkhawa” (literally translating “disease of worries”). When using disease of worries among respondents, it was confusing because contextually worries here do not constitute an illness. As such a number of other explanations were given to ensure we are on the same page. The Ministry of
Health Mental Health Programme uses the term “matenda okhumudwa” (literally translating “disease of disappointment”). Many Chichewa words come to mind but none seems to be very specific. For instance, we might say “kupsinjika” (burdened by a situation or act), or among secondary school students, someone described it as “kudandaula” (complaining) which in order to make more sense, we qualified as “kukhala moyo wodandaula kwambiri, kwa miyezi, chifukwa cha mwina kuti amakhala bwinobwino, ndiye makolo onse kumwalira ndiye wayamba kuvutika kwambiri ndipo sakuona tsogolo” (literally translating “living a life of bitter complaints for months, due to say, losing both parents suddenly and living standards seriously deteriorating that somebody sees no more good future), other described it as “kukhala ndi maganizo kwambiri” (troubled by negative thoughts and fear of unknown). The solution was to engage in a prior discussion that described depression citing examples.

3.8 Witchcraft

This word entails deferent things in Chichewa. It can mean “ufiti” (magical practices evil or not to other people), or "kutamba" (casting evil spells to harm others by wizards and witches) or “kupepetulidwa” (going out to a witch doctor and paying a witchdoctor to exact harm on somebody through magic).

As such if on asking you translate it as “ufiti”, it meant different things to different cultural backgrounds or contexts. This also necessitated a discussion before the answer is given.

3.16: Respondents would answer yes to only going to church, and prayer but not a traditional healer. Being seen as believing in traditional healers, or even taking going to church, prayer and going to a traditional healer as apprehensive. Many people want to be seen as not associating with traditional doctors (witchcraft), but to be seen as going to church, and praying. So many would answer yes to going to church and prayer and no to going to traditional healer. This in many cases was considered as an overall yes.

Section 5: Practices

5.3. Many people do not want to associate themselves with mental illness, which to many puts impressions of the stigmatized violent and dirt manifestations (wofuntha, wamisala,"mad man or woman"), and fear to disclose it if mild. However some few I met were very open about it. This could apply also to 5.5 and 5.7 and 5.9.

Section 6: Radio Listening Practices and Preferences

Many people in rural areas listen to radios than in towns because of DSTV which is more captivating.
Annex B: Situational Analysis Report

Prepared by: GCYDCA
REPORT ON MENTAL HEALTH INTEGRATED INNOVATION (MHII)

SITUATION ANALYSIS
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ABSTRACT

Mental health, worldwide, has claimed dominance in most of discussions, more especially in those related to development and youth. Africa in particular, has taken keen interest because it is envisaged that fighting Depression among young people is wisdom behind national development in all spheres. The Mental Health Integrated Innovation (MHII) is meant to facilitate the fight against Depression among young people in three districts in Zambia and Malawi, respectively. One of the initial and critical stages was the situational analysis which was meant to provide snap information about the existing knowledge, awareness and involvement levels of teachers and learners in the fight against Depression.

The situation analysis paved way for a larger and more comprehensive baseline survey in Malawi. Fifty two (52) participants, all of them teachers, were involved in the situation, drawn from Salima, Mchinji and Lilongwe districts of Malawi.

The survey asked participants to assess their own levels of knowledge, awareness and involvement in mental health. The reported levels are based on a self-assessment by these teachers, and do not reflect an objective measure of their actual level of knowledge and awareness. The MH literacy test and attitude tool developed for this project by the partners will be used for an independent measure of teachers’ pre and post-intervention knowledge and attitudes later in the project.
RESULTS OF THE SITUATION ANALYSIS

1.0 Assessing knowledge levels:

The situation analysis tool first focused on assessing the self-reported knowledge levels of the teachers on a 4-point scale of 1) very knowledgeable, 2) quite knowledgeable, 3) don’t know, and 4) not knowledgeable. The results of the analysis are summarized in Table 1-1 below.

Table 1-1: An assessment of knowledge levels

<table>
<thead>
<tr>
<th>Area on measurement</th>
<th>Very knowledgeable</th>
<th>Quite knowledgeable</th>
<th>Don’t know</th>
<th>Not knowledgeable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Meaning of mental health</td>
<td>7</td>
<td>15</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>2 Causes of mental illness</td>
<td>4</td>
<td>7</td>
<td>10</td>
<td>31</td>
</tr>
<tr>
<td>3 Types of mental depression</td>
<td>1</td>
<td>5</td>
<td>21</td>
<td>25</td>
</tr>
<tr>
<td>4 Stages leading into depression</td>
<td>0</td>
<td>14</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>5 Information about depression and</td>
<td>0</td>
<td>9</td>
<td>15</td>
<td>28</td>
</tr>
<tr>
<td>mental health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Referral information on depression</td>
<td>0</td>
<td>12</td>
<td>12</td>
<td>28</td>
</tr>
<tr>
<td>7 How to prevent depression</td>
<td>5</td>
<td>11</td>
<td>14</td>
<td>22</td>
</tr>
<tr>
<td>8 Where to go when depressed</td>
<td>3</td>
<td>12</td>
<td>6</td>
<td>31</td>
</tr>
<tr>
<td>9 Value of peer health education</td>
<td>4</td>
<td>14</td>
<td>8</td>
<td>26</td>
</tr>
<tr>
<td>10 Counselling skills</td>
<td>3</td>
<td>14</td>
<td>6</td>
<td>29</td>
</tr>
</tbody>
</table>

The Table above clearly indicates that the majority of the teachers assess their own knowledge of mental health as very low, with the highest number of participants (31, representing 60% of the total sample) indicating that they are not knowledgeable on the meaning of mental health and on where to go when depressed. Twenty nine participants (representing 56% of the total sample) indicated that they are not knowledgeable on counselling skills. Twenty eight participants (representing 54% of the total sample) also indicated that they are not knowledgeable on information about Depression and mental health and also on referral information on Depression.

The results of the analysis are graphically presented as shown in Figure 1-1 that follows.
The general picture from Table 1-1 above is that the majority of the teachers assess their own knowledge of mental health as very low (an average of 38 participants, representing 73% of the total sample) indicated that they are either not knowledgeable or don’t know if they have the knowledge about all the ten issues of mental health and Depression assessed in the situation analysis. The highest number of participants (46, representing 88%) indicated lack of knowledge and not knowing if they have knowledge on types of mental health; followed by 43 participants (representing 83%) mentioning lack of information about Depression and mental health; 41 participants (representing 79%) mentioning lack of knowledge on causes of mental health; and 40 participants (representing 77%) indicating lack of knowledge on referral information on Depression. Table 1-2 below summarizes the participants’ responses on lack of knowledge (not knowledgeable plus don’t know), presented in descending order of cumulative frequency and percentage of responses.
Table 2-1: An assessment of knowledge levels in descending order of frequency of responses

<table>
<thead>
<tr>
<th>Area on measurement</th>
<th>Cumulative frequency of responses</th>
<th>Cumulative % of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Types of mental depression</td>
<td>46</td>
<td>88</td>
</tr>
<tr>
<td>2 Information about depression and mental health</td>
<td>43</td>
<td>83</td>
</tr>
<tr>
<td>3 Causes of mental illness</td>
<td>41</td>
<td>79</td>
</tr>
<tr>
<td>4 Referral information on depression</td>
<td>40</td>
<td>77</td>
</tr>
<tr>
<td>5 Stages leading into depression</td>
<td>38</td>
<td>73</td>
</tr>
<tr>
<td>6 Where to go when depressed</td>
<td>37</td>
<td>71</td>
</tr>
<tr>
<td>7 How to prevent depression</td>
<td>36</td>
<td>69</td>
</tr>
<tr>
<td>8 Counselling skills</td>
<td>35</td>
<td>67</td>
</tr>
<tr>
<td>9 Value of peer health education</td>
<td>34</td>
<td>65</td>
</tr>
<tr>
<td>10 Meaning of mental health</td>
<td>30</td>
<td>58</td>
</tr>
</tbody>
</table>

**Conclusion on findings on knowledge levels**

The high prevalence of lack of knowledge could be attributed to limited literacy on mental health and lack of information on where to go for support. There could be other attributing factors that limit the peers from sharing information amongst themselves. The other attributing factor could be low utilization of mass media such as radios to reach a wider range of people.
2.0 Assessing awareness levels:

The teachers were also assessed on awareness levels on mental health and Depression on a 4-point scale of 1) very aware, 2) quite aware, 3) don’t know, and 4) not aware. The results of the analysis are summarized in Table 2-1 below.

Table 2-1: An assessment of awareness levels

<table>
<thead>
<tr>
<th>Area on measurement</th>
<th>Very aware</th>
<th>Quite aware</th>
<th>Don’t know</th>
<th>Not aware</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Your community has depressed people</td>
<td>9</td>
<td>17</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>2 People suffering from mental illness</td>
<td>7</td>
<td>14</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>3 Depression is treatable</td>
<td>2</td>
<td>13</td>
<td>14</td>
<td>23</td>
</tr>
<tr>
<td>4 Stigma on those suffering from mental illness</td>
<td>7</td>
<td>22</td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td>5 Counselling services available</td>
<td>1</td>
<td>16</td>
<td>8</td>
<td>27</td>
</tr>
<tr>
<td>6 Referral services available</td>
<td>3</td>
<td>23</td>
<td>5</td>
<td>21</td>
</tr>
<tr>
<td>7 Depression is preventable</td>
<td>7</td>
<td>13</td>
<td>10</td>
<td>22</td>
</tr>
<tr>
<td>8 Community involvement is required to overcome depression</td>
<td>2</td>
<td>13</td>
<td>8</td>
<td>29</td>
</tr>
<tr>
<td>9 NGOs, CBOs involvement is required to overcome depression and mental illness</td>
<td>2</td>
<td>20</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>10 Mental illness can be genetically transmitted</td>
<td>3</td>
<td>16</td>
<td>12</td>
<td>21</td>
</tr>
</tbody>
</table>

The results are presented diagrammatically in Figure 2-1 below.

**Figure 2-1: An assessment of awareness levels**

![Chart](chart.png)
Table 2-1 and Figure 2-1 show that the majority of the teachers assess their own awareness of mental health as very low. The highest number of the participants (29 participants, representing 56% of the total sample) indicated that they are not aware if community involvement is required to overcome Depression; while as 27 participants (representing 52%) indicated that they are not aware of the availability of counselling services. The least number of participants (18, representing 35%) indicated that they are not aware of stigma on those suffering from mental illness.

The general picture from Table 2-1 and Figure 2-1 above is that the majority of the teachers assess their own awareness of mental health as very low (an average of 31 participants, representing 60% of the total sample who indicated lack of awareness - don’t know and not aware- on all item descriptors in the assessment). The majority of the participants (33 of them, representing 77%) indicated lack of awareness on the fact that Depression is treatable; with the same number of participants also indicating lack of awareness if community involvement is required to overcome Depression. Thirty five participants (representing 67%), 33 participants (representing 63%), and 32 participants (representing 62%) also indicated lack of awareness on counselling services available, that mental illness can be genetically transmitted, and on the fact that Depression is preventable, respectively. Table 2-2 summarizes the participants’ responses on lack of awareness (not aware plus don’t know), presented in descending order of cumulative frequency and percentage of responses.

Table 2-2: An assessment of knowledge levels in descending order of frequency of responses

<table>
<thead>
<tr>
<th>Area on measurement</th>
<th>Frequency of response</th>
<th>% response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression is treatable</td>
<td>37</td>
<td>71</td>
</tr>
<tr>
<td>Community involvement is required to overcome depression</td>
<td>37</td>
<td>71</td>
</tr>
<tr>
<td>Counselling services available</td>
<td>35</td>
<td>67</td>
</tr>
<tr>
<td>Mental illness can be genetically transmitted</td>
<td>33</td>
<td>63</td>
</tr>
<tr>
<td>Depression is preventable</td>
<td>32</td>
<td>62</td>
</tr>
<tr>
<td>People suffering from mental illness</td>
<td>31</td>
<td>60</td>
</tr>
<tr>
<td>NGOs, CBOs involvement is required to overcome depression and mental illness</td>
<td>30</td>
<td>58</td>
</tr>
<tr>
<td>Your community has depressed people</td>
<td>26</td>
<td>50</td>
</tr>
<tr>
<td>Referral services available</td>
<td>26</td>
<td>50</td>
</tr>
<tr>
<td>Stigma on those suffering from mental illness</td>
<td>23</td>
<td>44</td>
</tr>
</tbody>
</table>
Conclusion on findings on awareness levels

Awareness levels have been found to be extremely low. This could be attributed to limited advocacy for Depression and low levels of interaction among teachers. This results into little or no chance of sharing knowledge between them. It is most likely that the service providers have limited links with help seeking people who in this case may be depressed.
3.0 Assessing involvement levels:

The teachers were equally assessed on their involvement levels on service delivery and support to service delivery on mental health and Depression on a 4-point scale of 1) very involved, 2) quite involved, 3) don’t know, and 4) not involved. The results of the analysis are summarized in Table 3-1 below.

Table 3-1: An assessment of involvement levels

<table>
<thead>
<tr>
<th>Area on measurement</th>
<th>Very involved</th>
<th>Quite involved</th>
<th>Don’t know</th>
<th>Not involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early identification of mental illness</td>
<td>4</td>
<td>10</td>
<td>12</td>
<td>26</td>
</tr>
<tr>
<td>Provision of referral information</td>
<td>3</td>
<td>13</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>Slowing down or elimination of stigma on the mentally sick people</td>
<td>5</td>
<td>6</td>
<td>9</td>
<td>32</td>
</tr>
<tr>
<td>Provision of counselling services</td>
<td>6</td>
<td>15</td>
<td>8</td>
<td>23</td>
</tr>
<tr>
<td>Encouraging others to train as counsellors</td>
<td>2</td>
<td>17</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>Encouraging NGOs/CBOs on mental health issues</td>
<td>9</td>
<td>10</td>
<td>8</td>
<td>25</td>
</tr>
<tr>
<td>Mobilising community members in helping the depressed/mentally sick</td>
<td>10</td>
<td>10</td>
<td>11</td>
<td>21</td>
</tr>
<tr>
<td>Information provision on causes of depression</td>
<td>1</td>
<td>18</td>
<td>9</td>
<td>24</td>
</tr>
<tr>
<td>Training other service providers</td>
<td>7</td>
<td>8</td>
<td>8</td>
<td>29</td>
</tr>
<tr>
<td>Promotion of peer health education</td>
<td>5</td>
<td>14</td>
<td>5</td>
<td>29</td>
</tr>
</tbody>
</table>

The results are presented diagrammatically in Figure 2-1 below.

Figure 3-1: An assessment of involvement levels
Table 3-1 and Figure 3-1 show that the majority of the teachers assess their own involvement in service delivery mental health and Depression as well as in supporting and encouraging those involved in the provision of such services of mental health as very low. The highest number of the participants (32, representing 62% of the total sample) indicated that they are not involved in slowing down or eliminating stigma on people with mental illness. Twenty nine participants (representing 56%) indicated that they are not involved in training other service providers while the same number of participants also indicated that they are not involved in the promotion of peer mental health education. Twenty six participants (representing 50%) also indicated that they are not involved in early identification of mental illness.

The general picture from Table 3-1 and Figure 3-1 above indicates lack of involvement for an average of 35 participants, representing 66% of the total sample (not involved plus don’t know) in service delivery mental health and Depression as well as in supporting and encouraging those involved in the provision of such services. The highest number of participants that registered lack of involvement in slowing down or eliminating stigma (41 participants, representing 79%); 38 participants (representing 73%) indicated lack of involvement in early identification of mental illness; 37 participants (representing 71%) indicated lack of involvement in training other service providers; 34 participants (representing 65%) indicated lack of involvement in promoting peer mental health education. A range of 60-63 % of the participants also indicated lack of involvement in other aspects assessed in service provision and support to service delivery. Table 3-2 summarizes the participants’ responses on lack of involvement (not involved plus don’t know), presented in descending order of cumulative frequency and percentage of responses.

Table 3-2: An assessment of involvement levels in descending order of frequency of responses

<table>
<thead>
<tr>
<th>Area on measurement</th>
<th>Frequency of response</th>
<th>% response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slowing down or elimination of stigma</td>
<td>41</td>
<td>79</td>
</tr>
<tr>
<td>Early identification of mental illness</td>
<td>38</td>
<td>73</td>
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<tr>
<td>Training other service providers</td>
<td>37</td>
<td>71</td>
</tr>
<tr>
<td>Promotion of peer health education</td>
<td>34</td>
<td>65</td>
</tr>
<tr>
<td>Provision of referral information</td>
<td>33</td>
<td>63</td>
</tr>
<tr>
<td>Encouraging others to train as counsellors</td>
<td>33</td>
<td>63</td>
</tr>
<tr>
<td>Encouraging NGOs/CBOs on mental health issues</td>
<td>33</td>
<td>63</td>
</tr>
<tr>
<td>Information provision on causes of depression</td>
<td>33</td>
<td>63</td>
</tr>
<tr>
<td>Mobilizing community members in helping the depressed/mentally sick</td>
<td>32</td>
<td>62</td>
</tr>
<tr>
<td>Provision of counselling services</td>
<td>31</td>
<td>60</td>
</tr>
</tbody>
</table>
Conclusion on findings on involvement levels

Evidence has shown that throughout all the responses, there was low or lack of teacher involvement in the fight against Depression. Lack of awareness, coupled with low knowledge and involvement levels can be termed as a crisis moment that needs immediate correction, mental health at crossroad! This desperate situation could be a combination of factors such as low literacy on mental health, little advocacy, separation of participation from involvement, lack of information sharing forums, and limited or no opportunities of service providers providing information to the public using the media of all kinds.

4.0 General conclusion and recommendations

The data collected on the situation analysis is conclusive enough to direct the need for integrated innovation that would bring together a net of communication strategies such as improved literacy, peer mental health education, and use of radios and televisions in providing additional knowledge, awareness as well as participation and involvement of community members in the fight against Depression among young people in Africa.
Annex C:

Mapping Report

- C.1 Mapping Tool
- C.2 Mapping Report

Prepared by: GCYDCA
SUMMARY SCHOOL MAPPING FORM

This form provides a framework for identifying, mapping and connecting schools to hospitals, communities and other relevant stakeholders for inclusion in the Mental Health Integrated Innovation (MHII) programme.

SECTION A: DISTRICT DATA

<table>
<thead>
<tr>
<th>District Information</th>
<th>Total Number of Schools in District</th>
<th>Total Number of Teachers</th>
<th>Total Number of MHFs</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Primary</td>
<td>Secondary</td>
<td>Total</td>
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</tbody>
</table>

Any other important data:
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<th>School 2</th>
<th>School 3</th>
<th>School 5</th>
<th>School 6</th>
<th>School 7</th>
<th>School 8</th>
<th>School 9</th>
<th>School 10</th>
<th>School 11</th>
<th>School 12</th>
<th>School 13</th>
<th>School 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learners’ Statistics</td>
<td>Teachers’ Statistics</td>
<td>MHFs</td>
<td>School Counsellors</td>
<td>MHF Clubs</td>
<td>G&amp;C clubs</td>
<td></td>
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<tr>
<td>No. of Boys</td>
<td>No. of Girls</td>
<td>Total no. of Learners</td>
<td>No. of male teachers</td>
<td>No. of female teachers</td>
<td>Total no. of teachers</td>
<td>Total no. of classroom blocks</td>
<td>No. of MHFs (teachers) (disaggregated)</td>
<td>No. of School Counsellors (disaggregated)</td>
<td>No. of MHF school clubs</td>
<td>Number of G&amp;C clubs</td>
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# SECTION C: CLUSTERING OF SCHOOLS

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<th>School 1</th>
<th>Name of School</th>
<th>Distance between schools</th>
<th>Name of hospital</th>
<th>Distance to the hospital</th>
<th>Name of NGO/CBO</th>
<th>Distance to the NGO/CBO</th>
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<td>Name of hospital</td>
<td>Distance to the hospital</td>
<td>Name of NGO/CBO</td>
<td>Distance to the NGO/CBO</td>
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<td>School 3</td>
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<td>Name of hospital</td>
<td>Distance to the hospital</td>
<td>Name of NGO/CBO</td>
<td>Distance to the NGO/CBO</td>
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<td>Distance to the hospital</td>
<td>Name of NGO/CBO</td>
<td>Distance to the NGO/CBO</td>
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<td>School</td>
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<td>Distance between schools</td>
<td>Name of hospital</td>
<td>Distance to the hospital</td>
<td>Name of NGO/CBO</td>
<td>Distance to the NGO/CBO</td>
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<tr>
<td>School</td>
<td>Name of School</td>
<td>Distance between schools</td>
<td>Name of hospital</td>
<td>Distance to the hospital</td>
<td>Name of NGO/CBO</td>
<td>Distance to the NGO/CBO</td>
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<td>12</td>
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</tr>
<tr>
<td>School</td>
<td>Name of School</td>
<td>Distance between schools</td>
<td>Name of hospital</td>
<td>Distance to the hospital</td>
<td>Name of NGO/CBO</td>
<td>Distance to the NGO/CBO</td>
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<td>14</td>
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</tr>
</tbody>
</table>
SECTION D: Draw actual maps
REPORT ON DEVELOPMENT OF MENTAL HEALTH INTEGRATED INNOVATION SYSTEM

PREPARED BY

FRANCIS CHRISTOPHER CHANTULO

PRESENTED TO

GCYDCA, LILONGWE

DATE

8TH MARCH, 2013
INTRODUCTION

This document summarizes the work that I carried out for Guidance, Counseling and Youth Development Centre for Africa in developing a computerized tool called Mental Health Integrated Innovation System (MHIIS) used for mapping districts to schools found in those districts, and organizations that are found within each school.

The tool, which can be used on a stand-alone computer or on the internet, is used to extract information pertaining to a particular school, found in a particular district.

Currently, the tool is used on 1 stand-alone computer to do the actual mapping, and on the internet (http://www.mhii.org) to view information about the districts and schools in those districts.

ABOUT THE MHII SYSTEM

The MHII system is made up of two parts, namely, Admin and Public. The next few sections explain how each one of these parts is used.

The Admin Section

This is where the actual mapping takes place. As the name implies, it can only be accessed by authorized personnel (The Administrator). The first thing that the Administrator does is to add the districts whose schools she wants to map, by providing these details: Name, District Education Manager, Deputy District Education Manager, and Information about the district. Once all districts are added, the Administrator then proceeds to add schools for each district.

These details are added for each school: Name, Type, District, Male Pupils, Female Pupils, Zone, and Surrounding Villages.

After the schools are added, the administrator then adds details of teachers who belong to that school, any CBO, NGO, Hospitals that surround that school and Counsellors that belong to that school.

The Public Section

This section is accessed by any interested person to view the mapping of the districts and the schools. To do this, the user must start the system on a stand-alone computer, or browse to this website: www.mhii.org. To view mapping information for a particular district, the user selects the district from the page that appears, and then choose the type of school which she is interested in (Secondary or Primary).

From there, all schools that belong to the selected district and type are displayed. The user can then select a school name to view more information, such as teachers, organizations, learners, counselors, mental health facilitators, who belong to that school. Users can also see pictures that will have been added by the Administrator.
SUMMARY

This report has just briefly explained the MHII system and what it does. I thank you in advance.

Francis Christopher Chantulo
Mapping Consultant
Annex D:

Rapid Assessment of Radio Listenership Report

Prepared by: Farm Radio Malawi
REPORT ON RAPID ASSESSMENT OF RADIO LISTENERSHIP AND ICT USAGE IN LILONGWE, MCHINJI AND SALIMA

ASSESSMENT DONE BY FARM RADIO MALAWI

GLOBAL MENTAL HEALTH PROJECT

SUBMITTED TO: THE EXECUTIVE DIRECTOR, FRM

DATE OF SUBMISSION: 7th January, 2013
1.0 INTRODUCTION

This report aims to give some highlights of a rapid assessment on radio listenership and mobile phone network coverage, preferred mobile phone service providers and mobile phone usage by youth, that was conducted in Lilongwe, Mchinji and Salima districts where the Global Mental Health (GMH) project will be implemented.

This assessment was done between December 20 and December 31, 2012 by Augustine Mulomole, GMH Programme Officer-Communication Strategy and Philip Chinkhokwe, GMH’s ICT for Development Officer.

The Global Mental Health Project aims to enhance the ability and capacity of responsible bodies and policy makers (including but not limited to: Ministries of Health and Education; youth organizations; schools; primary care health providers; and media organizations, particularly radio) to effectively deal with this issue; thus increasing its likelihood of success.

Through this project, young people will learn what Depression is, gain a better understanding of mental health issues, and how these issues can affect their lives and communities. With the use of an integrated approach in schools, radio programs, youth clubs and primary care clinics, the project’s long term objective is to increase awareness of Depression and take steps to ensuring that anyone who recognizes they need care, can identify where they can get it, and receive a measure of appropriate care.

The project envisions a centrally-produced mini-drama that will be used by select radio stations identified to broadcast the mini-dramas. The drama will be influenced by the young people who listen to it and the script writer will produce story lines in response to the direction given by the audience.

The rapid assessment of radio listenership among the youth was, therefore, conducted for the following reasons:

- To identify radio stations that are broadcasting in the targeted districts
- To find out which radio stations the young people are listening to (in Lilongwe, Salima and Mchinji)
- To find out what programmes the young people love listening to and why
- To find out if the young people are conversant with ICT issues such as mobile phones and how they use them
2.0 FINDINGS OF RADIO LISTENERSHIP ASSESSMENT

2.1 Findings from Lilongwe district

GMH project in Lilongwe district is targeting Secondary Schools only. The following are the Secondary Schools that have been targeted in the district:

2.1.1 BLOCK A: LILONGWE URBAN

✓ BWAILA SECONDARY SCHOOL
✓ CHIMUTU COMMUNITY DAY SECONDARY SCHOOL
✓ CHINSAPO SECONDARY SCHOOL
✓ CHIPASULA SECONDARY SCHOOL
✓ DZENZA MISSION COMMUNITY DAY SECONDARY SCHOOL
✓ DZENZA SECONDARY SCHOOL
✓ LIKUNI BOYS SECONDARY SCHOOL
✓ LILONGWE GIRLS SECONDARY SCHOOL
✓ MKWICHI SECONDARY SCHOOL
✓ ST. JOHN’S SECONDARY SCHOOL

Out of these schools, we managed to visit St. John’s, Chipasula, Dzenza Secondary School and Likuni Secondary School.

2.1.2 Radio Listenership

Most young people in Lilongwe said they love listening to the following radio stations, in order of preference:

➢ Galaxy FM
➢ Radio 2 FM
➢ Zodiak Broadcasting Station

2.1.3 Radio Programmes

Most young people gave the following characteristics for programmes which they love listening to:

➢ Programmes should be brief and straight to the point
➢ Most young people love sports and music programmes
➢ Radio presenters should be serious whenever they are presenting various programmes
➢ Radio stations should not be partisan, and neither should the presenters
➢ They love listening to the radio from three o’clock in the afternoon

2.2 Findings from Salima District
GMH project in Salima district is targeting Primary Schools only. The following are the schools that have been targeted in the district:

2.2.1 BLOCK B: SALIMA DISTRICT

- CHIMBALANGA PRIMARY SCHOOL
- CHIMWETA PRIMARY SCHOOL
- DEMERA PRIMARY SCHOOL
- Senga Bay CCAP PRIMARY SCHOOL
- KALONGA PRIMARY SCHOOL
- KAPIRA PRIMARY SCHOOL
- LINTHIPE PRIMARY SCHOOL
- MAFCO PRIMARY SCHOOL
- MAGANGA PRIMARY SCHOOL
- MIKUTE PRIMARY SCHOOL
- MSALURA PRIMARY SCHOOL
- NGOLOWINDO PRIMARY SCHOOL
- SALIMA L. E. A. SCHOOL
- SIMAYIWA PRIMARY SCHOOL

Out of these schools, we managed to visit Linthipe, Senga-Bay CCAP, Salima L.E.A and Msalura Primary Schools.

2.2.2 Radio Listenership

Most young people in Salima district explained that they love listening to the following radio stations, in order of preference:

- Radio 2 FM
- Zodiak Broadcasting Station
- Radio Alinafe
- Radio Maria

2.2.3 Radio Programmes

Most young people said they love listening to the following programmes

- Youth programmes
- Music programmes
- They love listening to the radio from three o’clock in the afternoon

2.3 Findings from Mchinji District

GMH project in Mchinji is targeting both Secondary and Primary Schools. The following are the schools that have been targeted in the district:
2.3.1 BLOCK C: MCHINJI DISTRICT
- BUA PRIMARY SCHOOL
- CHAPANAMA PRIMARY SCHOOL
- DOLE PRIMARY SCHOOL
- HOME OF HOPE PRIMARY SCHOOL
- KAMUZU PRIMARY SCHOOL
- KHOLONI PRIMARY SCHOOL
- LUDZI GIRLS SECONDARY SCHOOL
- MAGAWA SECONDARY SCHOOL
- MCHINJI MISSION COMMUNITY DAY SECONDARY SCHOOL
- MZULA PRIMARY SCHOOL

2.3.2 Radio listenership
Most young people in Mchinji district explained that they love listening to the following radio stations, in order of preference:
- Radio 2 FM
- Zodiak Broadcasting Station
- Mudziwathu Community Radio Station

2.3.3 Radio Programmes
Most young people said they love listening to the following programmes
- Youth programmes
- Music programmes
- They love listening to the radio from three o’clock in the afternoon

3.0 RECOMMENDATIONS ON RADIO LISTENERSHIP
The rapid assessment on radio listenership has provided us with the following information:

3.1 Lilongwe district
- The young people in this district love listening to Galaxy FM
- Galaxy FM should be considered as one of the radio stations to be used in the GMH project
- Galaxy FM is a commercial broadcaster which is one of the criteria for selecting a radio station to be used in the GMH project
- Currently, Galaxy FM does not have a lot of sponsored programmes which will work to the advantage of players in the GMH project because the station will be more than willing to take on board our preferences on how our programme is supposed to be handled on air
A new programme on a new radio station like Galaxy FM will attract a lot of attention and in the process build listenership for GMH programmes

3.2 Salima district
- The young people in this district love listening to Radio 2 FM
- Radio 2 FM should be considered as one of the radio stations to be used in the GMH project
- One of the criteria for selecting a radio station in the project is that we need a public broadcaster, of which Radio 2 FM is
- The station reaches out to almost all the districts in the country
- Radio 2 FM has a lot of youth programmes because almost 80% of its programming is designed for the young people

3.3 Mchinji district
- The young people in Mchinji district love listening to Radio 2 FM and Mudziwathu Community Radio Station
- Since Radio Station has already been recommended in this report, we should consider taking Mudziwathu Radio Station on board
- The GMH project recommends that one of the radio stations to be used in the project should be a community broadcaster
- Mudziwathu Community Radio station will act as a control radio station to determine how community broadcasters are faring in terms of radio programming

3.4 GMH Radio Programmes
Radio programmes in the GMH project should have the following characteristics:
- Very brief, preferably not more than 15 minutes
- Should contain news briefs
- Should contain exciting and entertaining music
- Should be broadcast between 3pm and 7pm.
- Feedback from the young people is very important
- Capacity for radio stations that have been recommended should be assessed
- Radio programmes should contain the following elements:
  - Quiz,
  - Public debates
  - Focus group discussions
  - Panel discussions
  - Question and answer competitions
  - Prizes for competitions
4.0 MOBILE TECHNOLOGY ASSESSMENT

This report aims to give some highlights of a Rapid Assessment on Mobile phone network coverage, preferred Mobile phone service providers and Mobile Phone usage by youth who are the core target group in the Global Mental Health (GMH) project. The assessment was carried out between December 20-31 2012 in Lilongwe, Mchinji and Salima where the project will be implemented.

Two criteria were employed to conduct the assessment

4.1 Visiting targeted areas
- In Lilongwe four areas were visited; St John’s, Chipasula, Likuni and Dzenza
- In Salima four areas were visited; Sengabay, Salima Boma, Salima (nsangu area) and Linthipe
- In Mchinji nine areas which are primary and secondary schools were visited

4.2 Phone calls
- To assess the signal reach phone calls were done to test the signals in the same places that were visited
- A cross sectional phone calling was done to other notable youth in Blantyre, Zomba, Balaka, Lilongwe, Kasungu, Mzuzu, and Karonga districts to solicit views on mobile phone usage

4.3 Objectives of the Rapid Assessment
The rapid assessment of radio listenership among the youth was conducted for the following reasons:
- To find out mobile phone network coverage in the targeted districts
- To find out the capacity, knowledge levels in mobile phone usage among the youth
- To learn for what purposes do young people use mobile phones in their localities
- To find out which mobile phone service providers they prefer and their reasons for their choice of these providers
- To find out what services and promotions do they like of the mobile service providers and why
- To find out whether young people are conversant with ICTs and other related issues like internet and multimedia and how they use them
- To find out the advantages, potential and possibilities of mobile phones for community-centered development work.
5.0 FINDINGS OF THE ASSESSMENT

5.1 Mobile phone service providers, network coverage, services and promotions in the targeted districts

The assessment has found out the following:

➢ The major mobile networks that cover the three districts are Airtel and TNM even though in the remotest rural TNM experiences poor signals.
➢ A number of respondents in Lilongwe urban are subscribers of both mobile networks unlike in Salima and Mchinji where most of them are Airtel subscribers.
➢ Many respondents cited both networks being competitive in their services and promotion provision but respondents singled out Airtel as youth and social centered in some of its activities.

5.2 Capacity, knowledge levels and purposes of using mobile phones

➢ Many respondents mentioned to be conversant with phone usage as calling, answering and texting which mostly they do with their peers to share news, views, and stories and to inform.
➢ Some of them mentioned taking part in SMS polls, phoning in to the radio and texting for requests or subscribing for information.
➢ Many of them expressed having participated in competitions via SMS.
➢ Many youth cited to use their phones for a number of issues:
  ✓ In Lilongwe, Mchinji and Salima youths said they use their phones to listen to a preferred radio station.
  ✓ Those with advanced phones use them to listen to stored music and surf the net.

5.3 Interactivity with other ICTs and Multimedia

Most young people in Lilongwe, Mchinji and Salima said they love listening to the radio stations, in order of preference and programming:

➢ Lilongwe youth prefer Galaxy FM seconded by Radio 2.
➢ Mchinji youth prefer Mudziwathu seconded by Radio 2 FM.
➢ In Salima, youth prefer Radio 2.
➢ Many respondents cited to be interacting with these stations using mobile phones to throw a comment on a topical issue, participate in a discussion, participate in opinion polls and vote in a competition; requesting and passing greetings and well wishes.
5.4 Advantages, Potential and Possibilities of Mobile Phones and other ICTs for community-centered development work.

- Mobile phones technology is the major adopted technology by many youth.
- During the assessment many respondents cited that they see potential and possibilities of these mobile phones to help in social transformation if proper communication and awareness is done.
- Some respondents in Lilongwe urban cited lack of proper communication, information framing and awareness in using mobile phones to communicate purposeful information.
- Being a mostly adopted technology youth train each other in the usage of phones
- Mobiles phones are shared, in Salima some youth cited that the one who wants to use the phone buys credit or takes it to the charging centre
- Mobile phone owners are information distributors: information is left to the phone owner who delivers the message to others
- Receiving known information is most exciting for a youth.
- Information from unknown sender is boring
- Most young people gave the following clues for messages both Radio and Mobile technologies to be applied in voice and text formats:
  - Messages should be brief and straight to the point
  - Interaction and engagement aimed at dialogue and transformations in relationships; SMSs or calls should be from an identified sender, it encourages them to respond and give feedback
  - Since they are youth they may need current issues information included say sports, music, entertainment news and gossips; which may encourage them to forward to their peers or encourage others to call in (if it is a system)
  - Facilitate two-way communication: between peers, colleagues and support groups, connecting people with expert advice and support.
  - Including awareness raising or mobilization, lobbying and campaigning.
  - Information should be locally generated and should be relevant to their needs

6.0 RECOMMENDATIONS ON MOBILE PHONE ASSESSMENT

The rapid assessment on Mobile phones assessment has provided us with the following information:
- Airtel and TNM are the major mobile networks available in the three targeted districts
Most youth in remote rural areas use Airtel while in rural urban and urban centers youth have both chips (Airtel and TNM) to enhance availability to and accessibility of their peers.

Both mobile networks are well understood by youth in terms of conditions, services, costs and promotions.

Most youth are already conversant with the potential and possibilities of using mobile phones in addressing social needs for transformation.

Many youth participate in several activities using their mobile phones like calling, texting, internet surfing, competitions, and quiz.

Youth are willing to participate in youth activities that are centered on the use of phones and radio.

Youth use their phones interactively with radio and other features.

Youths use their phones to listen to a radio station, participate in radio station activities using their phones.

Youth regard mobile phones as a convenient device to share their views and other information independently and privately at any time.

7.0 THE WAY FORWARD

After the successful rapid assessment which has given us the most needed and useful information on how to integrate mobile phones and other ICTs to compliment radio in the GMH project, below are the theoretical steps that we need to look into and frame up for actions:

- Mapping and planning information flows, designing the systems, setting up and implementing.
- Once the type of work and needs for mobile phone technology have been identified, the next stage is to explore the types of information flows that would be most suitable.
  - If we are deploying the Voice and SMS Platform as described then we need to set a design of how the information will flow.
  - This will help us to arrange the equipment needed that will help us do the following:
    - Provide information and advice services on mental depression and recovery information.
    - Collect information: including reporting, monitoring, data collection and management.
    - Facilitate two-way communication: between peers, colleagues and support groups, connecting people with expert advice and support.
    - Push messages: including awareness raising or mobilization, lobbying and campaigning and
    - Pull messages from our targets.
Depending on the objectives, the stakeholders, and their capacity, needs and interests, these flows need to balance appropriate levels of:

- Interaction and engagement aimed at dialogue and transformations in relationships;
- Strengthening demand for, and provision of, relevant information;
- Support for the provision of locally relevant content and data collection.

This type of analysis will enable us to clarify where mobile technologies can be most effective and useful, and identify the types of information flows (push, pull, exchange etc) which fit those purposes for example if we want to:

- Inform a group of people to raise awareness?
- Mobilize and motivate?
- Encourage and enable a group of people to participate and engage in decision making which affects them?
- Is the audience very general, or specific?
- Do we wish to strengthen existing relationships and communication or create new channels?
Annex E:

National Stakeholder Convention Report

Produced by: Farm Radio Malawi and GCYDCA
‘AN INTEGRATED APPROACH TO ADDRESSING MENTAL HEALTH CHALLENGES AMONG THE YOUTH IN MALAWI AND ZAMBIA’

REPORT ON NATIONAL STAKEHOLDERS’ MEETING

MALAWI INSTITUTE OF MANAGEMENT (MIM)

5th – 6th FEBRUARY, 2013
1.0 Introduction

The National Stakeholders meeting was one of the first major activities for the Mental Health Integrated Innovation (MHII) programme, which is being spearheaded by four (4) partners namely: Farm Radio Malawi (FRM), Farm Radio International (FRI); Dr. Stanley Kutcher in Halifax, Canada, who has developed innovative and effective mental health curricula and training programs; The Guidance, Counseling and Youth Development Center for Africa (GCYDCA) in Lilongwe, Malawi, which works with schools and youth groups to provide mental health services for young people. Using integrated community, educational, media-supported and health system approaches, the four partners are working with schools, health centers and youth clubs to train peer educators, health care providers and teachers to understand, recognize and identify Depression. Mental health training will be backed up by radio programs for youth, involving call-ins, mini-dramas and quizzes, which will raise awareness about Depression in an entertaining and evidence-informed way.

With funding from Grand Challenges Canada (GCC), the project aims to build mental health literacy through a series of peer training sessions, in collaboration with 5 radio stations in Malawi and Zambia to broadcast interactive radio programming about youth Depression. Through this integrated approach, the partners will work to strengthen the capacity of education and health systems to ensure that young people who recognize they are suffering from Depression can identify where to get help, and receive appropriate care. The radio campaign will work with youth, counselors, teachers, mental health experts and health providers to develop interesting youth-focused programs that are content-rich, accessible and entertaining. Programs will be broadcast for one school year (~8 months), and will be directed toward specific, measurable learning and behaviour outcomes.

This report, therefore, aims to highlight proceedings of the National Stakeholders Meeting which took place at the Malawi Institute of Management (MIM) in Lilongwe, Malawi from 5th – 6th February, 2013 and was officially opened by the Secretary for Education, Science and Technology, Dr McPhail Magwira.

2.0 Welcome Remarks

The welcome remarks were handled by the Master of Ceremonies, Mr. Rex Chapota, Executive Director for FRM who also offered the opening prayer. The main issues highlighted were as follows:

- Explained that the programme is being spearheaded internationally by Farm Radio International (FRI) as the grant holder
There are four partners in the Mental Health Integrated Innovation (MHII) programme: FRI, S&K Consultants, Farm Radio Malawi and the Guidance, Counseling and Youth Development Centre in Africa (GCYDCA)

He introduced the high table as follows:
- The Secretary for Education who is also the Patron of the Mental Health Programme, Dr. McPhail Magwira
- Dr. Stan Kutcher, Principal Investigator for the Mental Health programme
- Mr. Kevin Perkins, Executive Director, FRI
- Prof. Kenneth Hamwaka, Executive Director, GCYDCA
- Dr. Dixie Maluwa-Banda, Director of higher education, Ministry of Education

### 3.0 Opening Remarks

The speeches were made as follows:

#### 3.1 FRI Executive Director, Kevin Perkins
- He was so excited with the MHII programme and was looking forward to its actual implementation
- He thanked everyone for making it to the stakeholders’ meeting
- He was happy with the integration of various experts from the health, education and communication sectors
- He emphasized the need to interact so as to learn from each other for the benefit of the programme.

#### 3.2 The Director of Higher Education, Dr. Dixie Maluwa-Banda
- He was tasked to introduce the Guest of Honour and further ask him to deliver his official opening speech for the stakeholders’ meeting
- He appealed to the stakeholders to realize that mental health is an integral part of everyone
- The Ministry of Education is so excited with the MHII programme
- He described the intervention as very timely
- The Director emphasised the importance of mental health hence the need to give it space in the schools’ curriculum.

#### 3.3 Guest of Honour, Dr. McPhail Magwira
- He expressed happiness with the coming of the MHII programme which he described as very important
- He further pointed out that the project will be incomplete without an element of sports
He elaborated on the importance of Mental Health in schools right from basic education to Higher Education.

He thanked the implementing partners for the project and agreeing to work as a team.

Emphasized that MH needs an integrated approach so as to succeed.

He also acknowledged that the team set is robust and was confident they will succeed.

He lamented that previously MH programmes largely targeted for adults at the exclusion of youths and further said this was regrettably the case in both developing and developed countries.

He advised that the programme is actually a life saver for both youth and adults.

The guest of honour then appealed to the partners in the MHII programme to be very committed and see to it that the programme is indeed implemented.

### 4.0 Presentations

#### 4.1 Presentation One: Overview of Mental Health and Depression: Dr. Stan Kutcher

- Good mental health means adaptation to the environment
- With the ability to adapt, we can succeed
- Physical health and mental health are not separate concepts
- The brain gets 80 percent of the oxygen that we need
  - Every memory lives in the brain
  - Everything starts with the brain
- You cannot have health without mental health
- We have a severe stigma about mental health and mental illness
  - The stigma comes from fear
  - This fear can be taken away through mental health literacy
- The majority of mental illnesses begin before the age of 25
- Adolescent period is a fascinating period as civilisation develops. It’s a period of positive and negative outcomes in development.
- 12-25 years are periods of brain development. Mental illness could also manifest during this period in that period.
  - This is the period when the brain restructures itself.
  - At this age mental illnesses are mild
- Disorder
  - This is when the normal functions of the brain are not functioning anymore
- Problem
  - It is normal to experience problems in life
  - These are substantial challenges
Counseling is very helpful for mental health problems

- Distress
  - This is normal
  - You get annoyed
  - It is not a mental problem
  - It helps us adapt to the environment

- The youth should be educated to become ambassadors of knowledge
- With radio, we can speak one language with the young people
- Physical Health and Mental health should be seen in the same context.
- Brain is very important for our survival because it controls our feelings, cognition, memory, emotion, physical parts of the body, signaling.
- Emphasized that we need to embrace mental health in all facets of life.
- Mental Health also attracts stigma due to fear and ignorance hence emphasis in literacy in the programme.
- Early intervention is very important to prevent poor mental growth, disorders, drug abuse hence calls for everyone to join in the battle.
- He ended his presentation with an adage that “It takes a village to raise a child” hence need for everyone to play a part in Mental Health promotion.
- Let the youth be the ambassadors of knowledge.
- Let’s train them and use media like radio to reach out to them.
- More material can be accessed on: www.teenmentalhealth.org

4.1.1 Feedback from participants

- Distress is not a mental health and it doesn’t need any treatment. Is it part of mental health? How can one overcome distress? Does it lead to disorder?
  - Distress is part of mental health
  - There are different ways of adapting to the environment
  - Some ways of adapting to the environment, however, do not auger well in overcoming distress
  - Distress can lead to disorder or problem

- How can one be able to know that they have depression in the very early stages?
  - There are technologies to help identify depression in its early stages
  - Depression comes in various degrees: mild, severe

4.2 Presentation Two: Project Overview: Kevin Perkins, Prof. Kenneth Hamwaka, Rex Chapota
The project aims to help the young people understand depression, how they can identify and overcome it.

- Enhance capacity for schools, families and communities
- Three impact districts: Lilongwe, Mchinji, Salima

4.2.1 **Project Objectives:** Kevin Perkins, the FRI Executive Director outlined the project objectives as follows:

- Assess the current level of mental health literacy among the youth, educators and health care providers
- Increase mental health literacy
- Develop a youth friendly interactive radio based communication strategy

The FRI Executive Director further expounded on the objectives as follows:

- The overall goals include enhancing the capacity of teens, schools, families and communities to understand Depression as a mental disorder
- Differentiate Depression from usual stress and decrease stigma.
- The programme also aims at improving health seeking behaviour and interventions for youth suffering from Depression.
- He stated that In Malawi the chosen pilot regions are Salima, Lilongwe and Mchinji.
- In Zambia the ED for GCYDCA was to advise on the roll out later in the implementation of the project.

4.2.2 **Role Guidance, Counseling & Youth Development Centre for Africa:** Prof. Kenneth Hamwaka

- Explained that the programme will adopt an integrated approach incorporating various youth centred approaches like Peer Education, Train the trainer initiative for youth leaders, educators, counselors and teachers.
- Key activities will include baseline surveys, training of significant health care providers, mapping exercise and mental health curriculum development.
- The ED revealed that the mental health literacy education will reach 50 schools per country, 260 teachers, administrators, youth leaders and radio broadcasters will receive mental health education.
- A total of 1200 mental health literacy session in each country.
- We need to speak from a common understanding
o We need mental knowledge for peer educators
o There is need for mental health literacy training for peer educators
o There is need to conduct the Baseline survey and needs assessment related to mental health literacy to determine knowledge, attitudes and practices related to the issue of depression
o People should be aware and involved in issues of depression
o There is need to do some mapping in order to know what facilities are already in existence

4.2.3 Farm Radio Malawi role by Rex Chapota
o FRM will spearhead the comprehensive communication strategy for youth by the youth.
o Weekly interactive radio shows and radio drama will be part of the radio packages.
o The entire package will also consist of Mental Health hotline, Interactive Voice Response System and an impact assessment to inform the future path of the programme.
o The young people need to be given correct information in the correct manner
  ✓ We are in the process of identifying radio stations to work with in the MHII programme
o Having mini-drama series
  ✓ Young people should be given a chance to direct the mini-drama series
o There is need to develop a hotline where young people can use to get assistance
  ✓ Interactive Voice Response (IVR) system
  ✓ Most young people love listening to music and other things
o We should be able to evaluate and see how this programme can help young people address problems that affect them
o How can we use the power of radio to address the challenges affecting the young people

The presentation has been attached.

4.2.4 Feedback from participants
o In developing countries, signs and symptoms are physical and rarely psychological
o Let’s not forget the role of physical symptoms in patients and how this can be addressed
  ✓ Materials are currently being developed and this will be taken into consideration
o Drug abuse is a major causative agent for depression and mental disorders
o The media is only brought in at implementation stage and not at the planning stage
  ✓ The media have been invited to the stakeholders conference so we move along together
o Just very few schools and teachers have been targeted. How do we make the programme more encompassing so that it involves many schools and teachers?
o Why are we only operating in the central region when we have diverse cultural backgrounds as well as geographical differences?
  ✓ We are just piloting the programme. Based on the successes, the programme will be extended to other regions as well
  ✓ We need to consider the issue of mobility
  ✓ We cannot pilot test any intervention in the whole country
  ✓ We need to start from somewhere before we can get anywhere
  ✓ Radio will take care of other interventions across the country

4.3 Presentation Three: Mental Health Interventions by the Ministry of Education: Dr. Dixie Maluwa-Banda
  o Schools are a major socializing agent for the learners
  o Mental health and mental illness are on the same continuum
  o Many people confuse mental health with mental illness
    ✓ Mental health is the state of wellbeing in which every individual realizes his or her own potential
    ✓ How we feel about ourselves
    ✓ How we feel about others
    ✓ How we are able to meet the demands of others
  o What factors can lead to mental distress?
    ✓ Genetic make up
    ✓ Stress and trauma
    ✓ Substance abuse
    ✓ Physical illness
4.3.1 **Status of Mental Health in Schools**
- Some mental health activities are going on in schools
- Life skills education in schools
- Guidance and counseling
  - Traditional dances can be a good mental health facility
  - Songs and dances
- Participation in sports and recreation activities
  - People who participate in sports enjoy better mental health
  - Let’s find creative ways of doing sports

4.3.2 **Prospects for mental health**
- Mental health in schools needs to be taken seriously

*The presentation has been attached.*

4.4 **Presentation Four: The Status of Mental Health Services among the youth in Malawi**
Dr. Beatrice Mwagomba, Deputy Director of Mental Health Unit on Non-Communicable Diseases, Ministry of Health

- The department of non-communicable diseases was established in 2011
- The unit aims to coordinating all activities at national level
- Mental Health Status among the youth
  - Suicide is quite high among the youth
- Availability of mental health status among the youth
  - Public health services offer acute stabilization for intoxication, withdrawal and psychiatric complications for the youth with substance use problem
  - Public mental health institutions offer both inpatient and outpatient care
  - There is acute shortage of psychiatric nurses
  - There are mental health awareness radio programmes on MBC Radio 2 FM

4.4.1 **Opportunities**
- Presence of health sector strategic plan
- Newly developed action plan for the NCD and mental health includes promotion of mental health services
- Presence of youth NGOs and CBOs

4.4.2 **Challenges**
- An outdated mental health policy
- Mental health Act (1948) revision is not yet complete
- Lack of alcohol and drug abuse policies
  - Directives given by the authorities but without legal backing are ineffective
- Poor access to mental health services because the services are centralized
- There is need to bring together resources for mental health issues
- Resources could be used for research on mental health issues
- Poverty leads to substance abuse

### 4.4.3 Way forward

- Youth-friendly health services
- Youth participation
- Develop policies that relate to promotion of mental health issues
- Let’s all mainstream mental health issues then all of us will be mentally well

### 4.4.4 Feedback from participants

- Let’s share information for the sake of training the young people
- If you were presenting and we were discussing in Chichewa, how would we have been addressing this issue of mental health?
  - When something reaches illness, then it is a problem
  - Depression means ‘matenda okhumudwa’
  - Mental health is ‘malingaliro a ngwiro’
  - Mental illness can be interpreted in different ways
  - Some say mental illness is ‘matenda a kutimira kwa mtima’
- Mental illness and depression are quite complex issues in Malawi
- There is need to conduct formative research to establish meanings and definitions of certain terms
- Broadcasters should be able to do thorough and targeted research before we go into the actual programming
- Suicide should not be considered as a crime, it should be removed from the penal code because it is an issue to with depression and mental health
- Zomba mental hospital is training health surveillance assistants are being trained in mental health
  - Mental health education
Early identification in the schools, communities and villages

- There should be considerable work on translation
  - Let’s translate ideas which people can understand

## 5.0 Feedback from the Participants- Health, Education, Youth and Media sectors

### 5.1 Youth Sector

- Focus on the relationships between young people and their parents
- Children and their parents
  - Young people are not understood in their homes because of the generation gap
  - They end up being depressed
  - When young people talk to their parents about relationships, they get insulted
  - Young people end up being sidelined
  - Most parents are busy with their work and they don’t have time for their children
  - When young people are depressed they end up drinking, smoking and they end up losing their lives
- Focus on religious leaders and teachers
  - Spiritual leaders and teachers are part of the young people’s lives
- When pupils are not supported in school, they end up being school dropouts

#### 5.1.1 How do we do this?

- Use Parents Teacher Associations (PTAs)
- Church leaders can create platforms with parents
  - Community leaders can create platforms with parents and the young people
- Let’s target the social media so that the young people are able to get the right information
- ‘Young people’ is an umbrella term
- Our definition of youth should not be exclusionary. It should be such that even out of school youths are targeted.
  - We cannot have a wholesale intervention to address the young people’s problems
There is a point where we need to meet in the middle
Parents and the young people should come to a common understanding

- We should not think on behalf of our children
  - Let’s train our children to think on their own
- Rights have to be balanced with responsibilities
- We need to reach out to out of school youths
  - Voluntary work for the youths
- The young people should be able to own the programme
  - They already have structures such as in school and out of school youth clubs

5.2 The Media Sector

- Malawi Broadcasting Corporation (MBC) Radio 2 FM has a programme known as ‘Better Youth.’
- We need to find out which activities attract the youth
  - Sports is one of such activities
- Let’s target the social media
- Let’s attach incentives to our activities
- Involve the media from the planning stage such as the baseline study
- There are also consequences of addiction to social media
- There is need for orientation for the media as drivers of information
- The media need to be educated on issues relating to mental health as well, so as to appreciate the magnitude of the challenge.
- Producer’s manual to be produced for the media so as to be able to disseminate common messages, thereby avoiding inconsistencies.

5.3 The Health Sector

- The existing structures that are available in health centres should also be used for mental health interventions
- Mental health messages can be integrated in already existing programmes such as ‘Phukusi la moyo.’
- We need different messages for different age groups for the young people
- Let’s strengthen existing programmes like the Youth Friendly Services in hospitals which currently concentrate in reproductive health only. MH can now be incorporated in YFS.
- Legislation on mental health should be lobbied so as to empower implementation strategies.
✓ The current piece of legislation is outdated and is not fully serving the intended purpose.

5.4 The Education Sector

- School environments are not adaptive
  - There are a lot of vandalisms, riots in secondary schools these days
  - Rules and regulations of the schools are not agreed upon by the pupils
- Curriculum does not meet or address the needs of the pupils resulting into distress, then depression
- Some pupils do not qualify for secondary school education because the majority secures these places just on admission instead of being selected.
- Some pupils make demands to the schools which most of them are more social in nature than academic
- Misconceptions of freedoms or democracy by the pupils conflicts with the objectives of schools as institutions of learning

5.4.1 Suggestions

- The MHII programme should recommend to the Ministry of Education to mainstream Mental Health issues into the subject curriculum e.g. Biology, Languages
- Rules and regulations to be revised to reflect the pupil involvement in their formulation
- Teacher educationists should be capacitated

6.0 Any Other Business (AOB)

- Presentations should be made available to the participants
- The MH programme should be self-sustaining
- Let us have a broadcasters’ manual for producers at various radio stations to use
- Participants’ contact details should be circulated for networking purposes
- Information is available on www.teenmentalhealth.org

7.0 Closing remarks by Professor Kenneth Hamwaka

- He thanked people for attending the meeting and promised that all the suggestions will be incorporated.
- He pledged oneness in the fight against depression and further urged everyone to work together for one common good cause.
- Wished people to travel well under God’s guidance and blessings.
- He pointed out that what is excellent can still be made better and therefore encouraged the participants to continue perfecting the MHII programme
- The meeting finally finished with a prayer which was offered by Dr. Dixie Maluwa-Banda
## STAKEHOLDERS’ MEETING
AN INTEGRATED APPROACH TO ADDRESSING MENTAL HEALTH CHALLENGES AMONG THE YOUTH IN MALAWI AND ZAMBIA
MALAWI INSTITUTE OF MANAGEMENT (MIM)
5th – 6th FEBRUARY, 2013

### List of Participants

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<td>42. Fatsani Gunya</td>
<td>&quot;</td>
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<td>William Kumwembe</td>
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Annex F:

Ethical Clearance Letter
The Secretary for Health

OFFICE OF THE DIRECTOR OF HIGHER EDUCATION

24th January 2013

The Executive Director
Centre for Guidance, Counselling and Youth Development
P. O. Box 30058
Capital City
LILONGWE 3

Dear Professor Hamwaka,

RE: ETHICAL CLEARANCE – AN INTEGRATED INNOVATION APPROACH TO ADDRESSING THE ISSUE OF YOUTH DEPRESSION IN MALAWI AND ZAMBIA

Following your request for ethical clearance for a research programme that will seek to address the issue of youth depression in schools in Salima, Mchinji, Lilongwe, Nkhotakota, Dedza and Kasungu districts, I am pleased to inform you that the Ministry of Education, Science and Technology has no objection to the ethical standards presented in your protocol as part of research and associated activities of the Integrated Mental Health Programme.

I wish to commend you for this timely intervention as it will add value to the improvement of quality of education in Malawi.
Kindly receive our highest support as you carry out various activities of the programme.

Professor Dixie Maluwa Banda
DIRECTOR OF HIGHER EDUCATION
FOR SECRETARY OF EDUCATION, SCIENCE AND TECHNOLOGY
Annex G:

Memorandum of Understanding: Ministry of Education in Malawi
25th January 2013

The Executive Director
Guidance, Counselling and Youth Development Centre of Africa
P.O Box 30058
Lilongwe3- Malawi

REF: Memorandum of Understanding
An Integrated approach to addressing the challenge of depression among the youth in Malawi and Zambia

The Ministry of Education, Science and Technology in Malawi wishes to acknowledge receipt of a letter informing us that with funding from the Government of Canada through Grand Challenges Canada, GCYDCA together with Farm Radio International (FRI), Farm Radio Malawi (FRM), and Dr. Stan Kutcher plan to embark on an exciting three year initiative in Malawi and Zambia called An Integrated approach to addressing the challenge of depression among the youth in Malawi and Zambia.

The Ministry is highly excited with the intent and concept of addressing the challenge of youth depression in Malawi, and therefore wishes to join the partnership in implementing the program. Apart from improving the mental health of the young people, the objectives of the program are directly fulfilling the current Malawi National Education Sector Plan (NESP), as well as increasing access to learning opportunities and improving the quality of education.

As part of fulfilling its obligation, the Ministry of Education is committed to bring on board other stakeholders such as the Ministry of Health and the Ministry of Youth. Management has also formally accepted the appointment of the Secretary for Education as patron for this program in Malawi. The Ministry is equally proud to announce that it has granted you authority with pleasure to have access to educational institutions, its personnel, and the learners during the duration of the program.

Again, accept our heartfelt congratulations for this program and be rest assured of our support. The Ministry of Education wishes to renew its relations with GCYDCA and its partners and kindly accept the highest consideration.

_______________________________

Raphael Agabu
Director, Directorate of Inspectorate and Advisory Services
For: Secretary for Education, Science and Technology
7th January 2013

The Secretary to the Ministry of Youth & Sports  
Ministry of Youth & Sports  
Private Bag  
Lilongwe3- Malawi

Call for collaboration with Ministry of Youth:  
An Integrated approach to addressing the challenge of depression among the youth in Malawi and Zambia

The Ministry of Education wishes to inform you that it has agreed to collaboratively work with the Guidance, Counselling and Youth Development Centre for Africa (GCYDCA) together with Grand Challenges Canada, Farm Radio International (FRI), Farm Radio Malawi (FRM), and Dr. Stan Kutcher who have embarked on an exciting three year initiative in Malawi and Zambia called *An Integrated approach to addressing the challenge of depression among the youth in Malawi and Zambia*. The Secretary for Education, Science and Technology in Malawi is the Patron of the program.

The Ministry of Education strongly feels that engagement of other key government partners such as the Ministry of Youth and the Ministry of Health is vital hence this invitation for your Ministry participation and involvement throughout the life span of the programme.

As described in the attached concept note, *An Integrated approach to addressing the challenge of depression among the youth in Malawi and Zambia* provides a highly innovative, multi-partner strategy for improving the way that Depression is understood, recognized and treated in Malawi and Zambia.

We appeal for your support in all forms and we look forward to your active contribution at all phases of program implementation. Kindly find attached the program concept note to deepen your understanding and appreciation for the program.

Faithfully yours

Raphael Agabu  
Director, Directorate of Inspectorate and Advisory Services  
For: Secretary for Education, Science and Technology
7th January 2013

The Secretary to the Ministry of Health  
Ministry of Health  
Private Bag  
Lilongwe3 - Malawi

Call for collaboration with Ministry of Health:  
An Integrated approach to addressing the challenge of depression among the youth in Malawi and Zambia

The Ministry of Education wishes to inform you that it has agreed to collaboratively work with the Guidance, Counselling and Youth Development Centre for Africa (GCYDCA) together with Grand Challenges Canada, Farm Radio International (FRI), Farm Radio Malawi (FRM), and Dr. Stan Kutcher who have embarked on an exciting three year initiative in Malawi and Zambia called An Integrated approach to addressing the challenge of depression among the youth in Malawi and Zambia. The Secretary for Education, Science and Technology in Malawi is the Patron of the program.

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Director, Directorate of Inspectorate and Advisory Services  
For: Secretary for Education, Science and Technology