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**PLAGIARISM**

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1. I know that Plagiarism is wrong. Plagiarism is to use another’s work and pretend that it is one’s own.

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Good mental health is foundational to physical healthy, a state of emotional security and well-being, and to the socio-economic options that are available to a person across their life (Barry et al., 2013). However, the state of mental health and access to mental health services in Lower- and Middle-Income Countries (LMICs) is dire. Children and adolescents make up a large part of the population in most LMICs, and depression and anxiety among this demographic constitutes a sizeable portion of the mental health burden (Barry et al., 2013; Osborn et al., 2021). Access to the necessary care is scarce in the communities that need it the most (Osborn, Venturo-Conerly, et al., 2020; Osborn, Wasil, et al., 2020; Osborn et al., 2021). Universal mental health promotion programmes in schools have the potential to address some of the core problems outlined above, and promise efficient and scalable programs. However, there are still significant barriers to the implementation of these programmes (O’Reilly et al., 2018; Osborn, Venturo-Conerly, et al., 2020).

Mental health promotion refers to interventions that focus on giving participants the tools they need to live mentally healthy lives, and creating an environment which naturally lends itself to positive mental health (O’Reilly et al., 2018). Because these programmes aim to prevent the development of mental illness rather than treating problems after they have developed, they can be employed universally, across an entire population rather than only the people who are already at risk (Osborn, Wasil, et al., 2020; Rivet-Duval et al., 2011).

LMICs share the greatest portion of the mental health burden, but they simply do not have the funding for care services. Structural issues inhibit access to services, and stigma surrounding mental health issues prevents people from seeking care out of shame (Barry et al., 2013; O’Reilly et al., 2018; Osborn, Venturo-Conerly, et al., 2020). In South Africa there is a severe under-allocation of the health budget towards mental healthcare and an over-reliance on specialised facilities for treatment. Therefore, an otherwise progressive mental health policy is not actually implemented in areas that need it most (Docrat et al., 2019). Interventions need to be effective while also remaining financially feasible for national budgets that are already under immense strain. They must effectively manage the stigma surrounding receiving mental health care, to avoid alienating people who need that care (Osborn, Venturo-Conerly, et al., 2020; Osborn, Wasil, et al., 2020; Osborn et al., 2021). Another limitation of these interventions is that the measures they use have overwhelmingly not been developed for LMICs (Barry et al., 2013; O’Reilly et al., 2018; Osborn, Wasil, et al., 2020).

Several universal mental health promotion programmes attempt to meet these challenges. By promoting good mental hygiene and positive psychological concepts rather than relying on psychopathology, these interventions can improve general mental health, and skills for dealing with difficult emotional circumstances (Barry et al., 2013; O’Reilly et al., 2018; Osborn, Wasil, et al., 2020; Osborn et al., 2021; Rivet-Duval et al., 2011). Some have been specifically tested in LMICs and multicultural contexts (Barry et al., 2013; Osborn, Wasil, et al., 2020).

Two promising programmes, the Shamiri group intervention and the Resourceful Adolescent Program (RAP-A), were both delivered by a limited number of trained lay-persons in a classroom context, mostly teachers who did not require lengthy or expensive training. Each included both students who reported high depression and anxiety symptoms and those who did not (Osborn, Venturo-Conerly, et al., 2020; Osborn, Wasil, et al., 2020; Osborn et al., 2021; Rivet-Duval et al., 2011).

Shamiri was tested in Kenya, based on the idea of "wise interventions", which focus on singular concepts that contribute towards positive mental health rather than teaching complicated systems all at once (Osborn, Venturo-Conerly, et al., 2020; Osborn, Wasil, et al., 2020; Osborn et al., 2021). The intervention taught three concepts over a four week period: (1) A growth mindset, (2) gratitude, and (3) positive values (Osborn, Venturo-Conerly, et al., 2020; Osborn et al., 2021). This intervention had significant positive effects on students’ general well-being, and significant reductions in depression and anxiety symptoms (Osborn, Venturo-Conerly, et al., 2020; Osborn et al., 2021).

RAP-A was implemented in a multicultural school in Mauritius, and focused on teaching students strategies to bolster their self-esteem, problem solving skills, engaging with support networks, and more, over 11 one-hour sessions (Barry et al., 2013; Rivet-Duval et al., 2011). After a follow-up, it was found that students who participated, whether originally experiencing symptoms of depression or anxiety or not, reported much greater resilience and general mental health (Rivet-Duval et al., 2011).

Both programmes were able to make a positive impact on the students’ lives, and were able to navigate the significant challenges they face. Because they were generalized, both programmes circumvented the stigma surrounding alternatives. Because they were in school, they were easily accessible. Because they were facilitated by only a few teachers, they were financially and logistically feasible (Osborn, Venturo-Conerly, et al., 2020; Osborn et al., 2021; Rivet-Duval et al., 2011). These programs are a promising answer to the unique challenges facing mental healthcare in South Africa. More work must be done to prove scale these programs up, but they have shown significant positive results already.

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