REPUBLIC OF KENYA

MINISTRY OF HEALTH

NATIONAL FRAMEWORK FOR IMPLEMENTATION OF PROBLEM MANAGEMENT PLUS.

APRIL, 2018

"Enhancing Community Mental Health for Universal Health Coverage"

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For information about the PM+ intervention, refer to: World Health Organization. *Problem Management Plus (PM+): Individual psychological help for adults impaired by distress in communities exposed to adversity.* (Kenya field-trial version 1.0).Geneva, WHO, 2016.

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FOREWORD

The Ministry of Health is fully committed to providing quality services to the Kenyan citizens as enshrined in Article 43(a) of the constitution of Kenya, 2010; which states that every citizen has a right to the highest attainable standards of health care services ***including reproductive health care and the right to mental health care and services,*** and further emphasizes on rights based approach to health services delivery.

One of the major barriers to provision of essential mental health services is the shortage and inequitable distribution of skilled and qualified health personnel. There is especially huge shortage of psychiatrics, clinical psychologists and also medical social workers. One of the way of mitigating against this shortfall, but still maintain high quality mental health services, is by implementing the Problem Management Plus (PM +) intervention.

PM + is a low intensity psychological intervention for adults in communities exposed to adversity which means it can be delivered by lay professionals.

PM+ framework is Kenya's first, and perhaps even a world's first framework and hence the Ministry of Health is proud to be a leader in finding cost effective practical solutions to the expanding mental health care to those living in adversity, and in need of quality care. This framework has been adapted from the World Health Organization Framework and as such may also be applied beyond Kenya, and support other nations particularly those in Africa, to also roll out evidence-based treatment(s) to communities in most need.

Therefore, it is my expectation that under the devolved system of government, all the health actors, in Kenya will rally their support to ensure that this framework implementation and scale up facilitate provision of quality mental health care services in the country.

PETER TUM, OGW

PRINCIPAL SECRETARY, MINISTRY OF HEALTH

PREFACE

Adversities, difficult life circumstances, have become more common globally, with millions of people facing one adversity or the other. For example, displacements due to wars and natural calamities. Locally, adversities have been common due to various crisis and emergencies. People lose their loved ones; sources of livelihoods and may confront extreme stressors such as violent deaths and sexual violence. A huge population lives below the poverty line (Earning less than 2 dollars per day) and as such, live in areas where there is lack of security, basic services and livelihood opportunities exposing them to adversities. People who experience adversity are at greater risk of developing mental health and social problems. As a result, a range of mental health and psychosocial supports need to be available, including psychological interventions. Most of the times however, these interventions are rarely accessible to those who need them.

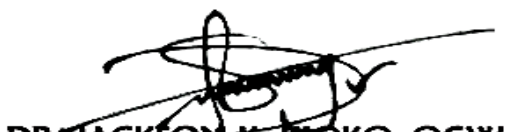
Achievement of Universal Health Coverage is in top gear in Kenya, and one of the key components is primary health care. With this manual, the Ministry of Health bridging the gap of primary mental health care by providing guidance on psychological interventions for people exposed to adversities. It is based on recommendations of the mhGAP programme by the WHO. Some mental health interventions can be simplified so that they can be quickly learned not only by professionals but also by people who are not mental health professionals. For example, cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT) for adult depression.

These simplified interventions are referred to as "low-intensity psychological interventions", as their delivery requires a less intense level of specialised human resource use. It means that the intervention has been modified to use fewer resources compared with conventional psychological interventions and non-specialized care providers can effectively deliver low-intensity versions of CBT and IPT as long as they are trained and supervised. This will help cover more people who may be experiencing severe levels of depression.

This framework describes PM+. To ensure maximum use, the intervention is developed in such a way that it can help people with depression, anxiety and stress, whether or not exposure to adversity has caused these problems. It can be applied to improve aspects of mental health and psychosocial well-being no matter how severe people's problems are.

The value of PM+ has been confirmed through independent randomized controlled trials in which Kenya was one of the participating sites.

I hope that you will use this manual and share your feedback with us so that we can further strengthen future revisions.



DR. JACKSON K. KIOKO, OGW MBS
DIRECTOR OF MEDICAL SERVICES

ACKNOWLEDGEMENTS

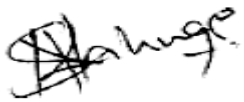
This framework was developed through consultative work under the leadership of Dr Kioko Jackson K. Director of Medical Services, the Mental Health Unit provided the secretariat team led by Ms Mary Chege, to coordinate the technical working group working in conjunction with Ms. Phiona Koyiet, National Coordinator Gender, Mental Health and Psychosocial Support World Vision Kenya, Dr. Alison Schafer Global Technical Advisor Mental Health and Psychosocial Support World Vision International and Dr. Hussein Salim head of Community Health and Development Unit.

Others involved in the consultation for development of this framework included; the County Governments: Nairobi, Nakuru, Nyeri and Nyamira, the National PM+ Technical Working Group (TWG), PM+ County Steering Committees, Mathari National and Teaching Hospital, University of Nairobi, Kenya Medical Research Institute.

This framework was reviewed and edited by the Department of Standards, Quality Assurance and Regulations led by Idah Ombura and Dr.Jamlick Karumbi, Department of Curative and Rehabilitative Health.

I recognize and appreciate the important contributions in form of; technical expertise, time and other support towards the development of this framework by all involved officers working with the Ministry of health at National and County levels, as well as staff from World Vision Kenya and other stakeholders.

Funding for this project that enabled this work was generously provided by Grand Challenges Canada, with match funds provided by World Vision International; Kenya and Canada offices, Wellspring Advisors, the Sexual Violence Research Initiative (SVRI) and World Bank Development Marketplace for Innovation to prevent Gender Based Violence.



DR. SIMON NJUGUNA
DIRECTOR OF MENTAL HEALTH

TABLE OF CONTENTS

OPERATIONAL DEFINITIONS

Advocacy:	Organized and coordinated efforts to change government policies and/or public attitudes about certain issues
Clinical Supervision	A reflection of practice on treatment provided to clients ensures quality care is meeting the needs of the client, where -by progress of both the client and the PM+ provider is monitored.
Community Sensitization:	A process by which the community is made to be aware and be responsive to certain ideas, events, situations or experiences.
Community awareness:	Creating an enabling environment and effect change in the behaviour of individuals and communities at large. E.g. local radio programs and posters to encourage individuals with symptoms of depression to seek treatment.
Managerial Supervision:	Refers to the day-to-day supervision of health workers, at whatever level for purposes of supporting the management of workloads, the types of work they undertake and their performance in those roles.
Master trainer:	Is a high-level professional at national and county level who has been certified to Train other Trainers, provide training and capacity-building, supervision to others.
Mental Disorders:	Is a syndrome characterised by clinically significant disturbance in an individual's in cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Usually associated with significant distress or disability in social, occupational or other important activities. With exception of culturally approved response to a common stressor or loss, socially deviant behaviour and conflict that are primarily between

the individual and society unless the deviance or conflict results from a dysfunction in the individual (DSM 5)

Mental Health: A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to a contribution to his or her community.

Mental Health Promotion: It is a process of enabling people to increase control over and improve their health. It moves beyond a focus on individual behaviour towards a wide range of social environmental interventions.

PM+ Plus Providers Trainers: This is a professional at the primary health level who has been certified to train, and supervises PM+ providers.

PM+ Provider: This is a trained lay professional who has met the entire competency to deliver PM+ to clients.

Problem Management Plus: A title that reflects the aims of the approach: to help people improve their management of practical (e.g. unemployment, interpersonal conflict) and common mental health problems (e.g. depression, anxiety, stress or grief).

Social marketing: Using various technologies to deliver key messages to individuals and communities.

Trans-diagnostic approach: Treatment that can address more than one diagnosis and can be used to treat different symptoms without a full diagnosis. Those that apply the same underlying treatment principles across mental disorders, without tailoring the protocol to.

Trans diagnostic: PM + can be used to treat different symptoms and mental health problems without clinical diagnosis.

EXECUTIVE SUMMARY

Background

The right to health, including mental health is guaranteed in the constitution of Kenya 2010. Mental health is the state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to a contribution to his or her community.

One of the challenges of offering mental health services is the inadequate number of skilled workers to offer the services. Problem Plus Management is one of the quick interventions which can be used to address the shortage.

Problem Management Plus (PM+) is an innovative cost-effective evidence-based treatment for common mental health problems, such as such as depression, anxiety and chronic stress, forming part of the WHOs Mental Health Gap (mhGAP) Series. It is unique, in that it is administered by minimally trained (and supervised) non-specialised service providers, such as Community Health Volunteers (CHVs), without any formal diagnosis, at the community and/or primary health care level.

This framework will guide the institutionalisation and coordination of PM+, and will be applied by policy makers, development partners, training institutions (Centres of Excellence) and PM + providers during implementation.

Development process

This document was developed through a series of consultative meetings to discuss the adoption and adaptation of the World Health Organization. *Problem Management Plus (PM+): Individual psychological help for adults impaired by distress in communities exposed to adversity.* (Kenya field-trial version 1.0).Geneva, WHO, 2016. This WHO was piloted in four counties, Nakuru, Nyeri, Nyamira and Nairobi and the findings were used in strengthening the adoption and adaptation of this framework to the Kenyan context.

The framework

It entails 5 strategic sessions, Stress management ("Managing Stress"), Problem solving ("Managing Problems"), Behavioral activation ("Get Going Keep Doing"), Strengthening social supports ("Strengthening Social Supports"), Relapse prevention ("Staying well and looking forward"), with each session lasting 90 minutes.

PM+ will be delivered largely by Health Volunteer (CHV) workforce, based on a sustainable training program for the following three cadres: -

1. PM+ Master Trainers
2. PM+ Provider Trainers/Supervisors
3. Trained PM+ Providers

There needs to be a lot of advocacy and communication reduce barriers which prevent people from getting services to meet their mental health needs. The desired impact of community awareness and social marketing is to enhance knowledge on mental health and ways to seek support for common mental health problems.

Monitoring and evaluation

Implementation of PM+ in health facilities/communities should undergo a semi-annual monitoring and evaluation assessment, to measure intended progress towards meeting the health facility PM+ implementation plan and ultimately the county's quality intervention strategy.

This assessment shall be a responsibility born by the County Community Health steering committee in-collaboration with the County health Management Teams.

Monitoring activities shall also include the quarterly submitted assessments of PM+ data obtained and consolidated from the health facilities implementing PM+.

Assessing such data will be essential to further promote the scale-up of PM+ across counties, and for evidence of the intervention's impacts to be documented for National MOH TWG to align with other national, regional and global health targets.

1. Scale up implementation of Problem Management Plus (PM+) in Kenya
2. Build capacity for the community health work force in quality delivery of Problem Management Plus (PM+)
3. Sustain the viability of Community Health Volunteers (CHVs) in delivery of mental health care at the community level.

LIST OF ACRONYMS

CBO	Community Based Organization
COE	County Centres of Excellence
CCSC	County Community Strategy Coordinators
GBV	Gender Based Violence
CGBVC	County Gender Based Violence Coordinators
CHA	Community Health Assistants
CHEW	Community Health Extension Worker
CHPO	County Health Promotion Officers
CHSU	Community Health Strategy Unit
CHDU	Community health development Unit
CHV	Community Health Volunteer
CHW	Community Health Worker
COE	Centre of Excellence
DHIS-2	District Health Information 2
DPHK	Development Partners of Health Kenya
GHQ	General Health Questionnaire
HENNET	Health Non-Governmental Organizations Network
HIS	Health Information System
IGAs	Income Generating Activities
INGO	International Non-Governmental Organisation
ISO	International Organization for Standardization
KEPH	Kenya Essential Package for Health
KMTC	Kenya Medical Training College
MhGAP	Mental Health Global Action Programme
MHIS	Management Health Information System
MHSMU	Mental Health and Substance Management Unit
MOH	Ministry of Health
NCDC	Non-Communicable Disease Coordinators
PM+	Problem Management Plus
PTSD	Post-Traumatic Stress Disorder

PSYCH LOPS	Psychological Outcomes Profile
SCCSC	Sub-County Community Strategy Coordinators
SCO	Sub-County Clinical Officers
SCHPO	Sub-County Health Promotion Officer
SCHRIO	Sub-County Health Records and Information Officer
SDGS	Sustainable Development Goals
SOP	Standard Operating Procedure
SVRI	Sexual Violence Research Initiative
TOR	Terms of Reference
TOT	Trainer OF trainers
TAU	Treatment as usual
TWG	Technical Working Group
UN	United Nations
WHA	World Health Assembly
WHO	World Health Organization
WHODAS	World Health Organization Disability Assessment Schedule
WVK	World Vision Kenya

1.0 INTRODUCTION

1.1 Background

Mental health is an integral part of health, and is referred to "being a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[1].

Mental disorders such as depression, anxiety disorders, and posttraumatic stress disorder (PTSD) are prevalent in poverty stricken low and middle income countries (LAMICs) (Kessler et al., 2008; Prince et al., 2007, Ormel et al., 2008), and are amongst the largest contributors to disability and functional impairment (Chisholm et al, 2007).

In 2016, World Health Organization (WHO) estimated that globally, 450 million people live with one or more mental disorders, and of these seventy-five percent (75%) cases, live in low and middle income countries (LMICs), of which approximately 80% receive no evidence based treatment mental healthcare[i]. This contributes significantly to global and national burdens of the disease, years lived with disability and loss of economic productivity[ii].

Adverse life events, including urban violence, are risk factors for common mental health problems, including depression, anxiety and posttraumatic stress disorders. Kenya's health system has limited resources to address and respond to these mental health needs and individuals do not commonly seek or receive treatment for such problems. This includes women and Men who experience a range of mental health and psychosocial challenges as a consequence of violence.

Women living in urban poverty areas are particularly exposed to common mental disorders, owing to intimate partner violence or other types of violence, unwanted pregnancy (Dibaba et al., 2013), lack of resources, limited opportunities, concurrent physical health problems, low education, limited social supports, or other risk factors.

Nevertheless, these women tend to receive no or minimal mental health support (WHO, 2000).

[1] World Health Organization (WHO) (2010b).*mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings*. Geneva, SW: WHO.

Kenya is directly affected and it is reported that 20-40% of individuals seeking hospital outpatient services experience mental disorder. Similar to global estimates, one in four people in Kenya will experience mental disorder at some point in their lives; equating to some 11.5 million Kenyans[iii]. However, mental disorder affects 100% of Kenyans, given that for each individual living with mental disorder, their illness inevitably impacts at least three (or more) others around them, such as family, friends, employers and community members.

1.2 Description of problem management plus (PM+)

Problem Management Plus (PM+) is an innovative cost-effective evidence-based treatment for common mental health problems, such as such as depression, anxiety and chronic stress, forming part of the WHO's Mental Health Gap (mhGAP) Series. It is unique, in that it is administered by minimally trained (and supervised) non-specialised service providers, such as Community Health Volunteers (CHVs), without any formal diagnosis, at the community and/or primary health care level.

http://www.who.int/mental_health/emergencies/problem_management_plus/en/

PM Plus Structure

PM+ is a brief intervention, entails 5 strategic sessions, built upon session after session (Figure 1-1), with each session lasting 90 minutes (5 x 90 minute individual sessions), as it makes use of core cognitive and behavioural treatment elements such as:

I. Stress management ("Managing Stress"),
II. Problem solving ("Managing Problems"),
III. Behavioral activation ("Get Going Keep Doing")
IV. Strengthening social supports ("Strengthening Social Supports")
V. Relapse prevention ("Staying well and looking forward")

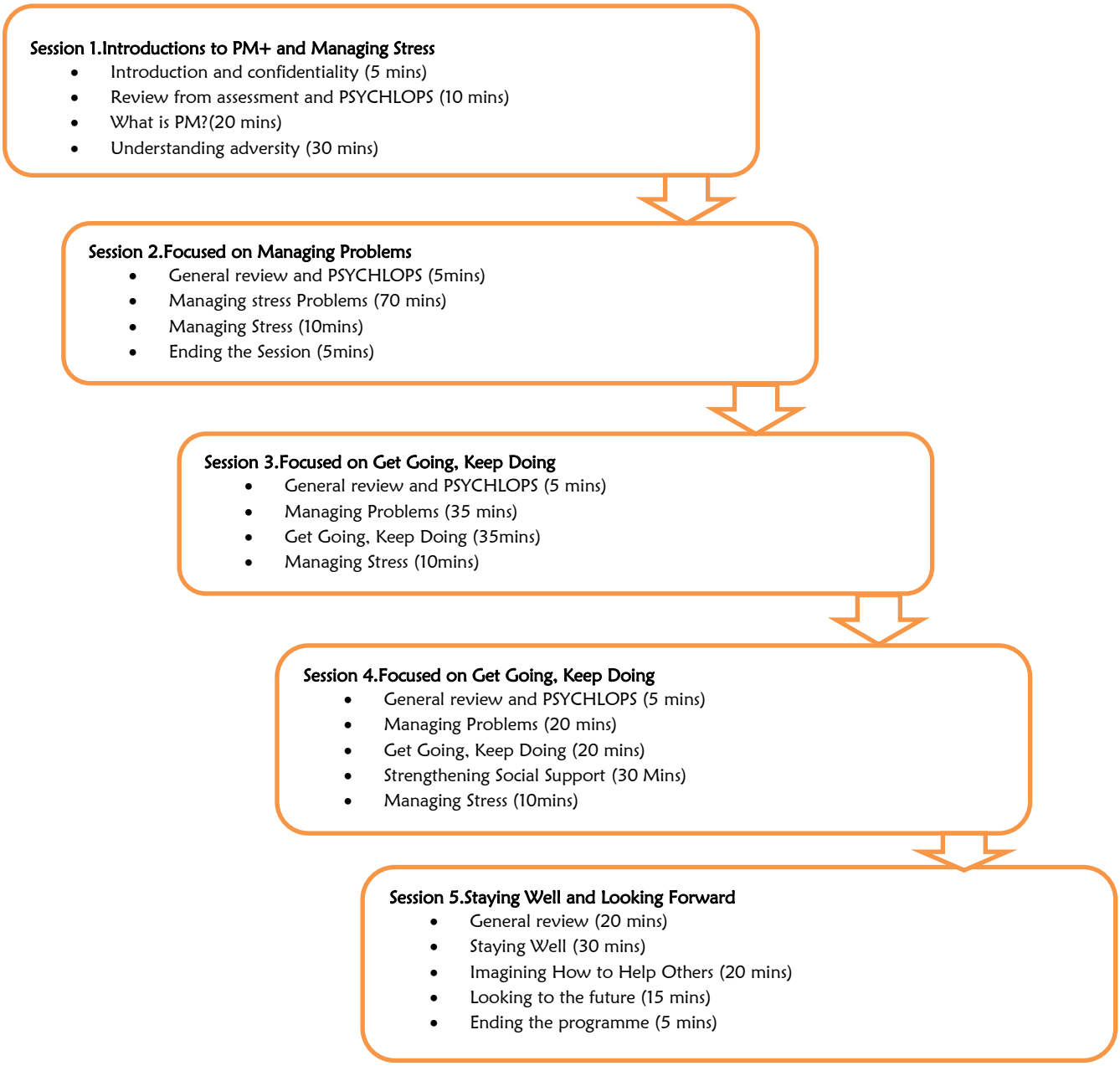


Figure 1-1: Summary of five Problem Management plus (PM+) session showing the weekly strategy taught each session.

1.3 Rationale

Globally, there is huge inequity in the distribution of skilled human resources for mental health. Shortages of psychiatrists, psychiatric nurses, psychologists and social workers are among the main barriers to providing mental health services and treatment in low- and middle-income countries. Low-income countries have 0.05 psychiatrists and 0.42 nurses per 100 000 people. Although in the high income countries the rate of psychiatrists is 170 times greater, and nurses is 70 times greater.

A recent health economics study[2] suggested that potential losses of economic output attributable to mental disorders could be as high as USD 2.5-8.5 trillion, and if left untreated, this figure could double by 2030[3].

Kenya is one of the world's poorest countries in the world, ranking 145 out of 188 countries in the United Nations Human Development Report for 2015[4]. Poverty, adversity and urban pressures, worsened by the lack of mental health staff are all risk factors for mental disorder[5]. In addition, household-level violence against women reported from Kenya are has amongst the highest rate (41%), in the world. These women experience sexual and/or physical violence by intimate partners in their lifetime, while in a 12-month period, 31% of women are living with active violence in their homes

Nevertheless, in many of these low- and middle income countries, including urban slums, various nonspecific counselling programmes are practiced with unknown efficacy and safety. These may involve informal non-specific counselling without any manual describing the techniques or procedures used, supervision of the persons delivering these interventions, and lack documented evidence of their efficacy.

Hence, *Problem Management Plus* (PM +), is positioned as a cost-effective community and primary level medical evidence based intervention, for the treatment for common mental health problems important in reducing the mental gap.

1.4 Goal

The goal of this framework is to guide a standardised implementation of PM+ in Kenya; with an overarching aim to support the implementation of Kenya's Mental Health Policy (2015-2030).

1.5 Objectives

To achieve this goal, the framework will work towards meeting the following objectives:

1. Scale up implementation of Problem Management Plus (PM+) in Kenya

[2] Chisholm, D., Sweeny, K, Sheehan, P., Rasmussen, B., Smit, F., Cuijpers, P., & Saxena, S. (2016). Scaling up treatment of depression and anxiety: A global return on investment analysis. *Lancet Psychiatry*. Published **Online** April 12, 2016, http://dx.doi.org/10.1016/S2215-0366(16)30024-4

2. Build capacity for the community health work force in quality delivery of Problem Management Plus (PM+)
3. Sustain the viability of Community Health Volunteers (CHVs) in delivery of mental health care at the community level.

1.6 Scope and application

This framework will guide the institutionalisation and coordination of PM+, and will be applied by policy makers, development partners, training institutions (Centres of Excellence) and PM + providers during implementation.

Target audience will include: -

1. The Ministry of health both at National and County level
2. Implementers of community Mental health services
3. Problem Management Plus (PM+) providers
4. Primary health care providers
5. Community Health Workers
6. PM + Centre of Excellence and Medical Training Institutions

Beneficiaries of this Problem Management Plus (PM+) Framework will include:

- **Primary beneficiaries**; clients who benefit directly from receiving the 5 x 90 minute PM+ sessions and are supported in learning new strategies to cope and manage adversity.
- **Secondary beneficiaries**. Individuals with significant influence over the primary beneficiaries, such as family members (including children), friends and the wider community.
- **Tertiary beneficiaries**. Members of the Kenya MOH personnel at national and county, whose capacity will be built to address mental health concerns at the primary healthcare levels, and develop their understanding about the different care requirements of individuals living with common mental health problems and mental disorders.

2. DEVELOPMENT PROCESS OF THE FRAMEWORK

2.1 Policy context

The development and review of this Problem Management Plus (PM+) frame work is anchored on the following national policies:

1. The Constitution of Kenya (2010): Article 43. (1) States that every person has the right ***to the highest attainable standard of health, this includes the right to health care services, and the right to mental health care and services.*** [iv]
2. The Kenya Government's Vision 2030[v]
3. The Universal Health Coverage roadmap
4. Kenya's commitment to the global Sustainable Development Goals (SDGs, 2016[vi]) – particularly SDG 3, "Good health and wellbeing", which includes specific consideration for reducing suicide, preventing and treating mental disorders, promoting mental health and strengthening the prevention and treatment of substance abuse and harmful alcohol use;
5. The Kenya Health Policy (2014-2030).
6. Kenya's global commitments to improved mental health care, including the World Health Assembly (WHA) Resolution 66.8, which calls upon all member states to contribute towards the Global Mental Health Action Plan (2015-2020).
7. The Kenya Mental Health Policy (2015-2030), which underpins Kenya's Ministry of Health (MOH) policy directives to achieve the vision of "a nation where mental health is valued and promoted, mental disorders prevented and persons affected by mental disorders are treated without stigmatization and discrimination.
8. Community Health Strategy

2.2 Background of problem management plus (PM+) Intervention

While ensuring that mental health services are delivered to the highest standards of quality as clients' safety and welfare are protected, the MOH who is statutory mandated to regulate implementation of measures as introduced by specific legislation in the field of mental health (Health Act Part ix – mental health section 73), collaborated with Grand Challenges Canada, the World Health Organization (WHO), the University of

New South Wales and World Vision Kenya, and developed 'Problem Management Plus (PM+) framework, to reduce the treatment gap for mental disorders[vii].

The development of this frame work was a highly participatory and consultative process. The document development process involved an initial situational analysis through a detailed review of documents, and conducting key informant interviews with key stakeholders at both national and counties levels regarding the organizational management.

The initial implementation of this framework was piloted in key areas to demonstrate its success before scaling up to the rest of the country.

2.3 Problem management plus (PM+) study

Gender-based violence (GBV) represents a major cause of psychological morbidity worldwide, and particularly in low- and middle-income countries (LMICs). Although there are effective treatments for common mental disorders associated with GBV, they typically require lengthy treatment programs that may limit scaling up in LMICs. The aim of this pilot study was to ascertain the extend of embedding PM+ within the Kenya Ministry of Health systems to deliver PM+ at primary health level.

In 2016, the Kenya Ministry of Health (MOH), World Vision Kenya, the University of New South Wales (UNSW) in partnership with WHO, piloted the transition to scale up the PM+. in Nyeri, Nairobi, Nakuru and Nyamira counties. PM+ model was tested in a randomized control trial (RCT) that supported adult women with common mental health problems, including women who had direct experiences of sexual and gender based violence (SGBV). It is in this project that more than half of the clients targeted with mild mental health conditions reported improved functioning.

This study revealed that Women receiving PM+ showed significantly reduced psychological distress and improvements were sustained after 3-months[6]of treatment [7], as compared to the treatment as usual (TAU) group who received basic counselling support from nurses. Women who received PM+ also showed significantly reduced symptoms of PTSD after the intervention[8] as well as increased functioning[9].

Improvements showed by women who received PM+ were also sustained after 3-months when compared with the PTSD symptoms[10] and functioning[11] of women who received TAU. The effects of these differences were strong, meaning the evidence strongly indicates that PM+ was the reason for women's improvements in symptom reductions and increased functioning[12].

Another interesting result showed that before treatment, women in the PM+ group reported taking an average of 6.23[13] days off work in the past 3 months and 5.10[14] days off work for women in TAU. After 3-months, the average number of days unable to work in the previous 3 months reduced for both groups, however women in the PM+ group reported significantly greater reductions in days off work or income generating activities (2.2[15] days), than those in the TAU condition (2.5[16]days)[17].

However, the study limitations identified were;

1. Low enrolment of men, due to fear and stigma revolving mental health, including the negative perception about men with common mental health disorders that needed to be demystified.
2. Significantly of concern was that the PM+ model was new, nonetheless the CHVs had varied education levels, hence this posed them with the difficulty for immediate mastery of the content,

The project trained 20 (10Male and 10 Female) master trainers in PM+ drawn from the Ministry of Health at the National and County Level. The master trainers trained and supervise 137 (82 female 55male) PM+ Helpers trainers who are Community Health Assistants. Approximate 30 Community Health Assistants were trained per county, a total of 137 ToTs in 4 Counties. These PM+ Helpers Trainers/ CHA's trained and supervise 1561 (1056 Female, 505 Male) Community Health Volunteers who delivered PM+ to 3624 (2175 Female and 1449 Males) clients who completed their PM+ Sessions across the 4 targeted counties.

Conclusion

The current findings indicate that it is viable program as well, and may be particularly applicable in settings where resources for supervision or the capacity of recipients restrict the number of sessions that can be offered. The brevity of the PM+ program enabled the intervention to be integrated within the primary health level.

Training the existing community health workforce to address mental health care needs is the most efficient way to respond to the needs, and shows capacity to greatly increase access and treatment for mental disorders.

In the context of the need for scalable interventions for women and men with experience of GBV and who were impaired by distress PM+ continued to show reduce psychological distress, impaired functioning, posttraumatic stress, personally identified problems, and health utilization.

The project recorded improve mental health because (a) increasing activity reduces depression; (b) developing the capacity to solve problems is an effective means to improve mental health, and can be especially relevant in post-adversity contexts; (c) receiving social support decreases stress responses; and (d) stress reduction techniques reduce anxiety, arguably as a result of arousal reduction. This was depicted by the data in the consenting and intervention psych lops

3. THE PM+ STRATEGIC FRAMEWORK

3.1 Key concepts of Problem Management Plus (PM+) Framework development.

The Problem Management Plus (PM+) Framework ultimately supports Kenya's MOH objectives to realise its vision and goal to attain "the highest standard of mental health care". To operationalize the Kenya Mental Health Policy (2015-2030) policy objectives, the following principles were applied in the frame work development.

3.1.1 Strengthening Leadership and Governance for mental health.

This PM + is intended for implementation in accordance to key Kenya MOH health positions at the national and county levels (figure 3-1). As custodians of the PM+ Framework, the standing national MOH Technical Working Group's main task will be to provide oversight of the PM+ Framework, both at the national and county levels, lead in capacity building for PM+ Providers and related personnel, as well as work in accordance to their Terms of Reference provided in Annex 1.

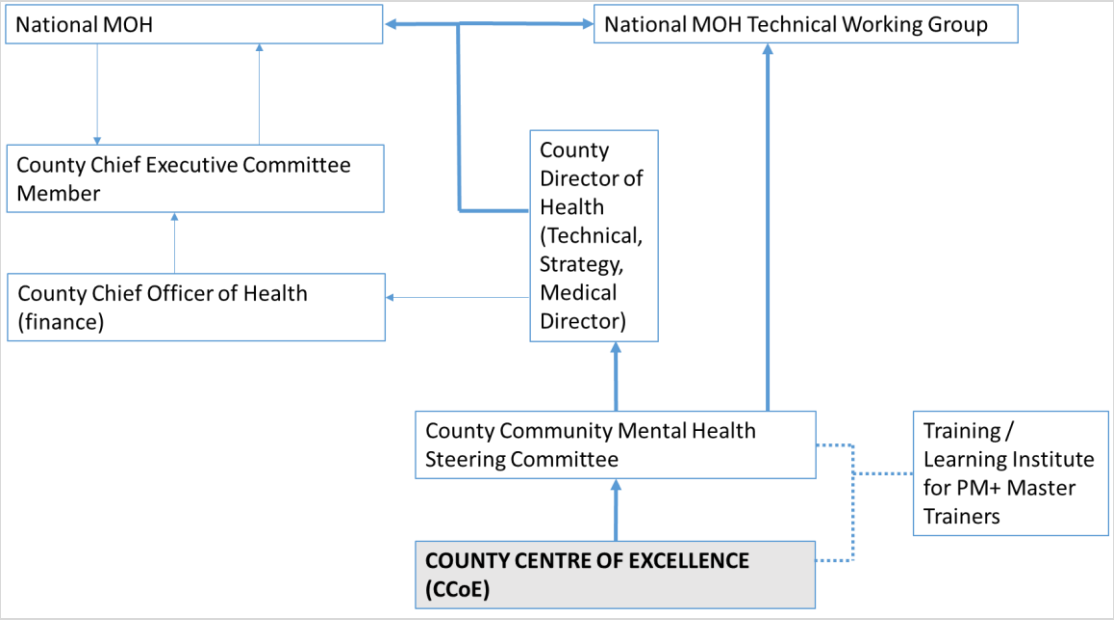


Figure 3-1: Reporting lines of PM + frame works groups as they link with key Kenya MOH systems, staff-position and learning centers

Each implementing County MOHs shall be expected establish a "County Community Mental Health Steering Committee and fundamentally take ownership of the

implementation process, via their health facilities and local health staff; albeit with a back and forth reporting schedule to national level to ensure that all COEs and implementation activities are fully

in compliance with the quality requirements for the intervention (Figure 3-2). Figure 3-2, also demonstrates how PM+ can, ultimately, be provided to individuals at the community level who require support for common mental health problems.

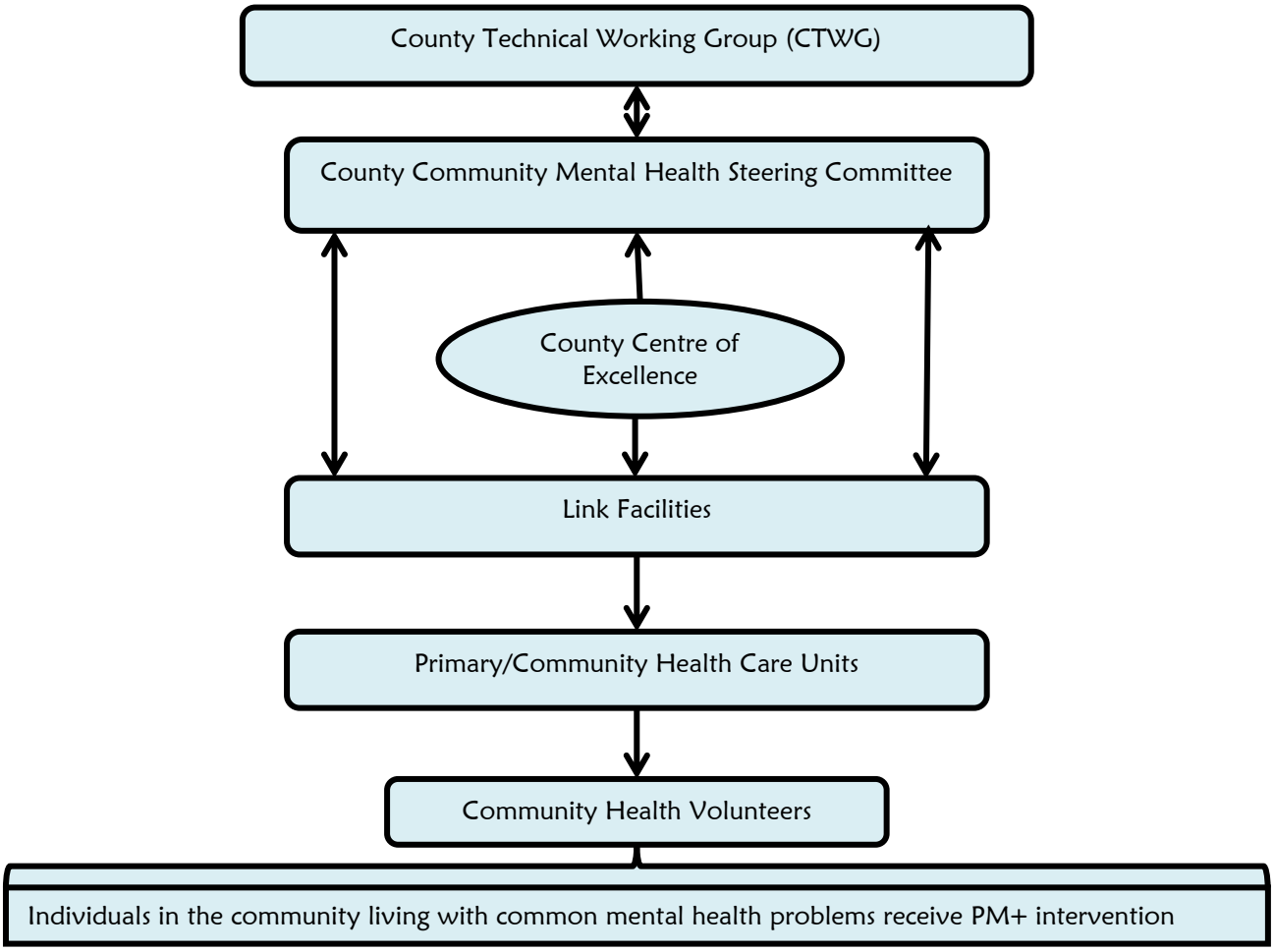


Figure 3-2: Summary of the operationalization of the PM +framework

3.1.2 Access to comprehensive mental health care services at all levels of healthcare

The organization of health service delivery system into a six-level pyramidal structure as per the Kenya Essential Package for Health (KEPH) Levels of Care, and four (4) categories of the healthcare tiers system as outlined in the *Kenya Health Policy* is to

guide the health sector strategic investments for continuity of improved quality services as outline in below in *Figure 3-3.*

The level of health care services is categorised as follow;

I. Level 1: The community level is viewed as foundational to communities being able to access health care. At this level, there are no facilities attached to the provision of health care, but services are offered through CHVs.

II. Level 2: The primary care level health facilities that include dispensaries.

III. Level 3: The health centres, and maternity/nursing homes where community's health needs are addressed. If the diagnosed health problems are non-addressable at these first two levels of primary health facilities, patients are referred to the fourth level. - Sub-County hospital.

IV. Level 4: Sub-county health referral facilities, where comprehensive examinations can be completed and more complex care needs addressed.

V. Level 5: The fifth level (Regional /County Health facility), and level 6 (National tertiary referral &teaching hospitals) where highly specialized services for various and more demanding diagnosis are provided

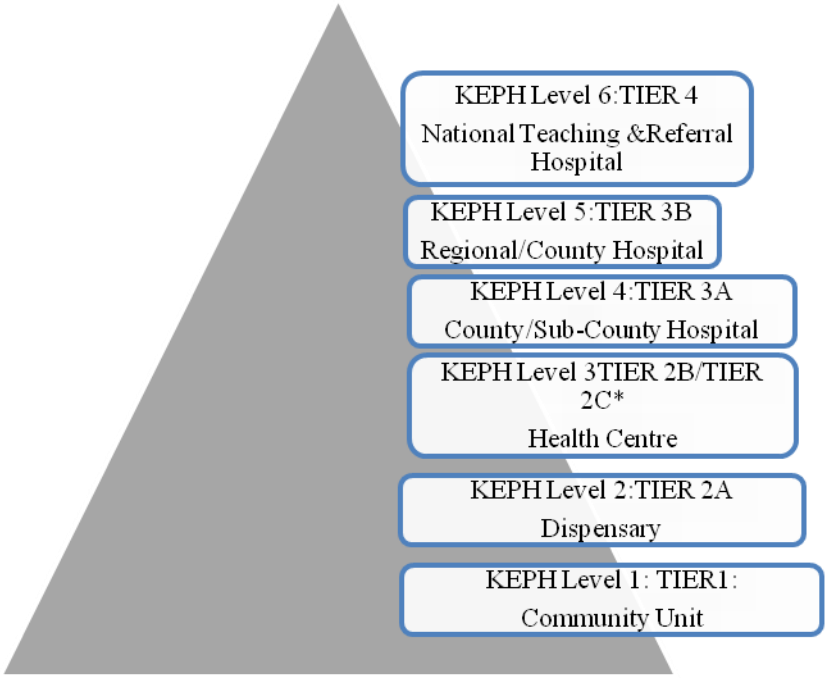


Figure 3-3: Health service delivery in Kenya (KHP2014-2030)

*This includes the ability to perform a Caesarean Section and do blood transfusion

3.1.3 Promotion of mental health, prevention of mental disorders and substance use

Mental health community awareness and sensitisation

Increasing mental health awareness and sensitisation on Problem Management Plus (PM+) practices, whereas both providers and clients are involved for total participation in the management of health services at the community level is crucial in reducing the mental health gap disorders.

The involvement of individuals, households and communities is expressed in people taking up responsibility for their own health as it provides them with a sense of ownership of all their undertaking in relating to their health status.

In line with the roles and responsibilities of the National MOH and County Health Management Teams, this framework suggests a range of mediums that could be utilized for the advocacy, promotion, and community sensitization about mental health issues and treatments available. Specific actions and mental health awareness will be determined and may include (but is not limited to):

- **Advocacy**: Organized and coordinated efforts to change government policies and/or public attitudes about certain issues. It may be undertaken at national, county or community levels and usually involves getting key stakeholders to talk about important issues to be addressed, defending new ideas and directing decision makers towards solutions. For example, advocacy at county MOH level for additional budgets to train more PM+ Providers.
- **Community awareness**: Ways to create an enabling environment and effect change in the behaviour of individuals and communities at large. For example, use of local radio programs and posters to encourage individuals with symptoms of depression to seek treatment
- **Social media marketing**: Using various technologies to deliver key messages to individuals and communities. E.g. brief videos on Facebook to describe common mental health problems and where people can go for support

3.1.4 Strengthen mental health systems.

In order to strengthen mental health systems, and realise the national strategies, the Community Health Strategy Unit (CHSU), particularly the community mental health services, are mandated with strengthening service delivery at Level 1, through Community Health Volunteers (CHVs), Community Health Assistants (CHAs) and Community Health Extension Workers (CHEWs).

For effective scale up of PM+ at level 1, Community Health Units must act as the link between the National MOH and the Community via link facilities and allowing the community work force, which includes Community Strategy Focal Point persons (CSFP), Community Health Assistants (CHAs) / Community Health Extension Workers (CHEWs) and Community Health Volunteers (CHVs) to be actively involved in PM+ scale up activities.

The following approaches will be deployed through the CHV and CHAs/ CHEWs to;

I. Provide level 1 services for all cohorts and socioeconomic groups, including persons living with disabilities, taking into account their needs and priorities.
II. Build the capacity of CHAs/CHEWs and CHVs to provide services at community level 1;
III. Strengthen health facility-community linkages through effective decentralization and partnership for the implementation of level 1 services
IV. Strengthen the community to progressively realize their rights for accessible and quality care; and to seek accountability from facility-based health services.

4. PM+ IMPLEMENTATION FRAMEWORK

This implementation plan aligns fully with all of Kenya's aforementioned policies and strategies, engaging multiple MOH units. To achieve an effective PM+ scale up for patient care the following actions plans are proposed;

4.1 Membership of the technical working group (TWG).

To coordinate the implementation PM+ strategy, an inter-sectoral national technical working group (TWG) appointed by the Director of Medical Services or Director General of Health as may be at the time of roll out, will be established, comprising of representation from the following organizations;

1. Director of Mental Health
2. Head of Community Health and Development Unit
3. Division of Non Communicable Diseases
4. Division of Health Information and Monitoring & Evaluation
5. Kenya Medical Training College
6. National Campaign against Alcohol and Drug Abuse Authority
7. Faith Based Organization Representative
8. National Council for People with Disabilities
9. County Director of Health
10. County Director of Preventive and Promotive Health Services
11. County Community Health Strategy Coordinator
12. County Mental Health Coordinator
13. County Health Promotion Officer
14. Representative PM +Master Trainer
15. Development and Implementing Partners
16. WHO Representative
17. Representative of the Kenya Mental Health Board

4.1.1 Roles and Responsibilities for the National TWG

For the PM+ Framework to be fully implemented, the following are critical roles and responsibilities National Technical Working Group (TWG);

1. Oversight of the implementation of the PM+ Framework and its integration with the Kenya Mental Health Policy (2015-2030)
2. Disseminate policies, standards, guidelines and provide leadership for purposes of supporting the PM+ Framework
3. Identify in collaboration with County Community Mental Health Steering Committees, COE that meet COE criteria
4. Facilitate the identification of the PM+ Master Trainers and their necessary allocation of time to commit to the PM+ Master Trainers program (including onward training and supervision of PM+ Trainers)
5. Advocate for PM+ activities at all leadership levels, including the inclusion of budget allocations for implementation of the PM+ Framework at county levels.
6. Monitor activity reports from PM+ Master Trainers and activities at county levels via regular reports from County Community Mental Health Steering Committees.
7. In collaboration with the Counties MOH ensure continuous Monitoring and end term evaluation of PM+ activities.
8. Review of County-level monitoring and evaluation reports from PM+ client databases, collated and reported by the County Community Mental Health Steering Committees.
9. Conduct National advocacy and promotion of mental health awareness and sensitisation about mental health care issues.

4.2 Establishment of County Community Mental Health Steering Committee

The County Director responsible for Health will appoint a County Community Mental Health Steering Committee to coordinate activities of the PM+ implementation, and oversee the rollout of the PM+ Framework in their county.

The chairperson of the County Community Mental Health Steering Committee shall be the County Director responsible for Health.

The County Community Mental Health Steering Committee will comprise of the following membership;

1. County Director Responsible for Health
2. County Mental Health Coordinator
3. County Director of Preventive and Promotive Health Services
4. County Community Health Strategy Coordinator
5. County Health Promotion Officer
6. Gender based violence coordinator
7. County health records and information officer.
8. Representative of training institution/Centre of Excellence
9. Development and Implementing partners.
10. Representative of faith based organizations

4.2.1 County Community Mental Health Steering Committee Roles and Responsibilities

For the PM+ Framework to be fully implemented, the following are critical roles and responsibilities County Community Mental Health Steering Committee;

1. Represent their counties at the national MOH TWG
2. Own and execute the PM+ Framework within the given County, with oversight provided by an established County Community Mental Health Steering Committee
3. Establish and provide report on the progress of COE and PM+ initiatives
4. Facilitate the identification of the PM+ Trainers and PM+ Providers and their necessary allocation of time to commit to the training programs and commitments thereafter.
5. Actively and collaboratively support implementation of PM+ services within communities
6. Advocate for PM+ activities at all leadership levels, including the inclusion of budget allocations for implementation of the PM+ Framework.
7. Provide feedback to the MOH TWG on PM+ activities
8. Support data management t health facilities (working with the COE) to establish a county-level database for PM+ data entry, and receipt of reports for regular monitoring and evaluation.

9. Conduct County promotion of mental health awareness and community sensitisation about mental health issues and treatments available
10. Provide progress reports to the County Health Management Teams.

4.3 Establishment of County Centres of Excellence

To support long-term sustainability of the PM+ Framework, capacity development of Kenya's health workforce and optimal scale up of the PM+ intervention throughout Kenya, County Centres of Excellence (COE) will be established and overseen by County Community Mental Health Steering Committee (figure 4-1).

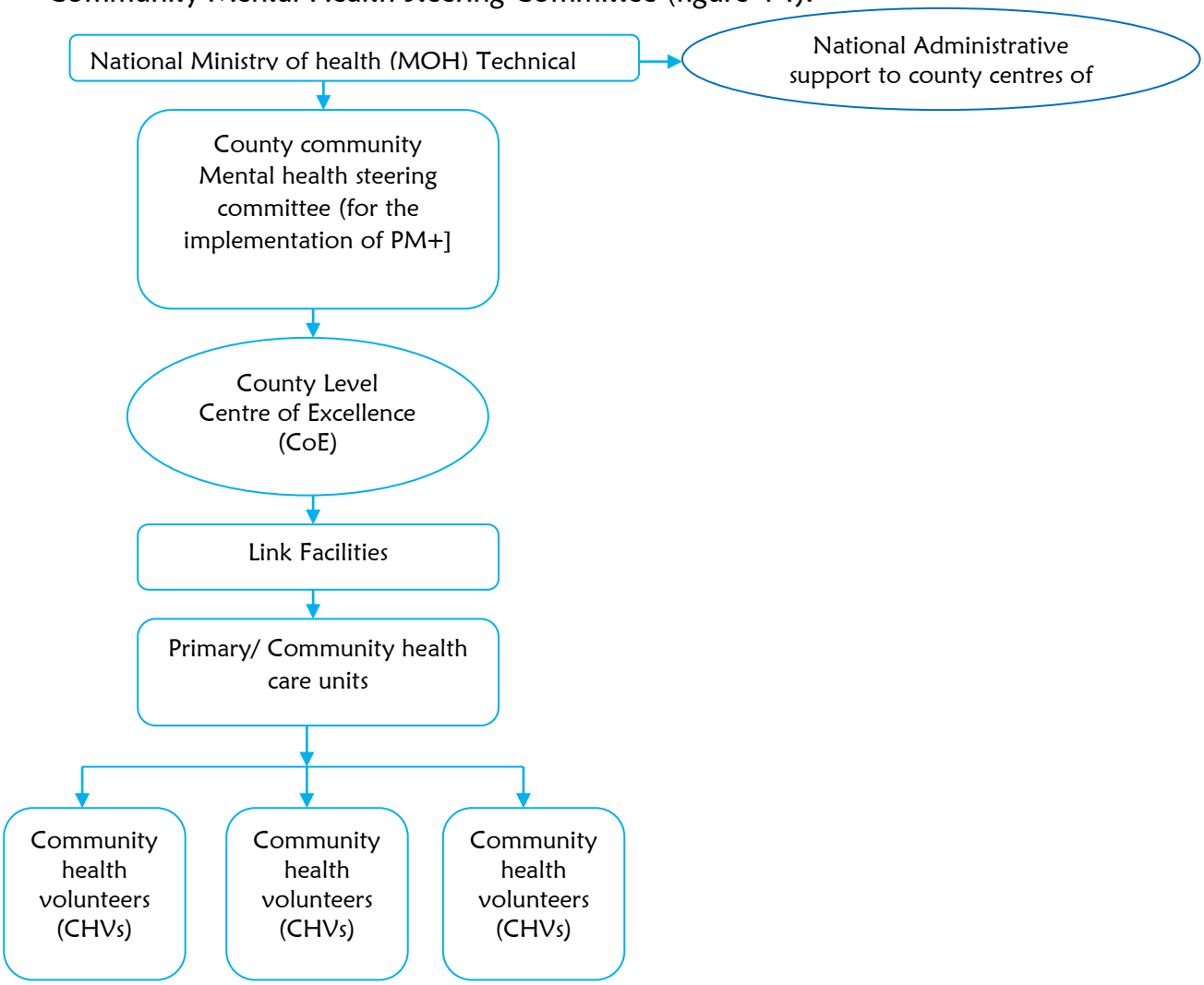


Figure 4-1: County Centre of Excellence management Organogram.

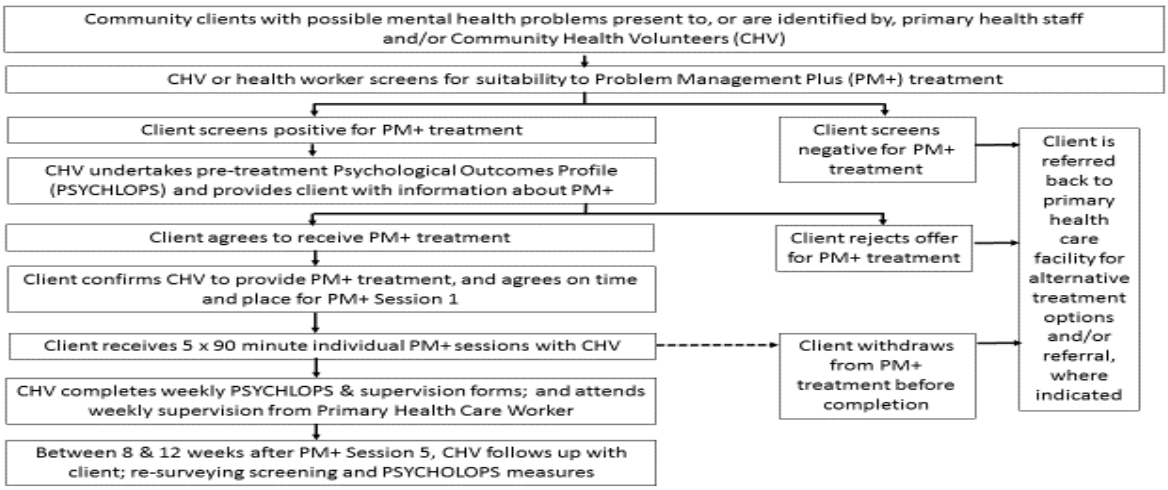


Figure 4-2: client's inclusion process.

COE will also function as a county PM+ resource centre, a best practice centre, a central hub for PM+ data management, a training service for PM+ Trainers, Supervisors and Providers, and a centre for best practices that can support other counties establishing this PM+ Framework long term accomplishments (Annex 3).

To qualify as a COE, a health facility will be required to *meet specific COE Criteria;*

- Committed PM+ Master Trainers (min.3) linked to that health facility
- Committed CHAs PM+ Trainers/Supervisors, showing commitment to ongoing training, supervision and support of CHVs as PM+ Providers
- Management must have demonstrated able leadership in running the PM+ intervention
- Health records information officer(HRIO) in place for PM+ data management
- Must have demonstrated capacity fully following the PM+ structure with clients (following protocols and SOPs)
- Clear and quality data management, including data storage, data entry, data reporting and data monitoring
- PM+ Helpers (CHVs) are organised into CBOs, each with TORs and financial sustainability plans
- Monitoring and evaluation processes are in place and reporting links to the County Community Mental Health Steering committee established

- Supervision – quality and regularity
- Effectively manages the printing and dissemination of PM+ materials for PM+ Providers
- COE financial and sustainability plan (which may be linked to CBOs). Integration with county financial systems.
- Physical space for training and supervision – or access to such space

A notable criterion for selection of a COE will be the inclusion of active strategies geared towards supporting alternative income generating activities (IGAs) for PM+ Providers; namely CHVs who will form into Community Based Organisations (CBOs), as this is deemed essential for the long-term sustainability of PM+ Providers, whose services will be free of charge to community members

Note: COE may vary in some ways, hence all COE will develop and function under its own Terms of Reference, approved by and reporting to their relevant County Mental Health Steering Committee.

4.4 Adapting materials to local language

Currently, PM+ manuals and learning resources are available only in English. However, the weekly session protocol to be followed by PM+ Providers is published also in Kiswahili. Hence, prior to commencing PM + activities, it will be important to enquire (from the PM + trainers and /or PM+ services providers) whether any of the training, supervision or manualised components require translation, and be made available.

If translation is required, it is important that a blind back-translation process is followed to ensure all the key concepts of the English words and topics are retained. See Annex 5.

4.5 Training and supervision of key PM+ Providers

For PM+ to be widely accessible, PM+ will be best provided to clients via the Community Health Volunteer (CHV) workforce.

4.5.1 Training a PM+ providers

For PM+ to be widely accessible, it will have to be delivered largely by Health Volunteer (CHV) workforce, based on a sustainable training program for the following three cadres: -

1. PM+ Master Trainers
2. PM+ Provider Trainers/Supervisors
3. Trained PM+ Providers

All PM+ trainers, including PM+ Master Trainers and PM+ Trainers, are expected to have consequently trained as PM+ Providers, and PM+ Supervisor, before being allowed to offer PM+ training and/or supervision to others cadres.

However, PM+ Trainers/ Supervisor, employed as County MOH health staff, may also have reasons to provide PM+ services as part of their health roles.

Annex 6, explains the selection criteria, training needs, expected training outputs and the resources required for the capacity building of the three cadres of PM+ Providers, PM+ Trainers, and/or PM+ Master Trainers.

4.5.2 Supervision of PM+ providers

Clinical supervision for all PM+ Providers, shall be mandatory, as long as they are providing the PM+ intervention to clients, and shall include peer supervision of all PM + trainers actively providing PM+ services in their role.

Clinical supervision shall involve;

- Provision of support in a process that reinforces the PM+ Strategies
- Discussion about clients' progress
- Discussion about difficulties experienced with clients or when delivering PM+ strategies
- Monitoring fidelity of the PM+ intervention and thus competency of PM+ Providers;
- Role-playing how to manage difficulties or to practice skills (to improve helpers' skills in PM+); and
- Helper self-care.

Note: it will be requirement that all PM+ Providers have a direct phone link to their supervisor to discuss specific cases and critical or such as suicide risks and urgent client referrals.

Immediately on completion of training, intensive supervision shall be conducted on weekly basis, and substituted by less-intensive ongoing supervision fortnightly as the

CHVs skills improve. Therefore, Clinical Supervision commitments will differ depending on the PM+ Provider's levels of experience, and is recommended that: -

- Newly trained PM+ Providers undertaking practice cases: Minimum of 2-hours group supervision per week, in groups not exceeding 8 PM+ Providers;
- Newly trained PM+ Providers recently completed training and practice cases (and having passed all competency assessments): Minimum of 2-hours group supervision per week, in groups not exceeding 12 PM+ Providers;
- Experienced PM+ Providers delivering PM+ services (with 6+ months' experience): Minimum of 2-hours group supervision per fortnight, in groups not exceeding 15 PM+ Providers

4.6 Responsibilities of PM+ Provider Trainer/Supervisors

PM+ Clinical Supervisors shall be responsible for the clinical supervision of CHVs, including:

- Maintaining up-to-date records of CHVs attending Clinical Supervision and basic case notes about their participation and any other necessary observations;
- Closely supervising CHVs during training practice cases;
- Assessing the competency of CHVs as PM+ Providers;
- Supervising CHVs, ongoing, as they provide PM+ services;
- Offering peer supervision for groups of PM+ Trainers who may be practicing PM+ in their health roles; and
- Providing ad-hoc emergency supervision and support to PM+ Providers, as required.

4.7 Roles and Responsibilities of PM+ Master Trainers

PM+ Master Trainers shall be responsible for the clinical supervision of PM+ Trainers, including:

- Maintaining up-to-date records of CHVs attending Clinical Supervision and basic case notes about their participation and any other necessary observations;
- Assessing the competency of PM+ Trainers as PM+ Providers
- Supervising PM+ Trainers as PM+ Providers during training practice cases;
- Supervising PM+ Trainers as they on-train PM+ Providers;

- Assessing competency of PM+ Trainers as PM+ Trainers;
- Supervising PM+ Trainers provision of Clinical Supervision for PM+ Providers;
- Assessing competency of PM+ Trainers as PM+ Supervisors; and
- Providing ad-hoc emergency supervision and support to PM+ Providers, as required.

4.8 Roles of PM+ Providers Trainers/Supervisors

The roles of the PM+ Supervisors shall include;

- To train and supervise a minimum of 15 CHVs as PM+ Providers, which will include:
- Be a point person for the assessment of prospective PM+ clients at the health facility and support the 'matching' of PM+ Clients with PM+ Providers (Annex)
- Provide ongoing weekly and/or fortnightly group 2-hour group supervision for PM+ Providers.
- Undertake management of client documentation, information, data and confidential files.
- Support CHVs in any emergency situations and where provision of client referrals requires facilitation
- Support the promotion of community mental health strategies and other advocacy/awareness initiatives.

5. ADVOCACY AND COMMUNICATION

Currently, advocacy in mental health is given a low priority, especially in most countries due to the stigma attached to mental illnesses as well as to persons with MNS disorders.

Mental health advocacy is necessary to reduce barriers which prevent people from getting services to meet their mental health needs. The desired impact of community awareness and social marketing is to enhance knowledge on mental health and ways to seek support for common mental health problems.

5.1 Mental health community awareness and sensitisation

The target groups for advocacy activities are general public, consumers, family, professional bodies, non-state actors, mental health workers, general health workers, planners and policy makers and other service providers.

Advocacy focuses more on empowering the community as agents of change, to be able to network; pool resources identify problems and potential solutions in collaboration with the key decision-makers to whom they advocate.

In line with the roles and responsibilities of the National MOH and County Health Management Teams, this framework suggests a range of mediums that could be utilized for the advocacy, promotion, and community sensitization about mental health issues and treatments available.

Table 5-1 Summary of the range of mediums utilized for mental health community awareness and sensitization.

Community forums/Neighbourhood forums:	Community members, including local leaders, join together to discuss mental health concerns and learn about PM+; possibly mobilised and facilitated by health workers and/or CHVs. Ideally, such forums bring together various members of the local health workforce, local administration, local government and community members.
Action groups/Support groups/User support groups:	Service users of PM+ unite to establish their own groups or networks, for continued social support and possibly new livelihoods opportunities. Such groups may also lead local level advocacy to promote change and improved mental health services.
Peer groups:	Groups formed to provide peer education about PM+ to community members; with a long-term goal to reduce stigma associated with mental health problems and promote positive help-seeking amongst their peers.
Information, Education and Communications (IEC) Materials:	Promoting PM+ and PM+ services through use of posters, leaflets, brochures and possibly social media. Each health facility providing PM+ should have posters and leaflets available for public consumption; geared towards explaining how common mental health issues are, that help is available, and how to access that help.
Media/mass media:	Use of local radio to discuss issues pertaining to mental health and PM+; and mass media for other more substantial initiatives (e.g., promotion of World Mental Health Day). Ideally, use of media (including social media) prompts further discussion and normalising about mental health issues (including reducing stigma), and encourages help seeking behaviour.
International Commemoration days	World Mental Health Day 10th October International Day against Drug abuse and illicit trafficking (IDADA) 26th June Suicide Prevention Day 10th September
Community health promotions and activities:	Communities are continuing to develop, implement and promote health programs. Agencies, CBOs and FBOs are building partnerships to make communities healthier. Inter-agency forums that include community members can contribute to community sensitisation about mental health when addressing other health challenges within the counties and communities (e.g., encouraging support for mothers with postpartum depression as part of maternal and child health promotions/activities).

6. MONITORING AND EVALUATION OF THE FRAMEWORK IMPLEMENTATION

Implementation of PM+ in health facilities/communities should undergo a semi-annual monitoring and evaluation assessment, to measure intended progress towards meeting the health facility PM+ implementation plan and ultimately the county's quality intervention strategy.

This assessment shall be a responsibility born by the County Community Health steering committee in-collaboration with the County Health Management Teams.

Monitoring activities shall also include the quarterly submitted assessments of PM+ data obtained and consolidated from the health facilities implementing PM+.

Assessing such data will be essential to further promote the scale-up of PM+ across counties, and for evidence of the intervention's impacts to be documented for National MOH TWG to align with other national, regional and global health targets.

1. Scale up implementation of Problem Management Plus (PM+) in Kenya
2. Build capacity for the community health work force in quality delivery of Problem Management Plus (PM+)
3. Sustain the viability of Community Health Volunteers (CHVs) in delivery of mental health care at the community level.

Table 0-1: Monitoring and evaluation matrix for measuring implementation plan of PM+

GOAL: Guide a standardised implementation of PM+ in Kenya									
OBJECTIVE 1: Scale up the implementation of Problem Management Plus									
MILE STONES	ACTORS	INDICATOR	BASELINE	TARGET					Total
				2018	2019	2020	2021	2022	5yrs
Establishment of National mental health steering committee	Principal secretary National heads of department	Exist national mental health steering committee	0	1	-	-	1	-	1
Establishment of National mental health TWG	Department of Mental Health and substance use	Exist national mental health TWG	0	1	-	-	1	-	1
Dissemination of the PM+ implementation framework	Department of Mental Health and substance use	# of Counties reached with the framework	**0**	**20**	**27**	**-**	**-**	**-**	**47**
Awareness creation amongst policy makers ,	National TWG	# of awareness meeting reports	0	2	4	4	4	4	20
Conduct PM+ TWG meetings at National Level	Department of Mental Health and substance use	# of TWG quarterly Meetings held	0	2	4	4	4	4	18
Establishment of County community mental health steering committee	County health department	# of counties with functional PM+ steering Committee	0	20	27	-	-	-	47
Integration of PM+ in DHIS 2	TWG and County community mental steering committee	# of counties PM+ reporting via DHIS 2	0	20	27	-	-	-	47
Awareness creation amongst training institution (KMTC) for integrating PM+	National TWG KMTC campus	% of meeting conducted at County KMTC campuses	0	10%	30 %	50%	70 %	100 %	100%
County level monitoring	Department of Mental Health and substance use County	# of audits reports submitted per Counties	0	4	4	4	4	4	20per county

	mental health steering committee								
OBJECTIVE 2: Build capacity for the community health work force in quality delivery of PM+									
Establish PM+ centre of Excellence in targeted counties	County TWG and County mental health steering committees	# of COE established per county	1	20	27	--	-	-	47
Trained MOH PM+ Master Trainers.	County steering committees Master Trainers	# of Master Trained	20	26	26	26	26	26	150
Trained PM+ Providers Trainers (TOT,CHAS)	County community mental Health steering committee PM+ Providers trainers	# PM+ providers Trainers	137	30	120	120	120	120	737
Trained CHV as PM+ Helpers	County mental health steering committee PM+ Providers Trainers	# of CHVs trained	1561	390	1560	1560	1560	1560	8191
Facilitate training for CBO for the identified gaps	County community Health steering committee	# of CBOs trained	10	5	8	8	8	8	45
Facilitate Entrepreneurship and leadership training for CBOs	County community Health steering committee	# of CBOs trained	10	5	8	8	8	8	45
Facilitate CBO with start-up kits for IGAs	County Government	# of CBO supported	10	5	8	8	8	8	45
OBJECTIVE : Sustain the viability of Community Health Volunteers (CHVs) in delivery of mental health care at the community level									
Established CBO	Community Strategy and Development Unit	# of CBO established	4	16	27	-	-	-	47
Formation of CBO IGA initiatives (Bussiness base)	Community Strategy and Development Unit	#of CBO -IGA established	4	16	27	-	-	-	47
Conduct Capacity assessment for	Community Strategy and Development	# of CBOs Assessed	10	5	8	8	8	8	45

CBO for income generating activities	Unit								
Established IGA monitoring committee	County steering committee	Profit margin (%)	0	0	0	5%	10%	15%	30%
Formation of CBOs for CHVs livelihoods	County community Health steering committee	# of CBOs established	10	5	8	8	8	8	45
Development of annual work plan and budget	County steering committees	# of counties submitted PM+ annual work / budget.	**0**	**20**	**27**	**47**	**47**	**47**	47

Annex 1: Terms of reference for National Technical Working Group

In accordance with Kenya's Ministry of Health (MOH) Quality Management System (ISO 9001:2008), the director of medical services is the appointing authority to the Technical Working committee (TWG) to spearhead the partnership and development of the PM+ scale up in Kenya.

Description:

Problem Management Plus (PM+) is an innovative evidence-based treatment specifically for low and middle income countries, forming part of the World Health Organization's (WHO) Mental Health Gap (mhGAP) Series. PM+ is unique in that it can treat common mental health conditions, such as depression, anxiety and chronic stress, without formal diagnosis and at the community and/or primary health care levels. It is feasible to be administered by minimally trained (and supervised) non-specialised service providers, such as community health volunteers (CHVs). PM+ is a brief intervention (5 x 90 minute individual sessions) and uses core cognitive and behavioural treatment elements. PM+ Strategies form the basis of the intervention and include: stress management ("Managing Stress"), Problem Solving ("Managing Problems"), behavioural activation ("Get Going Keep Doing") strengthening social supports ("Strengthening Social Supports") and relapse prevention ("Staying well and looking forward"). PM+ is a cost-effective community and primary level intervention based on evidence-based treatment for common mental health problems.

The TWG will be accountable to:

- The appointing authority, the Director of Medical Services;
- Keep the appointing authority informed about the TWGs work via circulation of minutes, reports and recommendations;
- Process directions proposed by the appointing authority, receiving approvals from that authority prior to implementation of activities; and
- Be committed to make timely decisions and take action towards completion of assigned tasks.

TWG meetings will be held monthly, based on the following formats:

- Members attend in person or one constant alternate and in case of absence in three consecutive meetings or written resignation the chairman will request the director of medical services to appoint a replacement;
- Meeting quorum: 50% plus 1;
- All meetings will be chaired by the TWG Chairman or his appointed alternate (a member of the TWG);
- Meeting decisions be made by consensus, and if not possible, TWG Chairman makes a final decision; If required subgroup meetings will be arranged outside of these standard meetings times, arranged by agreement of subgroup members;
- The TWG may consult or make reference to work, persons or information sources helpful to their purpose;
- The meetings will be guided by Ministry of Health ISO quality management system

Documentation of meetings and agendas:

- Minutes will be recorded and distributed by the Secretariat
- The Secretariat will prepare meeting agendas, in consultation with the chair and supporting papers, preparing meeting notes and information; and
- All minutes of prior meetings and meeting agendas will be circulated at least one week before the next scheduled TWG meeting.

Targeted Outputs for the TWG will (at a minimum) include:

- Oversight for the distribution of all relevant PM+ materials and resources (e.g., training manuals) for delivery of the PM+ Framework
- Provision and oversight for the dissemination of resources materials related to the PM+ Framework, including but not limited to:
    - Kenya health policy 2014-2030
    - Community mental health guidelines
    - Community strategy
    - Mental health strategic and investment plan
    - Any other relevant documents.

- Ensure timely delivery of:
    - Establishment of a County Centre of Excellence (COE), including strategies and plans for its long-term sustainability
    - Monitoring and evaluation reports as they relate to the PM+ Framework (includes baseline survey)
    - Periodic conferences on mental health
- Sustainable mechanisms: PM+ intervention in mental health at primary and community health levels.

The TWGs performance will be evaluated according to:

- A formal evaluation of the TWG, led periodically by the Chair; and
- Records of monthly meetings outlining key issues and progress towards resolution of TWG issues

Annex 2: Terms of reference of the County Mental Health Steering Committee

In accordance with Kenya's Ministry of Health (MOH) Quality Management System (ISO 9001:2008), the County Director of Health is the appointing authority of the county steering committee to spearhead the partnership and development of the PM+ scale up, as part of community mental health in the County.

Description: Problem Management Plus (PM+) is an innovative evidence-based treatment specifically for low and middle income countries, forming part of the World Health Organization's (WHO) Mental Health Gap (mhGAP) Series. PM+ is unique in that it can treat common mental health conditions, such as depression, anxiety and chronic stress, without formal diagnosis and at the community and/or primary health care levels. It is feasible to be administered by minimally trained (and supervised) non-specialised service providers, such as community health volunteers (CHVs). PM+ is a brief intervention (5 x 90 minute individual sessions) and uses core cognitive and behavioural treatment elements. PM+ Strategies form the basis of the intervention and include: stress management ("Managing Stress"), Problem Solving ("Managing Problems"), behavioural activation ("Get Going Keep Doing") strengthening social supports ("Strengthening Social Supports") and relapse prevention ("Staying well and looking forward"). PM+ is a cost-effective community.

The Steering Committee will be accountable to:

- The appointing authority – County Director for Health Officer of Health [insert county name];
- Keep the appointing authority informed about the committees work via circulation of minutes, reports and recommendations;
- Process directions proposed by the appointing authority, receiving approvals from that authority prior to implementation of activities; and
- Be committed to make timely decisions and take action towards the completion of assigned tasks.

Steering Committee meetings will be held quarterly, based on the following formats:

- Members will commit to attend scheduled meeting and contribute to the agenda;
- Members attend in person and in case of absence in three consecutive meetings or written resignation the chairman will request the appointing authority to appoint a replacement;
- Meeting quorum: 50% plus 1
- All meetings will be chaired by the appointed Steering Committee Chairperson, or their delegated alternate (a member of the Steering Committee);
- Meeting decisions be made by consensus, If not possible, the Steering Committee Chair makes a final decision;
- If required subgroup meetings will be arranged outside of these standard meetings times, arranged by agreement of subgroup members
- The Steering Committee may consult or make reference to work, persons or information sources helpful to their purpose;
- The meetings will be guided by Ministry of Health ISO quality management system.
- Frequency of meetings may be altered, as required, and at the call of the Steering Committee Chair

Documentation of meetings and agendas:

- Minutes will be recorded and distributed by the appointed Steering Committee Secretariat
- The Secretariat will prepare meeting agendas, in consultation with the chair and supporting papers, preparing meeting notes and information; and
- All minutes are to be circulated to Steering Committee members and the appointing authority no later than one week after each meeting.

Evaluation of the Steering Committee shall be assessed via:

- A formal evaluation of the Steering Committee, led periodically by the Chair;
- Quarterly meetings to review progress; and
- Progress evaluation reports carried out at the end of each quarter.

MODIFICATION OR VARIATION OF THE TERMS OF REFERENCE:

The terms may be amended, varied or modified in writing after consultation and agreement by group members.

Annex 3: County Centres of Excellence recommended operational architecture

The following table provides a summary outline for a COE and their recommended operational architecture.

TASKS	DELIVERABLES
What is the mandate of a COE?	To provide the infrastructure (real or virtual) under which PM+ services can be sustainably provided to community members in each county
What are the minimum activities the COE will need to implement?	• PM+ Training • PM+ Supervision • Management of PM+ Materials (e.g., assessment forms, manuals, client handouts, informed consent forms, supervision forms) • Potential for expansion for inclusion of other mental health interventions • To coordinate and oversee CHV & CBOs • Oversee fidelity of PM+ and the competency (including refresher trainings) for PM+ Providers • PM+ data management, entry and reporting
Who decides which health facilities become a COE?	The County Mental Health Steering Committee recommends the health facility as the COE. The National Technical Working Group formally accredits the COE, based on merit and their appropriate meeting of the COE criteria.
What are the criteria that a health facility needs to meet to be nominated as a COE?	• Committed PM+ Master Trainers (min.3) linked to that health facility • Committed CHAs PM+ Trainers/Supervisors, showing commitment to ongoing training, supervision and support of CHVs as PM+ Providers • A Sub-County Community Strategy Coordinator • Health records information officer(HRIO) in place for PM+ data management • Capacity and demonstration of fully following the PM+ structure with clients (following protocols and SOPs) • Clear and quality data management, including data storage, data entry, data reporting and data monitoring • PM+ Helpers (CHVs) are organised into CBOs, each with TORs and financial sustainability plans • Monitoring and evaluation processes are in place and reporting links to the County Community Mental Health Steering committee established • Supervision – quality and regularity • Effectively manages the printing and dissemination of PM+ materials for PM+ Providers • COE financial and sustainability plan (which may be linked to CBOs). Integration with county financial systems. • Physical space for training and supervision – or access to such space

Who is ultimately responsible for the COE?	The County Mental Health Steering Committee shall hold ultimate responsibility for the COE in their county, ensuring they: • Identify the location of the COE – preferably at the community level. E.g., modification of halls in the sub-county hospitals • Secure relevant resources for the COE • Comply with fair and recommended selection criteria of PM+ Trainers and Trainees • Actively support the formation of CBOs for CHVs • Support any logistics needed for the implementation of PM+ services and the functioning of the COE • Provide trainer and trainee certificates • Support the certification of the PM+ training curriculum • Document and report on PM+ tools (Integration with MOH 514/515 tools). • Oversee the effective management of PM+ data, data entry and reporting • Collate PM+ data (at least quarterly) for the purposes of real-time PM+ monitoring and evaluation • Report (at least 6-monthly) details of PM+ services to the National MOH TWG • Encourage the integration of PM+ services with other community programmes • Support the smooth functioning of referral systems • Pay special attention to the ongoing competency of PM+ Trainers, Supervisors and Helpers by checking in on competency assessments and progress of key PM+ and COE personnel • Pilot CBOs then expand to allow non-PM+ Providers (i.e., other CHVs) to join • Encourage, at the right time, the expansion of COEs to include other mental health interventions or initiatives in their counties to build these COE as county-hubs for community-based mental health care.
Who will manage the COE and what will their roles involve?	• **COE Oversight and Overall management;** County Mental Health Steering Committee) ➢ Ensures the standards are adhered to in PM+ services (best practice) ➢ Resource Mobilisation for PM+ Services ➢ Establishing COE ➢ Ensures supervision of PM+ Helpers • **COE Co-ordination:** PM+ Master Trainer (appointed by the County Director for Health and approved by the County Mental Health Steering Committee) ➢ Day to day running of the COE ➢ Collaborates with the ToTs, CHAs on matters of PM+ helpers and services ➢ Custody and management of COE materials and resources ➢ Links with CBOs on operations and sustainability • **PM+ Trainers and Supervisors:** Health facilities staff (E.g. CHAs/Other health workers) ➢ Train and supervise CHVs ➢ Reporting to the Sub-County Community Strategy Coordinator ➢ Clinical supervision • **PM+ Providers:** CHVs ➢ PM+ Helpers / service providers ➢ Identification, screening and referral of PM+ clients at the

	community level. ➢ Reporting to CHAs

Annex 4: Processes for identifying the COE Sustainability.

Each COE shall be managed in accordance with the management practices of the hosting health facility and under guidance of the County Community Mental Health Steering Committee.

This means that each COE will make its Annual Work Plan to undertake its functions, with a budget to be submitted to the steering committee to be allocated funds based on the county budget. These funds will be used for activities, including but not limited;

1. Its own purchase, printing and storage of PM+ materials (e.g., Intervention Manuals, Training Manuals, Copies of PM+ forms);
2. On-going PM+ or other training initiatives (e.g., Supervision, Refresher trainings);
3. Community awareness and sensitization initiatives (e.g., PM+ brochures, posters, advocacy, community meetings);
4. Spearhead initiatives for Community-Based Organizations (CBOs) as they relate to PM+ (or other community mental health care providers) to support PM+ Providers to engage in alternative income generation activities (IGAs).

IGAs and the formation of CBOs for CHVs will be critical to supplement CHV stipends and enable their continued provision of free PM+ services to community members. This includes the COE providing a support function for the formation (e.g., legal/constitutional registrations, CBO TORs, CBO assessments for optimal IGAs, CBO marketing and financial strategies, CBO trainings), management (e.g., oversight for smooth operations of CBOs and a mediation role for any disputes), and implementation of CBO initiatives – with the COE offering the CBOs a 'business base' for their activities.

IGAs for CBOs might include (but is not limited to): Chicken rearing, Rabbit keeping, Green house farming, Pig keeping, Fish farming, Soap making, Baking, Weaving or other crafts for local market needs, Outside catering services (e.g., tents for hire, chairs, public address systems); Table banking; Bee keeping; Pay to use sanitation on blocks; Water kiosks; Garbage collection for pay; or any other CBO-agreed initiative.

To generate funding for a COE to be a self-sustaining entity, each CBO will be required to contribute a percentage of profits to the on-going running of the COE and its resource needs. COE and their supported CBOs will be encouraged to independently identify funding opportunities for CBO start-up initiatives and on-

going COE and/or CBO costs. With training, use of advocacy and entrepreneurial skills, they may, for instance, realise funding opportunities from:

- County budget allocations as they link to health facility budget allocations. For example, from Non-Communicable Diseases/GBV/HIV/SRHR budgets, National MOH Department of Mental Health and Substance Use budgets, National MOH Community Health Strategy Unit budgets, or non-health budgets, such as from social welfare, gender or family focused government departments;
- Re-invested funds from CHV CBOs and their IGAs;
- Community savings groups;
- County or national government grants;
- Local or international grants;
- Local or international non-government organizations (iNGOs);
- Income from learning institutions conducting research
- Church groups;
- Micro-enterprise loans;
- Localized and/or national corporate investors;
- Individual community investors;
- Community fundraising;
- For-profit services, such as training staff from other counties or hosting COE education visits;
- Others specific to each county/health facility/locality.

Annex 5: Procedure for performing the blind back translation.

Introduction:

Currently, PM+ manuals and resources are available only in English. However, the week x week PM+ Session Protocol (this being the weekly session protocol to be followed by PM+ Providers) is published in Kiswahili. For better integration by PM +providers and the clients, the training, supervision or manualised components may require language translation.

Some counties may also find a need for different types of adaptations of the materials, such as for individuals who are differently-abled. Hence it is a requirement that the a*daptation of materials follows a systematic process called* **'A blind back translation'** *to ensure all the key concepts of the English words and topics are retained.*

1. Translator Person 1 translates the material from language A (e.g., English) to language B (e.g., Kikuyu);
2. Translator Person 2 (who has not seen the original material) translates the material 'back' from language B (e.g., Kikuyu) to language A (e.g., English)
3. Together, the trainer (or other mental health professional) and Translator Person 1 reviews the 'back' translation; checking that key terms, and in particular, the meaning of key concepts have been appropriately interpreted. If necessary, community consultations may be necessary to ensure key concepts and their translated language match the understanding of local people.
4. Where there are discrepancies, the trainer and Translator Person 1 decide on the best use of language to ensure the original terms or conceptual meanings are correctly inferred. The material is then revised and finalized to the new language – Language B (e.g., Kikuyu).

Annex 6: Problem Management (Pm+) training matrix

Actors	PM+ Master Trainers ("Master Trainers")	PM+ Trainers / Supervisors** ("PM+ Trainers")	"PM+ Providers" (or "PM+ Helpers")
What is their selection criteria?			
	• A passion and positive attitude regarding community mental health, including belief that non-professional helpers can effectively administer evidence-based mental health treatment. • A Degree/Diploma in psychology, psychiatric nursing, nursing, clinical medicine, clinical officer, social work, clinical social work or other related disciplines. • Minimum 2-years' experience working in client-focused mental health services and provision of mental health treatment. • Excellent English speaking, reading and writing skills; • Agreement, time and commitment to meeting all training requirements and delivering on post-training expectations and roles • Strong interpersonal skills and team work	• A passion and positive attitude regarding community mental health, including belief that CHVs can effectively administer evidence-based mental health treatment. • Current employment as an active health worker in a MOH health facility; clinic, centre, hospital and/or other allied health service • Minimum of degree/diploma or certificate in a health or related field (e.g., nursing, social work, clinical officer, psychology, counselling, community health and development or other related disciplines • Excellent English speaking, reading and writing skills, in addition to knowledge of local language(s) used by communities and their CHVs; • Access to CHVs for onward training and supervision of PM+ • A known and demonstrated supportive relationship with CHVs linked to their	• A passion and positive attitude regarding community mental health • Currently registered as a CHV in a Community Unit linked with a recognized MOH health facility. • Completion of basic CHV training from MOH. • Minimum of primary or secondary education – strong reading and writing skills (preferably English and/or Kiswahili, but not essential). • Agreement, time and commitment to meeting all training requirements and delivering on post-training expectations and roles • A respected member of the local community • Respect and understanding for diversity amongst clients (beliefs, norms and values)

Actors	PM+ Master Trainers ("Master Trainers")	PM+ Trainers / Supervisors** ("PM+ Trainers")	"PM+ Providers" (or "PM+ Helpers")
		health service; • A genuine interest in providing mental health care in their community • Agreement, time and commitment to meeting all training requirements and delivering on post-training expectations and roles • Strong interpersonal skills and team work Prior training or experience in the following will be highly regarded: • training in community mental health care; • provision of evidence-based mental health interventions; • clinical supervision; • Training and facilitation skills.	
Who will select them for training?			
	National MOH Technical Working Group (TWG)	County-specific Community Mental Health Steering Committee	• County Director of health • In some counties, PM+ Trainers (e.g, CHEWs/CHAs)
Who will train them?			
	A previously trained Kenya MOH Master Trainer, and/or Consultant (For information about appropriate consultants for PM+ Master Trainer trainers, contact the National MOH TWG)	PM+ Master Trainers (For information about appropriate PM+ Master Trainers, contact the relevant County Community Mental Health Steering Committee)	PM+ Trainers relevant to specific counties**
What will be their initial training program?			
	• 10 days (ideally as a 2-week residential)	• 10 days classroom intensive training on	• 8 days classroom intensive training

Actors	PM+ Master Trainers ("Master Trainers")	PM+ Trainers / Supervisors** ("PM+ Trainers")	"PM+ Providers" (or "PM+ Helpers")
	classroom intensive training to become PM+ Providers, PM+ Trainers and PM+ Supervisors • 1 x supervised practice case = 5 x 90 minute sessions • During practice case, attend 1 x 90 minute weekly group clinical supervision session for the period of time that the practice cases are active. *(Note that clinical supervision for PM+ Master Trainers may be provided remotely, e.g., via Skype.)*	PM+ (which may or may not be a residential program, depending on budget and time) • 2 x supervised practice cases = 5 x 90 minute sessions per case • During practice cases, attend 1 x 2-hour weekly group clinical supervision session for the period of time that the practice cases are active. • 2 days Classroom 'refresher' training on being PM+ Providers • 2 days classroom training on being a trainer • 2 days classroom training on being a clinical supervisor	on PM+ (not-residential, but located conveniently for CHV access) • 3 x supervised practice cases = 5 x 90 minute sessions per case • During practice cases, attend 1 x 2-hour weekly group clinical supervision session for the period of time that the practice cases are active. • 2 days Classroom 'refresher' training on being PM+ Providers
What resources will be needed for their training?			
	• Training venue (and/or residential venue), meals and snacks for all classroom trainings • Regular training materials (e.g., projector and screen, stationery, flipcharts, markers, notebooks, blank paper etc. Specific training materials to be identified by the Master/Consultant Trainer) • Printout copies of pre-prepared role-plays, case studies, or other 'handouts' as directed by the	• Training venue, meals and snacks for all classroom trainings • Regular training materials (e.g., projector and screen, stationery, flipcharts, markers, notebooks, blank paper etc. Specific training materials to be identified by the PM+ Master Trainer) • Printout copies of pre-prepared role-plays, case studies, or other 'handouts' as directed by the PM+ Master Trainer • 1 x PM+ Manual per	• Training venue, meals and snacks for all classroom trainings • Regular training materials (e.g., projector and screen, stationery, flipcharts, markers, notebooks, blank paper etc. Specific training materials to be identified by the PM+ Trainers) • Printout copies of pre-prepared role-plays, case studies, or other 'handouts' as directed by the PM+ Trainers

Actors	PM+ Master Trainers ("Master Trainers")	PM+ Trainers / Supervisors** ("PM+ Trainers")	"PM+ Providers" (or "PM+ Helpers")
	Master/Consultant Trainer • 1 x PM+ Manual per participant • 1 x PM+ Trainers manual per participant • 1 x PM+ Supervision Manual per participant • 1 x PM+ Training for Trainers Manual per participant • Relevant budget, which may include transport allowances • Budget for Consultant Trainer (which may include daily rates, travel, per diem, accommodation etc.)	participant • 1 x PM+ Trainers manual per participant • 1 x PM+ Supervision Manual per participant • Relevant budget, which may include transport allowances • Budget for PM+ Master Trainer (which may include daily rates, travel, per diem, accommodation etc.)	• 1 x PM+ Manual per participant • Maybe translated copies of the PM+ Protocol • Relevant budget, which may include transport allowances, or other CHV stipends.
What is the estimated costs for training a cohort of 10 individuals?			
	To be confirmed Within County KHS 7,000/person/day Outside County KHS 15,500/person/day	To be confirmed KHS 5,000/person/day	To be confirmed KHS2,000/person/day
What is expected and what will be their role after training?			
	• To onward train and supervise a minimum of 15 PM+ Trainers, comprising: ➢ 10 days classroom intensive training on PM+ (including classroom based competency assessments per PM+ Trainers); ➢ run 2 x 2 hour small clinical supervision groups (of 7-8 PM+ Trainers each) each week for the period of practice cases; ➢ Assess the competency of PM+ Trainers as	• To onward train and supervise a minimum of 15 CHVs as PM+ Providers, which will include: ➢ Mapping and supporting the recruitment of CHV trainees; ➢ 10 days classroom intensive training on PM+ (including classroom based competency assessments per CHV), ➢ run 2 x 2 hour small group clinical supervision groups (of 7-8 CHVs each) each	• Commit to providing PM+ services to identified and assessed clients; • Commit to attending weekly 2-hour clinical supervision (or fortnightly as per SOP 4.5); • Support the promotion of community mental health strategies and other advocacy/awarenes s initiatives.

Actors	PM+ Master Trainers ("Master Trainers")	PM+ Trainers / Supervisors** ("PM+ Trainers")	"PM+ Providers" (or "PM+ Helpers")
	PM+ Providers (which entails visiting at least one session per PM+ Trainers with a practice case client); ➢ 2 days Classroom 'refresher' training on being PM+ Providers; ➢ 1 days classroom training on being a trainer; ➢ 2 days classroom training on being a clinical supervisor; ➢ classroom based competency assessments for PM+ Trainers as trainers and supervisors; ➢ Undertake supervision of one to two PM+ Trainers' training sessions; assess trainer competency; and ➢ Undertake supervision of one to two clinical supervision sessions run by PM+ Trainers to assess competency. • Be available for negotiated onward training of additional PM+ Trainers and/or CHVs via the County Centre of Excellent (COE) • Support the promotion and dissemination of the Kenya Mental Health Policy (2015-2030) • Provide monthly activity reports to the TWG.	week for the period of the practice cases; ➢ Assess the competency of the CHVs by attending at least session per CHV with a direct practice case; ➢ 2 day classroom 'refresher' training on being PM+ Providers. • Be a point person for the assessment of prospective PM+ clients at the health facility and support the 'matching' of PM+ Clients with PM+ Providers/CHVs as per SOP 4.2. • Provide ongoing weekly and/or fortnightly group 2 hour group supervision for PM+ Providers, as set out in SOP 4.5. • Undertake management of client documentation, information, data and confidential files, as set out SOP 4.3. • Support CHVs in any emergency situations and where provision of client referrals requires facilitation (as per SOP 4.6). • Support the promotion of community mental health strategies and other advocacy/awareness initiatives.	*CHVs should not commit to any more than 5 active PM+ clients in a single week.*

Actors	PM+ Master Trainers ("Master Trainers")	PM+ Trainers / Supervisors** ("PM+ Trainers")	"PM+ Providers" (or "PM+ Helpers")
• What will be the resources needed for them to fulfil their post-training role?			
	• Training materials • Transport • Stationery • Manuals for PM+ Trainers • Copies of the Kenya Mental Health Policy (2015-2030) • Copies of key tools and forms (e.g., Assessment forms and PSYCHLOPS) • Forms for PM+ Master Trainer competency assessments – Classroom plus Observed assessments as: PM+ Provider, PM+ Trainer, PM+ Clinical Supervisor	• Documented agreement from management supervisor allowing them the necessary time required for continued clinical supervision of CHVs and related document management. • Training materials • Transport • Stationary • Manuals for CHVs • Copies of key tools and forms (e.g., Assessment forms and PSYCHLOPS, Referral forms etc.) • Forms for PM+ Trainers competency assessments – Classroom plus Observed assessments as: PM+ Provider, PM+ Trainer, PM+ Clinical Supervisor	• Stationary • Copies of key tools and forms (e.g., PSYCHLOPS, Referral forms etc. • Secure document wallet/bag • Stipends • Forms for CHV competency assessments – Classroom plus Observed assessments as: PM+ Provider
Who will supervise them?			
	MOH Master Trainer or Consultant Trainer	PM+ Master trainers	PM+ Trainers (see ** Important note for Counties)
In what activities will they be supervised and how often?			
	• PM+ Master Trainer practice cases - weekly 90-minute group supervision with small groups of 7-8 • Observation of at least one PM+ session during practice cases • PM+ Master Trainers delivering training to PM+ Trainers (at least	• PM+ Trainers practice cases - weekly 2 hour group supervision with small groups of 7-8 • Observation of at least one PM+ session during practice cases • PM+ Trainers delivering training to CHVs (at least one	• PM+ Trainers practice cases - weekly 2 hour group supervision with small groups of 7-8 • Observation of at least one PM+ session during practice cases (but may require more

Actors	PM+ Master Trainers ("Master Trainers")	PM+ Trainers / Supervisors** ("PM+ Trainers")	"PM+ Providers" (or "PM+ Helpers")
	one observation, but may require more if capacity requires more support) • PM+ Master Trainers providing supervision to PM+ Trainers (attending at least one supervision session being run by PM+ Master Trainers)	observation, but may require more if capacity requires more support) • PM+ Trainers providing supervision to CHVs (attending at least one supervision session being run by PM+ Trainers)	depending on capacity of the CHV) • Regular PM+ Clinical Supervision, post-training, with intensity of clinical supervision gradually reducing as the CHV becomes more experienced
How will they be deemed 'competent'?			
	• Classroom competency assessment as PM+ Provider • In-field competency assessment as PM+ Provider • Classroom competency as PM+ PM+ Master Trainer • In-field competency assessment as PM+ Master Trainer • Classroom competency assessment as PM+ Clinical Supervisor • In-field competency assessment as PM+ Clinical Supervisor	• Classroom competency assessment as PM+ Provider • In-field competency assessment as PM+ Provider • Classroom competency as PM+ Trainer • In-field competency assessment as PM+ Trainer • Classroom competency assessment as PM+ Clinical Supervisor • In-field competency assessment as PM+ Clinical Supervisor	• Classroom competency assessment as PM+ Provider • Observed competency assessment as PM+ Provider
*Notes: *Throughout Kenya, some counties differ according to who can train, provide management supervision and/or clinical supervision to CHVs. For example, some counties may only approval for CHEWs or CHAs to deliver CHV training and/or supervision. As such, counties may need to think carefully about who they select as PM+ Trainers in light of the expectation that they will, in future PM+ scale up activities, need to on-train CHVs and provide for their clinical supervision.*			

Annex 7: List of PM+ Contributors

No.	Name	Position	ORGANISATION
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8.	Wilson Barongo	County Mental Health Coordinator	Ministry of health - Nyamira County
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13.	Elizabeth Mwangi	Psychiatric Nurse/Master trainer	Ministry of health - Nakuru County
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19.	Orione Irungu	Clinical Supervisor	World Vision Kenya - Nyeri County

20.	Fredrick Owade	Clinical Supervisor	World Vision Kenya - Nakuru County
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27.	Dr.Catherine S.Mutisya	Psychiatrist	Mathari National Teaching and Referral hospital
28.	Mary Chege	Assistant Principal Medical Social Worker/Master trainer	Ministry of health - National

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