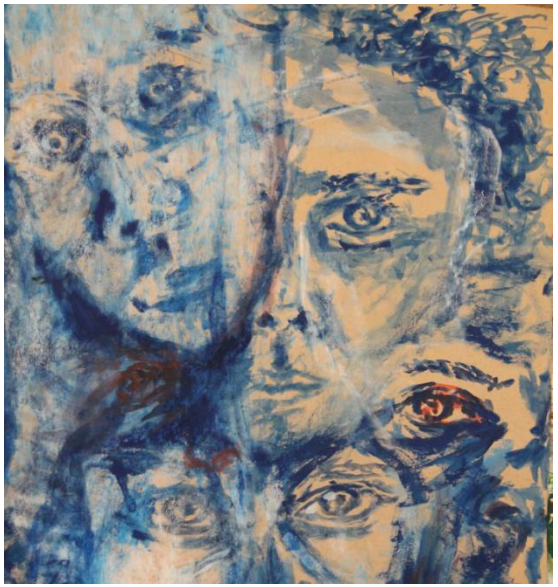
National Strategic Plan for Mental Health Services 2019 - 2023

Towards quality of care in mental health services



Ministry of Health and Child Care, Zimbabwe

‘Being Bipolar’

By Katy

“I was diagnosed, initially with clinical depression, then later with bipolar depression. It was hard for me to take on this new identity and I didn’t want to be told I would have this for the rest of my life. Since then I have discovered that many other people in Zimbabwe have some form of depression…. dialogue on it has really begun to open up, but there is still such a way to go to be able to treat sufferers with dignity and give them the help and resources they need”

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Acknowledgements

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By Tanyse

“It felt like a never ending fog, the constant tiredness and disjointed thinking as if I were functioning or …malfunctioning from a shattered mind. It is an overwhelming, crippling experience that robs the colour out of life….”

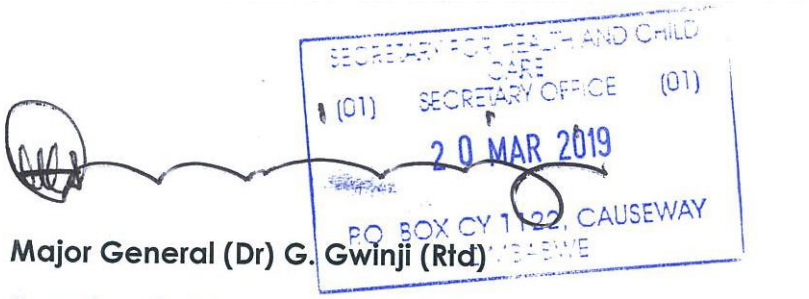
Foreword

Mental, neurological and substance use disorders contribute significantly to disease burden globally and locally. There remains a significant treatment gap for these conditions and there is need to scale up mental health services in order to improve access to care for those who need it. The National Strategic Plan for Mental Health Services in Zimbabwe 2019- 2023, succeeds the Zimbabwe National Plan for Mental Health Services 2014-2018. This plan continues to operationalize the Zimbabwe Mental Health Policy and Goal 7 of the Zimbabwe National Health Strategy which aims to improve the mental health status of our nation.

This strategic plan is also in line with the World Health Organisation's Comprehensive Mental Health Action Plan 2013-2020 which aims to improve mental health leadership and governance; provide comprehensive, integrated mental health services; implement strategies for mental health promotion and prevention as well as to strengthen information systems, evidence and research.

The plan was developed in consultation with various stakeholders and followed a situation analysis of the state of mental health services in Zimbabwe done at the end of the last plan. This new plan of action builds on the achievements of the past and aims to learn from the challenges faced in the previous years. It utilizes approaches to mental health care that aim to integrate care and improve quality of care from primary health care to tertiary specialist care. There is a focus on improving systems within mental health care services to improve service delivery and quality of care; improving mental health awareness and promoting community empowerment; promoting research as a tool to inform policy and planning as well as strengthening our mental health human resources.

It is our hope that together with various stakeholders and partners, we can work towards achieving the objectives set out in this plan and ultimately provide a service we can all be proud of.



Major General (Dr) G. Gwinji (Rtd)

Secretary for Health and Child Care

Introduction

Mental health is an integral part of health and is defined as "a state of mental well being where an individual realises their full potential, can cope with the normal stresses of life and can contribute productively to their community" (WHO). Mental health disorders therefore affect not only individual lives but their families, the communities they are part of and the nation's social and economic progress.

One in four people worldwide are affected by a mental or neurological disease in their lifetime making mental health disorders one of the leading causes of global disease burden (WHO). Depression is now the leading cause of disability affecting over 300 million people worldwide (Friedrich, 2017). Depression is also a major contributor to suicide which claims more than 800 000 lives a year and has become the second leading cause of death among young people (WHO, 2014). Substance use makes up a large proportion of the disease burden among young people (Gore, 2011). In Africa the prevalence of substance use is rising and the demand for treatment is high (Parry, 2004). Although effective treatments for most mental health disorders including depression and substance use exist, most patients do not get adequate help (Patel, 2010).

This National Mental Health Strategic Plan of 2019 to 2023 follows the Zimbabwe National Strategic Plan for Mental Health Services of 2014 to 2018 which was based on the Zimbabwe National Mental Health Policy of 2007 before which mental health services had been guided by the Zimbabwe Mental Health Plan of Action of 1984. These previous policy and planning documents were all developed in consultation with various stakeholders as was done for this plan as well.

This strategic plan aims to improve mental care in Zimbabwe by: improving the quality of our mental health service delivery and patient care in line with international best practice; improving mental health awareness and empowering our communities; promoting research and development of locally relevant, innovative solutions to challenges in our mental health system; reviewing our legislation in line with current international guidelines and strengthening our human resources through training and skills development.

From 2019 to 2023 we will target several high priority areas including improving quality of care in all mental health units; mhGAP training of non specialist health workers to improve mental health care in primary care facilities; alcohol and substance use disorder treatment; community awareness of mental health issues as well as community participation in treatment. We hope through this strategic plan, to strengthen the mental health of our nation and improve the quality of life of many Zimbabweans affected by mental illness.

Context and Situation Analysis

Zimbabwe is a sub-Saharan country sharing borders with Zambia to the north, Mozambique to the East, Botswana to the West and South Africa along its southern border. According to the inter- censal demographic survey of 2017, Zimbabwe has a population of over 13 million people, 40% of whom are below the age of 15. Zimbabwe has an agro-based economy and the majority of the population reside in non urban areas. Zimbabwe is faced with significant disease burden of communicable and non communicable disease and mental health disorders contribute significantly to this burden.

Historically, prior to independence in 1980, mental health care was a low priority and services were inaccessible to the majority of the population. Inguthseni was established in Bulawayo in 1908 as an asylum mainly for the black population and was changed into a mental health hospital in 1933 after a psychiatrist was assigned to run it from the United Kingdom. Training of a small number of specialist psychiatric nurses only started in 1970. At this time there was little mental health education included in general nurse training or the medical undergraduate curriculum. (MOHCC, 1984)

Independence came with significant changes to the structure of health services with emphasis on primary healthcare and improving access to healthcare for all. The intake for psychiatric nurses was increased and mental health care was included as mandatory in the general nurse training and undergraduate medical training. A diploma in psychiatric health was started in 1982 for doctors going to work at district hospitals, a Masters of Science in Clinical Psychology began in 1982 and in 1984 a specialist Masters of Medicine in Psychiatry degree was established at the University of Zimbabwe. From 1984 a program to decentralise healthcare was set up with upgrading of infrastructure at provincial and district level. In 9 of the 10 provinces a provincial hospital was built or refurbished and district hospitals were also built or refurbished. Local clinics and rural health centres were established at primary health care level allowing for a referral system to be set up. Mental health services were to be part of care at every level of care. Socioeconomic challenges interfered with the decentralisation process however and only 2 Provincial units were established. (MOHCC, 1984)

Zimbabwe currently has four tertiary psychiatric units namely Inguthseni in Bulawayo, Harare Hospital Psychiatric Unit and Parirenyatwa Annexe in Harare and Ngomahuru Hospital in Masvingo. There are four psychiatric units at provincial level in Chinhoyi, Gweru and Marondera as well as in the district of Mutoko. There are also two forensic psychiatric units, Chikurubi Special and Mlondolozi Special Institutions. Harare Hospital Psychiatric Unit was recently refurbished through partnership with Medicines San Frontiers, with renovations to the original acute admission unit and sub acute unit as well as construction of a new outpatient facility. MSF further supported staff services, training and helped to set up a community psychiatry outreach team to support mental health services in Harare City clinics. This work greatly improved the service provision at Harare Hospital Psychiatric Unit and motivated the staff in their work. All the other units are however in dire need of refurbishment. There is a lack of admission facilities for children and adolescents, and lack of suitable services for effective occupational therapy. There is also need to improve the living conditions for forensic patients.

There are currently 917 registered mental health nurses in the country and 17 psychiatrists. There are 6 Clinical psychologists, 13 Clinical Social Workers and 10 Occupational Therapists working in the government sector. There is high patient to staff ratio across

all disciplines, highlighting a need to recruit and retain mental health professions and to increase numbers in all available training programs (see table 1).

Patient numbers are currently very high at tertiary units indicating possible recentralisation of services (see table 2). Major diagnoses reported to be seen in the last year include Alcohol and substance related conditions, Schizophrenia, Organic Psychosis and Depression. A concerning number of attempted suicides where also reported by some units as well.

There is a critical shortage of drugs country-wide. The Health Levy directed partly towards psychotropic drug procurement has had a limited effect on drug supplies as most units still have between 1 to 3 months stock of even the most basic drugs, primarily first generation antipsychotics with minimal stocks of antidepressants and mood stabilizers (see Table 3)

Mental Health Care in Zimbabwe is governed by the Mental Health Act of 1996 and guided by the Mental Health Policy of 2007. There is a need to review the Mental Health Act to bring it in line with contemporary approaches to mental health care and protection of human rights. Given the increased prevalence, policies to address alcohol and substance use are needed. Moreover, the lack of finances within the mental health sector calls for possible tax legislation to fund mental health services. Funding of mental health activities is a major facilitator for this mental health plan. To implement this plan effectively, there is an urgent need for public funding and partnership with private and non-governmental organisations.

Review of the strategic plan 2014 to 2018 and SWOT analysis

A stakeholder meeting to review the previous strategic plan of 2014 to 2018 was held in December 2018. We discussed both the achievements and challenges of the last four years. To aid the development of a new strategic plan, we conducted an analysis of the strengths, weaknesses, threats, and opportunities (SWOT analysis) for mental health in Zimbabwe

Achievements in the mental health services from 2014 to 2018 included:

Administration, Staffing and Service Delivery: During the previous 4 years some staffing and administration challenges began to be addressed.

- Ten posts for provincial mental health coordinators at matron grade were established though yet to be filled substantively.
- There was financial recognition of the post basic training in mental health through paying of a post basic allowance to registered mental health nurses.
- A training program for mental health nurses was established at Parirenyatwa School of Nursing through the department of Nursing Services and its first graduates completed their program in 2018.
- Six psychiatrists completed their training, two of whom have taken up posts at Harare Psychiatric Unit and at Parirenyatwa respectively.
- Through Medicines Sans Frontiers (MSF) facilitation, staff in the prison mental health services were supported and upskilled. When the MSF program was expanded to Harare Psychiatric unit, staff there were also supported and gained new skills through workshops held and interaction with international staff working through MSF.
- The World Health Organisation together with MSF helped support training in the Mental Health Gap Action Program (mhGAP) of 250 health workers in Harare and Bulawayo City as well as Manicaland province allowing for upskilling of registered general nurses in management of mental health problems.
- A mental health discharge plan was developed and launched

Infrastructure

- The MSF renovation project of Harare hospital psychiatric unit breathed new life into mental health services and encouraged the staff. The acute and subacute units were refurbished and a new outpatient building was built for the unit

Research: Various research grants with interest in mental health problems in Zimbabwe were awarded to researchers over the last four years, which promoted mental health research and training. These included:

- The "Improving Mental Health and Research in Zimbabwe" (IMHERZ) award – part of the Novel Education Clinical Trainees and Researchers (NECTAR) grant from the National Institute of Health (granted to the University of Zimbabwe, College of Health Sciences from 2010-2015 under Prof. Hakim). This brought much needed attention to mental health research and training.
- In 2015, the African Mental Health Research Initiative (AMARI) through the Developing Excellence in Leadership, Training and Science (DELTAS) program was also awarded to the UZCHS (under Prof. Chibanda, with Dr. Mangezi as local PI) to promote African mental health research.
- The Friendship Bench project (also led by Prof. Chibanda) funded by Grand Challenges Canada developed a low-cost, task-sharing initiative to train village and community health workers to deliver a basic psychological intervention for common mental disorders. This project has since been rolled out to Harare and Gweru, and is being piloted for rural settings in Masvingo. This Zimbabwean intervention has been adapted to Kenya, Tanzania, and New York City.
- Data was collected for a national survey on alcohol and substance use among university and tertiary level students.
- The Global Youth Tobacco Study was carried out in 2014

Legislative changes

- Zimbabwe became a party to the WHO Framework Convention on Tobacco Control
- The National Alcohol Policy Final Draft was presented to Cabinet

Mental Health Promotion and Prevention:

- Over the last 4 years, yearly commemorations of the Mental Health Day, the International Day against Drug Abuse as well as the World No Tobacco day have been held in different venues each year to promote awareness about mental health issues countrywide.
- Road shows were also held to promote awareness about alcohol and substance use disorders in all 10 provinces.

SWOT Analysis of the mental health services system

STRENGTHS	**WEAKNESSES**
Passionate staff Existence of local training programs in mental health Knowledge and some skills Multidisciplinary teams Availability of primary infrastructure Presence of a primary healthcare system Referral system from primary healthcare level	Lack of financial resources Poor visibility of the service Stigma Poor interdepartmental, multidisciplinary and intersectoral communication and collaboration Poor implementation of policies and plans
THREATS	**OPPOURTUNITIES**
Socioeconomic instability Brain drain Burnout of staff High burden of Mental Illness	Global recognition of mental health challenges Potential to increase number of mental health professionals Identified budget line for mental health Good will and support for mental health in health leadership Interest from international partners and local private partners Research and implementation opportunities

Mission, Vision and Guiding Principles

The mission of the mental health services in Zimbabwe as stated in the mental health policy continues to be:

> *To provide for all Zimbabweans, a comprehensive, coordinated, quality mental health service that is integrated into the general medical health system with the aim of improving the mental health of the nation.*

The objective of the strategic plan is to provide a detailed, time bound, feasible action plan to achieve this mission

The principles as highlighted in the mental health policy by which this plan is guided include:

1. Mental health as a fundamental human right
2. Provision of the highest possible quality of care
3. Professionalism in service provision and ethical treatment of patients
4. Decentralisation and integration of services to allow accessibility and sustainability
5. Multidisciplinary approach to mental health care
6. Multisectoral approach to mental health care
7. Community involvement and empowerment
8. Partnership and Collaboration with local and international partners

During the next five years we aim to focus on following five key areas within the mental health service:

1. **Improve Quality of Patient Care and Service delivery:** this will involve developing and implementing standard operating procedures and quality of care protocols within the service. This will require in service training of staff in SOPs, professionalism, ethics and human rights and developing a culture of self reflection, self appraisal and self care in order to improve the quality of our services. Other critical areas in this objective will be to improve our infrastructure and ensure consistent medication supply.
2. **Improving mental health awareness and community empowerment**: this will focus on increasing awareness of mental health issues through a focused media drive, annual commemorations of key mental health related events, a school mental health awareness program and community led mental health programs such as the Friendship Bench
3. **Research and Data Management**: this will tackle the gap in local research data that is needed to inform policy in mental health and will involve formation of a coordinating multidisciplinary research taskforce, formation of a mental health research database compiling all researches done on mental health issues nationally and coordination of relevant national studies on pertinent mental health issues. The mental health data collection system will also be reviewed to allow routine data to inform policy and planning as well as to aid in monitoring and evaluation.
4. **Review of Legislation:** this will focus on reviewing and updating our mental health act, development of policy recommendations and guidelines for treatment and rehabilitation of alcohol and substance use disorders as well as a proposal for a levy to be taken from alcohol sales tax to go towards funding mental health activities in Zimbabwe.
5. **Mental Health Training, Human resource development, administration of mental health services:** this key area will involve strengthening the mental health workforce through improved training of mental health nurses, psychologists and psychiatrists as well training of non specialist health workers in mental health through the WHO mhGAP program.

Objective 1: Improve Quality of Patient Care and Service delivery			
Key Activities	**Baseline (Current)**	**Outputs/ Targets**	**Time frame**
1.1 Ensure Standard Operating Procedures (for managing admission /discharge/violent patients/suicidal patients) are adopted by all currently functional psychiatric units,	1 unit currently using SOPs (Harare Psychiatric Unit)	8 psychiatric units and 2 forensic psychiatric units trained in use of SOPs and using the SOPs in daily routine	1 unit trained in SOPs and adopting SOPs by end of each quarter commencing 2nd quarter 2019 ending 2nd quarter of 2021 and continuously thereafter
1.2 Develop and adopt of SOP for key conditions	4 SOPs currently developed	5 additional SOPs developed 8 psychiatric units 2 forensic psychiatric units trained in use of SOPs and using the SOPs in daily routine	1 SOP developed per quarter commencing 3rd quarter 2019 ending 2nd quarter of 2020 Training and adoption of each SOP as it is developed quarterly
1.3 Establish and implement guidelines for rehabilitative ward programs to ensure therapeutic ward environments	No guidelines currently developed	1 evidenced based, locally relevant rehabilitative ward program guideline developed Implement at 3 pilot sites, if feasible roll out to all 8 psychiatric units and 2 forensic psychiatric units	Guidelines developed by end of second quarter 2019 Piloted in 3 units by end of 2019 Roll out to all units by end of 1st quarter 2020
1.4 Develop and implement quality of care standards document for use in mental health units	No quality of care standard currently in use	One evidenced based, national standard of care document for all psychiatric units developed in consultation with relevant stakeholders	Standards document developed by end of 3rd quarter 2019 Implementation of document/ checklist in all units by first quarter of 2020
1.5 Improve Quality of Care through in service training of staff in Quality of Care, SOPs, 5S model and Kaizen	Some training in QOC done during initial training The 5S model and Kaizen being implemented in selected hospitals by the Department of Quality Assurance but not in Psychiatric units as yet	QOC training done in all 8 psychiatric units and 2 forensic psychiatric units 5S model and Kaizen implemented in all 8 psychiatric units and 2 forensic psychiatric units	One psychiatric unit trained each quarter from the 3rd quarter 2019 and then refresher courses thereafter continuously 2 pilot sites for the 5S model identified and trained with help of the Department of Quality Assurance
1.6 Ensure consistent psychotropic drug procurement and supply to all psychiatric units, provincial, district hospitals and local clinics	Psychotropic medication a key priority for the health levy but drug stocks remain critically low	Quarterly drug stock reports from all psychiatric units and forensic psychiatric units Quarterly meeting with Health Levy Committee to update them on drug stocks in tertiary and provincial units Review and update the essential drugs list for psychotropic drugs yearly	Commencing 1st quarter 2019, continuous
1.7 Develop and implement Self Appraisal Protocol for individual staff members and	Nursing staff appraisals currently being done	2 self appraisal protocols developed (one for staff members and one for units)	Self appraisal protocol developed by start of 4th quarter 2019

for units	Rest of staff not being appraised regularly	Yearly self appraisal of each staff member and for each unit	Self appraisals to commence 1st quarter 2020
1.8 Improve mental health assessments	Standardized assessment form drafted Limited use of objective neuropsychological assessment tools	Standardized psychiatric assessment form for legal assessments for use at district, provincial and tertiary level of care Piloting and roll out of the form by Provincial mental health coordinators, doctors at district, provincial and tertiary units Procurement of IQ assessment test kits, Neuropsychological test kits (one of each test kit per unit)	Finalised form ready by end of 1st quarter 2019 Training of Provincial Mental Health coordinators and tertiary unit staff by end of 2nd quarter 2019 Assessment tests procured by end of 1st quarter 2020
1.9 Ensure regular meetings of the Mental Health Review Tribunal (MHRT), Special Boards and Hospital Mental Health Boards	Inconsistent meetings of the MHRT, Special Boards and Hospital Mental Health Boards	Quarterly meetings of the MHRT, Special Boards and Hospital Mental Health Boards	Continuous from first quarter 2019
1.10 Renovation of tertiary, forensic and provincial psychiatric units	Psychiatric units present in 6 of the 10 provinces One unit, Harare Psychiatric unit already renovated	50% of psychiatric units renovated by end of 2023 Renovation of space for psychiatric ward at Mutare Provincial hospital	Renovation of at least one unit every year from 2020 until 2023 Psychiatric ward at Mutare provincial hospital established by end of 2022
1.11 Establish dedicated child/adolescent outpatient and admission facilities	3 outpatient child and adolescent units functional 1 tertiary unit with admission facilities	Mental Health staff at provincial units trained in basic management of child and adolescent conditions All provincial and tertiary units to have outpatient child and adolescent facilities All 4 tertiary units to have admission facilities for children	One province trained per quarter starting 2nd quarter 2019 through to Establish outpatient clinics in each unit as training is done Admission facilities identified, renovated and opened at tertiary units by end of 2020
1.12 Establish alcohol and substance rehabilitation units at each provincial hospital and at tertiary units based on guidelines from the Alcohol and substance rehabilitation taskforce	No public alcohol and substance rehabilitation units	10 public alcohol and substance use rehabilitation units established 2 alcohol and substance rehabilitation programs within the forensic psychiatric units	1st unit opened by end of 3rd quarter 2019 1 units opened per quarter thereafter with all units functional by 2022
1.13 Strengthen community mental health services through supervisory visits	58 District mental health focal persons already active. No Provincial Mental Health Coordinator Post currently filled. 8 Coordinators in acting	Monthly supervision visits of clinics by district mental health focal person with reports sent to Provincial Coordinator	Monthly supervision visits to commence by 3rd quarter 2019 and to be continuous

	capacity.	Monthly supervision visits of districts by provincial mental health coordinators with reports sent to head office Supervision visits of one province per quarter by head office	

Key Areas Objective 1

Quality of Care Training

The World Health Organisation recommends that Mental Health Services should preserve the dignity of those affected by mental health disorders; provide acceptable clinical and non clinical care; provide care that reduces the impact of mental health disorders and improve quality of life of those affected; promote the use of interventions that improve self efficacy and coping skills of those affected and make efficient, effective use of the resources available to them (WHO, 2003). The Ministry of Health and Child Care Quality Assurance and Quality Improvement Policy recommends that Health care including mental health care should be patient centred, respectful and responsive to patient needs. It also encourages strengthening of health worker performance through in service training, supportive supervision, peer to peer and self evaluation (MOHCC, 2013).

Quality of care will be a key component of our mental health services in this strategic time period. We hope to achieve this by developing our local quality of care standards document for mental health services against which service provision will be measured. This standard will be incorporated into basic and in service training of mental health staff and help create a culture of patient centred, responsive quality mental health care.

'Warm Embrace' by Isheanesu

"When one goes through mental health challenges sometimes all they need is emotional support, love and encouragement…"

The 5S and Kaizen Model in Healthcare

The 5S Kaizen model is a management tool originating from Japan that is a cost effective means of promoting orderliness, organisation, cleanliness and standardization in the workplace (Gapp, 2008). It aims to **sort** through workplaces and remove unnecessary items with the aim to improve use of space, avoid distraction and improve safety; **set in order** to improve work flow, **shine** meaning to clean consistently; **standardize** by creating procedures and schedules to maintain order and finally to **sustain** through self discipline and self appraisal. Kaizen aims at a culture of continuous improvement of how work flows, identifying and managing challenges (Ahlstrom, 2004).

This model has been piloted in 11 public hospitals in Zimbabwe through the Department of Quality Assurance and Japan International Cooperation Agency (JICA) and has been found to improve resource management, reduce wastage, reduce clutter and reduce patient waiting times.

We aim in this strategic period to work together with the Department of Quality Assurance to implement the 5S and Kaizen model in mental health units to improve our work environment, service delivery and quality of patient care.

Infrastructure development

Modernising mental health care facilities is key to providing a safe and calm environment and facilitating delivery of quality mental health care. Most mental health infrastructure in Zimbabwe was built before independence and these buildings, though still an asset are no longer providing appropriate environments for good mental health care in line with current approaches to care. There is an urgent need to refurbish and repurpose existing infrastructure in line with national mental health priorities and decentralization has to be core in this action. There is also need to develop structures for mental health care in every province in order to promote decentralization of care and improve the efficiency of the mental health system.

Objective 2: Improving mental health awareness and community empowerment			
Key Activities	**Baseline (Current)**	**Outputs/ Targets**	**Time frame**
2.1 Improve media presence of the mental health dept and mental health activities	Government of Zimbabwe website with a page for the Mental Health Department already present No structured media agenda for mental health No social media presence for the department of mental health	Structured monthly media content agenda set up (12 topics/ year) Review content of mental health department website once a month in line with monthly agenda (12 content review/year) Facebook page, twitter handle set up- 2 social media posts done a week in line with monthly agenda (24 posts/ year) Bulk SMS on topical mental health issue done monthly in line with monthly agenda (12/year) Tv/Radio program done once monthly in line with monthly agenda (12/year) Print media articles once a month in major newspapers in line with monthly agenda (12 articles a year)	Structured media agenda completed by end of 1st quarter 2019 Continuous time frame for media outputs starting 2nd quarter 2019
2.2 Commemorate international days to promote awareness of mental health issues	Yearly commemorations of World No Tobacco day, International Day against Drug Abuse and Illicit trafficking and World Mental Health Day No regular commemorations for World Autism day, World Suicide Prevention Day	Yearly commemorations of: World Autism Day 2 April World No-Tobacco Day 31 May International Day against Drug Abuse and Illicit trafficking 26 June World Suicide Prevention Day 10 September World Mental Health Day 10 October	Commencing 2019, running continuously
2.3 Develop local Information, Education and Communication (IEC) material on pertinent mental health issues	Some IEC material in circulation, most not locally designed	4 topics to be focused on IEC material a year	Quarterly agenda to be complete by end of 1st quarter 2019

		Designing one new, locally relevant print poster and flyer per quarter in line with the quarter's topic Distribution of posters and flyers to each province 4 times a year	Commencing 2nd quarter 2019, running continuously
2.4 Adoption of the Friendship Bench as a Ministry of Health program	Friendship Bench already running as a project in Harare City Council clinics with Community Health Workers	Training of district mental health focal persons and primary care counsellors in friendship bench principles (screening for common mental health disorders, basic problem solving therapy, behavioural activation and referral guidelines) in pilot districts Friendship Benches set up at selected clinics in the pilot provinces and community awareness about the availability of the service done Roster for primary care counsellors to cover the bench and weekly supervision of primary care counsellors by local clinic nurses and the district mental health focal person	Pilot province by 2nd quarter 2019 Additional province included each quarter until 2023
2.5 Develop and implement a School and Higher Learning Centre Mental Health Awareness Programme	School health policy already in place with a component for psychological support	Locally relevant, curriculum for school and higher learning centre mental health awareness developed in collaboaration with School Psychological Services (MOPSE) and Ministry of Higher and Tertiary Education Implementation of school and higher learning centre mental health awareness program through provincial mental health coordinators and City Health Coordinators starting with one	Curriculum developed by 4th quarter of 2019 Implementation to commence 1st quarter 2020

		school per term per province, one higher learning centre per semester	
2.6 Develop and disseminate guidelines for workplace mental health care	No national standards or guidelines for mental health care, organisations and companies have individual policies and protocols	National guidelines for mental health in the workplace developed with consultation of relevant stakeholders	Stakeholder consultations conducted in the 4th quarter 2019 Development of guidelines by 2nd quarter 2020 Adoption and dissemination of guidelines by 3rd quarter 2020

Key areas Objective 2

Media and mental health

Media has a strong influence on how individuals view the world and social media is increasingly surpassing the influence of primary social networks such as family and friends (Srivastava, 2018). Media can shape our understanding and perception of life and life experiences and its influence can be both positive and negative. Media can contribute to the stigma surrounding mental health disorders through inaccurate, undignified portrayals of persons with mental illness or distorted views of mental health care however media has the power to break down misconceptions and myths (Wahl, 1995). The media can humanize the experience and give space to stories that bring hope. Print media, audiovisual media and social media can all be a vehicle to provide accurate information about mental health disorders.

In this strategic time period, we plan to increase traditional media and social media presence as mental health services aiming to provide locally relevant and accurate information on mental health disorders in a strategic, systematic approach. We also aim to continue major commemorations on the mental health calendar but to increase the media coverage of these events and any other mental health events in the nation.

The Friendship Bench

The Friendship Bench is a research based organisation that began as a research programme to investigate a low cost psychological intervention for depression, anxiety and other common mental health problems delivered by lay health workers at primary health care level (Chibanda, 2011). It was first piloted in Mbare at the polyclinic after depression and other common mental health disorders were found to be highly prevalent in the community and among clinic attendees in the early 2000s. The intervention was developed by Prof. Dixon Chibanda, a psychiatrist who was then working at Harare hospital in conjunction with Kings College London and eventually won a Grand Challenges Canada research grant due to its innovative nature. The trust has since run a successful randomised control trial that proved the intervention is effective.

The program has since been scaled up to include all City of Harare polyclinics, the trust has a standing Memorandum of Understanding with the City of Harare. The WHO is also supportive particularly because of its task shifting nature. The program has been recognised as an innovative home grown solution to managing depression at community and primary health care level and as the department of mental health we have been considering how to include it in our primary health mental health care package countrywide.
The program has been recognised and is being implemented in New York City, USA in their City Health Department.

In this strategic period, the mental health service would want to adopt the Friendship Bench model as part of community mental health services. It can provide a task shifting, cost effective and acceptable approach to community mental health and community empowerment in this area.

Maternal mental health and child outcomes

Women are more likely to develop mental health problems in the perinatal period due to biological and psychological changes associated with pregnancy. Up to 20% of mothers in developing countries experience depression after child birth (WHO). Social determinants such as poverty, limited access to education and poor social support also contribute to increased risk of mental health challenges in the child bearing phase of life (Fischer, 2012). Maternal mental health problems affect quality of life of mothers and also affect their children's outcomes such as nutritional status, cognitive, social and emotional development (Bennett, 2016). We aim, in this strategic time period, to integrate a maternal mental health support component into the existing maternity services to help support our nations mothers and help improve childhood outcomes.

School mental health programs

Between 10 and 20 % of children and adolescents experience mental health disorders worldwide an half of all mental health problems begin before the age of 15 . Over 40% of children under 5 years of age in low to middle income countries are at risk of developmental problems (Lancet, 2016).

Schools are uniquely placed to impact the health of both learners and the families and communities they are a part of. Children spend much time in school and schools can significantly influence emotional and psychological development. School mental health programs can help promote mental health of learners and facilitate screening and early detection of mental health disorders (Hendren, 1994). Empowering teachers as part of the school mental health program would also ensure sustainability of such a program.

The Zimbabwean School Mental Health Policy has defined 8 components as part of a comprehensive school health program and all of these components involve some aspect of mental health (MOHCC, Zimbabwe School Health Policy, 2017). These components include:

- Competency based health education: this could incorporate aspect about the brain and behaviour, psychological and emotional development, psychological disorders and how to get help
- Psychosocial support services: this could include training to improve psychosocial competence and promote life skills that promote resilience and coping
- A safe and sanitary environment: which could include mechanisms to protect learners from exposure to substances and alcohol, as well as promote a non violent and psychologically safe environment.
- Disaster management: which could include managing the psychological impact of any such disaster

- School based health and nutrition programs: This could include screening programs for common mental health and substance use problems
- School-Family-Community linkages: which could include be included in mental health awareness programs
- Support for learners with special needs: which could include support for learners with developmental and behavioural disorders
- Health promotion for school staff: this could include mental health support for staff and screening and early intervention for mental health disorders, substance use, stress and burnout

During this strategic time period, we aim to work closely with the Ministry of Primary and Secondary Education as well as the Ministry of Higher and Tertiary Education and other stakeholders to develop a School mental health awareness curriculum and support program for staff to be implemented through the Provincial and District Mental Health Coordinators and focal persons.

Objective 3: Research and Data Management			
Key Activities	**Baseline (Current)**	**Outputs**	**Time frame**
3.1 Form a research and development task force to direct research agenda and to identify existing local data useful to clinical practice in mental health	No taskforce currently available No mental health research database	Formation of a multisectoral research and development taskforce Quarterly meetings of the taskforce with reports to head office Mental health research database compiled and reviewed yearly	Taskforce established by end of 1st quarter 2019 Current research database compiled by end of 3rd quarter 2019
3.2 Develop and implement a research agenda based on current situation and data available	Research currently being conducted but not directed by a national agenda One national survey of alcohol and substance use among university students currently underway	Document with evidenced based, locally relevant national mental health research agenda developed Document distributed to relevant partners to encourage research along the lines of the national agenda Conduct 1 national study every 2 years as the department of mental health in line with the research agenda	Document developed by end of 2nd quarter 2019 and distributed to all relevant health institutions, research partners and universities
3.3 Coordinate national surveys	Data collected for a national survey on alcohol and substance use among university students	1 research protocol in line with national research agenda developed and implemented every year	Yearly research protocol developed by 1st quarter starting 2020 Implementation of research protocol by 3rd quarter done in 3rd quarter yearly Study report complete by end of last quarter each year
3.4 Review and update data collection systems for mental health information to ensure accurate records	Current quarterly mental health return form submitted from clinic level	Reviewed monthly mental health returns form Review mental health component included in DHIS Quarterly department reports compiled	Form reviewed end of 2nd quarter of 2019 Proposed components presented to the Health Information Systems and Electronic Heath Records by end 2nd quarter of 2019 Starting 1st quarter 2019 and continuous

Key Areas Objective 3

Research and mental health advocacy

Research data can be a powerful advocacy tool as it can draw attention to the scale of mental health challenges in a community (Kidia, 2017). Research can highlight priority areas that policy and service provision need to focus on. Research can also help promote local and global support for mental health issues in Zimbabwe. International guidelines recommend that mental health policy and planning be informed by local data (Tomlinson, 2009). We have attempted to this in preparation of this strategic plan by conducting a situational analysis.

In this strategic time period we have dedicated one objective to research and development of innovative solutions to mental health challenges in Zimbabwe. We aim through this objective to help organise mental health research efforts, create a database of existing studies and direct future research towards filling gaps in our data.

Mental Health Information Systems

Data collection and management of mental health information is to inform policy and planning. Data helps to assess the needs of the population, monitor efficacy of interventions and monitor and evaluation program performance (WHO). The WHO recommends that mental health data be collected at facility level and at system level to allow for monitoring of plans and objectives. There is also a need to translate strategic objectives into measurable items that can be included in the information collection system. In this strategic time period, we aim to improve the mental health data collection systems, incorporate the objectives of this plan into the information collection system in order to monitor progress and evaluate our program.

By Kazz

Inspired by the lack of vitality that manifests as depression….a feeling of nothingness..

Objective 4: Review of legislation			
Key Activities	**Baseline (Current)**	**Outputs**	**Time frame**
4.1 Review the Mental Health Act of 1996	Existing mental health act	Formation of a multisectoral taskforce/ working group to spearhead reform Stakeholder consultations done New Mental Health Act developed, locally relevant and in line with global recommendations	Formation of taskforce by end of 3rd quarter 2020 Stakeholder consultations to commence by 1st quarter 2021 Draft bill developed by end of 2021
4.2 Develop a national alcohol and substance use treatment and rehabilitation regulations and guidelines for treatment and rehabilitation of patients with alcohol and substance use disorders	National policy on alcohol use currently drafted not yet launched	Formation of a multisectoral taskforce for alcohol and substance use rehabilitation through a national alcohol and substance rehabilitation stakeholders meeting Monthly meetings of taskforce National regulations for alcohol and substance use disorder rehabilitation developed National guidelines on alcohol and substance use rehabilitation developed	National stakeholders meeting conducted by February 2019 Taskforce/ working group formed by end of first quarter 2019 National policy and guidelines developed by end of 2nd quarter 2019 Launching of Alcohol Policy and Drug Master plan by end of 3rd quarter 2019
4.3 Coordinate reviewing and finalising the National Drug Control Master plan	Draft National Drug Control Master plan available but in need of review	Coordinate interministerial meetings to review and finalise the draft with relevant ministries Bi-monthly interministerial meetings Reviewed draft finalised and launched Regulations drafted to allow masterplan to be enforced	Bi-monthly interministerial meetings to commence 1st quarter 2019 Final draft ready for launching by end of 3rd quarter 2019 Drafting of Regulations to be complete and launching of Drug Control Master plan by end of 3rd quarter 2019
4.4 Propose introduction of a mental health levy derived from alcohol and tobacco taxes to fund mental health and rehabilitation activities	Existing levies to fund other health activities already present	Briefs on current alcohol and substance use problems in Zimbabwe prepared Consultative meetings with relevant stakeholders done Drafting of proposed bill	Briefs prepared by end of 3rd quarter 2020 Consultative meetings completed by June of 2021 Proposed bill drafted end of 2021

Key areas Objective 4

Mental health legislation

The purpose of mental health legislation is to protect the rights of those affected by mental illness as they are often faced with stigma, discrimination and are prone to abuse (WHO, 2003). Legislation also serves to govern involuntary care and forensic psychiatry. There is a need to continuously review and improve mental health legislation to keep it in line with contemporary approaches to metal health. The WHO recommends that mental health law should include aspects of:

- Promotion of Mental Health and Prevention of Mental Disorders
- Ensuring access to Basic Mental Health Care
- Mental Health Assessments in line with international guidelines
- Promoting less restrictive types of Mental Health Care
- Promoting Self-Determination
- Ensuring periodic review of legislation
  (WHO, 1996)

During this strategic time period, we will be reviewing the Mental Health Act of 1996 to bring our mental health legislation line with international guidelines and modern clinical approaches to mental health care.

Objective 5: Mental Health Training, Human resource development, administration of mental health services			
Key Activities	**Baseline (Current)**	**Outputs**	**Time frame**
5.1 Substantively fill posts for provincial mental health coordinators **5.2 Strengthen the Provincial Mental Health Coordinator and District Mental Health Focal person network through training, supervisory visits and quarterly meetings**	9 Provincial Mental Health Coordinator posts currently available, 1 substantively filled Identified District focal persons for mental health providing services but no posts for district mental health coordinators	All provincial mental health coordinator posts substantively filled 58 District Mental Health coordinator posts established Quarterly training capacity building sessions by head office with Provincial Mental Health Coordinators Quarterly training and capacity building of district mental health focal persons by provincial mental health coordinators	All provincial mental health coordinator posts filled by end end of 2019 District mental health coordinator posts established by end of 2020 Quarterly capacity building and training from end of 1st quarter 2019
5.3 Public Mental Health module for clinical psychologists, clinical social workers, psychiatric nurse practitioners and psychiatrists with attachments to provinces and to head office	Community mental health module currently part of psychiatry training but no formal attachments in the field	Written curriculum for public mental health module for trainee clinical psychologists, clinical social workers, psychiatric nurse practitioners and psychiatrists developed in collaboration with training institutions 2 six week attachments to provincial hospitals during the course of training supervised by training institutions and head office mental health department 1 six week attachment to head office during the course of training	Curriculum developed by 2nd quarter 2020 Implementation to commence 1st quarter of 2021
5.4 mhGap training of non specialist health workers	3 of the 10 provinces have had training in mhGAP of health workers done (250 health	WHO mhGAP training done in Matebeleland North, Matebeleland South, Masvingo,	One provincial training conducted quarterly commencing 2st quarter 2019 and then referesher courses conducted, one province per quarter

	workers mhGAP trained to date) Remaining 7 still to have training workshops No program evaluation has been done	Mashonaland East, Mashonaland Central and Mashonaland West Midlands training 30 non specialist health workers per province Monitoring and Evaluation protocol developed for the program with WHO Program evaluation done for the 3 provinces initially trained	continously M&E protocol developed by end of 2019 Program evaluation done in trained provinces commences 1st quarter of 2020
5.5 Establish a 3rd mental health nurse training program at Ngomahuru Hospital	2 mental health nurse training programs currently running at Ingutseni and Parirenyatwa	Consultations with Nurse Training Department, Nursing Council of Zimbabwe and other relevant stakeholders to develop a proposal of a new school Presentation of proposal to relevant authorities Upgrading of Ngomahuru Hospital to accommodate a school of mental health nurse training and relevant inspections by nursing Council of Zimbabwe and Health Professions Authority Employment of required staff compliment Launch of new program	Proposal completed and presented by end of 2020 Upgrading of Ngomahuru hospital to commence 1st quarter of 2021 to be completed by end of 2021 Launch of new program 1st quarter 2022
5.6 Training in alcohol and substance use disorder management to facilitate opening of government rehabs in each province	No in-service training in addictions care currently being done	Training of a team of health workers at each provincial hospital and at each tertiary unit in addictions management	First cohort to be trained by the end of the 2nd quarter 2019
5.7 Improve training of and number of clinical psychologists	Masters in Clinical Psychology currently not running Internship program for Bsc graduates currently in place but not supported by	Liason meetings with University of Zimbabwe, Dept of Psychology to lobby for reopening of Masters program Establish 25 training posts for clinical psychology at psychiatric	Meeting with UZ department of Psychology by end of 1st quarter 2019 Establish 12 posts by end of 2020

	government No mandatory government service for clinical psychologists currently in place	units Establish one year mandatory government service for clinical psychologists who have qualified before registration with AHPC	Establish 25 posts by end of 2022 Commence mandatory year of service starting January 2020

Key areas Objective 5

Public health training for mental health workers

There is a need to build capacity in mental health workers in public and global mental health principles in order to build up mental health leadership in Zimbabwe. Specialist mental health staff need to function as both clinicians and public health advocates in order to build awareness about mental health issues and promote decentralization of care. Exposure to the public mental health system is essential for trainee mental health workers to gain a balanced perspective of the mental health system and to contribute to possible solutions. Such exposure could also work to promote decentralization of specialist services to provincial centres.

The WHO mhGAP

There is a significant treatment gap with up to 75 % of people needing mental health services not having access to care in most developing countries (WHO, 2008). There is also a critical shortage of specialist mental health workers. The WHO Mental Health Gap Action Programme (mhGAP) aims at scaling up services for mental, neurological and substance use disorders in low to middle income countries by training non specialist health workers in basic management of mental health disorders to allow better access to care. The programme provides an integrated package of interventions based on best practice for key priority conditions. These priority conditions are depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs, and mental disorders in children. The WHO mhGAP training has been done in 3 provinces in Zimbabwe, with 250 health workers having been trained to date. This program will be a vehicle for promoting decentralization of mental health services and improving access to care during this strategic time period.

Funding and partnerships

Financing health is key in provision of quality health services. Health is generally funded through public finances (taxes, levys and user fees), grant assistance and private out of pocket payments (WHO, 2003). How health is financed affects equity; efficacy and effectiveness of service provision. Mental health is mostly funded by public finance, 60% of funding for mental health comes from taxes worldwide (WHO, 2003).

Patients with mental health challenges are often disadvantaged financially and out of pocket payments can become an unnecessary barrier to treatment. The WHO recommends that where possible governments aim for mandatory coverage of mental health services which Zimbabwe has attempted to do. This however is difficult to achieve in low income settings where mental health often receives less than 1% of the health budget (Dixon, 2018). This tends to then result in lower quality of service being provided. Developing and protecting dedicated funding for mental health services would improve the quality of service we provide to those affected by mental health problems.

The WHO recommends that planning should drive the budgeting process and a budget should generally reflect priority objectives (WHO, 2003). We have aimed to this during this strategic plan where we have planned based on local data and developed a budget based on national priority areas (See Appendix 3, the calendar and approximate budget for 2019 as the template we would be using each year).

In this strategic time period we hope to partner with private and non-governmental organisations to help fulfil the key objectives of this plan. We however also aim at this juncture to develop a sustainable financial model for Zimbabwe's mental health services through a dedicated mental health levy taken from alcohol sales. This would ensure a consistent form of income for mental health services and allow longer term planning in the future.

Implementation Plan

We aim to implement this strategic plan in 2 phases as follows:

Phase 1(Initial 30 months) - Improving quality of care and empowering the community

- Improving Accessibility to mental health services and Quality of Care within mental health services through QOC and mhGAP training
- Ensuring availability of psychotropic medications
- Addressing the growing alcohol and substance use problem through establishing a Treatment and rehabilitation taskforce; guidelines for treatment and rehabilitation of alcohol and substance use disorder; developing and implementing training on addictions management for staff
- Community empowerment through commemorations, a media drive, school mental health and Friendship Bench modelled community programs
- Establishment of the research taskforce and setting a research agenda

Phase 2 (Subsequent 30 months) - Ensuring sustainability, securing the future

- Reviewing our legislation in line with current approaches, establishing an alcohol levy to finance mental health services
- Improving human resources establishment, improving training and refresher courses
- Infrastructure development and refurbishment

Outputs will be measured quarterly to allow monitoring of this plan and each year a review of the strategic plan will be done at departmental level together with experts in policy and planning from the MOHCC. An interim review with stakeholders will be done after 30 months at the halfway point. A situational analysis will be done towards the end of the strategic plan and a final review with stakeholders will be done at the end of the 60 month period.

Appendices

1. References

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2. Tables for situational analysis

Table 1: Mental Health Staff 2018

.	TERTIARY INSTITUTIONS				PROVINCES						SPECIAL INSTUTIONS	
Institution	Ingutsheni	HPU	Ngomahuru	Pari Annex	Mash West Chinhoyi Hospital	Midlands (Gweru Hospital)	Manicaland (Mutare Provincial Hospital)	Mat South	Mat North	Mash East (Marondera Hospital)	Chikurubi	Mlondolozi
Psychiatrist	2	5	0	4	0	0	0	0	0	0	1	1
Medical Doctors (non – Specialist, permanent non rotational)	7	4	2	2	0	0	0	26	5	1	1	0
Registered Mental Health Nurses	150	28	37	19	12	9	4	19	196	3	2	6
Registered General Nurses	70	19	28	5	0	3	1	550	236	9	2	
Psychologist	2	0	0	1	0	0	0	0	0	0	3	0
Clinical Social Workers	3	0	1	1	0	0	0	0	0	1	2	2
Occupational Therapists	5	1	0	2	2	1	0	0	3	2	0	0
Rehabilitation Technicians	16	1	2	1	0	4	0	12	17	5	3	0
Community Health Nurses	-	0	0	2	0	0	0	21	11	0	0	0
Environmental Health Tech	-	0	1	0	0	2	0	7	65	2	1	1
Village Health Workers	-	-	1214	0	0	0	0	408	1182	0	N/A	N/A
PITCT Staff	-	6	4	0	0	0	0	33	216	0	4	0
Ancillary Staff eg Security	410	9	167	2	4	0	0	264	399	0	2	0
Other Staff	68	7	0	4	0	0	2	86	203	4	0	1

Table 2: Patient numbers attended to in Mental Health Units 2018

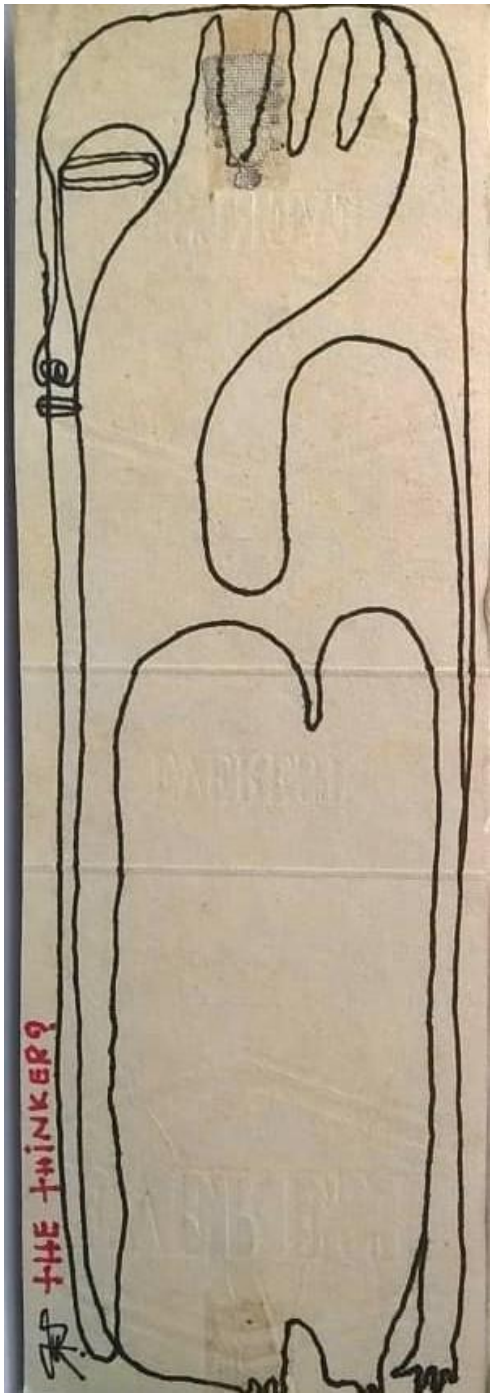
	JANUARY		FEBRUARY		MARCH		APRIL		MAY		JUNE		JULY		AUGUST		SEPTEMBER		OCTOBER	
Tertiary institutions	Adm	Opd	Adm	Opd	Adm	Opd	Adm	Opd	Adm	Opd	Adm	Opd	Adm	Opd	Adm	Opd	Adm	Opd	Adm	Opd
Ingutsheni	139	1503	103	1437	128	1224	110	1539	105	1738	108	1456	104	1351	140	1731	116	1332	103	1284
Harare	73	818	52	786	32	685	53	685	77	845	74	802	73	825	81	925	75	824	85	1016
Parirenyatwa	77	943	67	787	57	57	59	670	80	672	72	738	54	674	67	745	69	722	51	828
Ngomahuru	47	132	41	90	40	200	43	301	34	148	38	161	32	117	52	121	45	141	35	80
Provinces																				
Chinhoyi	26	85	15	57	24	73	23	54	24	99	22	107	34	225	56	284	20	93	15	201
Mat North	29	1026	26	947	49	882	28	835	26	804	31	665	34	435	24	1013	24	370	39	1063
Mash East	14	236	9	215	20	199	6	217	11	191	15	226	14	203	14	255	8	231	5	295
Mat South	248	2534	354	2453	269	3229	288	2987	320	2763	299	2993	309	2342	317	3475	348	2672	262	3191
Manicaland	0	415	0	685	0	550	0	500	0	468	0	543	0	600	0	625	0	588	0	685
Midlands	32	200	31	196	29	219	21	221	27	230	32	237	42	261	37	271	41	161	41	268
Special Instutitions																				
Chikurubi	4	0	3	0	2	0	4	0	0	0	3	0	2	0	2	0	3	0	0	0
Mlondolozi	13	0	13	0	40	0	09	0	08	0	19	0	17	0	08	0	09	0	26	0

Table 3: Drug Stocks (as of November 2018)

	TERTIARY INSTITUTIONS				PROVINCES					SPECIAL INSTUTIONS	
	Ingutsheni	Harare	Ngomahuru	Parirenyatwa	Manicaland (Mutare)	Midlands (Gweru)	Mat South	Mat North	Mash East (Marondera)	Chikurubi	Mlondolozi
Benzhexol 5mg	√	√	√	√	√	√	√		√	√	√
Biperdine 2mg	O/S	O/S	O/S	O/S	O/S	O/S	O/S		O/S	N/A	√
Chlorpromazine 200mg	√	√	√	√	√	√	√		√	√	√
Carbamazepine 200mg	√	O/S	√	√	√	√	√		O/S	√	√
Diazepam 5mg	√	√	√	√	O/S	√	O/S		√	√	O/S
Fluoxetine 20mg	√	O/S	O/S	O/S	√	√	√		√	O/S	O/S
Haloperidol 5mg Tablets	√	√	√	√	O/S	O/S	√		√	√	√
Lithium Carbonate 400mg	O/S	O/S	√	O/S	O/S	O/S	O/S		O/S	N/A	O/S
Methylphenidate (Ritalin) 10mg	O/S	N/A	O/S	O/S	O/S	O/S	O/S		O/S	N/A	O/S
Phenytoin 100mg	O/S	O/S	O/S	√	O/S	√	O/S		O/S	N/A	√
Phenobarbitone 30 mg	√	O/S	√	√	√	√	O/S		O/S	√	√
Risperidone	O/S	O/S	O/S	O/S	O/S	O/S	O/S		O/S	√	√
Sodium valproate 200mg	√	√	√	√	√	√	√		√	√	√
Sulpiride 200mg	√	O/S	√	O/S	√	√	√		√	√	√
Thiamine 100mg	O/S	N/A	O/S	O/S	O/S	O/S	O/S		o/s	N/A	O/S
Trifluoperazine 5mg	√	O/S	√	√	√	√	O/S		√	√	√

The Thinker…..Thinking too much about life's challenges

By Ishe



3. Calendar and estimated costing for 2019

MONTH	ACTIVITY	BUDGET
JANUARY	Preparation for Substance Abuse Stakeholders Meeting (To be held 01/02/19) Research Taskforce 1st Meeting- 24/01/19	$6 000 $200
FEBRUARY	Treatment of Alcohol and substance Use Disorders Stakeholders Meeting- 01/02/19	
	Mental Health Review Tribunal Sitting- Date TBA	$1 460
	Special Boards Sitting Chikurubi and Mlondolozi- Date TBA	$1 460
	Alcohol and Substance Use Treatment Taskforce 1st meeting- 08/02/19	$200
	Alcohol and Substance Use Treatment Taskforce 2nd meeting- 22/02/19	$200
MARCH	I.E.C. material production (posters 2000, Brochures 4000, Banners X 2) on Childhood Disorders including Autism.	$1 200
	I.E.C. material production (posters 2000, Brochures 4000, Banners X 2) on Alcohol Use Disorders and Safe Drinking	$1 200
	Preparations for the World Autism Awareness Day	$15000
	Alcohol and Substance Use Treatment Taskforce 3rd meeting- 08/03/19	$200
	Development of SOPs and Quality of Care (QOC) Guidelines 1st Meeting with key experts- 11/03/19	$700
	Launch of Strategic Plan for Mental Health Services 2019-2023 (Date TBA)	$6000
APRIL	World Autism Awareness Day (including childhood disorders) commemorations- 05/04/19	
	Fundraising Dinner for Child Mental Health Services 06/04/19	$10000
	Development of Quality of Care Guidelines 2nd Meeting with key experts + finalization of guidelines 12/04/19	$700
	Alcohol and Substance Use Treatment Taskforce 4th meeting + finalization of policy statement and guidelines on Treatment and Rehabilitation of Substance Use- 19/04/19	$200
MAY	Mental Health Review Tribunal Sitting	$1 460
	Special Boards Sitting (Chikurubi and Mlondolozi)	$1 460
	Development of I.E.C. material on Cannabis and Cough Syrup Abuse (Posters, Brochures, Banners)	$1 200
	mhGAP Training for Midlands Province (+ SOP and QOC Training and Support visit for Gweru Provincial Unit) 06/05/19-10/05/19	$22 460 + $3895
JUNE	Fundraising function for treatment and rehabilitation of substance use services 27/06/19	$10 000
	World No Tobacco Day and International Day Against Drug Abuse Commemorations (combined)- 28/06/19	$15 000
JULY	Mental Health Review Tribunal Sitting TBA	$1 460

	Special Boards Sitting (Chikurubi and Mlondolozi) TBA	$1460
	mhGAP Training for Mashonaland West Province(+ SOP and QOC Training and Support visit for Chinhoyi Hospital Psychiatric Unit) 10/06/19- 14/06/19	$22 460 + $3895
AUGUST	I.E.C. Material Development Suicide Prevention (Posters, Banners, Brochures)	$1 200
	I.E.C. material production on Prescription Drug Abuse	$1200
	Preparations for World Suicide Prevention Day	$15 000
SEPTEMBER	World Suicide Prevention Day Commemorations 10/09/19	
	Preparations for the World Mental Health Day	$15 000
	mhGAP training Mashonaland East (+SOP &QOC Training for Marondera and Mutoko Psychiatric Units) 26/09/19	$3 866
OCTOBER	World Mental Health Day Commemoration- 10/10/19	
	QOC training Parirenyatwa, HPU and Chikurubi + support visits	$4000
	I.E.C. material production on Crystal Meth abuse	$1200
NOVEMBER	Mental Health Review Tribunal Sitting	$ 1 460
	Special Boards Sitting (Chikurubi and Mlondolozi)	$ 1 460
	mhGAP Training for Masvingo Province (+ SOP& QOC Training for Ngomahuru support visit) 11/11/19- 15/11/19	$22 460 + 3895
DECEMBER	mhGAP training Matabeleland North, Matabeleland South (+ SOP and QOC Training and Support visit for Ingutsheni and Mlondolozi Psychiatric Units) 09/12/19- 13/12/19	$22 460 + $4134
	Total Year Budget	**$226 805**

By Lynda

Recovery…..Restoration…..Resilience….

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