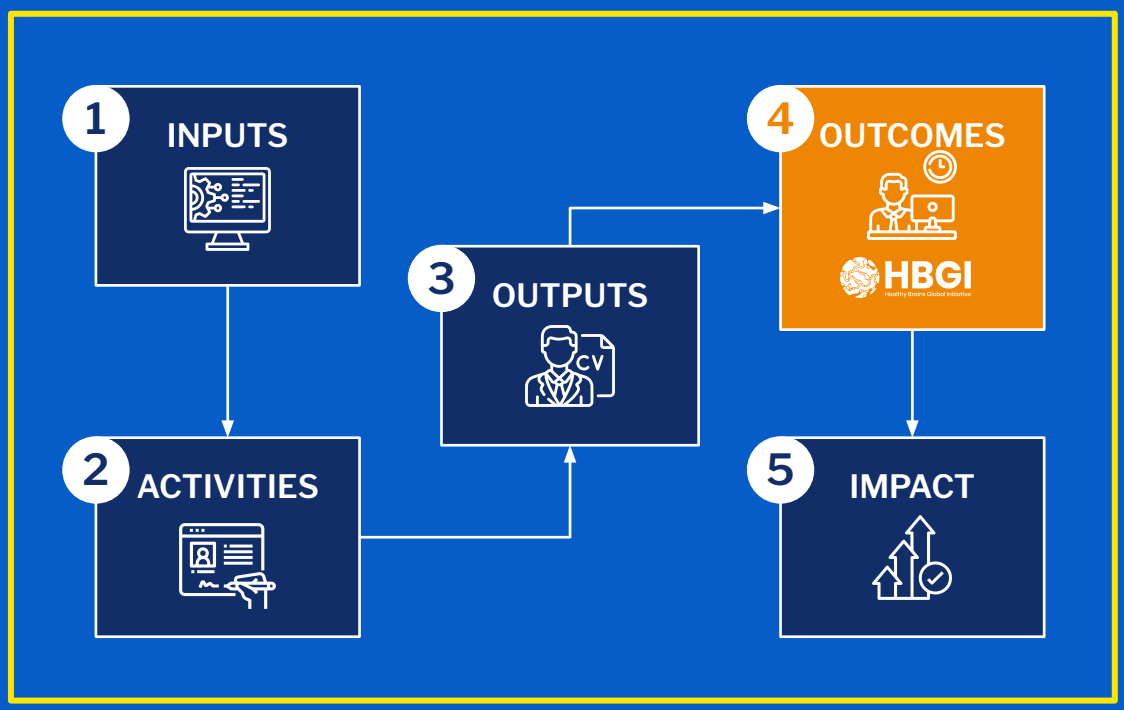
HBGI
Healthy Brains Global Initiative

Paying for Outcomes on Mental Health Programs

A Summary of the Responses to HBGI's Call for Expressions of Interest



March 2023

Purpose of this Report

This report summarizes the responses received to the Healthy Brains Global Initiative's (HBGI) Call for Expressions of Interest (EoIs), launched in summer 2022. The report showcases each of the submitted programs, whilst highlighting in more detail some of the more compelling examples, demonstrating how each program could be contracted by linking payments to clear, measurable, and verifiable deliverables with individual level impact. Each program summary was produced in collaboration with the submitting organizations.

The report supports HBGI's dialogue with funders and donors as we develop our Outcomes Funds, from which we will contract and manage programs addressing the causes and consequences of poor mental health. By showcasing these programs and their possible outcomes, the report offers real examples for funders and donors to consider, whether they are contributing as part of a pooled Outcomes Fund or as a single donor, supporting a specific contract addressing a specific area of interest.

We hope this report stimulates and drives the conversation on effective contracting and innovative financing in mental health, so that greater impact can be delivered for individuals.

Whether you are a funder, donor, service provider, government, research institution, or other, we hope this report is of interest. We welcome your feedback and comments. If you are interested in learning more about HBGI's approach, outcomes funding, or one of the showcased programs, please get in touch using the contact details provided at the end of the report.

Welcome to the Report

When we started talking to potential donors and strategic partners about the HBGI Outcomes Funds, they asked us: what sort of programs are you going to be contracting? What sort of outcomes are you likely to be paying for? Is there really the interest and capacity out there to deliver and be paid for outcomes like this?

So, we ran the exercise that has culminated in this report. We reached out to the global market of providers of services tackling poor mental health and its causes and consequences.

I am so excited when I look at this report and see the impact that is already being delivered and that we have the potential to grow. There is such depth of commitment, as well as experience and expertise. There is a breadth here of organizations, from small, local NGOs to large internationals, public, private and nonprofits. We can truly reach into at-risk communities across the world.

I also hear loudly the vital voice of lived experience. Services cannot be designed in isolation in Washington or Geneva and then imposed on people in distant lands. Services need to start by listening to the needs of every single individual in their own personal context.

It has taken over six months to communicate with the market, to gather the responses, and to discuss with each of them how their program fits in an outcomes-funded model. My colleague, Shomsia Ali, has engaged personally with each organization and given a huge amount to get us to this point. I thank her and all these remarkable providers for their time and their vision.

I hope you find the report as interesting and inspiring as I do. I believe it provides a unique perspective on global programs targeting mental health.

Richard Johnson
Chief Executive Officer, HBGI

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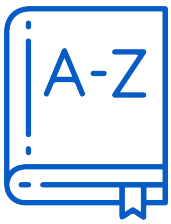
Glossary

CBT	Cognitive behavioral therapy
CHW	Community healthcare workers
CMD	Common mental disorders
DBT	Dialectical behavior therapy
EoI	Expression of Interest
HCW	Healthcare worker
iNGO	International non-governmental organization
LMIC	Low- and middle-income countries
MNS	Mental, neurological and substance
NCDs	Non-communicable diseases
NGO	Non-governmental organization
NIHR	National Institute for Health and Care Research
NIMH	National Institute for Mental Health
OECD	The Organization for Economic Cooperation and Development
PTSD	Post-traumatic stress disorder
PHQ	Patient Health Questionnaire
S/CMD	Severe/common mental disorders
UNDP	United Nations Development Program
WHO	World Health Organization



Executive Summary

Who We Are

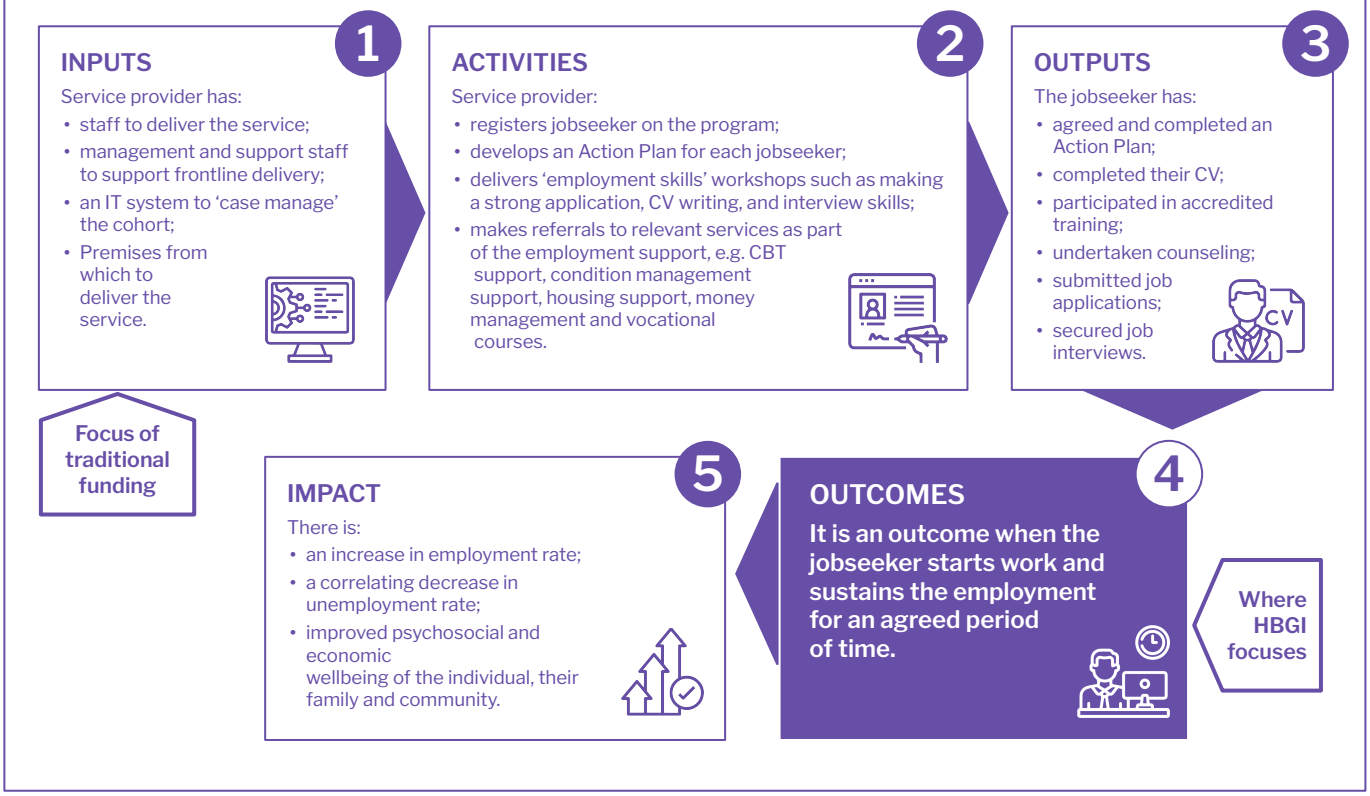
The Healthy Brains Global Initiative (HBGI) was established with the support of the WHO, UNICEF, and the World Bank. We are a nonprofit organization, registered in the United States but operating with a global team. We are using innovative contracting to create a sea change in the scale and impact of mental health services and programs - either contracting and funding directly ourselves or as technical partners with governments. In all cases, we focus on results and the impact at the individual level, paying for outcomes rather than inefficient processes and inputs.

Funding of Mental Health Programs: From Grants to Outcomes-Based Contracting

Programs which address the causes and consequences of poor mental health continue to be overwhelmingly funded using traditional contracting models, namely grants or fee-for-service arrangements. Funders and donors closely track their grants and expenditure, with expenditure being tied to 'inputs' and success being mostly defined by whether the allocated funds were utilized and accounted for, regardless of whether the program delivered the desired results.

There is, however, a slow tide of change in public service outsourcing: interest in linking payments to program 'outcomes' is growing. HBGI wishes to accelerate this approach in the contracting of mental health services by introducing a new wave of programs using an 'outcomes-based' contracting model, paying for the outcomes (results) rather than the inputs to drive increased impact.

Where outcomes sit in service delivery (example of an employment-support program)



Outcomes on Mental Health Programs: A Focus on Functional Outcomes

It is now well established that poor mental health is closely associated with a number of adverse real world outcomes. These include things like impaired occupational achievement, educational underperformance, comorbid physical illness, and even the trajectory of infant development based on maternal mental illness. To address this, HBGI wants programs to focus on, and be paid for, achieving outcomes that make a real difference to the individual - outcomes which truly change a person's life and life chances. We call these outcomes ***'functional outcomes'***.

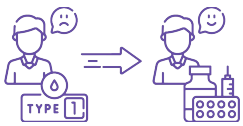
Example of functional outcomes

Newborn achieving developmental milestones

Returning to school and improving educational attainment

Securing a job

Reduction in alcohol use



Better management of a physical health condition

Can Programs Which Address Poor Mental Health be Contracted on Outcomes?

In short, yes. This is what this report demonstrates.

The Call and its Purpose

In 2022, HBGI launched a Call for Expressions of Interest (EoIs) in order to curate a list of possible fundable programs to support our engagement with funders and donors as we develop our Outcomes Funds.

We were interested in collating compelling examples of the types of programs that *could be* contracted and paid for on the basis of outcomes. We want to show that such programs exist, how outcomes can be defined and delivered, and that there is an appetite in the 'service provider market' to use this model to unlock a new scale of impact in programs which address poor mental health, whilst simultaneously using this Call to engage with the market, understanding its experience and knowledge of outcomes-based contracting.

The Response to the Call

Submissions received from

organizations and partnerships

Proposing

programs

To be delivered in over

countries

The response to the Call supports and confirms the premise under which the Call was issued, namely that:

1. *there is an active and engaged service provider market interested in outcomes-based contracting.*
2. *outcomes-based contracting, including linking payments to functional outcomes, can be applied effectively to programs targeting poor mental health.*

The potential for this market to grow is significant. HBGI's Call for EoIs, with its limited timescales and distribution channels, only scratched the surface of a much wider pool.

The Proposals - An Overview

Proposals were received from a ***wide range of providers***, including: local and international NGOs (including for and nonprofits); research and academic institutions, and; existing health service providers such as hospitals.

The potential ***beneficiary groups*** of the programs are diverse and include (not necessarily mutually exclusive): young people; frontline practitioners (including health and non-health professionals); workers and employers; expectant and new mothers; people with comorbid physical and mental health conditions; people with substance dependency, and; geographically-based communities, such as those in isolated rural areas.

The ***types of programs*** proposed include: integrating mental health identification and treatment with existing healthcare screening, such as those for maternal care; school-based support, including counseling; livelihood programs; programs integrating sport and physical activity with mental health support, and; interventions focusing on tech-based solutions. A number of the programs address trauma. Programs are a mixture of existing programs already being delivered, which could be replicated and scaled, and new ideas to pilot.

All *could* be paid on outcomes, with a focus on functional outcomes. The ***possible functional outcomes*** that could be delivered across the proposed programs broadly fall into the following themes: livelihood outcomes (e.g., securing employment); in-work outcomes (e.g., improved employee retention); learning outcomes (e.g., staying in and completing formal learning); improved maternal and child health outcomes (e.g., child weight gain); improved comorbidity and physical health outcomes (e.g., adherence to treatment plan); system strengthening outcomes (e.g., improving frontline staff capacity), and; violence reduction (e.g., reduction in reported crimes).

Whilst the full report summarizes all of the proposed programs individually, illustrating how they could be paid on outcomes (co-developed with each individual organization) the table on the following pages provides an overview of 11 of the most compelling submissions. These programs are strongly structured, with an identified need being met for a well-defined target population, and clear, measurable and verifiable outcomes already defined or easy to define. These are programs which are relatively, or could become quite quickly, 'outcomes-based contract-ready'.

The Eleven Highlighted Programs Summarized

Organization and proposed geography of delivery	Proposed program overview	Possible outcomes (Please note: we list here only the main functional outcomes to which payments could be linked. The full report details the other outcomes - and outputs - for each program)
British Asian Trust *Bangladesh, India, and Pakistan*	Mental health and livelihood support for women in peri-urban and urban areas	Outcome payments could be linked to: · each woman who secures employment; · each woman who retains employment for at least six months; · increase in a woman's monthly earnings by target amount/percentage increase (this could focus on those women who are already in work, as well as those who secure employment for the first time); · improvement in socio-emotional wellbeing measured using a standardized assessment.
CorStone *Kenya*	Strengthening young people's emotional and social wellbeing in government schools	Payments could be linked to: · each self-reported improvement in mental health and wellbeing (e.g., anxiety and depression) of young people, using approved pre- and post-training questionnaire; · functional outcomes, including improved attendance at school, exam scores, and grade improvements (specifics to be determined, e.g., against baseline).
Finemind *Uganda*	Training of CHWs to provide mental health support to young mothers in rural community	Payments could be linked to: · improved wellbeing – each young mother who recovers from depression (PHQ score of ≤ 5 for two consecutive sessions); · each functional outcome achieved, related to the young mother (for example, increase in job satisfaction and productivity, increase in household income, or reduction in intimate partner violence).
Harvard University-led consortium *India*	Using a digital platform to train and supervise CHWs in the delivery of a rehabilitation program for people with schizophrenia	The objective is to support psychosocial rehabilitation and promote recovery for patients with schizophrenia, therefore the primary outcome of interest is disability and functioning. Payments, at the individual level, could be linked to: · each patient who records improvement in their IDEAS score at the end of the 12-month program; · each person who identifies and then secures their 'functional' outcome, for example, return to employment, return to education, or commencing voluntary work; · each person who identifies and then achieves improvement in physical health, for example: improved BMI score, improved cardiorespiratory fitness, sustained management of blood pressure, and improved serum glucose and serum lipids.
Innovators In Health *India*	Integrating mental health screening and support with a TB identification and treatment program	Payments could be linked to the following: · each individual who records an improvement in their mental health via approved pre- and post-treatment questionnaire; · an increase in treatment commencement for people diagnosed with TB (against a baseline); · an increase in TB treatment adherence and completion (against a baseline).
Social Finance *Open – possibly Ukraine*	Mental health and integrated employment support	Payments could be linked to the following: · each individual engaged (enrolled) on the program; · each individual securing paid employment; · each individual sustaining work (e.g., for at least 13 weeks, or other period that demonstrates sustainment).

Stronger Brains *Open*	Screening the brain health of students for early intervention and prevention	Payments could be linked to a combination of outcomes, related to brain health and functional outcomes, including: · key indicators of healthy brain function, such as improved brain processing speed, focus and attention, working memory, social cognition, and executive control, measured by a simple online computerized assessment and monitored over time against normative data. This can be recorded at an individual child level; · each child who records a functional outcome, including improved school attendance, school completion, and school success (for example improved academic achievement); · job success (if program focused on older children and as a possible long-term outcome).
The Health Research Unit Zimbabwe *Zimbabwe*	Occupational and mental health screening and support for health workers and educators	Payments could be linked to the following: · each health worker/educator screening positive or diagnosed with a disease, including a mental health condition; · of those screening positive, each health worker/educator referred for further investigation and treatment; · each health worker/educator whose condition is appropriately managed (measured at agreed interval e.g., six and 12 months later); · improved workplace satisfaction (against a baseline); · reduction in workplace absenteeism rates (workplace records) – with percentage decrease; · decrease in staff attrition rates (against baseline).
Triggerise *Kenya*	Using a digital platform to provide mental health and HIV support to young people	The outcomes of young people having improved and sustained sexual and mental health leading to improved sexual health and decreased HIV risk behaviors, and young people having improved agency and quality of care in their options of mental health and HIV service providers could be tied to a number of possible HIV and mental health metrics, to which payments could be attached, including: · each individual accessing HIV testing services; · each HIV positive youth who takes up treatment services and returns every quarter; · each PrEP client adhering to treatment; · each PrEP client returning for HIV tests every three months during reporting period; · each new community-based trained mental health service provider added to Tiko; · each individual taking up additional mental health services.
Village Enterprise *Uganda*	Poverty alleviation and mental health support in rural community	The primary outcomes to which payments could be linked include: · each new microbusiness launched six months into the program cycle; · each new microbusiness sustained/still in business one year later. Payments could also be linked to household level economic outcomes such as increased income, assets, and savings amongst participant households, at least one year after program launch, compared to a control group.
Waves for Change *South Africa*	Physical therapy and teamwork for young people exposed to a high-level of trauma	Payments could be linked to the following: · each child who completes (10-month) Surf Therapy program; · each peer mentor sustained as mentor six and 12 months post training; · each child in Surf Therapy program who records improved self regulation and social connectedness after 10 months in the service (method for recording this to be explored ahead of contract but could include Inclusion of Other scale); · each improved heart rate variability post program recorded (against baseline at the start of program).

The Way Forward

We will disseminate this report as widely as possible, to raise awareness of the global growing mental health challenge and how mental health is a cross-cutting theme. We are also promoting the benefits of outcomes-based contracting in challenging waste in public service funding.

This report will be circulated through a range of channels including: our dedicated launch event; digital platforms including our website, social media channels, and direct mail to our existing and growing contact database; our Lived Experience Council and Board, and their extensive networks; other partners and supporters such as the Wellcome Trust and WHO AFRO and; mental health advocacy networks. We aim to reach a wide audience including: the service provider market, donors, researchers, global institutions, governments, policy makers and influencers.

Demonstrating our commitment to investing in and building the capacity of the service provider market, we will be running a ***series of free, virtual capacity building events***, open to all. The sessions will cover topics such as: understanding outcomes and outcomes contracting; building effective performance management systems; operational design considerations for an outcomes-contracted program, and; understanding working capital, including Impact Bonds.

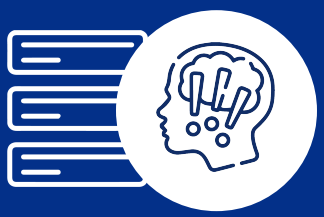
HBGI, and the providers we feature, are determined to positively impact as many individual lives as possible. We know funders and donors are too – our engagement with them so far informs us of this. We very much look forward to continuing this dialogue, building on the promising conversations already started. As we develop our Outcomes Funds, we look forward to collaborating with all – providers, donors and funders, governments, researchers and, of course, service users – in ensuring funding in this area delivers the maximum real world impact on the lives of those we are all here to support.

Introduction to HBGI and Outcomes

Healthy Brains Global Initiative: Who We Are

HBGI was established in collaboration with the World Bank and with the support of the WHO and UNICEF. Our early funding was largely from the Wellcome Trust, Johnson & Johnson, and Otsuka. ***We were set up to address the global lack of prioritization and funding for mental health*** - the biggest unmet health and social challenge, impacting more than one billion people globally, creating an economic burden of more than US$3 trillion.

HBGI addresses this critical issue through introducing a new wave of programs targeting poor mental and brain health and its causes and consequences. ***We use an 'outcomes-based' contracting model, i.e. paying for the outcomes rather than the inputs, to drive the impact of these programs,*** to minimize waste, increase accountability, and encourage innovation and localization.



HBGI uses outcomes-based funding to contract a range of programs targeting the causes and consequences of poor mental and brain health.

Mental health is cross-cutting and touches us all throughout our lives. HBGI-contracted programs might include services delivered in mainstream health provision, but they might also focus on wider livelihood issues such as poverty, child pregnancy, newborn mortality, alcohol and substance use, or unemployment. The service providers might be NGOs (for or nonprofits), local or international, or governments.

With the oversight of a Board of Directors and an experienced management team, and with guidance from a Lived Experience Council, we operate in three ways:

1. pooling the funds of donors into Regional or Thematic Outcomes Funds (e.g., a Fund for Africa or a Fund for Technology), which HBGI manages and uses to contract new programs, identified in partnership with stakeholders, with HBGI as the 'outcomes funder'.
2. working with individual donors who have an interest in particular populations or challenges; to contract and oversee specific programs for these donors.
3. supporting fund holders, such as governments, to design and mobilize contracted programs, building and operating performance management systems to drive the outcomes and impact of these programs.

More information on how we work can be found here.

WHAT THE PROVIDERS SAY

> *Working with HBGI has been exciting as it has introduced us to new ways that we could put our existing commitments to outcomes and data to work. During the process, we've had multiple conversations with HBGI and partners regarding how to refine proposed outcomes for outcomes-based payment structures. These conversations have been inspiring and illuminating, allowing us to think through together how mental health and related outcomes can best be adapted for outcomes-based payment.*

Kate Leventhal
Chief Program Officer, Corstone

What Do We Mean by 'Outcomes'?

Most social development programs are funded through grants. These are usually paid to reimburse agreed-upon budgets. On occasion, they are tied to 'inputs'. On an educational-focused program, this might mean inputs such as teachers being hired or maybe the number of classroom hours delivered. Most donors closely track this expenditure and success is ultimately measured in terms of whether the allocated funds are utilized/spent (sometimes called 'absorption' or 'disbursement').

Over the last 30 years there has been growing interest in linking payments not to pre-agreed budgets and tightly prescribed (and inflexible) service specifications, but to the ***outcomes*** instead.

This has been most widely applied in the commissioning of employment support services, with two key outcomes: unemployed people securing and entering employment, and; sustainment of that employment for a period of time. Elements of outcomes-based contracting (also known as payment-by-results and, in a development context, results-based financing) have also been used in other OECD public services outsourcing, notably in the commissioning of rehabilitation services for people leaving prisons.

In practice, outcomes-based contracting may not be purely outcomes-based. Program dependent, some contracts may have a mixture of payments. Whilst the bulk of program funding is attached to achieving defined and agreed outcomes, some of the payment could also be linked to outputs or 'intermediary outcomes'. A factor driving this decision is the need to ensure adequate cash-flow for the service provider whilst the outcomes, which are a little further down the line, are achieved. For example, on an employment program, whilst 80% of the funding may be attached to achieving an employment outcome for the individual, and the individual then staying in the job for at least six months, 20% may be attached to the output of 'registering or enrolling' an individual on the program.

The results chain on the next page illustrates where 'outcomes' are placed, using the example of an employment support program.

EXAMPLE

The Results Chain for an Employment Support Program

Examples of inputs, activities, outputs, outcomes, and impact

1

INPUTS

Service provider has:

- staff to deliver the service;
- management and support staff to support frontline delivery;
- an IT system to 'case manage' the cohort;
- premises from which to deliver the service.

2

ACTIVITIES

Service provider:

- registers jobseeker on the program;
- develops an Action Plan for each jobseeker;
- delivers 'employment skills' workshops on topics such as making a strong application, CV writing, and interview skills;
- makes referrals to relevant services as part of the employment support, e.g. CBT support, condition management support, housing support, money management, and vocational courses.

3

OUTPUTS

The jobseeker has:

- agreed and completed an Action Plan;
- completed their CV;
- participated in accredited training;
- undertaken counseling;
- submitted job applications;
- secured job interviews.

4

OUTCOMES

It is an outcome when the jobseeker starts work and sustains the employment for an agreed period of time.

5

IMPACT

There is:

- an increase in employment rate;
- a correlating decrease in unemployment rate;
- improved psychosocial and economic wellbeing of the individual, family, and community.

What are 'Functional Outcomes' and Why do they Matter on Mental Health Programs?

HBGI is interested in 'functional outcomes'. These are the things that truly change someone's life chances, such as: a newborn achieving developmental milestones; a return to school and improved educational attainment; a reduction in alcohol use; better management of a physical health condition, or; someone securing a job.

Tying payments to the achievement of functional outcomes on mental health programs is becoming increasingly important given that it is now well established that poor mental health is closely associated with a number of adverse real world outcomes. These include things like impaired occupational achievement, educational underperformance, comorbid physical illness, and even the trajectory of infant development based on maternal mental illness. Furthermore, assessment of the quality of mental healthcare has traditionally defaulted to more easily measured process and structure metrics (i.e. 'inputs'), which are removed from true patient outcomes. While they are easier to measure, improvement in these metrics does not always translate into improvement in patient-centric outcomes (i.e. functional outcomes). If mental health services are to address the adverse real world outcomes associated with poor mental health, they must focus on achieving tangible outcomes for the individual. If HBGI contracts the delivery of training, for example, we want to see and pay for the result of that training, such as health workers then identifying mental health issues and providing quality care or referring efficiently to specialists.

EXAMPLES OF FUNCTIONAL OUTCOMES

Newborn achieving developmental milestones

Returning to school and improving educational attainment

Securing a job

Reduction in alcohol use

Better management of a physical health condition

Outcomes-Based Contracting – Why it Matters

Outcomes-based contracting has the advantage of focusing on the desired result (the outcomes) and tying payments to this. This delivers greater impact for each dollar spent, and more importantly, delivers greater impact on the life of the individual service user. A good outcomes contract which is well-designed, priced appropriately and proactively performance managed has a number of advantages over the traditional input-based/fee-for-service contracting, including:

- Enabling ***a ground-up, localized approach*** that is culturally relevant, because it ***focuses on each individual*** and their outcome instead of imposing a top-down, prescribed process led by the commissioner. The program is able to flex around the individual's needs as the commissioner has focused on paying for outcomes rather than defining the service.

- Increasing the ***quantity and quality*** of performance as payment is directly linked to results. A well-designed outcomes contract not only attaches payments to outcomes, it also ensures the service provider has to deliver a minimum level of service, non-adherence to which can be financially penalized. This is particularly important in ensuring all service users, regardless of the outcome, receive a good quality service.

- Delivering greater ***value for money*** as spend is focused on and tied to results and impact, rather than process.

- Addressing donor fatigue – as funding is directly linked to ***evidenced results,*** shifting away from funding yet another service which fails to deliver the desired impact.

- Increasing ***accountability*** to service users, as well as to funders.
- Increasing ***transparency*** over where the money goes (i.e. excludes 'leakage' like corruption or bureaucratic waste).

- Enabling ***flexibility*** and incentivizing ***innovation*** (in response to service user need, but also in response to changing context, for example pandemic or conflict).

- Tracking, recording, and reporting on activity at every stage of the program, providing ***a rich data source*** in support of 'implementation research' - capturing what is working for wider dissemination and learning.

Funders and donors want to realize these benefits but unfortunately are precluded by their existing, rigid procurement processes. HBGI's Outcomes Funds and our approach to working with individual donors (in which we contract and performance manage contracts for them) enables donors to pay for performance without their usual internal constraints. At the same time, HBGI supports them to build their institutional capacity in outcomes contracting and management.

More information about outcomes funding, particularly in fragile contexts, can be found in Appendix A.

Ten Questions that a Good Outcomes Contract Addresses

1. **What does success look like?**
   The overall objective has been clearly and simply defined and agreed with all key stakeholders.
2. **Who is being targeted?**
   There is a clear, well-defined target population/cohort group.
3. **What is purchased?**
   The funding is tied to a few highly relevant and easy-to-understand deliverables along the results chain - ideally as close to the outcomes as possible.
4. **What are the 'minimum standards'?**
   There is a clear definition of the minimum **quality** criteria that the deliverables must meet.
5. **At what price?**
   The price that is agreed upon enables and/or incentivizes high performance and takes into account actual operating costs. Cheapest is not best if it doesn't deliver results.
6. **How is delivery confirmed/what triggers payment?**
   The payment decisions are based on trusted and independent verification of delivery and results.
7. **How much is paid when?**
   The payments to the service providers are structured to ensure cashflow in the system (or working capital is brought in, e.g., from social/impact investors lending upfront capital).
8. **What kind of performance management ensures success?**
   The incentive to deliver high performance increases when payment is attached to outcomes. In addition, there is tracking, reporting, and monthly review/challenge to drive the quantity and quality of this. There is transparency and regular publication of results.
9. **What assurance model oversees this?**
   There are layers of assurance, undertaken by the service provider, by the funder, and possibly by a third-party independent monitor.
10. **What are the consequences of under-delivery?**
    The contract clearly defines any payment adjustments, penalties, or 'step-in-rights', as well as other contractual obligations regarding safeguarding, equity, and environment.

Overview of the Call for Expressions of Interest

WHAT THE PROVIDERS SAY

HBGI not only introduced us to outcomes-based contracting approach, but worked in cooperation and collaboration to help us think along those lines.

This method of designing and delivering mental health services will not only be effective but also efficient and client-centered. It will help us to track the changes in a systematic way to showcase the efficacy of our program and break the myth that persons with mental illness are a lifelong burden to society. The outcomes-based approach creates a pathway for generating hope for all stakeholders.

Sarbani Das Roy
Secretary, Iswar Sankalpa

The Purpose of the Call

HBGI launched a Call for Expressions of Interest (EoIs) in order to curate a list of possible fundable programs to support our engagement with funders and donors as we develop our Outcomes Funds.

We were interested in collating compelling examples of programs that *could be* contracted and paid for on the basis of outcomes – that will deliver tangible, real world impact on vulnerable people's lives. We hoped to generate a diverse set of possible programs to showcase to funders and donors. Some, but not all of these programs, may have had previous experience of outcomes funding, but all are likely to be amenable to being paid on outcomes.

We wanted to show that such programs exist, how outcomes can be defined and delivered, and that there is an appetite in the 'service provider market' to use this model to unlock a new scale of impact for programs which address poor mental health and its causes and consequences.

As well as supporting our engagement with donors and funders, we used the Call to engage with the service provider market – understanding what types of programs could be delivered, by whom, their experience of contracting (in particular outcomes-based contracts), their program readiness, and their strengths and assets in delivering services to a wide range of people, developing collaborative relationships along the way.

The Process

The Call was issued in July 2022 with a 'soft' closing date of early September 2022. Submitting organizations were asked to send a brief proposal of about four pages outlining: their proposed intervention; target group; the need/challenge they were addressing; clear, measurable, and verifiable outcomes that could be delivered, and; a high-level budget.

Keen to reach as wide an audience as possible, the Call was disseminated through a number of channels, which are detailed in the call-out box below.

July - August 2022
Call for EoIs launched

September 2022
'Soft' closing date

October - November 2022
EoIs evaluated

December - January 2023
Proposed programs summaries produced

FOR YOUR INFORMATION

Dissemination Channels

The Call was disseminated through:

- digital platforms, including HBGI's website and social media platforms, including LinkedIn;
- direct mail to HBGI's existing contact database;
- HBGI's Lived Experience Council and their extensive networks;
- HBGI's supporters and other stakeholders, including our Interim Board and the Wellcome Trust;
- mental health advocacy networks, such as the Global Mental Health Action Network;
- briefing events organized with partners, including Grand Challenges Canada and WHO AFRO.

Evaluation Criteria

Whilst we decided to ***showcase*** every one of the valid submissions received, the evaluation criteria (please see callout box below) assisted in determining which of these to ***highlight*** in more detail, including in our dialogue with potential funders and donors. That is, the most compelling programs, where impact is tangible, the program is of interest to funders, it addresses a clear need, adds value, and demonstrates life and/or system change.

In evaluating the proposals, HBGI also sought the views of representatives of our Lived Experience Council and Interim Board, in particular looking for the perspective of mental health professionals and people with lived experience, whilst keeping in mind that outcomes contracting is a new form of funding for the majority of the market.

The evaluation criteria, along with the purpose and that no funding nor contract was to be awarded, were clearly detailed in the Call. The full Call, including requirements of the submission, can be found in Appendix B.

FOR YOUR INFORMATION

The following scoring criteria was used to select a small subset of the EoIs to highlight in more detail.

Criteria	Score
This is a population/community/system that is currently not reached by such a program (i.e. we are obviously going to be adding value).	15
It is a concrete program in terms of the numbers to be reached, resources to be deployed, timeline, activities, and overall cost.	30
There are clear, measurable, verifiable outcomes that we will be able to cost (i.e. attach a unit price to).	20
There is an obvious link to mental health.	15
There is evidence of the proposed program/intervention working (e.g., performance data).	10
The organization is credible, with a track record, capacity, and stability.	10

A High-Level Summary of the Submissions:

Emerging Themes

Submissions received from

organizations and partnerships

Proposing

programs

To be delivered in over

countries

Key Takeaway Message

HBGI is delighted to have received a strong response to a Call which did not have funding attached to it.

The response supports and confirms the premise under which the Call was issued, namely that:

1. ***there is an active, engaged, and interested service provider market.*** There is an appetite among service providers to be paid on delivering clear, measurable, and verifiable outcomes. There is a demonstrable commitment to delivering the greatest possible impact on as many lives as possible.
2. ***outcomes-based contracting can be applied effectively to programs targeting poor mental health*** and its causes and consequences. In particular, payments could be linked to functional outcomes that deliver real impact on individual lives, such as a return to employment or improved treatment adherence.

The potential for this market to grow is significant. HBGI's Call for EoIs, with its limited timescale and distribution, only scratched the surface and we continue to receive new EoIs and interest several months after the closing date.

In this section we provide a high-level analysis of the emerging themes from the submissions in order to showcase the range of programs proposed.

Geography: Where Proposed Programs Could be Delivered

At the time of launching the Call, HBGI had identified four geographical regions as areas of focus. For this reason, the submissions focus on: Africa; South Asia; Eastern Europe (in particular Ukraine), and; the United States (focus on California). HBGI remains open to opportunities, and as such we welcome and also showcase proposed programs from other regions, including Latin America and the Caribbean.

The majority of responses (circa 65%) focus on African countries, and about 30% focus on South Asian countries. Whilst the majority of programs are clear on their target geography, a number of proposed programs, in particular the technology-focused interventions, are open to location, subject to local contextualization and adaptation.

This map shows the primary proposed country of delivery. A number of organizations are open to geography and/or can deliver across multiple locations, some of which are indicated below.

Africa

Ghana
- Pantang Hospital

Kenya
- Nzumari Africa
- UKOO
- Triggerise
- batyr
- CAPMHK
- CorStone

Lesotho
- Partners in Health

Liberia
- LiCORMH
- The Carter Centre
- Partners in Health

Malawi
- Save The Children
- Partners in Health

Mozambique
- PATH

Namibia
- Zvandiri

Rwanda
- YLabs
- Partners in Health

Sierra Leone
- Partners in Health

South Africa
- Waves for Change
- Centre for Community Impact
- Stellenbosch University
- Zvandiri

Uganda
- Finemind
- Village Enterprise
- African Centre for Suicide Prevention and Research (ACSPR)
- SEEK-GSP
- Makerere University School of Public Health

Zimbabwe
- THRU ZIM (The Health Research Unit Zimbabwe)
- SPANS

South Asia

Bangladesh
- British Asian Trust

India
- Sangath (and Harvard Medical School)
- Harvard-led consortium
- Banyan Academy of Leadership in Mental Health (BALM)
- British Asian Trust
- Innovators in Health
- CorStone
- Arogya World
- Iswar Sankalpa

Nepal
- Save The Children

Pakistan
- British Asian Trust
- Aga Khan Foundation

Philippines
- MLAC Institute

Eastern Europe

Ukraine
- Teenergizer
- Trauma Resource Institute

Americas

Brazil
- Brazilian Coalition on MH Innovations and Impact

USA (California)
- Harvard Medical School
- TrustCircle

Mexico
- Glasswing

Open
- Red Dot 365
- SELF Circles Inc
- Social Finance
- ICRC
- Stronger Brains
- Opa Mind

HBGI has done a great job in keeping up momentum and bringing the providers together into a community. It's a rare feat and I salute HBGI for it. We're all in this together. Mental health is a real challenge, something we can conquer only if we work together.

Nalini Saligram
Founder & CEO, Arogya World

Organizations: The Types of Organizations Responding to the Call

Through the Call, HBGI has engaged and continues to engage with a range of organizations across the mental health sector.

Submitting organizations represent a diverse market, including:

- local NGOs;
- international NGOs (iNGOs);
- for-profits and nonprofits (both small and large, and inclusive of NGOs);
- academic and research institutions, and;
- existing health service providers.

The majority of organizations fall in the NGO category. Whilst most of the organizations are established, with a strong track record in delivery, a small number are newly established.

Almost all of the proposals received are from individual entities. There are a small handful which are from partnerships/consortiums.

Submissions generally demonstrated good buy-in or close working with key local stakeholders including local government and other local service providers. This is of particular importance when contracting programs to ensure they are locally appropriate, part of the local ecosystem, and working within existing structures to ensure longer-term impact and sustainability.

Target Population: Who are the Potential Program Beneficiaries?

The proposed programs target a wide range of potential beneficiaries.

A number of the programs focus on **frontline workers,** specifically building their skillset and capacity so that they are able to identify and support people with poor mental health (whether through onward referral or initial psychosocial intervention). Frontline workers include healthcare workers, both in health facilities and working in the community. This includes non-mental health professionals such as doctors, nurses, midwives and pharmacists. The proposed programs also target non-health workers, building their capacity to provide similar support, including lay community workers/volunteers, educators, such as teachers and other school-based support staff, and those in law enforcement/criminal justice.

Other potential beneficiaries include **disease-specific cohorts;** for example, people with comorbid physical health needs, including non-communicable diseases (NCDs) such as diabetes and hypertension and communicable diseases such as TB and HIV. Programs focusing on these cohorts generally, though not exclusively, propose to integrate mental health screening and care within existing physical healthcare structures. **Expectant and/or new mothers** are also a focus of a number of the proposed programs, and similarly the proposals focus on integrating mental health screening and treatment, particularly for depression, within routine maternal healthcare.

Other prominent cohort groups include: **employees (and employers), those experiencing homelessness or substance dependency, and young people.** Nearly half of the programs (circa 45%) in some way focus on young people.

A number of programs also propose to work with **geographically-based communities,** including isolated and/or rural communities such as those in northern Uganda or the state of Bihar in India, or disadvantaged people in urban areas.

Whilst most of the programs focus on people with common mental health conditions such as depression and anxiety, a few target those with severe mental health conditions such as schizophrenia and bipolar.

In general, the **proposed programs target vulnerable communities** that are not being reached effectively by such interventions. The programs, if funded, would add value.

Proposed Programs: The Types of Interventions Proposed

There is a wide range of interventions proposed, linked to the causes and consequences of mental ill health. Types of interventions include:

- **school and education-focused programs;**
- **livelihood and poverty alleviation programs;**
- **workplace-focused programs, and;**
- **programs which strengthen healthcare systems, including building the capacity of organizations and frontline practitioners.**

Linked to the potential beneficiaries, programs focus on areas such as:

- **homelessness, substance dependency and violence;**
- **comorbidity of physical and mental poor health, and;**
- **trauma, particularly in young people.**

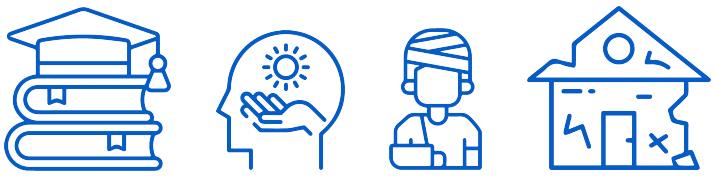
There are several proposals that seek to explore the potential **benefits of technology in addressing poor mental health,** for example, using technology to nudge positive behavior, train non-health specialists on basic mental health support, and record, track, and understand individual behavior patterns in order to manage general wellbeing.

A number of the programs propose similar interventions or approaches, for example:

- **school-based support** for young people, such as school-based counseling or resilience training for students;
- **integrating mental health support with other NCDs**, for example mental health and HIV, or mental health and NCDs in the workplace;
- **addressing perinatal depression** by integrating mental health screening and intervention with routine maternal healthcare.

There is a mixture of **proposed new and previously delivered programs.** Where programs are already in existence or have been previously delivered, the proposition is generally to scale (e.g., to increase the volume, the reach, and maybe the geographies) or to replace/continue existing funding.

Program readiness varied across the organizations. Whilst some programs were concrete, in terms of clear interventions linked to desired outcome, target beneficiary group, resources to be deployed, timeline, and overall cost, others will need more support in defining a clear and coherent program ahead of any potential contract award.



Outcomes: Providers' Experience with Outcomes Funding and Types of Functional Outcomes that Could be Delivered

The market is varied in terms of service providers' experience with outcomes contracting. A small number of these programs are already contracted on outcomes. Most, however (and therefore the organizations too), are new to this mode of contracting. This is expected, given that this is a new approach to funding in the mental health sector. Many of the providers demonstrate strong capacity and capability to deliver outcomes contracted programs effectively, regardless of previous experience. Others will need more initial and ongoing capacity building support from HBGI in framing their proposals and in mobilizing and delivering their programs.

In developing this report, HBGI supported the submitting organizations to identify possible outcomes, in particular functional outcomes, which could be delivered. In most cases, a combination of output and outcomes, to which payments could be linked, have been outlined in the summaries included in this report. It is worth noting that a program could deliver a number of (functional) outcomes (for example, an intervention focusing on mental health in schools could deliver improved school attendance and educational attainment for the children and improved workplace satisfaction for the teachers).

The possible functional outcomes that could be delivered across the proposed programs broadly fall into the following themes:

- **Livelihood outcomes:** a number of proposed programs seek to deliver job or income focused functional outcomes through improving mental health. Examples range from sustained employment for people with enduring mental health conditions in Ukraine to increased household income for villagers living below the global poverty line in Uganda, to employment outcomes for people with mental health experiencing homelessness in Ghana and India.

- **In-work outcomes:** a number of programs focusing on employers and/or existing workforces could deliver in-work functional outcomes. The types of outcomes include reduced absenteeism of employees and increased staff retention as a result of improved mental and physical health of employees in the workplace.

- **Learning outcomes:** these outcomes are proposed across a range of programs which focus on young people, targeting both in- and out-of-school children, with interventions focusing on improving wellbeing, building resilience, and developing trauma coping strategies. Examples of possible functional outcomes include: return to school or school attendance improvement; increase in educational attainment; completion of education, and; reduction in bullying in schools.

- **Improved maternal and child health outcomes:** poor maternal health can adversely impact child development. As such, proposals which focus on improving maternal mental health and wellbeing could be paid on the outcomes they achieve for the child, for example, improvement in infant weight gain or exclusive breastfeeding, and the mother, for example, improved wellbeing.

WHAT THE PROVIDERS SAY

Working with HBGI has supported us to refine our thinking around outcomes-based funding, and to better communicate our impact to new audiences. It has encouraged us to map out and share the mental health outcomes we have evidenced our programs achieve and to link these to wider societal issues.

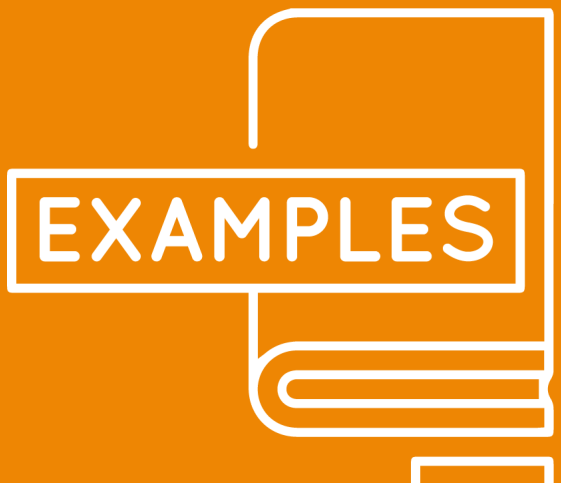
Paula Yarrow
Global Development Director, Waves for Change

- **Improved comorbidity/physical health outcomes:** programs which integrate mental and physical healthcare could deliver improved physical as well as mental health outcomes. For example, improved treatment adherence and health outcomes (such as viral suppression) for young people living with HIV in Kenya, or improved identification and treatment outcomes for rural population living with TB in India, or diagnosis and improved treatment outcomes (such as management of NCDs including diabetes and high blood pressure) for healthcare workers in Zimbabwe.

- **Violence reduction and/or reduction in incarceration of people with mental health:** a number of proposed programs seek to achieve these outcomes as a result of improved mental health and/or mental health awareness training. For example, a reduction of reported incidence of violence in Mexico as a result of trauma training for frontline professionals working with trauma victims (including hospital staff and teachers), or reduction in number of people with poor mental health being incarcerated as a result of effective training on mental health for professionals within the criminal justice system in Kenya, or breaking the cycle of generational violence through family therapy for communities in the Philippines.

- **System strengthening outcomes:** a number of programs focus on strengthening healthcare systems and could deliver outcomes related to improving capacity, both of organizations and healthcare workers, such as building the capacity of non-mental health focused health professionals to identify mental health conditions in routine care, and reducing stock-out of vital medications.

- **Multiple outcomes:** this refers to where a range of functional outcomes could be achieved across the same program, depending on the beneficiary and their specific need. This most likely applies to programs which are working with location-specific populations to address common mental health disorders or programs focusing on people who, whilst sharing similar challenges may have different definition of 'recovery', for example those experiencing poor mental health and homelessness. The functional outcomes achieved by the program will be specific to each individual, facilitating a unique level of localization. For example, whilst securing employment may be an outcome for one individual, family reconciliation may be the right outcome for another.



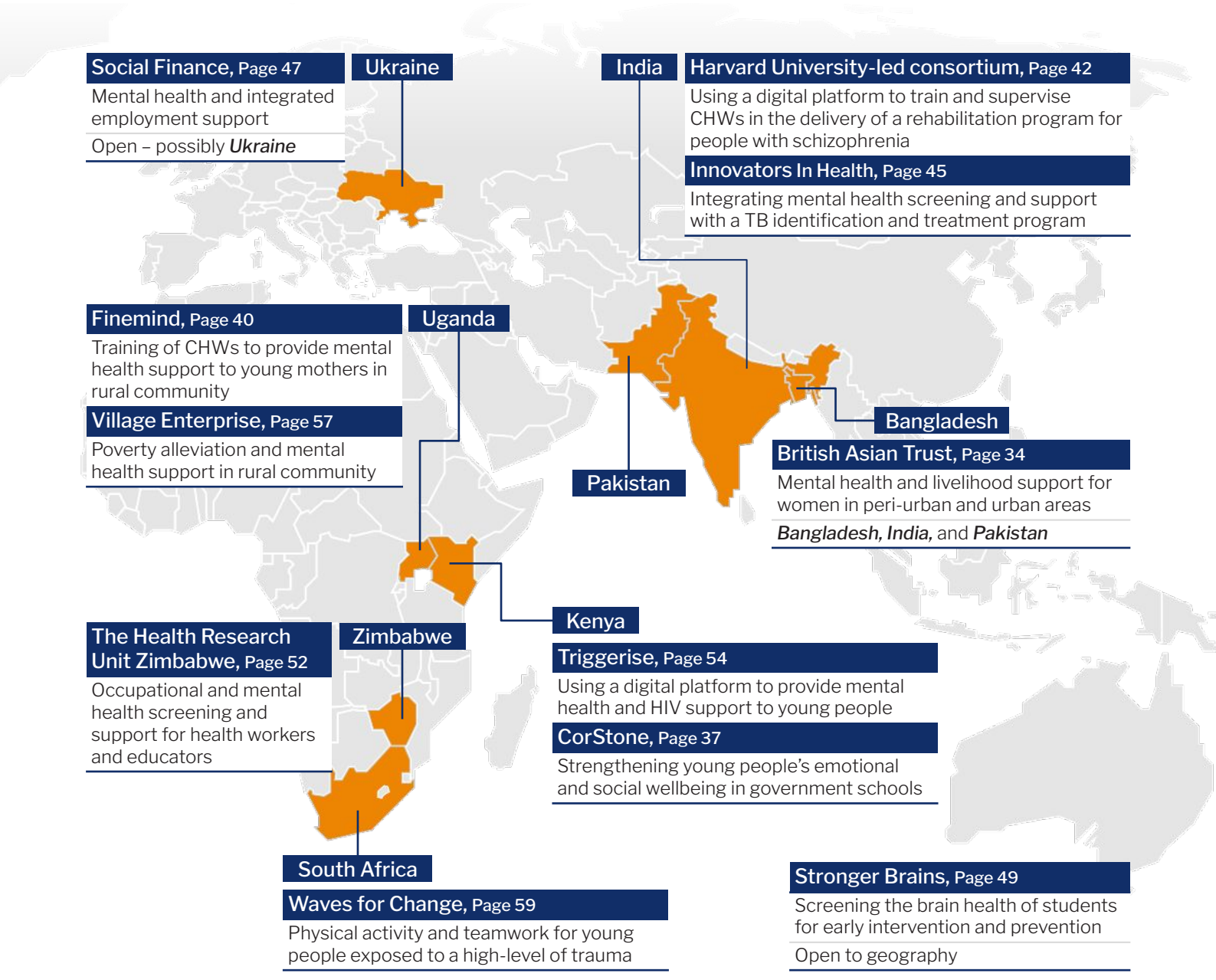
Eleven of the Most Compelling Programs Highlighted

The Most Compelling Programs Highlighted

This section focuses on the individual proposals received, in particular highlighting 11 programs in more detail. These are compelling examples of programs that are strongly structured, with an identified need being met for a well-defined target population, and clear, measurable, and verifiable outcomes already defined or easy to define. These are programs which are not just amenable to being paid on outcomes, but which are relatively/or could become quite quickly 'contract-ready'. We think they represent well the breadth and the potential of the provider market.

We could have highlighted many more programs in this section, but in the interest of efficiency and space limited it to these 11. We encourage you to review the next section of the report, which features the remaining submissions, as it includes some very strong programs.

The 11 programs are plotted in the map below and then, in the following pages, highlighted individually in alphabetical order. As noted, all costs are in USD.



British Asian Trust

Improved wellbeing and employment outcomes for women in Bangladesh, India and Pakistan

Provider overview:

The British Asian Trust (BAT) was established in 2007 by leaders from the British Asian community with the aim of tackling poverty and inequality in South Asia. BAT's programs address systemic problems and inequalities in the areas of education, livelihoods, mental health, child protection, and conservation.

In the space of mental health, BAT has been working with partners to improve mental health outcomes in South Asia since 2012, particularly in Pakistan. Their US$1 million flagship mental health program from 2018-2021 created mass awareness around mental health, reaching over 16 million people through media campaigns, and provided access to community-based mental health information and support to over 40,000 people. BAT also formed the first Pakistan Mental Health Coalition, convening key stakeholders to exchange best practices, collaborate, and influence policy and practice.

BAT has extensive expertise and a strong track record in outcomes-based contracting. For example, BAT acted as the Transaction Manager and convened the outcomes funding on the Quality Education India Development Impact Bond, the largest education impact bond in the world.

Duration and estimated cost:

This is a three-year program, costing US$2 million.

Over the three years, the project will support a total of 5,000 women with vocational and mental health support, resulting in an estimated 4,500 women accessing and staying in employment for at least six months across India, Pakistan, and Bangladesh.

Target group:

The program focuses on women aged 15-45 living below the poverty line in peri-urban and urban areas. The specific target locations will be identified in collaboration with partners and based on criteria developed from current projects. There is an option to target specific sectors, such as the ready-made garment industry in Bangladesh, to address specific need/high prevalence, and collaborate with the private sector. This can be explored further on any contract award.

Challenge/need:

Evidence from the World Bank shows that economic, social, and emotional pressures have an adverse effect on an individual's ability to function on a daily basis, affecting their behavior, relationship, productivity, and overall capability to take advantage of economic opportunities available to them. Research undertaken in Sindh in June 2021, in which a 'psychological autopsy' was carried out on 33 registered suicide cases, found that 24% had previously expressed their wish to die due to stressors such as financial constraints, chronic physical or mental health problems, and social difficulties. Anecdotally, from across BAT's programs, BAT has seen the impact of mental health issues on economic outcomes for women. For example, in their livelihoods program, mental health issues have been identified as a key cause of people dropping out of the training, incomplete attendance of the modules, and/or low confidence that make it a challenge to build a business or other livelihoods.

Program overview:

The proposed program is designed to promote the economic empowerment of women by mitigating drivers of women's poverty, including: poor access to mental health support; low educational attainment and lack of skills development; poor access to markets and jobs, and; social and cultural gender norms affecting women's agency and mobility.

The program will integrate mental health support with skills training and support to strengthen women's ability to access and retain employment. Specific interventions include:

- vocational training and hand-holding support for job retention;
- specialist mental health training modules related to women in employment, and;
- counseling sessions and mental health assessments for training cohorts.

Possible outcomes:

Outcome payments could be linked to:

- each woman who secures employment;
- each woman who retains employment for at least six months;
- increase in a woman's monthly earnings by target amount/percentage increase (this could focus on those women who are already in work, as well as those who secure employment for the first time);
- improvement in socio-emotional wellbeing measured using a standardized assessment.

If the program focuses on a specific sector, such as the garment sector, HBGI would like to also see payments linked to: increased wages; promotion in the workplace (if possible), and; improved mental health as evidenced through reduction in absenteeism.

Evidenced success:

A previous pilot in Bangladesh by BAT's partner SAJIDA Foundation (with 20,000 vulnerable workers) and Primark's MySpace program in India showed mental health interventions in Ready-Made-Garment factories result in reduced absenteeism and staff turnover, and improved productivity and working environment.

BAT's Women's Economic Empowerment and Mental Health programs, with thousands of women in Pakistan and Bangladesh, have revealed increasing demand for mental health support for women in work and the importance of integrating mental health support within health, education, and workplace settings.

CorStone

Strengthening young people's resilience strategies for improved wellbeing and educational outcomes for young people in Kenya*

Provider overview:

CorStone is an internationally recognized nonprofit organization with the mission to develop and provide resilience training programs to transform the life trajectories of marginalized and vulnerable youth in lower and middle-income countries (LMICs).

Since 2011, CorStone has developed, researched, and conducted evidence-based, innovative school-based resilience programs for delivery to nearly 200,000 marginalized youth and 3,000 teachers in 1,500 schools in India, Kenya, and Rwanda. The program, called Youth First, can be adapted to many LMICs and low-resource settings among vulnerable youth, with the goal of government and/or large-scale community system uptake.

Current countries that CorStone operates in include India, Kenya, and Rwanda. In addition, ready partnerships exist in Senegal, Ghana, Cambodia, and the US (California, Texas, DC), pending funding.

Duration and estimated cost:

This is a five-year program, costing a total of US$4-5 million at ~$1 million per year.

Target group:

The program proposes to work with 2.6 million youth per year in Kenya's 11,000 government junior secondary schools.

Challenge/need:

At least one in seven youth in Sub-Saharan Africa face mental health problems and approximately one in 10 have a diagnosable mental illness. Youth mental health concerns are further fueled by systems of entrenched inequalities, discrimination, and resource scarcity. Kenya's youth are no exception: they face rising alcohol and drug misuse; teenage pregnancies (often resulting from transactional relationships or abuse), and; intensifying poverty.

Twenty-six percent of Kenya's students have symptoms of depression and 13% have symptoms of anxiety. While prevention and promotion are crucial, Kenya has focused to date on diagnosis and treatment. In recognition of this gap, the recent Kenya Mental Health Policy, Mental Health Action Plan, Mental Health Taskforce, and Suicide Prevention Strategy all put forward preventive school-based mental health services as policy priorities, yet no programs have yet been rolled out to all youth.

Strengthening a young person's resilience is a promotion and prevention strategy that provides a strong foundation of mental health and wellbeing to help youth build self-awareness, find their voices, stand up to discrimination, and complete their education. Resilience includes building agency, drawing on assets like emotional awareness and regulation, goal-setting and planning, assertive communication, creative problem solving, and conflict resolution.

Program overview:

In 2022, CorStone and local partner BasicNeeds Kenya entered into a Memorandum Of Understanding (MoU) with the Kenyan Ministry of Education to transfer capacity to the government to institutionalize its Youth First resilience program within all 11,000 junior secondary schools nationwide, serving 2.6 million youth annually. In Youth First, students attend peer support groups, facilitated by trained schoolteachers, one hour/week during the school day. The six-month program provides in-depth training in topics such as character strengths, social-emotional and communication skills, goal-setting, problem-solving, conflict resolution, reproductive and sexual health and gender rights. Youth First utilizes a cascading training model, whereby local CorStone-trained trainers provide training to government Master Trainers, who then train school teachers, who in turn deliver the program among their students.

Possible outcomes:

CorStone's vision is to bring about system change so that education systems more fully support the mental health and wellbeing of vulnerable youth. Their aim is for 100% of youth in Kenya to receive resilience programming as a core, guaranteed component of their schooling. A key outcome is therefore the Kenyan Education System institutionalizing the program. Whilst HBGI recognizes and supports this, for the purpose of outcomes-based contracting, payments could be linked to:

- each government school teacher trained;
- each Education Department Master Trainer trained;
- each student who completes the six-month program;
- each self-reported improvement in mental health, wellbeing (e.g., anxiety and depression) of young people, using approved pre- and post-training questionnaires. This could also be applied to teachers;
- functional outcomes, including improved attendance at school, exam scores, and grade improvements (specifics to be determined, e.g., against baseline). HBGI is particularly keen to see the link between Youth First and functional outcomes and would work with CorStone in developing clear, measurable and verifiable functional outcomes.

The resilience of each student will also be measured, and payments to improvement could be attached, for example, using Connor-Davidson Resilience Scale (10-Item Version), Schwarzer's General Self-Efficacy Scale, or KIDSCREEN Psychological Wellbeing Subscale.

Evidenced success:

Youth First has significantly improved the lives of youth participants in Kenya, as well as school environments and teachers' wellbeing. Annual assessments have shown consistent improvements in mental, emotional, and physical wellbeing and education. For instance, youth have improved 21% in resilience, 8% in self-efficacy, and 10% in social wellbeing over the course of the program. Teachers' approaches to classroom discipline have also improved, including a 22% reduction in punishment and a 15% reduction in aggression over the course of the program. Teachers reduced job-related burnout by 10% and improved their mental health by 5%.

* Youth First can be adapted to many LMIC and low-resource settings among vulnerable youth, with the goal of government and/or large-scale community system transfer. Current countries include India, Kenya, and Rwanda. Ready partnerships exist in Senegal, Ghana, Cambodia, and US (California, Texas, DC), pending funding. CorStone presents this model as an illustration of the model and welcomes inquiries for other locations.

Finemind

Training of CHWs in mental health to aid depression recovery and economic outcomes for young mothers in Uganda

Provider overview:

Finemind uplifts communities in Uganda by providing mental health services that nurture hope and belonging. They offer free widespread mental health services that address the barriers of stigma and social determinants in communities in Uganda. Working with the Ugandan government, the overall aim is to have mental health support integrated within mainstream primary healthcare systems.

Duration and estimated cost:

The program cost is US$650,000 over three years.

Target group:

The specific focus of the program will be on young mothers in the Agago District of Uganda.

Challenge/need:

Finemind addresses the problem of the current ineffectual mental healthcare system in Agago District, Uganda, where intergenerational trauma from a brutal civil war, genocide, refugee migration, and the AIDS epidemic is prevalent. Finemind operates from the premise that rebuilding community-wide mental health will lead to greater agency in the community, i.e. stronger, more capable individuals and families and eventually prosperous, thriving communities. For this proposal, Finemind focuses on young mothers to uplift the community.

Program overview:

The proposed program works with young mothers who, through their routine interaction with CHWs (e.g., midwives, nurses and pharmacists), have been identified as having poor mental health (using PHQ-9 form). The CHWs who have received training from this program go on to provide individual counseling support to the young mother, with the aim of seeing improved mental wellbeing and functional outcomes.

The purpose of the funding request is to, through working with existing healthcare services (e.g., clinics and hospitals), scale and extend this program by training more CHWs so that more young mothers can be supported across the region. Specifically, CHWs will be trained using WhatsApp technology, delivered in partnership with Bean Voyage, a global leader in training methodologies.

The benefits of training through WhatsApp include customizable lessons, interaction, flexibility, convenience, accessibility, and low cost. CHWs will be trained in CBT based psychosocial support and interpersonal counseling. In addition to their mental health training (by facilitators), CHWs receive ongoing support from Finemind's coaches to ensure support for their own wellbeing, as well as adherence to quality and fidelity requirements.

Possible outcomes:

Payments could be linked to the following outputs:

- each new CHW enrolled; each new CHW who completes training; and each CHW who is still providing counseling six and 12 months later;
- each new coach trained; and each new coach who is still providing support six and 12 months later;
- each young mother who receives at least one counseling session; and each young mother who completes the program (on average, four separate counseling sessions).

And the following possible outcomes:

- improved wellbeing – each young mother who recovers from depression (PHQ-9 score of ≤ five for two consecutive sessions);
- each functional outcome achieved, related to the young mother (for example, increase in job satisfaction and productivity, increase in household income, or reduction in intimate partner violence).

Ahead of any contract award, HBGI would work closely with Finemind to clearly identify functional outcomes, including how they could be measured and verified.

Evidenced success:

As a result of Finemind's programming, patients report better life outcomes, including higher levels of employment, better physical and emotional health, and greater mental health stability. Results show an almost six-point decrease in depression symptom severity scores for patients as evidenced by the PHQ-9 Depression Screening Tool. Regarding economic empowerment support for young mothers, at least half of the women on existing program are progressing well with an increase in sales and a capital share of their business.

Harvard University-led consortium

Psychosocial rehabilitation and improved physical health for patients with schizophrenia in India

Provider overview:

This is a collaboration across five institutions:

1. ***Sangath***, an NGO in Bhopal with a track record spanning over 25 years evaluating the effectiveness of task-sharing psychosocial interventions by training and supporting a range of frontline lay providers across diverse primary care and community settings in India.
2. The ***National Institute of Mental Health and Neuroscience (NIMHANS)***, a government institution in Bengaluru and the apex center for mental health and neuroscience education, research, and clinical practice in India.
3. The ***All India Institute of Medical Sciences (AIIMS) Bhopal***, a leading government medical research institution, medical school, and tertiary medical center in Bhopal.
4. The ***Department of Global Health and Social Medicine at Harvard Medical School***, which focuses on advancing global health research, with emphasis on advocating for the right to access quality healthcare for the world's most disadvantaged patient populations.
5. The ***Division of Digital Psychiatry at Beth Israel Deaconess Medical Center (BIDMC)***, which has led pioneering studies in digital mental health with emphasis on utilizing digital tools to identify digital biomarkers of mental illness to uncover what factors influence both recovery as well as relapse in patients with schizophrenia.

Duration and estimated cost:

A cost of US$1.2 million in years one-three, reducing to US$400-600,000 in years four-six, as the emphasis shifts to sustaining program delivery and expanding to additional sites. Over the six years, the total estimated budget is circa US$5-6 million.

Target group:

The program targets people with a primary diagnosis of schizophrenia as per the ICD-10 diagnostic criteria and who have an overall moderate severity of the illness based on the Clinical Global Impression-Schizophrenia scale.

Challenge/need:

An estimated 3.5 million plus people in India live with schizophrenia. Recent epidemiological studies in India have observed a mortality rate among individuals living with schizophrenia that is twice the rate observed in the general population.

In addition, it is estimated that upwards of 75% of individuals living with schizophrenia do not have access to essential mental healthcare. Urgent attention is needed towards responding to their medical and physical health needs. Psychosocial interventions hold potential to meet this demand, as these interventions are focused on rehabilitation and skill-building, engaging in social activities, managing mental health symptoms, and promoting recovery and community reintegration, and can meaningfully reduce disability and improve mental health and functioning for individuals living with schizophrenia.

Program overview:

The proposed program addresses the mental, functional, and physical health needs of individuals living with schizophrenia through the implementation of a task-sharing* psychosocial rehabilitation program in primary care settings.

The proposal is to extend the delivery of an evidence-based psychosocial rehabilitation program for schizophrenia called the ***Community Care for People with Schizophrenia in India (COPSI)*** by leveraging a digital platform developed and tested by the team to train and supervise more frontline CHWs in the delivery of COPSI. COPSI focuses on community rehabilitation for patients with schizophrenia and was successfully delivered by CHWs across primary care settings in multiple sites in India.

The COPSI program will be delivered by trained CHWs in three phases: i) intensive engagement phase (0–3 months), including six to eight home visits made by the CHWs; ii) stabilization phase (4–7 months), with sessions delivered once every 15 days; and iii) maintenance phase (8–12 months), with sessions delivered once a month.

COPSI is 12 months in duration for the patient and includes content such as proactive management of illness, adherence management strategies to reduce non-adherence to treatment, support to improve physical health, chronic disease prevention, and self-management, and support to improve vocational functioning of the patient.

In addition, the COSPI program will be supported by a novel digital platform (an app) called mindLAMP, which provides passive and active monitoring of patient outcomes, enabling support to patients through prompts, reminders, and self-monitoring features, and affording clinicians insights about their patients' symptoms and lifestyle behaviors to further tailor and improve the support provided.

The program will be implemented in community settings in the states of Madhya Pradesh and Karnataka, where the team has established the acceptability and impact of the intervention and mindLAMP app. CHWs in each setting will be trained and supervised to deliver COPSI supported with mindLAMP.

Possible outcomes:

The objective is to support psychosocial rehabilitation and promote recovery for patients with schizophrenia, therefore the primary outcome of interest is disability and functioning.

Payments, at the individual level, could be linked to:

- each patient who records improvement in their IDEAS score at the end of the 12-month program. IDEAS - Indian Disability Evaluation and Assessment Scale - has been widely used in research and clinical practice with patients with schizophrenia across numerous settings in India. IDEAS assesses disability across four domains: self-care, interpersonal relationships, communication and understanding, and work;
- each person who identifies and then secures that 'functional' outcome, for example, return to employment, return to education, or commencing voluntary work;
- each person who identifies and then secures improvement in physical health, for example: improved BMI score, improved cardiorespiratory fitness, sustained management of blood pressure, and serum glucose and serum lipids improvement.

For the first two deliverables, before any contract award, HBGI would work closely with the consortium to clarify how these would be identified, tracked, and measured for each individual, whilst recognizing that the functional and health goals will be specific to each individual patient.

Interim payments could also be attached to outputs including:

- each patient who completes at least 12 sessions of COPSI program;
- each CHW trained on delivering the COPSI program;
- each CHW still practicing six months post training.

Evidenced success:

There is now definitive evidence in support of the effectiveness of task-sharing psychosocial interventions for improving outcomes across a range of mental disorders, including schizophrenia, in primary care settings in LMICs, as reflected by a recent umbrella review of meta-analyses covering over 100 clinical trials. Specifically, in a randomized controlled trial, it was found that the COPSI program combined with facility-based care was more effective than facility-based care alone in reducing disability and symptoms of psychosis among individuals living with schizophrenia. The COPSI program focused on community-based rehabilitation for patients with schizophrenia and was successfully delivered by CHWs across primary care settings in multiple sites in India, including Kancheepuram district in Tamil Nadu, Goa, and Satara District in Maharashtra. In addition, two landmark trials were published, both from Ethiopia (2022): a non-inferiority trial demonstrating that task-sharing care for schizophrenia is equivalent to and as cost-effective as specialist-delivered care in primary care clinics; and a cluster-randomized trial conducted in a rural district, which found that community-based rehabilitation combined with facility-based care could significantly reduce disability among patients with schizophrenia at 12-month follow-up compared to facility-based care alone.

* Task sharing enables low- and mid-level health professionals, such as CHWs, auxiliary nurses, midwives, and other frontline health workers, to perform tasks and procedures that would normally be restricted to higher level health professionals, thereby freeing up time for these higher-level providers within a health system to deliver more emergent needed services. (source: Centers for Disease Control and Prevention).

Innovators in Health

Improved mental health and TB treatment outcomes in Bihar, India

Provider overview:

Innovators In Health (India) was founded in 2010 by Manish Bhardwaj - an alumnus of the Massachusetts Institute of Technology (MIT), USA. Their community-based health interventions have more than doubled TB case-finding, cut neonatal mortality by half, and supported mothers experiencing depression.

Duration and estimated cost:

The proposed program will cost circa US$310,00 (INR 2.5 crore) for a total of three years.

Target group:

The program targets the rural community of Bihar, India. The catchment population (~3 million) lies within the Indo-Gangetic plain of Northern Bihar. Forty-five percent of the land area is marked hazardous to annual floods. The average family size is five, with per capita income being US$310 (half of state average and less than a third of India's average) - forcing families to live in abject poverty. The population is mostly involved in agricultural activity for a living, with many being small-marginal farmers and/or landless laborers. Seventeen percent of the population belongs to "scheduled castes," recognized by the Government of India to have suffered extreme discrimination, and economic and educational disadvantages.

Challenge/need:

As highlighted in a USAID paper, people with TB (PwTB) suffer higher rates of depression than the general population. This is due to a decreased ability to work due to the illness, along with rejection from family and society due to stigma. The paper further highlights that 46-73% of PwTB suffer from fear and hopelessness leading to anxiety and depression. Depression and anxiety are significantly linked to lower or non-adherence to TB treatment, lower treatment success rate, shorter survival time within the first six months of follow-up after treatment initiation, loss to follow-up, and early death.

Program overview:

The program will integrate mental health support within existing TB identification and treatment programs, working closely with the existing Public Healthcare System (including the District Mental Health Program). CHWs, who provide end-to-end support to TB patients (from identification to completion of treatment), will be trained on mental health.

This training will include:

- basic knowledge of mental health;
- how mental health and TB are interlinked;
- identifying possible symptoms of poor mental health;
- psychological screening at initiation and during treatment support;
- CBT-based psychosocial counseling;
- tele-counseling hotline support, and;
- how to make appropriate referral for psychiatric care, when needed, in order to increase TB treatment uptake and adherence.

CHWs will be supported by Schizophrenia Research Foundation (SCARF), a WHO collaborating partner. SCARF will provide initial mental health training to CHW, provide refresher training as required, and provide ongoing support/supervision to the CHWs.

Possible outcomes:

Payments could be linked to the following:

- each CHW who completes mental health training;
- each individual who records an improvement in their mental health via approved pre- and post-treatment questionnaire;
- an increase in treatment commencement for people diagnosed with TB (against a baseline);
- an increase in TB treatment adherence and completion (against a baseline).

Evidenced success:

Previous programs demonstrate the effectiveness of training CHWs in basic mental health to improve general wellbeing and depression in rural communities, such as the Maternal Mental Health program, funded by Bill and Melinda Gates Foundation and piloted by Innovators In Health in 2018. The program was designed to help improve the mental health of pregnant and lactating mothers with depression. Their intervention, being one-of-a-kind in India, screened rural women on a psychological screening tool (Edinburgh Postnatal Depression Scale), offered doorstep counseling sessions, and layered it with Interactive Voice Response System (IVRS) episodes available through a toll-free line in their local dialect. A seven-months intervention was able to leverage high impact: women suffering from depression reported feeling “connected” and “less isolated” with both the in-person counseling as well as the IVRS episodes; the sessions on stress management and childcare were widely popular and most subscribed of all the programs offered; CHWs began recognizing depression around them including in their own past, and; within a year, mental healthcare professionals were deployed in district hospitals by local health administration. In 2022, a maternal mental health policy was drafted and implemented across state based on the findings of the intervention. Innovators In Health played a critical role in the policy implementation through its advocacy.

Social Finance

Sustained employment for individuals with enduring mental health needs, geography is flexible

Provider overview:

Social Finance is a nonprofit organization founded in 2007 and based in the UK. Social Finance partners with governments, donor agencies, foundations, the social sector, and investors to find better solutions to society's most difficult problems – such as reducing youth unemployment, helping children avoid being taken into care, rehabilitating ex-offenders, and providing mental health support. Social Finance pioneered the first Social Impact Bond (SIB), a tool to provide upfront investment in preventative services where commissioners only pay for outcomes achieved.

Duration and estimated cost:

The actual program cost depends on geography (see below), but is likely to be circa US$3.5 million over three years.

Target group:

The proposed programs targets individuals with serious and/or enduring mental health needs who are able to work and are un- or underemployed.

To implement Individual Placement Support (IPS) in any setting, delivery is guided by a fidelity scale which measures service quality, with adherence to eight guiding principles, including being open to all who want to work. Integration of the service with a clinical/treatment team is vital as most referrals will come from clinical staff in mental health teams. The target population in any context will be informed by such factors. The proposal, at this stage, is not country specific. Implementation of IPS to date has mainly been in high and higher middle-income countries; this will likely be a factor for whether the program could be implemented with fidelity to the model, or whether an impactful but lower fidelity model should be explored. There is interest in exploring implementing this in post-conflict Ukraine, where an OECD report notes that in 2016, 32% of internally displaced people experienced PTSD, and 22% experienced depression. The scale will be even more vast now, due to the 2022 invasion of Ukraine.

Challenge/need:

Employment rates for people with mental disorders sit lower than the overall population employment rates. Data suggests that 55% of people with mental health problems make unsuccessful returns to work, and of those who return, 68% have less responsibility, work fewer hours, and are paid less than before (source: EU Compass for Action on Mental Health and wellbeing).

There is significant evidence that work promotes recovery for people with severe and enduring mental health conditions. Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Work is strongly linked to health, purpose, and community.

Program overview:

IPS is an evidence-based supported service designed to help people with severe and/or enduring mental health conditions to gain paid employment, with employment support embedded within existing clinical/treatment team. IPS relies on rapid engagement of the individual with employment and a “place then train" approach. To implement IPS in any setting, delivery is guided by a fidelity scale which measures service quality, with adherence to eight guiding principles.

Possible outcomes:

Payments could be linked to the following:

- each individual engaged (enrolled) on the program;
- each individual securing paid employment;
- each individual sustaining work (e.g., for at least 13 weeks, or other period that demonstrates sustainment).

Evidenced success:

IPS was developed in the US and there are now examples in at least 20 countries. Globally, including the UK, there have been 28 randomized control trials conducted on the impact of IPS in 14 different countries. Consistently (in 27 trials) the employment rates are more than doubled in IPS compared to standard vocational rehabilitation.

Meta-analysis of IPS RCT studies in Europe confirm success rates translate well:

- RCT across six European countries showed that 55% of IPS entered work vs. 28% of control group. IPS users were significantly less likely to be re-hospitalized.

Published European study implies IPS has long-term positive impact:

- 37% of IPS users are in work five years later vs. 9% of control group;
- 44% of IPS users worked more than two and a half of the five years vs. 11% of control group;
- IPS users had longer job tenure, earned more per hour and worked more hours vs. control group (20 hours/week on average vs. 17 hours for control group);
- IPS users also had fewer hospital admissions and spent fewer days in hospital vs. control group, with health impact strongest two or more years after intervention began.

Stronger Brains

Improved brain health and functional outcomes for school children, geography is flexible

Provider overview:

A registered Australian charity, co-founded by Professor Emeritus Michael Merzenich and Wendy Haigh, Stronger Brains works with children and young people in schools/colleges, employment services, disability services, and prisons to break the cycle of intergenerational disadvantage by reversing the impacts of toxic stress and adversity on brain health.

Duration and estimated cost:

This is a five-year program. Cost is location dependent but circa US$2500-$5,000 per professional participant (e.g., teacher) per annum for the intervention (this includes supervision and support with data analysis and quality control), US$1000 per student for the brain training, and approximately US$50 per student for the initial brain health assessment.

Target group:

The program will work with all school students aged 11 – 12 years within a defined geographical region of South Asia, Africa, California, and/or Ukraine. Based on previous pre-pandemic programs, it is expected that circa 40-50% of those screened will require early intervention to prevent progression to poor mental health. For a number of different reasons, half of those screened are expected to complete the program.

Before contract award, HBGI will work with Stronger Brains to ensure the program has been contextualized for relevant location.

Challenge/need:

Approximately 70% of mental health problems present before the age of 18. These can significantly impair education and employment outcomes, relationships, physical health, addictions, violence and crime, and other life outcomes. Landmark epidemiological studies like the ACE Study have shown the correlation between poor mental health and childhood adversity (including physical, sexual, and emotional abuse, physical and emotional neglect, household dysfunction, including parents with addictions, poor mental health, domestic violence, incarceration, divorce, and poverty). With the advances in neuroscience, the impact on the brain of childhood adversity can be reversed.

Program overview:

The proposed program will universally screen the brain health of all school students aged 11 – 12 years within a defined geographical region, to identify those at risk of progression to poor mental health (including addictions, eating disorders, self-harm, and suicide) for early intervention and prevention. Early intervention comprises:

- ***Brain education*** – which teaches students about their brain, why they behave the way they do and how they can build a stronger brain;
- ***Personalised Empowerment Plan (PEP)*** – this engages students in healthy brain activities that calm the brain and prepare it for training (e.g., art/music/animal therapy, mindfulness, physical exercise as well as mentoring) whilst addressing practical impediments to success, such as homelessness, and;
- ***Personalised Neuroplasticity Plan (PNP)*** – this builds new neural pathways in the brain to measurably strengthen key brain functions such as processing speed, focus and attention, working memory, social cognition, and executive function.

Over time, statistically significant improvements in brain health will be seen, leading to reductions in progression to poor mental health and associated life outcomes such as poor school attendance/completion, poor job success, poor relationships, poor physical health (including addictions), violence, and crime.

The circa 12-month program will be delivered by working with relevant organizations (e.g., school – so buy-in from schools is crucial) to build their capacity by training their frontline staff (e.g., teachers, health professionals, employment/disability/social services staff) to deliver the screening and intervention through a train-the-trainer model.

Possible outcomes:

Payments could be linked to a combination of outcomes related to brain health and functional outcomes, including:

- key indicators of healthy brain function, such as improved brain processing speed, focus and attention, working memory, social cognition, and executive control, measured by a simple online computerized assessment and can be monitored over time against normative data. This can be recorded at an individual child level;
- each child who records a functional outcome, including improved school attendance, school completion, school success (for example, improved academic achievement);
- job success (if program is focused on older children and as a possible long-term outcome).

Intermediary payments could also be linked to program outputs, including:

- number of partner organization's staff trained to effectively deliver better brain health outcomes;
- the number of graduates employed as peer Brain Health Coaches.

Evidenced success:

From 2018-2020, Stronger Brains was commissioned by the Commonwealth Government of Australia to work with 300-400 young people aged 16-24 years and at high risk of long-term unemployment across 10 different locations throughout the states of Queensland and New South Wales. This program, called “Rewire the Brain,” aimed to reduce welfare dependency by improving brain health. Rewire the Brain not only improved education and employment outcomes of these high-risk young people, but also improved their mental health outcomes. For example, of the participants with severe or very severe mental wellbeing at the start of the program, 86% recorded statistically significant improvements in their depression levels, 75% recorded improvements in their anxiety and 79% reported improvements in their stress levels. After three months of the program, 90% were engaged in either education or employment. Participants included migrants and refugees, young people not in education, employment, or training, Indigenous young people, young people demonstrating suicidal behaviors and self-harm, homeless young people, young people with a criminal record, young people with disability and many more young people who were at risk of long-term welfare dependence under existing government health, education, and employment systems. The program delivered a net return on investment of over 177%.

The Health Research Unit Zimbabwe

Improved health, including mental health, and workplace outcomes for health workers and educators in Zimbabwe

Provider overview:

The Health Research Unit Zimbabwe (THRU Zim) is based at the Biomedical Research and Training Institute (BRTI) in Harare Zimbabwe. BRTI, a nonprofit institution, was established 25 years ago to promote the health and wellbeing of people in Africa through research and training in biomedicine.

Duration and estimated cost:

The program will cost US$12.2 million over five years.

Target group:

The program will work with health workers and educators.

Challenge/need:

The program was developed in response to the high levels of mental health needs amongst health workers, in part due to the very difficult conditions within which they work in Zimbabwe. The health system has experienced a massive health worker exodus, frequent stockouts of essential medical supplies, reduction in real pay coincident with the hyperinflationary economy and very difficult working conditions, with resultant intermittent industrial action in the past paralyzing a struggling health system. In addition, strikes by health workers have now been banned, and employers have no control over wages set by central government. Health providers feel disenfranchised and there is persisting low morale and high prevalence of common mental disorders amongst health workers, with associated attrition and suboptimal patient care. The education sector has also experienced similar issues with attrition of teachers, strikes, and closures of primary and secondary schools, affecting provision of education in Zimbabwe. These aspects were accentuated during the COVID-19 pandemic.

Program overview:

This is an occupational health service for existing health workers and educators, provided by trained staff who work with a network of service providers (including mental health providers) to ensure onward referral as required. The program will provide integrated screening for infectious and NCDs, combined with mental health screening at the workplace, with immediate management and/or onward referral for those who require it.

The screening will cover: mental health, HIV, TB, sexually transmitted infections, hypertension, diabetes, anemia, and visual impairment. Mental health screening will be conducted using the 14-item Shona-Symptom Questionnaire (SSQ-14) which was developed and validated in Zimbabwe and used widely for screening. It will be administered using Audio Computer-Assisted Self-Interviewing (ACASI), which has been shown to be superior to interviewer-administered screening. Those requiring onward mental healthcare support will be referred to specialist mental health partner organization for individual, phone-based counseling, at no additional cost to patient. The number of sessions will be dependent on individual need.

Possible outcomes:

Output measures, to which payments could be linked to include:

- each health worker/educator accessing the screening service;
- each health worker/educator screening positive or diagnosed with a disease;
- of those screening positive, each health worker/educator referred for further investigation and treatment.

Outcome measures, to which payments could be linked to include:

- each health worker/educator whose condition is appropriately managed (measured at agreed interval, e.g., six and 12 months later);
- quality of life improvement (validated EQ5D questionnaire);
- improved workplace satisfaction (against a baseline);
- absenteeism rates before and after the program (workplace records) – with percentage decrease;
- staff attrition rates decreasing (against baseline).

Evidenced success:

A 24-month evaluation (June 2020 – July 2022) showed that 6,792 health workers took up the service in a previous iteration (Kavenga et al 2021, Chingono et al 2022). Uptake of all services, including screening for common mental health disorders, was very high and chronic conditions (common mental disorders, hypertension, diabetes, and obesity) were highly prevalent. The linkage to care was 60% (which is high given medication is self-funded) and the service was very acceptable with high levels of satisfaction reported. The screening also found 7% undiagnosed diabetes, which is significant. Importantly, the majority of men (>95%) accessing the service took up mental health screening, a group that has traditionally been difficult to reach.

Triggerise

Improved mental health and HIV treatment adherence for young people in Kenya

Provider overview:

Triggerise is an NGO which increases access to health services and skills training for underserved young people. Using a mobile-based digital platform, Triggerise connects young people to a network of service providers to enable them to access quality assured, youth responsive free or subsidized health information, services (both public and private), and products, particularly around sexual and reproductive health, that meets their needs and helps them realise their full potential. Triggerise currently operates across six African countries: Uganda; Kenya; Ethiopia; South Africa; Burkina Faso, and; Cameroon.

Duration and estimated cost:

The program will cost US$3.15 million over three years.

Target group and geography:

The program will focus on young people aged 15-24, which includes groups with particularly high rates of mental health issues, people living with HIV, and people with increased vulnerability to HIV infection (such as key populations: female sex workers; men who have sex with men; transgender community members, and; people who inject drugs).

The program will focus on three regions of Kenya: Nairobi; Mombasa, and; Kisumu Counties.

The proposal is to scale the program in Kenyan counties where Triggerise currently operates, which have the highest HIV/AIDS and teenage pregnancy rates, and where there is significant need for a mental health focused intervention.

Challenge/need:

With 35% of new HIV infections occurring among young people in Kenya, and with two-thirds of cases occurring among young women and vulnerable groups, this cohort will not achieve agency around their own health and livelihoods unless their mental health is simultaneously addressed.

There are clear links between HIV diagnosis and poor mental health. People living with HIV are at a higher risk of developing mood, anxiety, and cognitive disorders such as depression.

Rates of mental health problems are higher among people vulnerable to acquiring HIV, with poor mental health also increasing the risk of HIV acquisition due to higher prevalence of HIV risk factors among people with poor mental health such as poverty, high-risk sexual activities, drug abuse, sexual abuse, and social marginalization. The need for mental health services is therefore particularly pressing amongst young people in Kenya.

Program overview:

The program integrates mental health services into the HIV continuum of care via the 'Tiko' platform to:

1. drive mental health awareness at community and facility levels, and;
2. ensure those living with HIV or are at risk of it are also simultaneously recognizing and accessing support for their poor mental health.

The Tiko platform, available digitally including on smart phones, integrates mental health service (such as self-screening using PHQ-4, peer navigation and training of mental health providers using mhGAP intervention guide) with a suite of HIV/AIDS services including: HIV self testing; retention on antiretroviral therapy (ART); viral load testing, and; uptake and persistence on Pre-Exposure Prophylaxis (PrEP) medication. Tiko platform connects those at risk of HIV and those living with HIV to local mental health services and services across the entire HIV continuum of care, all the while using behavioral economics principles such as nudges (reminders, subsidies, and instant retail reward) to motivate uptake and sustained use of medications.

The Triggerise team includes roles responsible for identifying and onboarding onto the Tiko platform community-based organizations that specifically work with key populations and provide HIV and mental health services, which enables trained 'peer navigators' to enroll and conduct follow-up with the young people along the mental health and HIV user journey. At the same time, the Tiko platform enables the implementer and the outcome funder to keep a track of the uptake of services in real time.

Possible outcomes:

The outcomes of:

1. young people having improved and sustained sexual and mental health leading to improved sexual health and decreased HIV risk behaviors, and;
2. young people having improved agency and quality of care in their options of mental health and HIV service providers, which could be tied to a number of possible HIV and mental health metrics, to which payments could be attached, including:
   - each individual accessing HIV testing services;
   - each HIV positive youth who takes up treatment services and returns every quarter;
   - each PrEP client adhering to treatment;
   - each PrEP client returning for HIV tests every three months during reporting period;

- each new community-based trained mental health service provider added to Tiko;
- each individual taking up additional mental health services;
- each individual who demonstrates increased empowerment over their mental health, and their sexual health, measured using multi-scale Likert questions.

Evidenced success:

The Tiko platform tracks and records activities and is able to provide real time data on user behavior and service uptake through the platform. Triggerise has an ongoing pilot project integrating mental health and HIV services in Mombasa County, Kenya. While results from this project remain at a very early stage, we are seeing young people beginning to access mental health services in addition to HIV services, with 387 young people accessing mental health services in the first year of the project, with an expected total of 3,750 by Q3 2024. Triggerise has achieved clear results under the 'In Their Hands' program in Kenya around motivating increased sexual and reproductive health service uptake and HIV testing uptake.

Country	Enrollment (01/2020-06/2022)	% of Users Taking Up Sexual Reproductive Health Service (same period)	HIV Testing Uptake
Kenya	**499,595**	**83.5%**	**89, 856**

Village Enterprise

Increased income levels and wellbeing of extremely poor households in Uganda

Provider overview:

Village Enterprise aims to end extreme poverty in rural Africa through entrepreneurship and innovation by delivering a poverty graduation program that equips Africans living in extreme poverty with cash transfers, training, and mentoring to create income-generating, sustainable businesses and savings groups. Village Enterprise currently operates in Uganda, Kenya, Rwanda, and Ethiopia.

Duration and estimated cost:

The program cost is approximately US$26.8 million over four years.

The estimated cost breakdown is: US$17.2 million to support 64,500 entrepreneurs to create 21,500 small businesses and support 420,000 vulnerable Ugandans (on average 6-7 dependents/entrepreneurs) out of extreme poverty. Targeted mental health services for circa a third* of the participants would cost approximately US$9.6 million over four years.

The program could be scaled up or down, funding dependent.

Target group:

Village Enterprise will work with rural Ugandans living in extreme poverty (living below the international poverty line of US$2.15/day) with women and youth as priority subpopulations.

Challenge/need:

Forty-two percent of Uganda's population live below the international poverty line of US$2.15/day. Formal jobs in rural east Africa are limited and the population often lacks access to the necessary resources, skills, and training to start their own businesses. In addition, northern Uganda has a recent history of conflict, where from 1986-2006 over 100,000 people were estimated to be killed and another 60,000-100,000 speculated to have been abducted by the Lord's Resistance Army. The WHO estimates that 10% of people who experience trauma during armed conflict develop serious mental health problems, and another 10% will develop behavior that will hinder their ability to function effectively. People who were children during the conflict are now adults dealing with the lingering after-effects. Poor psychological wellbeing is a consequence, but also a determinant of unemployment and poverty. Thus, multifaceted programming that both addresses mental health and cultivates economic opportunity is needed.

Program overview:

The program will increase the wellbeing of approximately 64,500 households living in extreme poverty by combining the Village Enterprise evidence-backed, multifaceted graduation approach with a targeted psychotherapy model. The graduation program increases income levels and wellbeing of extremely poor households by providing the training, mentoring, and business seed funding needed to launch sustainable micro enterprises, as well as supporting the creation of village savings and loan groups that increase financial stability and improve interpersonal wellbeing. Psychosocial wellbeing would be further improved using group interpersonal psychotherapy, delivered by lay counselors, that would empower participants to strategize solutions to their problems, learn coping mechanisms, practice interpersonal skills, and identify support structures that they can continue to lean on after the therapy has ended.

Possible outcomes:

The primary outcomes to which payments could be linked could include:

1. each new microbusiness launched six months into the program cycle;
2. each new microbusiness sustained/still in business one year later.

Payments could also be linked to household level economic outcomes such as increased income, assets and savings amongst participant households (target: up to 15% increase in consumption (as a proxy for income)) and assets (savings plus assets, net liabilities) at least one year after program launch, compared to a control group.

The program will track and record other data to which payments could be attached, including:

- each individual who records improved psychosocial wellbeing (including mental health, self-efficacy, and future expectations) (target: at least 0.15sd);
- each individual who records a reduction of salivary cortisol level (target: tbd);
- each individual who sustains or increases improvements in psychosocial wellbeing (including mental health, self-efficacy, and future expectations) (target: at least 0.15 sd);
- each individual who sustains or further reduces salivary cortisol level (target: tbd).

Evidenced success:

Village Enterprise implemented the first Impact Bond for poverty alleviation in Africa from 2017-2020 in Uganda and Kenya. The Village Enterprise Development Impact Bond exceeded its targets, sustainably improving the livelihoods of 95,000 East Africans - including 70,000 women and children - and shielding them from the worst of the pandemic's economic impacts.

Results from a randomized controlled trial, conducted by IDinsight, from November 2017 to August 2021, demonstrated positive and sustained spending and net worth, projecting an average increase in lifetime income per household of US$1,430 and an increase in lifetime household income across the communities of over US$21 million in total.

* This estimate came from a study done by the BOMA project, which works with a similar population, and found that one third of the participants had scores that predicted severe depression: source

Waves for Change

Improved wellbeing and functional outcomes via surf therapy for children experiencing trauma in South Africa

Provider overview:

Waves for Change (W4C) delivers community-based, child-friendly mental health services in under-resourced communities across South Africa and other LMICs. W4C works with children growing up in adverse environments, where they are frequently exposed to prolonged environmental stressors such as violence and poverty, resulting in changes to the architecture of the developing brain through a toxic stress response. W4C trains, supports, and supervises local mentors who deliver group-based, physical activity and after school programs in communities with a high prevalence of risk factors, such as maltreatment and violence in homes, which undermine child and adolescent mental health and make mental health disorders more likely to develop.

Duration and estimated cost:

The Surf Therapy program costs US$466 per child (20 Surf Therapy session) and US$460 per trained coach to deliver physical activity services using W4C's 5-Pillar Method. The program reaches a minimum of 2,000 children and 45 youth coaches annually, across five W4C sites. The program will also train an additional 100 youth coaches annually in using physical activity based mental health services (from partner organizations), who will in turn reach an additional 2,000 children.

Target group:

W4C works with children experiencing trauma - those growing up in adverse environments, where they are frequently exposed to prolonged environmental stressors such as violence and poverty, from communities with a high prevalence of maltreatment, violence in homes, schools and neighborhoods, and experiencing long-term poverty and inequality.

Challenge/need:

The Child Gauge authors (2022) point out that in South Africa, fewer than 10% of children and adolescents who need a mental health service receive it. Access to mental health services is very low in the communities W4C works with for reasons such as: no culturally appropriate mental health services e.g., in local languages; and lack of facilities and trained professionals e.g., approximately one social worker for every 50,000 people and one school counselor for every 5,000 children living in volatile communities. Mental health support is usually only available to the most extreme cases across the communities W4C partners with.

Even then, only four to six outpatient counseling sessions are offered via the public health system and there are many barriers to accessing this support, including transport costs and availability, lack of family support or understanding of mental health challenges associated with trauma, and an overburdened system. Outpatient counseling is also expensive, with the average cost of a one-to-one session with a mental health professional equating to R800 or US$60 for one hour.

Program overview:

W4C has two delivery models:

1. direct delivery of evidence-based Surf Therapy program, reaching 2500 children annually across five sites in South Africa;
2. replicating (and scaling) this model in other geographies, using other physical activities, for example rugby or yoga, which are delivered by a network of trained partners.

For ease, the proposed program here refers to delivery model 1 – direct delivery of surf therapy. However, both models are open for discussion, depending on funder and preferred geography.

Surf Therapy is the direct delivery of evidence-based model that uses surfing as therapy for children and young people who are exposed to high levels of trauma, violence, and adversity. It is a 10-month program (weekly two-hour sessions), which includes working with trained peer mentors. Surf Therapy program is underpinned by W4C's 5-Pillar Method. The method has been co-developed by children and young people living in volatile communities, alongside mental health experts and Universities of Cape Town, Western Cape, New School (New York), and Edinburgh Napier. The method supports mentors to embed trauma-sensitive design principles and create the key conditions needed at their surfing program for effective mental health promotion with at-risk populations.

The 5-Pillar Method is transferable to any physical activity program, so is also applicable to model 2. The principle is using physical activity as a vehicle to deliver mental health promotion and prevention programs.

Possible outcomes:

A mixture of outputs and outcomes to which payments can be attached, include:

- each child starting surf/physical activity therapy;
- each child who completes the (10-month) program;
- each peer mentor (18 - 25 years old) trained;
- each peer mentor sustained as a mentor six and 12 months post training;

- each child in a Surf Therapy program who records improved self regulation and social connectedness after 10 months in the service (method for recording this to be explored ahead of contract, but could include Inclusion of Other scale);
- each improved heart rate variability (HRV) post program recorded (against baseline at the start of program).

HBGI would also want to see (and support W4C in developing) how payments could be linked to functional outcomes for each young person, such as children staying in school and/or improved attendance (as part of this, method for monitoring and verifying outcomes would need to be explored to select the most appropriate and reliable tool).

Evidenced success:

In an evaluation of the W4C Surf Therapy program, looking at Behavioral and Biological Indicators of Risk and Well-Being in a Sample of South African Youth, and published in the Journal of Child & Adolescent Trauma (Beranbaum, Van der Merwe, DePierro, D'Andrea, 2021), findings suggested that children in the W4C Surf Therapy service had elevated age adjusted HRV compared to age-related norms, indicative of overregulation of behavior and emotion when entering the service. Participants endorsed high rates of exposure to violence, such that 100% of participants had witnessed violence and all but two participants (98.2%) had directly experienced violence. After eight weeks in the Surf Therapy service, improvements in HRV appeared and were sustained for 10 months to endline, suggesting that children felt more safe and settled, and that conditions to allow for an effective psychosocial intervention were created after eight weeks in the service.

A later evaluation (Beranbaum, 2022) found that Surf Therapy is an efficacious, trauma-informed intervention for violence-exposed youth. Data was collected at two time points, six months apart, utilizing a comparison group. The study found that Surf Therapy, using the 5-Pillar Method, provided a careful balance of psychosocial education, social support and emotion regulation skill-building within the outdoor physical activity context of surfing, which significantly strengthened interpersonal connectivity and reduced impulsivity/risk taking tendencies.

W4C works closely with a number of universities to evaluate the impact of their programs, including with the University of Cape Town's Centre for Public Mental Health team. W4C is also part of the multi-partner ALIVE program, a five-year research project funded by the Wellcome Trust, led by two Principal Investigators, Prof Crick Lund and Prof Mark Jordans at King's College London, UK.

All Other Submissions Showcased

WHAT THE PROVIDERS SAY

HBGI has worked closely with us to develop a proposal which aims to integrate our existing TB program along with a community mental health initiative. Through the various processes, we have been guided with ideas and possible ways in which we can take our program ahead and further strengthen it. What has been really interesting and helpful has been how our content was efficiently and effectively compressed for the presentation to highlight the best aspects of our proposed project.

Aranya Sawhney Malik
Project Manager, Innovators In Health (India)

The Remaining Programs Summarized and Showcased

This section showcases and individually summarizes the remaining ***40*** programs.

HBGI collaborated with each of the organizations to co-develop their summary. We express our gratitude to the providers for spending the time and energy to do this with us, particularly in identifying possible outcomes.

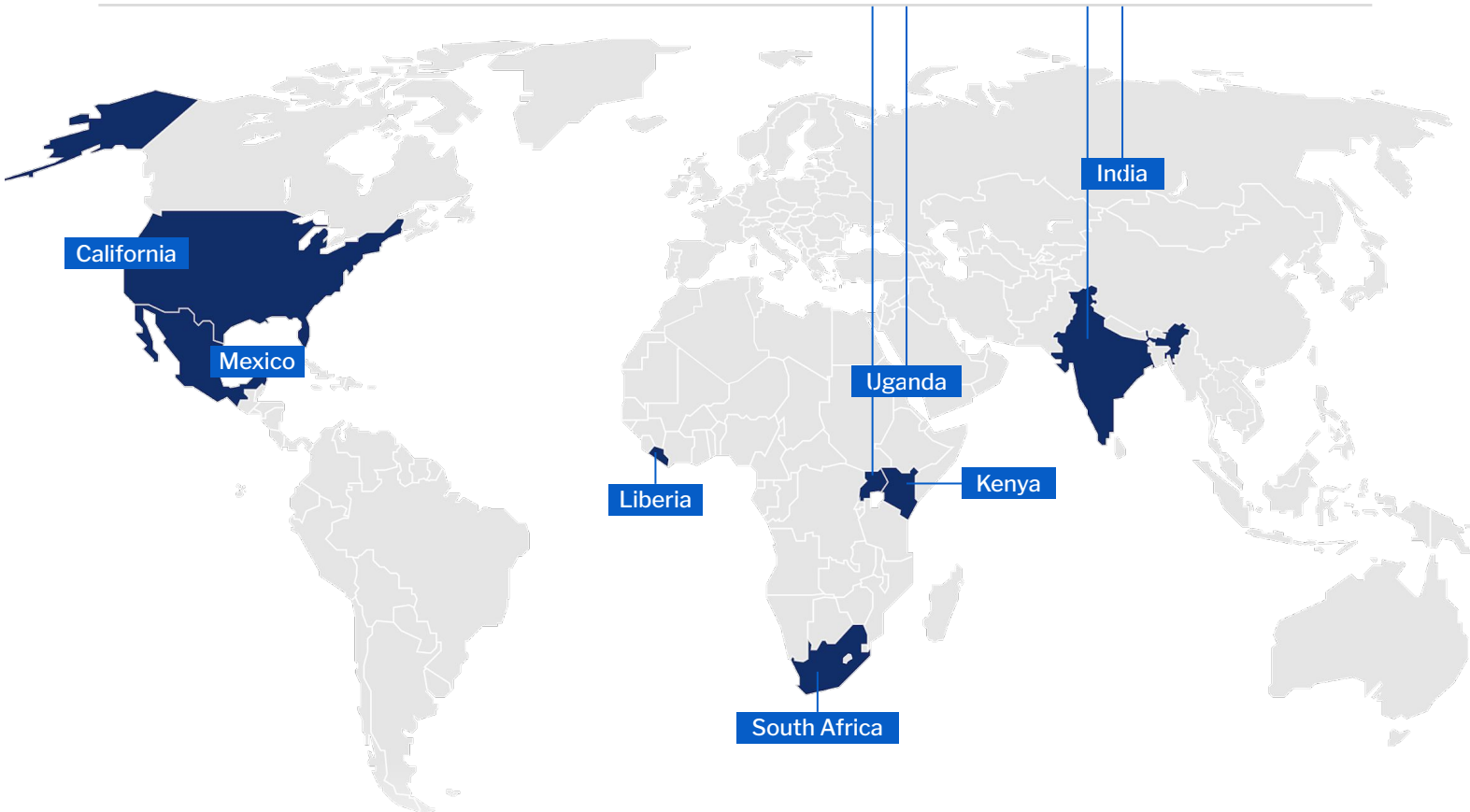
Each individual summary sets out how the program ***could be contracted*** to link payments to outcomes. Payments may need to be linked to a mixture of both outputs and outcomes. It should be noted that at this stage, outputs and outcomes are *indicative*. Ahead of any contract award, the outcomes would be agreed and finalized jointly with relevant stakeholders, including the provider, donor/funder, and other key partners.

The degree of program readiness differs amongst this group. Whilst this section includes some very strong proposals which, though not featured in the highlighted section, could, with some initial support, become contract-ready relatively quickly, it does also feature proposals which would require more concentrated support in order to further develop their program for contract award. However, with the right technical assistance and performance management support, the programs could be amenable to outcomes contracting and deliver successfully. We strongly encourage you to peruse as many of these programs as possible.

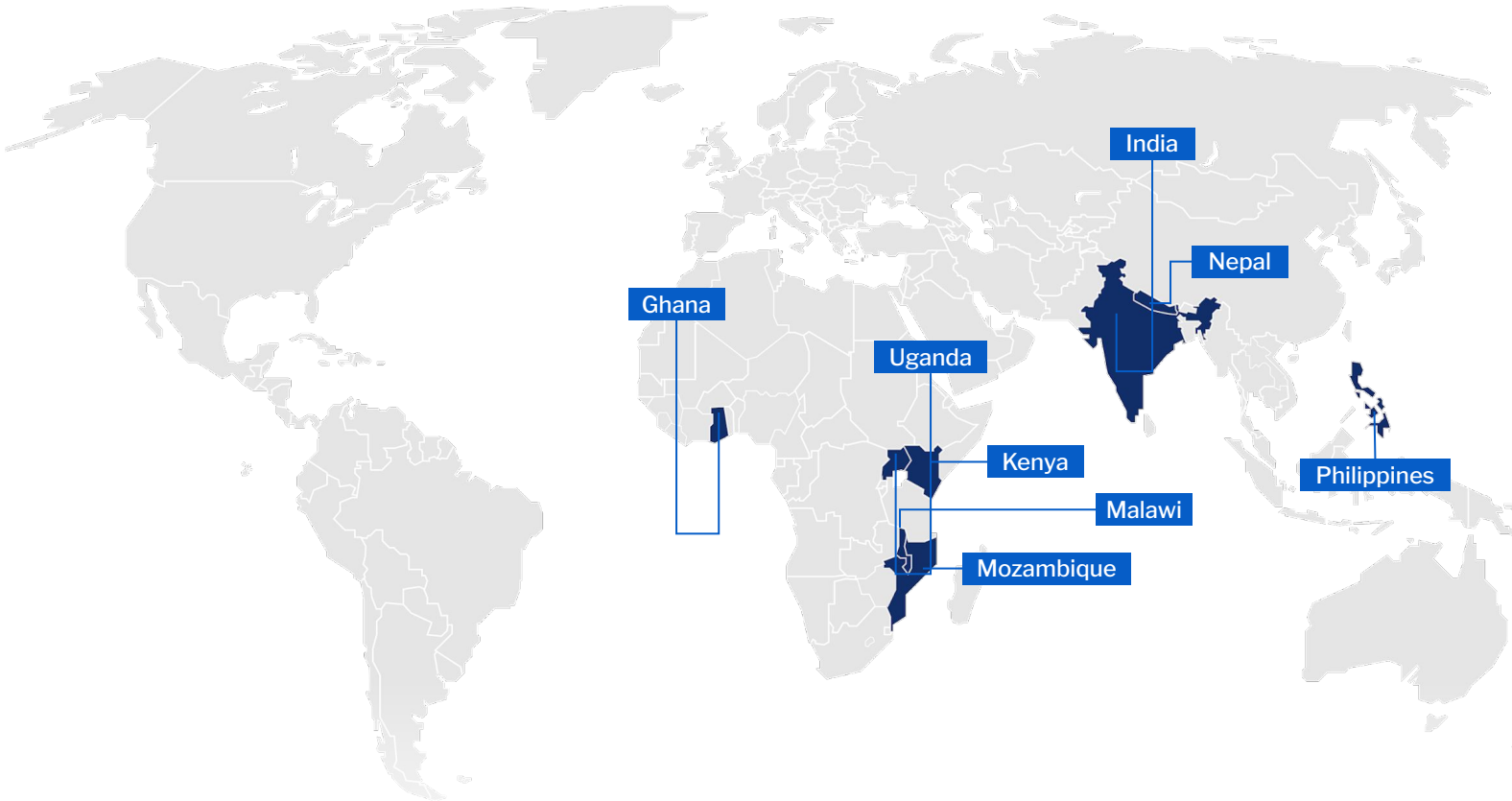
The tables on the following pages outline each program's focus and proposed location of delivery. They are followed by the individual summaries, arranged alphabetically by organization name.

Organization	Proposed Program	Geography
African Centre for Suicide Prevention and Research	Community-based group psychotherapy to address depression and improve livelihood outcomes	Uganda
Aga Khan Development Network	Improved access to mental health support for adolescents	Pakistan
Arogya World	Achieving healthier workplaces by integrating mental health and NCD advice and support	India
	Creating a healthy city, including improved mental health, in Bangalore	India
Banyan Academy of Leadership in Mental Health	Trained lay community members to improve community mental health in Tamil Nadu	India
batyr	Improved mental health (including awareness and support accessed) amongst young people as a result of peer-to-peer support	Kenya
Brazilian Coalition on Mental Health Innovation and Impact	Improved mental health promotion and literacy in high schools in order to deliver improved learning outcomes for students	Brazil
British Asian Trust	Improved mental health and learning outcomes for public school teachers and students	Bangladesh, India, and Pakistan
	Improved mental health and educational outcomes for out-of-school children	Pakistan and India
	Improved mental health and treatment adherence for patients	Pakistan

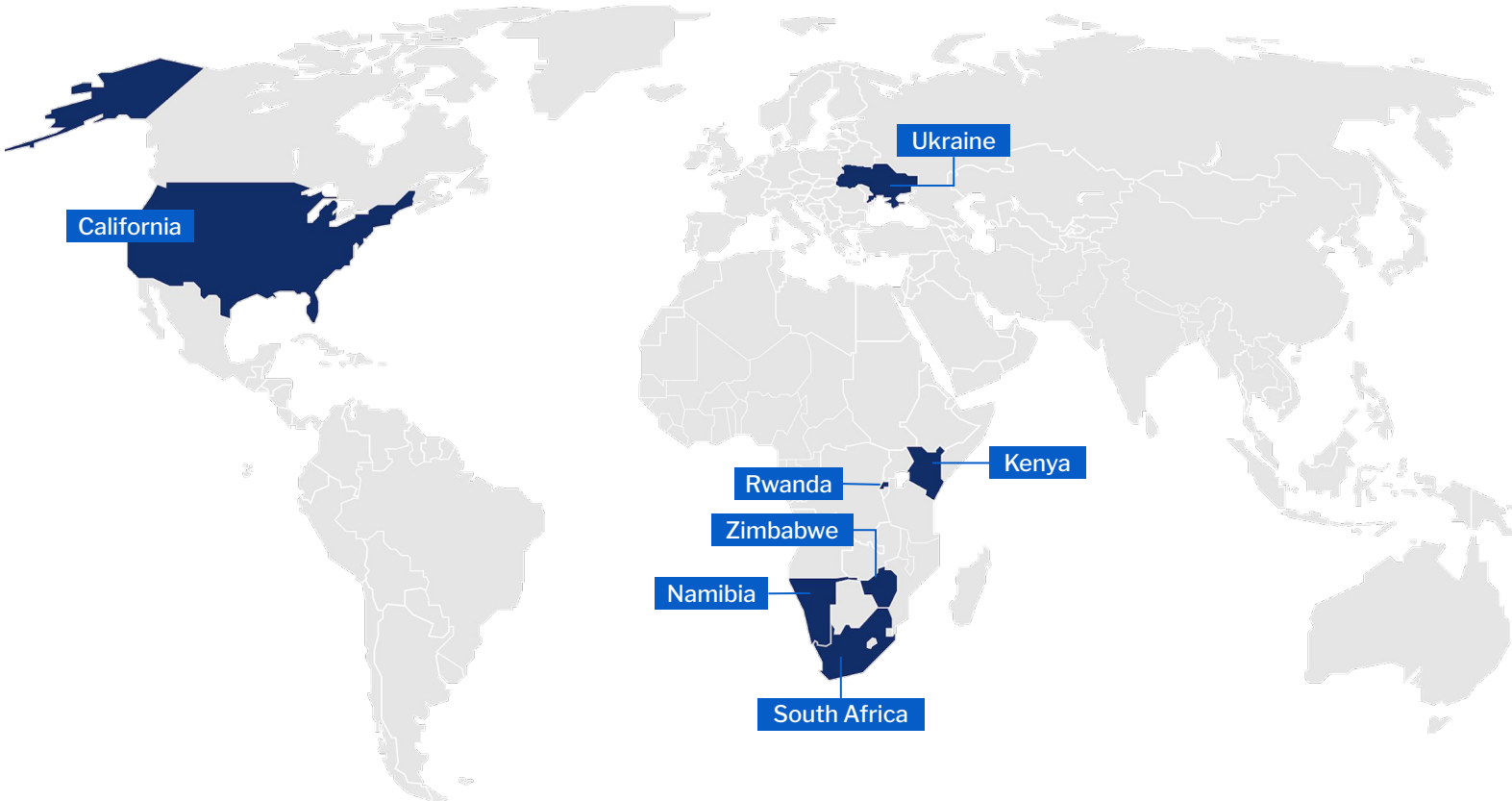
Organization	Proposed Program	Geography
The Carter Center	More health workers trained and community health facilities equipped to address perinatal depression in expectant mothers	Liberia
Centre for Community Impact	Improved mental health and reduction in intimate partner violence	South Africa
Coalition Action for Preventative Mental Health Kenya	A reduction in the number of people with poor mental health being incarcerated as a result of mental health training for criminal justice professionals	Kenya
CorStone	Resilience training for improved wellbeing and educational outcomes for girls in KGBV schools in Bihar	India
Glasswing	Improved mental health and reduction in violence for those affected by violence	Mexico
Harvard Medical School	Improved access and quality of counseling received by young people	California
International Committee of the Red Cross	Improved mental health and functional outcomes for people in places of conflict	Open
Iswar Sankalpa	Improved mental health and functional outcomes for homeless people in Kolkata	India
Liberia Centre for Outcomes Research in Mental Health	Supporting improved wellbeing and substance-dependency recovery	Liberia
Makerere University	Improved mental health identification and treatment for refugees	Uganda



Organization	Proposed Program	Geography
MLAC Institute for Psychosocial Services	Trauma recovery and functional outcomes for families experiencing violence	Philippines
Nzumari Africa	Psychotherapy and employment outcomes for young parents	Kenya
Opa Mind	Voice technology application to support employees' wellbeing globally	Open
Pantang Hospital	Improved mental health and rehabilitation of homeless people with poor mental health	Ghana
Partners In Health	Strengthened care for people with severe mental health conditions	Open – Africa
PATH	Perinatal depression screening and counseling in maternal child health services to improve wellbeing in mothers	Mozambique
Red Dot 365	Improved mental health awareness and management amongst school children, applicable globally	Open
Sangath	Addressing depression and improving treatment and functional outcomes for people with diabetes in Gujarat	India
Save the Children	Improved caregiving, food security, child diet, and maternal mental health	Malawi
	Improved wellbeing and safety for school children	Nepal
SEEK GSP	Addressing depression and improving income and treatment outcomes for rural communities	Uganda



Organization	Proposed Program	Geography
SELF Circles	Developing skills to strengthen resilience in young people, globally applicable	Open
Society for Pre and Post Natal Services	Improved perinatal mental health for parents	Zimbabwe
Stellenbosch University	Reduction in depression/anxiety and improved academic achievement via digital interventions for university students	South Africa
Teenergizer	Trained peer-to-peer counselors and improved mental health of young people via online counseling	Ukraine
Trauma Resource Institute	Reduction in post-traumatic stress and improved school performance for educators and students	Ukraine
TrustCircle	Improved wellbeing for student using AI-based social-emotional learning platform	California
UKOO	Improved wellbeing and educational performance for young queer people	Kenya
YLabs	Increased mental health literacy and access to psychosocial support for young people	Rwanda
Zvandiri	Improved wellbeing and treatment outcomes for young people living with HIV	Namibia and South Africa



African Centre for Suicide Prevention and Research

*(community-based group psychotherapy to address depression and improve livelihood outcomes in **UGANDA**)*

Provider

Located in Kakiika, Mbarara city in Uganda, African Centre for Suicide Prevention and Research (ACSPR) aims to be the leading center for suicide research and prevention in LMICs. ACSPR is an NGO and has been operating for two years. It is led by Dr. Godfrey Zari Rukundo.

Need being met

Depression has an estimated lifetime prevalence of 10% in the general population (Gosling, Parry et al. 2022) and is the leading mental illness, with a high disease burden, in LMICs. In Uganda, depression has a prevalence of 17% to 46% (Nakimuli-Mpungu, Odokonyero et al. 2014).

There is no national coverage of community mental healthcare in Uganda (Molodynski, Cusack et al. 2017).

Group psychotherapy can help to address this gap in rural and low-income areas, which have high volume of patients but few health workers and mental health clinics, as it facilitates the treatment of multiple individuals simultaneously (Malhotra/Baker 2019).

The high burden of depression in Mbarara, Uganda at 27.7% (Allen, Laban et al. 2021) can be partially managed with group psychological support.

Program overview

The proposed intervention is community-based group psychotherapy for adults with depression.

Initial screening will identify potential participants for the program. Those with clinical diagnoses of depression who score at least five on the PHQ- 9 form will be enrolled in the intervention. Organized into groups of eight to 10 people, these sessions will be facilitated by a trained health worker. The sessions will run for six months, including weekly group sessions which cover the following topics: introductory issues; psychoeducation about depression; sharing and externalizing problems; positive coping skills to manage depressive thinking and excessive worries; problem-solving skills, and; skills for coping with stigma and discrimination. In addition, the sessions will provide training in basic livelihood skill and planning livelihood activities. Each session will include practical take-home assignments to practice the skills learnt during the session.

The participants will be followed up every three months for up to 18 months for ongoing support and monitoring.

Possible outcomes

As the organization and proposed intervention is new, HBGI would work closely with ACSPR to further understand and develop the program so that there is a focus on outcomes. HBGI would particularly like to see stronger links between the mental health support and livelihood activities. HBGI would propose to trial this program initially in a specific location, potentially with a control group for comparison. Payments could be linked to the following outputs and outcomes:

- each person who accesses and then completes the group psychotherapy program;
- improvement in depressive symptoms in each participant (PHQ scores compared pre- and post-intervention);
- participants identifying functional outcome goals and each participant who then achieves these on completion of program. HBGI would like to see this linked to livelihood activities.

Aga Khan Development Network

*(improved access to mental health support for adolescents in **PAKISTAN**)*

Provider

Established in 1967, the Aga Khan Development Network (AKDN) brings together human, financial and technical resources to address the challenges faced by the poorest and most marginalized communities in the world. AKDN works in 15 countries in South and Central Asia, East Africa, and MENA with gender equality and inclusion mainstreamed throughout all their programs. As one of AKDN's three key agencies in health, the Aga Khan Foundation (AKF) harnesses its longstanding work with communities and village organizations to enable the optimization of health and wellbeing and allow people to reach their full potential.

Need being met

AKDN, through Aga Khan Health Services (AKHS) in Gilgit-Baltistan and Chitral (GBC) regions of Pakistan, reviewed five years of mortality data from their service population of approximately 710,000 individuals and discovered that 231 deaths were categorized as suicide, with 49 deaths presenting depression and/or anxiety as an underlying cause (this is likely to be a conservative figure given that there is much underreporting). Of these deaths, 75% were among those aged 15-39 years. However, there are no mental health programs outside of schools for adolescents in GBC.

Program overview

Pathways to Care is designed to improve awareness of, and access to mental health services and support for adolescents. Recognizing that different approaches suit different people, the program has five distinct but related pathways to ensure more adolescents can access the support they need:

Training of frontline health professionals (e.g., doctors, nurses) in existing clinics and hospitals in mental health awareness, treatment, support, and referrals so that they can recognize possible poor mental health in young patients. Each clinic will have a Mental Health Terms of Reference (ToR) in place, governing its approach to supporting adolescents presenting with possible poor mental health.

Teleconsultation for these trained health professionals - mental health specialists, such as those from partner research institutions, psychologists, and AKF health advisors, will provide ongoing support and training on mental health awareness and support for these professionals and health providers.

Mental health digital application - a digital application will be developed, as a resource bank for youth who prefer or need to research mental health independently. As example, this solution can share CBT/DBT techniques, videos, and games that offer illustrative education on mental health.

Mental health hotline - partnering with a national telephone helpline, AKF will implement and rollout free mental health support to adolescents in Pakistan.

Safe Space mentors - establishing physical spaces as a 'safe space' for those who want in-person support. Safe Spaces will be led by trained peer mentors to provide a range of mental health support for adolescents through activities such as group discussions, crafts, and roleplay on mental wellbeing. Mentors will be trained and supported by AKF health staff.

Possible outcomes

Ahead of contract award, HBGI would work closely with AKDN to develop the program in line with an outcome-based funding model, including further refining outcomes for the adolescents. At this stage, payments could be linked to a number of possible outputs and outcomes:

- each clinic/hospital that has a TOR in place (estimate 200 over five years);
- each health professional reporting increased confidence in mental health recognition and referrals (measured in pre/post surveys);
- each county in Pakistan hosting AKF's mental health hotline;
- each safe space established with a trained peer mentor;
- each peer mentor operating after six-12 months as a safe space mentor;
- increase in mental health awareness in communities at large and access to service amongst adolescents (against a baseline survey).

Arogya World: Program 1

*(achieving healthier workplaces in **INDIA** by integrating mental health and NCD advice and support)*

Arogya World, a nonprofit registered in the USA, works to prevent NCDs through supporting healthy living in India. Arogya submitted proposals for two different programs, including for their flagship program, Healthy Workplace. Both programs are detailed here.

Need being met

India is a young country: 27 years is the median age. Workplaces matter as that is where people in their 20s and 30s can be reached and supported to improve their lifestyle habits. Employers can also be supported to improve the quality of health programs they provide to employees. India has 0.5 billion people in its labor force, according to World Bank estimates and this is expected to grow to over a billion by 2050 (per United Nations Development Program 2016). In 2021 India's Health Minister estimated that India is adding 12 million people to the working population each year and that the proportion of the working age population will increase to 65% by 2036. The formal organized workplace sector is a good place to start to bring about systems change so that a preventative approach can be adopted to dealing with NCDs.

Program overview

Healthy Workplace targets over 100 workplaces to become healthier by integrating mental health, NCD support, and lifestyle change advice. A number of activities are proposed, including: leadership training for 100 companies on mental health and NCDs; helping these companies to set up peer counselor programs; extending mental health support to factory floors, and; supporting 10 companies to become tobacco free workplaces. This is an expansion of the existing program (186 Healthy Workplaces established in 2022) which has worked with high profile and large employers, including Indian Railways (with 1.3 million employees).

Possible outcomes

Ahead of any contract award, HBGI would work with Arogya to further refine the program to ensure that it is aligned to outcomes contracting, with a strong focus on mental health. At this stage, indicative paid outputs and outcomes could include:

- each peer counselor trained and practicing six months post training in the workplace;
- each company/factory with trained and active peer counselors;
- improvement in employees' mental health evidenced through:
    1. reduced sickness,
    2. reduction in staff turnover,
    3. WHO5 index in each participating company;
- percentage increase in healthy behaviors among employees (e.g., fresh fruit consumption and exercising) measured by survey and target of 20% set;
- each employee who has their blood sugar level and blood pressure under control (with time period to be determined);
- each company which becomes tobacco-free;
- each employee who takes part in annual health checks.

Arogya World: Program 2

*(creating a healthy city, including improved mental health, in **BANGALORE, INDIA**)*

Need being met

The prevalence of NCDs in India is significant. Two out of three deaths are from NCDs. Seventy-seven million people live with diabetes, an equal number are said to be pre-diabetic and a similar number undiagnosed. Seventy-five percent of India's teenagers do not exercise regularly, 10% are pre-diabetic, and 35% of 10-12 year olds have high blood pressure.

In Bangalore, up to three out of four adults are said to be diabetic or pre-diabetic, about 22% of the population is overtly diabetic, 65% of the people are physically inactive, and 43% are obese. Bangalore is one of the worst performing districts in the state. Improving mental health can support the management and prevention of NCDs.

Program overview

Arogya World, in collaboration with ROTARY and BPAC, has embarked on an ambitious effort to make Bangalore India's first Arogya (Healthy) City. This involves working with multi-sector partners (including government, civil society, and the private sector) to make visible pledges to measurably improve the health of Bangaloreans. The pledges will center around NCD and mental health prevention and use technology in a city known for its leadership in tech.

The project will run for four years, with impact being measured and reported every two years. Specific activities will include:

- encouraging partners to make six or more pledges to improve mental health in Bangalore;
- augmenting healthcare capacity in Bangalore by training 10,000 frontline workers (over four years) including from the city's 181 Health & Wellness Centers (HWCs), on NCD prevention and mental health – working with partners including Project Echo and NIMHANS;
- engaging with 100,000 consumers to access stress reduction text messages, and;
- working with NIMHANS' Youth Forum to support young people (target 20,000 college students) to voice their concerns/doubts/life-challenges that relate to their mental wellbeing and then help them access support from trained peer counselors.

In anticipation of securing funding, as of November 2022, 21 'pledgemakers' have already made pledges to work with the program, including a commitment to address poor mental health.

Possible outcomes

Detailed work will need to be undertaken to better understand the theory of change for this program, and the results chain so that activities are closely linked to desired outcomes and impact. However, at initial scoping, payments could be linked to the following outputs and outcomes:

- each partner who makes mental health pledges; and then a further payment on those pledges being delivered;
- each frontline worker trained on NCD and mental health prevention;
- each peer youth counselor trained;
- each young person accessing psychological support from peer counselors;
- improved mental health amongst young people accessing counseling (WHO5 index – and possibly against baseline or control group).

Banyan Academy of Leadership in Mental Health

*(trained lay community members to improve community mental health in **TAMIL NADU, INDIA**)*

Provider

Banyan Academy of Leadership in Mental Health (BALM) is the sister organization of 'The Banyan', a 30 year old organization supporting vulnerable communities (e.g., those living on the streets, from poor households and those living in remote locations) who experience poor mental health. BALM was established in 2007 to improve research, education, training, and advocacy in mental health, working in collaboration with others to bring about policy change.

Need being met

National Mental Health Survey (NMHS, 2016 - India) shows that the prevalence of any mental disorders (weighted percent) in India is 10.6% (which is greater than 10 crore individuals). The survey also reported that there is a treatment gap of 84.5%. Depending on the type, mental disorders affect the individuals' family life, work life, and social life to a great extent (30% - 70%). For every one lakh population, India has only 0.80 mental health nurses, 0.29 psychiatrists, 0.07 psychologists, and 0.06 social workers (WHO, 2017). Rural and tribal India in particular has very poor access to mental healthcare. To meet this gap, it is important to train lay community workers in mental health to make support more accessible.

Program overview

The proposed program entails neighborhood non-technical human resource capacity development in community mental healthcare, delivered in collaboration with partners such as The Banyan, state and local governments, funders, and other NGOs. Specifically, training lay community members in community mental healthcare, in order to: promote and raise awareness of mental health amongst the community (increasing mental health literacy and knowledge of support services available); undertake initial screening of at-risk people and then making onward referral to local clinics and hospitals for further screening and care; provide support to caregivers (e.g., more information on diagnosed disorders, counseling and advice on how to support a family member who is unwell); provide linkages with social care and welfare support; provide follow-up and aftercare (to ensure any treatment is followed/completed), and; support rehabilitation of persons with poor mental health (e.g., education, livelihood activities, community integration, housing, and relationship mending).

Possible outcomes

Payments of service could be linked to a mixture of outputs and outcomes, including:

- each lay community member i) trained; ii) still operating six months later, and; iii) supported to secure other employment (including self-employment) and/or volunteering opportunities;
- each panchayat in the 20 districts of Tamil Nadu which has at least one trained community member in mental health;
- each person screened for mental health disorder;
- of those who are identified as having poor mental health, each person who is referred for onward mental health support (e.g., psychologists at government hospitals);
- increase in functional outcomes of people screened and supported e.g., linked to livelihood (employment secured, income increased); education (training completed, school attendance improved); family (reconciliation with family member, reduction in domestic violence); health (screening for NCDs, treatment commencement and adherence). The details of how functional outcomes are selected, measured, and verified would need to be worked through ahead of any contract award.

batyr

*(improved mental health (including awareness and support accessed) amongst young people in **KENYA** as a result of peer-to-peer support)*

Provider

batyr was started in 2011 by a young person with lived experience of depression and suicide who felt that the effects of stigma prevented him from accessing help until crisis. batyr's programs apply contact-based interventions, now a core part of stigma reduction in mental health. batyr was the name of a talking elephant in Kazakhstan and is all about giving a voice to the elephant in the room: poor mental health.

Need being met

The Ministry of Health in Kenya launched a suicide prevention strategy for 2021-2026, emphasizing the need for stigma reduction, increased research and data, and the integration of activities across communities, health, and education systems to address lives being lost to suicide every day. Young people are identified as a priority population by the Taskforce on Mental Health in Kenya. About 50% of all mental illnesses start by the age of 14 and 75% by age 24 (Ministry of Health, 2020). Yet, there are less than 500 specialized mental health workers in Kenya serving a population of 50 million.

Program overview

'Learn from the Herd' is an evidence-based model from Australia that provides peer-to-peer mental health support for young people (14-35 years). The proposal is to implement this program in Kenya in collaboration with the Coalition Action for Preventive Mental Health Kenya (CAPMHK). CAPMHK comprises community and NGOs, driving community-based preventive and promotive initiatives. Through a partnership between batyr and CAPMHK, a train-the-trainer model will be developed, contextualized and implemented in education and community settings. The Learn from the Herd model will involve batyr training youth advocates and community workers in Kenya who will then be able to deliver and scale the program across the country.

The program delivers the Lived Experience Training Program (Being Herd) to young people and carers with lived experience (18-30 year olds) who undergo comprehensive, evidence-based training, facilitated by batyr trained peers, to learn how to share their lived experience story of mental ill health, hope, and resilience in a safe and impactful way to help others. Trained and ready, these young peers reach out wider, to more young people and their communities through youth led prevention activities, delivered at scale. These evidenced mental health programs will be delivered in schools, universities and community settings, and are designed to educate by sharing knowledge, tools, strategies, and help-seeking pathways that support stronger mental health.

Possible outcomes

Payments could be linked to a mixture of outputs and outcomes including:

- each trainer and peer (lived experience) trained in mental health support;
- each trainer and peer (lived experience) still delivering programs six and 12 months later;
- demonstrated reduction in public and self-stigma for i) young people, and; ii) community members (pre- and post-program surveys, measured through validated measures such as the Self-Stigma of Mental Illness Scale, General Self-Efficacy Scale, and the Social Distance Scale);
- improvement in levels of mental health literacy for young people (pre- and post-program surveys utilizing validated measures such as the Mental Health Literacy or the Mental Health Knowledge Scale).

Further outcomes (measured against a control group) could include: increased rates of young people seeking help from professional services; increased rates of young people seeking help from informal pathways, i.e. educators, carers and informal health providers, and; increased rates of young people utilizing healthy, self-care strategies to manage their mental health as a way of preventing crisis, and further strain on limited services.

Brazilian Coalition on Mental Health Innovation and Impact

*(improved mental health promotion and literacy in High Schools in order to deliver improved learning outcomes for students in **BRAZIL**)*

Provider

The #FOCANAMENTE Project is a ***collaborative initiative*** of the Brazilian Coalition on Mental Health Innovation and Impact Ecosystem. It is a newly formed movement of civil society organizations to leverage a mental health culture through advocacy and special projects deployment. The collaboration involves the following: ASEc+| Movimento Saber Lidar, Instituto Ame Sua Mente, Instituto Bem do Estar, Instituto Vita Alere, Essência Sustentável, Raia Drogasil Group and SoulBeeGood. The project will be managed by SoulBeeGood, a Mental Health Impact Venture Builder, which focuses on the connection and engagement of multiple specialized stakeholders, combining the design and social innovation approaches with evidence-based methods to generate impact. SoulBeeGood has a scientific association with the Center for Studies on Families and Educational-Social Institutions (NEFIES) from the Federal University of Rio Grande do Sul (UFRGS). NEFIES is responsible for leading, implementing and managing the scientific evidence construction and research activities included on the project's roadmap.

The project will be piloted in a state (to be identified) in Brazil.

Need being met

The need being met by the program is the promotion of Mental Health Literacy (MHL) and wellbeing culture in Brazilian public educational institutions, focusing on youth and young adults (aged 14 to 24). Fifty percent of Brazilian adolescents and young people felt the need to ask for help due to mental health issues, yet 40% of these did not ask for any help. For those who did, only 2% relied on school personnel[1]. Mental health is not yet on the agenda of the official school health programs, despite some evidence demonstrating positive impacts of school mental health programs on students' cognitive, emotional, and social performance.[2,3,4,5,6,7] Training on MHL for education managers, administrators, and school personnel can improve the promotion of a mental health culture in the public educational system.[8] An empowered mental health educational culture can reduce negative impacts related to mental health, including poor academic performance and attendance, school dropouts and a range of other negative health, including physical health, and social outcomes.[2,9]

Program overview

The program's objective is to promote MHL and socio-emotional development in the educational ecosystem for youth, young adults, and school staff in order to improve functional outcomes for young people, relating to education.

The program will be initially piloted within a specific geography, focusing on:

1. students, and;
2. school staff (teachers/school personnel).

The intervention for the students is a short-term intervention based on structured conversation circles and workshop trainings which cover social and emotional literacy, coping techniques, and mindfulness based on the Toolbox intervention delivered by ASEc+. This intervention was selected in 2022 by HundrED as an innovation in education. The intervention can be implemented in a hybrid format, carried out through a digital platform for groups of 15 to 20 adolescents and young people. It is an eight-hour program to be implemented over four weeks.

The intervention for the school staff focuses on MHL training, implemented by the Instituto Ame Sua Mente. The training will be based on a distance-education format, to be delivered through a digital platform. It is structured in six modules, which cover the following contents: basic definitions of mental health; the role of the school in health promotion; the science of mental health prevention; the most frequent mental disorders in the school context; identification and case management strategies, and; the use of protocols to guide more assertive referrals to the mental healthcare system and other specialized services. It is a 38-hour course delivered over five months.

Possible outcomes

HBGI suggests piloting this program in selected schools with a control group for comparison.

Payments could be linked to a mixture of outputs:

1. each student who completes the Toolbox intervention;
2. each school staff who completes the MHL training.

And outcomes, including:

- improvement in student's wellbeing, positive emotions, and self-care (as measured using the PERMA Profiler);
- increase in staff's mental health literacy (validated MHL Assessment);
- reduction in reported incidents of bullying (using DSCS - Delaware School Climate Survey);
- improved academic performance;
- improved school attendance of cohort (against a control group or baseline).

[1] Unicef U-Report, 2022; [2] MBarry, 2010; [3] Abed, 2014; [4] Farrell, 2008; [5] Jacowski, [6] Laureano, Estanislau, & Moura, 2014; [7] Marchesi, 2006; [8] Frauenholtz, Mendenhall e Moon, 2017; [9] Vieira, 2014; [10] Rodrígez, 2022).

British Asian Trust

An introduction

Provider

The British Asian Trust (BAT) was established in 2007 by leaders from the British Asian community with the aim of tackling poverty and inequality in South Asia. BAT's programs address systemic problems and inequalities in the areas of education, livelihood, mental health, child protection, and conservation.

In the space of mental health, BAT has been working with partners to improve mental health outcomes in South Asia since 2012, particularly in Pakistan. Their US$1 million flagship mental health program from 2018-2021 created mass awareness around mental health, reaching over 16 million people through media campaigns, and provided access to community-based mental health information and support to over 40,000 people. BAT also formed the first Pakistan Mental Health Coalition, convening key stakeholders to exchange best practices, collaborate, and influence policy and practice.

BAT has ***extensive expertise and a strong track record in outcomes-based contracting. F****or example, BAT acted as the Transaction Manager and convened the outcomes funding on the Quality Education India Development Impact Bond, the largest education impact bond in the world.*

BAT submitted proposals for four different programs, one of which was 'highlighted' earlier. The three other programs are summarized separately here.

British Asian Trust: Program 1

*(improved mental health and learning outcomes for public school teachers and students in **SOUTHEAST ASIA**)*

Proposed population

The proposed program targets teachers, and children with or at-risk of poor mental health in public schools in Bangladesh, India, and Pakistan.

Need being met

There is a high prevalence of poor mental health amongst school children in the three countries. In Bangladesh one in three is identified to be at-risk of developing poor mental health; in India, about one in eight of the youth population suffers from psychological disorder, and; in Pakistan, one in four children are identified to be at-risk of developing poor mental health. Global evidence and BAT's own pilot in Pakistan demonstrate the role of schools in early identification and management of adolescent mental health and potential to improve outcomes such as retention, attendance rates, and wider learning outcomes.

Program overview

The proposal is to scale to other geographies a successful pilot from the Punjab region, which utilizes a technology-enabled School Mental Health Program, developed using the WHO's globally endorsed framework. The program will be strengthened through the integration of direct mental health interventions within the curriculum. As well as improving understanding of their own and their students' mental health, the online training program enables teachers to implement the following in the classroom:

- basic counseling skills;
- positive disciplinary strategies to manage behavioral problems, and;
- life skills teaching through circle time activities (i.e. bringing children together in a circle to participate in fun activities that promote social interaction and positive relationship).

The program also promotes parent-teacher collaboration and allows teachers to identify and refer young people to local services (which will be identified before program commences) for common mental health issues.

Possible outcomes

Impact at the individual level could be measured (and paid for) as follows:

- improvement in learning outcomes and attendance rates for young people with/at-risk of mental health issues in public school (against a control group or against initial baseline data);
- improvement in socio-emotional wellbeing of at-risk young people based on standardized tests (and against a baseline);
- improvement in mental health literacy/knowledge of teachers based on pre- and post-training assessments.

British Asian Trust: Program 2

*(improved mental health and educational outcomes for out-of-school children in **PAKISTAN** and **INDIA**)*

Proposed population

The program targets vulnerable out-of-school children (including street children, trafficked children, or children engaged in child labor) living in urban areas of Pakistan and India.

It is a one-year pilot, reaching 1,500 – 2000 young people followed by scale-up over three years reaching ~20,000 young people.

Need being met

A UNICEF report highlights that between March 2020 and February 2021, schools across countries in South Asia were closed for an average of 146 instruction days. As a result, an estimated nine million children are expected to drop out of school permanently. These are likely to be children who are already vulnerable.

Out-of-school children living or working on the street, orphans, and abandoned or trafficked children are already among the most vulnerable in society to a range of exploitation and abuse, including child labor, physical and sexual violence, and drug abuse. The adverse impact of this on their mental health is well documented.

Program overview

Building on BAT's work supporting vulnerable children across its programs, this holistic program will strengthen and deliver the following areas of intervention in order to improve positive outcomes, increase agency, and prevent relapse for the young people:

- ***Outreach*** **-** via trained local teams, who will identify and then engage with vulnerable children (e.g., on the street) to build their trust and identify their needs and required support. This team will also train police and child protection officers who regularly interact with vulnerable out-of-school children, so that they can engage with them in an effective and empathetic way and are able to make appropriate referrals for onward support.
- ***Rehabilitation*** **-**
    1. capacity building local NGOs and services working with vulnerable children in empathy and sensitivity, trust building and mental health, to be able to work with the children and young people to identify their specific needs, help them process their trauma, and have agency over their future, before helping them to access support services targeted to their specific needs (for example, support for substance dependency);
    2. working with children and young people to develop their own support groups to provide a safe space, support, and advocate for their needs.
- ***Reintegration*** **-** providing a holistic package of support meeting individual needs, whether to reintegrate into their families or communities, go back to school, start vocational training, or other employability support.

Possible outcomes

A mixture of output and outcome payments could be linked to:

- each child/young person enrolled and then retained in school (minimum period of time to be determined);
- improvement in socio-emotional wellbeing of each at-risk child/young person based on standardized tests/reduction in mental health symptoms using pre- and post-outcome measures;
- reduction in vulnerability to exploitation and abuse (such as trafficking, violence or drug abuse) of children and young people as measured on a standardized scale, such as each child who completes six months of rehabilitation for substance abuse. (This outcome would need to be refined at contract award based on the specific needs of beneficiaries).

British Asian Trust: Program 3

*(improved mental health and treatment adherence for patients in **PAKISTAN**)*

Proposed population

The proposed target group is patients (with a priority focus on diabetes, but also could include TB, HIV, COVID-19) from underserved communities in Pakistan who are experiencing poor mental health.

Need being met

Global literature highlights that adverse mental health has a significant impact on the treatment adherence, disease severity, and subsequent outcomes across a number of diseases, including diabetes, TB, and HIV. As such, patients are predisposed towards developing depression and anxiety, which may result in non-compliance, delayed treatment and treatment failure, all of which negatively impact their overall health (Lee et al, 2020).

Program overview

The proposed program aims to address the mental health needs of patients (with a priority focus on diabetes, but could also include TB, HIV, and COVID-19), leading to improved mental wellbeing and treatment outcomes. The goal of the program is to create awareness around the idea of 'no health without mental health' and provide patients with access to an integrated treatment plan through:

- awareness raising and community engagement on mental health;
- training frontline health workers (e.g., doctors, nurses, and CHWs) to screen and refer for mental health issue, and;
- training lay counselors to provide basic mental health support, including group support and talking therapies.

In doing so, the program, working with existing primary healthcare services (e.g., health clinics and hospitals), will integrate mental health support within existing care packages for physical health (e.g., diabetes). The program will cover mental health prevention, promotion, screening, treatment, and onward referral for a variety of mental health conditions, including: common mental health disorders (e.g., depression and anxiety); severe mental illnesses (e.g., psychosis) and; comorbid conditions (e.g. psychosocial distress in the management of diabetes and other diseases).

Possible outcomes

Payments could be linked to the following outcomes:

- each individual patient who records an improvement in treatment adherence/outcome;
- each individual patient who shows reduction in symptoms of depression and/or anxiety as measured through pre- and post-test scores;
- each individual patient who shows improvement in socio-emotional wellbeing measured using a standardized mental health/quality of life assessment.

The Carter Center

*(more health workers trained and community health facilities equipped to address perinatal depression in expectant mothers in **LIBERIA**)*

Provider

The Carter Center is a non-governmental, nonprofit organization founded by former U.S. President Jimmy Carter and First Lady Rosalynn Carter, in partnership with Emory University in 1982. Its Mental Health Program, with 40 years of experience in the U.S. and globally, has worked with the Liberian government and local stakeholders since 2009 to develop the public behavioral health system. This includes developing a mental health workforce, drafting and strengthening national mental health policies and legislation, implementing anti-stigma and advocacy activities, and addressing mental health issues during emergencies. The Mental Health Program's efforts have produced over 360 mental health clinicians including 140 focused on child and adolescent mental health.

Need being met

Perinatal depression affects 19-25% of women in LMICs and is a risk factor for adverse health outcomes including increased rates of stillbirth, pre-term delivery, low birth weight and infant and maternal mortality. Despite the deleterious impact on women, children, and their families, maternal mental health remains an underfunded and neglected service delivery priority. A small but growing number of interventions have been developed to be delivered by non-specialists to address these critical health gaps, including Thinking Health Program (THP), a psychosocial intervention developed in Pakistan that implements a cognitive behavioral therapy (CBT) approach for the management of perinatal depression through 16 counseling sessions during pregnancy and after delivery.

Program overview

An adapted and validated version of the THP for Liberia is being piloted across 60 health facilities across Montserrado County, reflecting a broader effort to integrate mental health screening in normal maternal healthcare. To date, 140 general Community Health Volunteers (gCHVs) have been trained in basic screening and referral, and 200 CHWs have been trained in screening and implementation. The program uses PHQ-9 and WHO Disability Assessment Schedule as screening tools.

The proposal is to scale the pilot in the remaining counties of Liberia to reach more community health facilities and train more gCHVs and CHWs. Ahead of any contract award, as part of program development, HBGI would work with The Carter Centre to determine the targets for this reach, including how many more mothers to be supported.

Possible outcomes

Payments for outputs and outcomes could be attached to the following:

- each gCHV and CHW trained, and then retained at six months post training;
- each public community health facility with screening and referral protocols in place;
- each pregnant woman screened;
- each woman with positive mental health screening referred for further support;
- each referred woman adhering to and completing identified treatment.

Payments could also be linked to: improvement in health amongst mothers (e.g., symptoms of depressive illness or care-seeking behaviors) and improved health outcomes for infants (e.g., weight gain). On any contract award, HBGI would work closely with the Carter Center to refine the outcomes to which payments are linked, with a particular interest in exploring health outcomes for the infants.

Centre for Community Impact

*(improved mental health and reduction in intimate partner violence in **SOUTH AFRICA**)*

Provider

Centre for Community Impact (CCI), formerly known as John Hopkins Health and Education in South Africa (JHHESA), is a South African local health, social behavior change and communication organization. For 16 years CCI has been a trusted nonprofit, dedicated to designing, implementing, monitoring, and evaluating evidence-informed social and behavior change communication programs to influence behavior change, increase service utilization and positively influence knowledge, attitudes, and social norms.

Need being met

There is a growing recognition of the linkages between Intimate Partner Violence (IPV) and mental illness. IPV is defined by WHO as physical violence, sexual, emotional or psychological abuse, and controlling behaviors within an intimate relationship (Heise and Garcia-Moremo, 2002). IPV is more prevalent on women than on men and is a known risk factor for subsequent psychiatric disorders (Jonas et al., 2007). The WHO multi-country study using population-based surveys showed that women with experience of physical or sexual violence were nearly four times more likely to attempt suicide than women without such experiences (Devries et al., 2011). This data indicates the urgent need to create awareness and provide support through the layering of mental health interventions within Gender-Based Violence (GBV)/IPV prevention and response programs, with a specific focus on young men and boys, often the perpetrators of GBV/IPV.

Program overview

By addressing young men and boys' poor mental health, we address a risk factor which contributes to the high number of GBV/IPV incidents across the country. The proposal is to integrate mental health awareness and support into the existing Brothers for Life (BfL) program, targeting young boys and men (aged 15-35).

BfL is a national mass media and community mobilization campaign targeting young boys and men, with a focus on the range of risk factors driving the prevalence of GBV/IPV and other health issues including HIV and AIDS, alcohol abuse, and multiple concurrent sexual partners. It operates as individual clubs, with participating young men and boys known as club members. There are 15 BfL clubs operating across Johannesburg, Ethekwini, Mbombela, and Emalahleni.

Mental health interventions will be integrated into BfL clubs by: i) establishing a new mental health team to oversee activities across all the clubs, comprising: a Psychosocial Support Manager; a trained psychologist, and; social workers. The team will deliver direct interventions (including individual and group therapy) as well as provide wider support to young men in the community. The team will grow as the number of clubs and club members grow to ensure equity in service access; ii) training two peer Life Coaches per club, who will raise awareness, provide support, and make onward referral as required. The Life Coaches will be trained on recognizing poor mental health symptoms, awareness of local services, and providing initial mental health support. Life Coaches will also raise awareness of mental health, and tackle stigma amongst young men and boys in the community, through working with schools and other community services. The Life Coaches will be supervised and supported by the new in-house Mental Health Team.

To increase the number of young men supported with their mental health the program will also establish more BfL clubs and members in regions with high need (guided by data, e.g., high prevalence of GBV, reported crime statistics, and population data).

Possible outcomes

HBGI will work with CCI ahead of any contract award to develop the program to ensure it is coherent, with a clear theory of change . As part of this, deliverables that are clear, coherent and measurable will need to be agreed. Initial indicative outputs and outcomes, to which payments could be linked could include:

- reduction in reported GBV/IPV incidents amongst cohort (against a baseline);
- each peer life coach trained (and retained six months later);
- each new BfL club created and operating – for at least six months;
- functional outcomes related to young boys and men involved in the program including: reduction in school drop-out rate; improved academic performance, and; employment;
- each program beneficiary accessing further professional mental health support (e.g., counseling and group therapy);
- recorded improvement in mental health amongst cohort (against baseline);
- increased mental health awareness (against a baseline).

Coalition Action for Preventative Mental Health Kenya

(a reduction in the number of people with poor mental health being incarcerated as a result of mental health training for criminal justice professionals)

Provider

Coalition Action for Preventative Mental Health Kenya (CAPMHK) is a mental health ecosystem accelerator organization made up of a wide variety of community-based groups and NGOs from across the country, each delivering different mental health initiatives and interventions. CAPMHK was established in 2020 and officially registered in 2021.

Need being met

A recent report by the mental health task force (2020) indicated that a quarter of Kenyans suffer from mental illness and that this is highly manifested in the workplace, in schools and when people come in conflict with the law.

A number of laws in Kenya criminalize what is in essence mental ill health, for example legislation which criminalizes attempted suicide, legislation governing narcotics and petty offences (for example, touting, truancy and vagrancy laws) and the Prostitution Act. This results in a large number of people with poor mental health (including trauma and substance addiction) having to deal with the criminal justice system rather than receive support in addressing their poor mental health. Public health issues becomes criminal justice issues. As a result, Kenyan prisons are overcrowded: a system that is designed to support 14,000 now supports over 50,000 inmates.

Program overview

The program aims to reduce the number of people with psychosocial and intellectual disabilities who come into contact with the law from being incarcerated. It will train judicial officers (judges, magistrates, members of the Office of the Director of Public Prosecution (ODPP), correctional officers and police officers) on trauma-informed approaches to administration of justice. This will be twinned with advocacy and awareness raising within communities, including similar training for other professionals (such as legislators, policymakers and religious leaders) on preventive mental ill health and community-based mental health support.

The training will be delivered in-person, with trainees selected in collaboration with the Judiciary Training Academy, National Police Service, Director of Public Prosecution Training Institute, Law Society of Kenya, selected law schools, and the Prisons Department. Trainers will be trauma and justice-informed trainers from the USA and/or Canada and practicing Mental Health Court Judges from the USA, given that the USA has existing and effective mental health courts.

Possible outcomes

Possible outcomes to which payment can be linked could include:

- each professional (judges, magistrates, ODPP, police officer, and legal advocate) trained;
- each community organization/leader (e.g., religious leader and youth leader) receiving psychosocial training;
- a reduction in the number of people with poor mental health being imprisoned (against a control group or baseline).

CorStone

*(resilience training for improved wellbeing and educational outcomes for girls in KGBV schools in **BIHAR, INDIA**)*

Provider

CorStone is an internationally recognized nonprofit organization with the mission to develop and provide resilience training programs to transform the life trajectories of marginalized and vulnerable youth in LMICs.

Since 2011, CorStone has developed, researched and conducted evidence-based, innovative school-based resilience programs for delivery to nearly 200,000 marginalized youth and 3,000 teachers in 1,500 schools in India, Kenya and Rwanda. The program, called Youth First, can be adapted to many LMICs and low-resource settings among vulnerable youth, with the goal of government and/or large-scale community system transfer.

Current countries that CorStone operates in include India, Kenya, and Rwanda. In addition, ready partnerships exist in Senegal, Ghana, Cambodia, and US (California, Texas, DC), pending funding.

CorStone submitted two proposals which demonstrates the adaptivity of the model to different settings and cohorts. One of the proposal has been 'highlighted' whilst the other is detailed here.

Need being met

In Bihar, girls are at exceptionally high risk of abuse, exploitation, and poor education outcomes. For instance, 95% of women have less than 12 years of education, 64% of girls are married before age 18, and 45% of women have experienced physical or sexual violence. In 2004, the Government of India established the national network of Kasturba Gandhi Balika Vidyalaya (KGBV) residential schools to help address gender and caste disparities in education. KGBVs are girls-only hostels in which 75% are girls from scheduled castes, minorities, and/or tribal communities, and 25% are girls from families below the poverty line. Many of the girls who attend KGBVs have either dropped out of school during the primary grades or have never gone to school. They are at the highest risk for exploitation, child marriage or abuse. For instance, girls living in poverty are three times more likely to be married before age 18, and an estimated 90% of forced labor victims are from scheduled castes and minorities. Resilience building provides a strong foundation of mental health and wellbeing that in turn helps a girl from any background build her self-awareness, find her voice, stand up to caste, gender, and economic discrimination, and complete her education.

Program overview

The purpose of the program is to build on the already delivered phase one, by scaling and expanding existing resilience training for girls (Girls First) to all 536 KGBV schools in Bihar, to improve general wellbeing. Resilience includes building agency, drawing on assets like emotional awareness and regulation, goal-setting and planning, assertive communication, creative problem solving, and conflict resolution.

Girls attend facilitated peer support groups, led by trained school teachers, one hour/week during the school day. The six-month program provides in-depth training in topics such as character strength development, social-emotional and communication skills, goal-setting, problem-solving, conflict resolution, reproductive and sexual health, and gender rights.

Program utilizes a cascading training model, whereby CorStone trainers provide training to government Master Trainers, who then train KGBV school teachers, who in turn deliver the program among their students. All Girls First-KGBV trainers are women who have been raised and reside in Bihar and are intimately familiar with the challenges faced by KGBV girls.

Possible outcomes

CorStone's vision is to bring about system change so that education systems more fully support the mental health and wellbeing of vulnerable youth, particularly at-risk girls. Their aim is for 100% of girls in Bihar's KGBVs to receive resilience programming as a core, guaranteed component of their schooling. A key outcome is therefore Bihar Education System institutionalizing the program. Whilst HBGI recognizes and supports this, for the purpose of outcomes-based contracting, payments could be linked to:

- each Education Department Master Trainer trained;
- each KGBV school teacher trained;
- each girl who completes the six-month program;
- each self reported improvement in mental health, wellbeing (e.g., anxiety and depression) of girls, using approved pre- and post-training questionnaire;
- functional outcomes (e.g., improved attendance at school; improved exam scores; and grade improvements - specifics to be determined, e.g., against baseline).

The resilience of each girl will also be measured, and payments to improvement could be attached, for example, using Connor-Davidson Resilience Scale (10-Item Version), Schwarzer's General Self-Efficacy Scale, or KIDSCREEN Psychological Wellbeing Subscale.

Glasswing

*(improved mental health and reduction in violence for those affected by violence in **MEXICO**)*

Provider & Geography

Glasswing International is an innovative, nonprofit development organization. Founded and led in El Salvador, it works in 12 countries in the Americas. Glasswing address the root causes and consequences of violence and poverty through education and health programs that empower youth and communities and strengthen public systems.

Glasswing is currently implementing SanaMente in the Northern Triangle (El Salvador, Guatemala, and Honduras) and propose to scale this work to Mexico.

Need being met

Latin America is home to only 8% of the world's population, but 37% of its homicides, and over a third of Latin Americans reported being a victim of violent crime in 2016 alone. Chronic and acute exposure to violence results in widespread trauma, which has severe negative consequences for individuals, communities, and the region as a whole. Traumatic events, including experiencing or witnessing violence, are linked to chronic physical and mental health problems, diminished educational and economic outcomes, and an increased likelihood to inflict or be victimized by further violence. Despite high levels of trauma, there are extremely few mental health supports to mitigate its effects in countries such as Mexico. Mental healthcare remains stigmatized and underfunded, and mental health professionals are in devastatingly short supply. According to the Mexican Psychiatric Association, mental disorders affect almost 30% of Mexico's population, however only 2% of the health budget is allocated to mental health. There is an evident lack of mental health experts in Mexico and only one out of every five patients receives proper medical treatment. There are approximately 4,600 psychiatrists in Mexico, yet to address the needs of the population there should be over 12,000 psychiatrists in the country.

Program overview

Glasswing is working with public institutions and workforce that most frequently interface with those experiencing trauma, including staff in schools, hospitals and clinics, and law enforcement. Glasswing is transforming these institutions into trauma-informed ecosystems, where staff members are equipped to recognize and manage the impact of stress and trauma - on themselves and on the people they serve. Through the institutional adoption of Glasswing's methodology, schools, hospitals, clinics, and police stations will become spaces where staff are equipped and prepared to help reduce the impact of stress and trauma - both on themselves and the community - thus reducing the cycle of violence and trauma on public systems and communities. Ultimately, the program in Mexico would train 19,245 service providers with the potential to reach up to 9.7 million community members each year. This work will serve as a proof point for the effectiveness of community-based mental health supports in resource-constrained environments, laying the groundwork to bring similar approaches to any region buckling under cycles of violence and trauma.

Possible outcomes

As a result of this extensive capacity building, the following outputs and outcomes are expected, to which payments could be linked:

- each professional trained on trauma awareness, and linked to this, each organization whose relevant workforce is trained on trauma awareness;
- each professional who demonstrates improved emotional regulation and coping skills (measured by Emotional Regulation Questionnaire, Brief Resilient Coping Scale, and Beck Hopelessness Scale);
- a statistically significant increase in protective factors for all students at participating schools, as measured by Communities That Care Youth Survey (which evaluates protective factors like neighborhood attachment, school commitment, and social skills);
- a statistically significant reduction in violence, a core contributor to and consequence of trauma;
- reduced rates of peer-to-peer violence in participating schools, as measured by Self-Reported Delinquency Scale (SRD) and school discipline records;
- a reduction in violent behavior for youth that receive individual care from a trained interventionist, as measured by the SRD;
- a reduction in readmission for a violent injury for patients that receive individual care from a trained interventionist, as measured by hospital data;
- a reduction in abuse of force perpetrated by police officers, as measured by the experimental evaluation of force abuse created in partnership with the World Bank, Inter-American Development Bank (IDB), and Ifo Institute;
- a statistically significant increase in perceptions of safety in the community overall, as measured by Cómo Vamos (a validated survey instrument that measures quality of life).

For most of these outcomes, a baseline would need to be established and target to be determined ahead of program delivery.

Harvard Medical School

*(improved access and quality of counseling received by children in **CALIFORNIA**)*

Provider

Harvard Medical School's Mental Health for All Lab, led by Vikram Patel, is at the forefront of global mental health's efforts to scale-up evidence-based psychosocial interventions through task-sharing with diverse frontline providers. In this proposal, Patel is joined with John Weisz (Harvard University), widely acknowledged as the preeminent clinical scientist designing psychosocial interventions for adolescents for delivery in school settings.

Need being met

More than 20% of American youths will experience a mental health disorder, in particular depression and anxiety disorders, which account for nearly half of the total burden of ill-health in young people. Depressive and anxiety disorders pose serious social, academic, and health risks, including risk of suicide, as well as serious longer-term risks such as substance abuse, marital, and relationship dysfunction, and job failure. Despite the robust evidence of the effectiveness of brief psychosocial interventions for these disorders, a staggering 75% of youths who need mental healthcare do not receive these interventions. Access is especially limited for racial and ethnic minority youths and those from low-income families. Specifically in California, while one in six youth aged six to 17 experience a mental health disorder each year (NAMI California), 66% of children and adolescents with a mental health disorder do not receive treatment. School-based counseling offers an alternative to clinic-based treatment, but this currently has poor reach.

Program overview

The proposed program will train school counselors and other school staff to deliver evidence-based, brief psychosocial interventions for mood and anxiety disorders via the tried-and-tested EMPOWER program. A technology-based program currently operating in India and the USA, EMPOWER builds the capacity of frontline providers to learn, master, and deliver evidence-based, brief psychosocial interventions. The digital approach ensures that the same content is delivered in the same way for all who receive the training, eliminating the cost and complexity of repeatedly training new trainers and monitoring their fidelity across all training events and contexts. The EMPOWER approach accompanies providers through three broad stages of growth:

1. learning a new treatment through a competency-based digital curriculum with the support of a coach;
2. mastering the treatment through case-based practice with supervision by an experienced provider, and;
3. following credentialing based on tailored competency assessments (based on the WHO's EQUIP tools), delivering the treatment with continuing quality assurance through peer supervision.

Once providers have attained a specified level of competency, they can 'graduate' to deliver the intervention with the focus shifting to ongoing peer quality assurance which, over time, can enable counselors to ultimately grow into experts who can coach future generations of fresh learners.

Possible outcomes

The aim is to improve access to and the quality of counseling young people receive. In addition, address inequity (for example, children from minority backgrounds and lower income households accessing care). Payments could be linked to outputs including:

- each counselor/educator who completes EMPOWER training and is competent in it (access);
- each trained counselor/educators still practicing six months post training completion (access);
- each student who access and completes school-based counseling (access).

Payments could also be linked to individual level outcomes including a combination of self-reported improvement in wellbeing, using a recognized reporting matrix or cohort sample survey (e.g., in depression/anxiety) and confirmed functional outcome (e.g., improved attendance at school, reduced drop-out rates) against an initial baseline (quality).

Payment could also be structured so that the unit cost of the relevant output/outcome is higher if a member of an underserved community accesses the service. For example, the unit cost for a young person from Latino background accessing counseling is slightly higher – to encourage the service to address current inequities. This will need to be developed with the provider ahead of any contract award to ensure it is fair, incentivizes the intended outcome, and is practically applicable.

International Committee of the Red Cross

(improved mental health and functional outcomes for people in places of conflict)

Provider & Proposed Geography

The International Committee of the Red Cross (ICRC) is an impartial, neutral, and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of armed conflict and other situations of violence, and to provide them with assistance.

ICRC's Mental Health and Psychosocial Support Program (MHPSS) is an integral part of its humanitarian assistance.

Open to geography.

Need being met

More than one in five (22.1%) people in a conflict-affected area lives with some form of mental health condition, three times more than the general population worldwide (versus 1 in 14) (Lancet, 2019).

Mental health needs increase in situations of armed conflict/violence, both by inducing new conditions and exacerbating preexisting ones. Psychosocial problems worsen due to disruption of family social networks, and limited access to essential services, leading to poorer economic productivity. Violence can be used by armed groups with the intention of creating psychological distress such as spreading fear, undermining personal coping, creating an environment of chaos, and breaking down community cohesion. During armed conflict, populations are highly exposed to sexual violence, forced disappearances, risk of children association with armed forces, and physical disabilities, among others. This exposure poses a risk to a population's mental health and wellbeing.

COVID-19 has created more mental health and psychosocial needs, especially for millions of people already living through conflicts and disasters.

Program overview

ICRC propose to continue to provide mental health and psychosocial support to beneficiaries in places of conflict including: survivors of violence (including victims of sexual violence and child victims); families of missing persons; people experiencing torture and ill treatment; people needing physical rehabilitation and the war wounded; support helpers, and; emergency responders.

Possible interventions could include:

- mental health activities - specialized mental healthcare such as psychiatric treatment or specialized psychological treatment, and psychological support such as counseling;
- basic psychosocial support - such as information and sensitization activities, psychoeducation for health promotion, social cohesion, and resilience-building activities, and;
- psychosocial support activities - such as group activities for prevention of psychological decline in people at risk.

Possible outcomes

Depending on country, beneficiary type, and actual program delivered, a mixture of outputs and outcomes to which payments could be linked include:

- each new beneficiary accessing mental health and psychosocial support;
- each beneficiary presenting evidence-based reduction in distress at program closure;
- each beneficiary presenting evidence-based improvement in functioning (e.g., evidence of productive life such as engagement with education/employment) at program closure;
- each trained and retained community actor providing mental health and psychosocial support and still volunteering six months later;
- each frontline professional provided with mental health and psychosocial support. Overall outcomes could include reduction in staff turnover against a baseline.

Iswar Sankalpa

*(improved mental health and functional outcomes for homeless people in **KOLKATA, INDIA**)*

Provider

Established in 2007 by mental health professionals, Iswar Sankalpa has grown into a multi-pronged delivery organisation, extending services to both the homeless and urban home-based poor population with psychosocial needs in Kolkata, India. Through its nine programs, the organization seeks to *'ensure the dignity and holistic wellbeing of persons with psychosocial disability, particularly for those from underprivileged parts of society, in a humane manner and, in addition, empower them in attaining their rights.'* A nonprofit, the organization provides services across Kolkata and rural West Bengal; reuniting homeless people with their families across the country and beyond.

Need being met

According to the Census of India (2011), West Bengal holds the seventh position among the states of India for homelessness with over 134,000 homeless people. 70,000 of these are in Kolkata. A significant percentage of these individuals suffer from poor mental health conditions. The state of West Bengal has the fourth highest prevalence of mental health disorder at 13%, according to the National Mental Health Survey (2016); and the highest prevalence of psychosis and other severe mental health illness, including schizophrenia, at 1.26%. The proposed intervention aims to address a lack of affordable and accessible pathways to comprehensive mental healthcare and treatment for the homeless population, following a community-based rehabilitation model of care. Iswar Sankalpa also seeks to integrate mental healthcare within the general healthcare system while building participation of key stakeholders (government, community, and families of the service users) in the process.

Program overview

A number of interlinked interventions, aimed at improving the overall quality of life for people experiencing psychosocial disabilities, in particular urban adult homeless people found on the streets of Kolkata, have been proposed. Interventions include the Naya Daur program - a WHO-recognized community outreach model of holistic mental healthcare, treatment and support for homeless people with psychosocial disabilities, supported by a cadre of community health volunteers. Linking in with other Iswar Sankalpa interventions, the program also provides: access to shelter care; skills training and supported employment opportunities, and; access to entitlements (such as voter ID card and other identification documents that allow people to access various government schemes and benefits).

Individual 'homeless' status is verified through a number of ways, including: observation by the team as sleeping on the streets for at least 15 days; referral by a partner organization, and; police referral.

Possible outcomes

Payments could be linked to the following outputs and outcomes:

- each community health volunteer trained in providing mental health support and retained for at least six months;
- each homeless person with psychosocial disability i) accessing safe shelter; ii) receiving psychosocial treatment program for at least six months, and; iii) utilizing physical/mental health treatment from government facilities;
- each person achieving functional outcomes, such as: maintaining self-care (e.g., personal hygiene); rehabilitation with family; livelihood (secure job, access training); return to education, and; then sustaining that outcome at six months;
- each individual who records an improvement in their mental health and wellbeing (via psychometric scales assessing functionality and disability levels).

Liberia Centre for Outcomes Research in Mental Health

*(supporting improved wellbeing and substance-dependency recovery in **LIBERIA**)*

Provider

Formed from the Mental Health Policy of 2009, The Liberia Centre for Outcomes Research in Mental Health (LiCORMH) conducts research in mental health to inform mental health service delivery in Liberia. LiCORMH has been operational since September 2013. It works in collaboration with the Technical Coordination Committee of Mental Health in Liberia.

Need being met

LiCORMH seeks to address the growing mental health crisis in Liberia, a continuing legacy of the bitter civil war. Poor mental health not only affects those who were victims of the war (e.g., those witnessing violence, those who were victims of sexual attacks, and those who lost loved ones) but also the perpetrators. Many of these perpetrators were young boys during the civil war, involved in the war through coercion but who have now turned to drugs and other substances as coping mechanisms for the trauma they suffered. The outbreak of Ebola and then COVID-19 has exacerbated poor mental health across the country.

Program overview

The proposed program focuses on: i) strengthening and expanding existing mental health recovery support groups ('cells') for those who are in the recovery phase of their mental health journey, and; ii) providing support for young people experiencing drug dependency. This involves training health workers within existing health facilities and services to recognize, diagnose, and manage cases of addiction.

Possible outcomes

Ahead of any contract award, HBGI would work closely with LiCORMH to develop the program, ensuring it is coherent, with clear target group and results chain. Possible outputs and outcomes, to which payments could be linked include:

- each individual who reports an increase in wellbeing as a result of being involved in the cell recovery groups (using an internationally recognized measuring form);
- each health worker trained on recognizing drug misuse in young people;
- each health worker retained for at least six months post training;
- each young person accessing support for drug dependency;
- a reduction in the number of young people in recovery dependent on drugs, or an increase in the numbers deemed 'clean' (timescale would need to be agreed as well as measurement, such as against a baseline or control group);
- agreed functional outcomes for each young person being achieved (e.g., returning to school).

Makerere University

*(improved mental health identification and treatment for refugees in **UGANDA**)*

Provider

Makerere University School of Public Health is one of the four schools under the Makerere University College of Health Sciences, a constituent College of Makerere University. Established in 1922, Makerere University is one of the oldest universities in Africa, currently ranked the second best research institution on the continent. It is the first university in East Africa to offer degrees in public health and is the leading school of public health in the region. Its mission is to provide innovative teaching, learning, research, and services which are responsive to national and global needs.

Need being met

Despite the high prevalence of mental, neurological and substance use (MNS) problems amongst refugees, relatively low rates of emotional and substance use visits in primary care are registered. This implies that many MNS problems remain unattended by refugee health services (Kane et al., 2014, Ellis et al., 2010). Uganda hosts a large population of refugees who are at a higher risk of MNS use disorders. Urban refugees experience high levels of both stigma and depression with adolescent girls and young women being disproportionately affected (Logie et al., 2020). Eighty-four percent of urban young refugees exhibited symptoms of stigma in Mbarara city (Bahati et al., 2022). According to a Multi-Sector Needs Assessment in Uganda, 22% of refugee households reported that at least one family member was in psychological distress and it estimated that within the South Sudanese refugee community, only 29% of people identified as needing mental health services received them (REACH, 2018) which indicates a large treatment gap of over 70%.

Program overview

The proposal is to implement a comprehensive community-based mental health services package (CCMHS) targeting refugees with mental health conditions, including severe mental health and epilepsy in four selected districts in northern Uganda, three of which are refugee hot spots. The CCMHS package integrates three components:

1. strengthening clinical recognition, referral, assessment and management of severe and common mental disorders (S/CMDs) by existing HCW and community resource persons within existing primary healthcare service;
2. establishing psychosocial and socioeconomic support services for people with SMD through patient support groups (PSGs), and;
3. conducting stigma-reduction activities (including training two CHWs from each village to support stigma reduction activities and PSGs within the community).

Please note: whilst the program focuses on refugee communities, as this community lives alongside the host community, to ensure equity, the service will be available to all, particularly to all young people aged below 24 years.

Possible outcomes

HBGI would work closely with Makerere University to refine the outputs and outcomes to which payments could be linked, including strengthening the measurement and verification modalities. Current examples of outputs and outcomes to which payments could be attached include:

- each CHW i) trained to identify, diagnose and manage severe mental disorders, and; ii) retained for at least six months post training;
- each individual who is screened, identified, diagnosed, and supported by CHWs;
- each individual who achieves a remission of the disorders of interest (measured using recognized standard tools such as Positive and Negative Syndrome Scale- Schizophrenia/Psychosis);
- each PSG formed;
- proportion of refugees reporting reduced perception of stigma and discrimination (measured using the Discrimination and Stigma scale (DISC-12) and against baseline);
- each functional outcome achieved, including: employment secured and retained for at least six months; measurable improvement in the economic status of participating households, and; access to education for young people.

MLAC Institute for Psychosocial Services

*(trauma recovery and functional outcomes for families experiencing violence in the **PHILIPPINES**)*

Provider

Mindfulness, Love and Compassion (MLAC) Institute for Psychosocial Services, Inc. is a nonprofit organization composed of psychologists offering nationwide psychosocial support. MLAC advocates for mental health and wellbeing for communities experiencing trauma and marginalisation. Since its inception in 2010, it has been working with communities in the Philippines, utilizing applications of clinical psychology, grounded in culture-based practices and global mental health approaches.

Need being met

The proposed program focuses on Barangay Pantay Bata, City of Tanauan, in Luzon Island, Philippines. It has a population of almost 2900, but the target population in the proposed site is 50 families. Previous medical missions and repeated encounters with local government officials suggests that there have been reports of deaths and intergenerational family violence associated with the community's cultural beliefs. Anecdotal firsthand accounts of violence include children in the community wishing for a gun for Christmas, or adolescents avenging the death of their deceased kin. In these communities, killing is normalized and aggression gets what one wants, according to a developing emergency report by the local government of Tanauan. The effect of violence on mental health is well evidenced, for example, current research has identified the following mental health conditions as significantly more common among those exposed to violence either directly (e.g., as a victim or perpetrator) or indirectly (e.g., as a witness): multiple mental health conditions; depression and risk for suicide; PTSD, and; aggressive and/or violent behavior disorders. (source: Prevention Institute).

Program overview

A two-pronged intervention designed to address family violence and domestic abuse is proposed. This includes: i) a family-based intervention targeting intergenerational trauma inflicted on families, especially children, and; ii) a preventive approach to deter future family violence and to equip the community members with resources to help them navigate adversities. The details of the intervention will be confirmed post initial research, which will co-create a culturally adapted program with the families.

Possible outcomes

Potential outcomes to which payments could be linked would need to be refined post program finalization but could include:

- at the individual level - improved functional outcomes for family members, for example, improved school attendance for children;
- at the family level - reduction in incident reports of family violence (against a baseline); program engagement and completion for each family, and; psychoeducational awareness on family dynamics, touching on violence and prevention completed.

HBGI recognizes that further work will need to be undertaken to develop the program and the associated outcomes at the individual and family level.

Nzumari Africa

*(psychotherapy and employment outcomes for young parents in **KENYA**)*

Provider

Nzumari Africa is a community-based organization in Huruma, Kenya, working with youths of diverse backgrounds, to make decisions, co-create, implement, and manage programs that affect and influence lives of young people. Nzumari Africa was conceptualized in 2000 as a project by the National Council of Churches of Kenya to address the challenges that young people were facing in Huruma and Mathare area, including poor mental health, high unemployment rate, HIV & AIDS, poor sanitation, perennial tribal conflicts and semi illiteracy and illiteracy. The organization has evolved from a project, to a youth group, to becoming a community-based organization in 2012.

Need being met

The WHO estimates that 12 million girls aged 15-19 years and at least 777,000 girls under 15 give birth in developing countries. The Kenya Health Information Management System (KHIS) for the period January to May (five months) for years 2019 and 2020 shows that the number of girls aged 10-19 years presenting with pregnancy in health facilities was 326,919. The fact that one out of ten 10 year olds in developing countries experience a mental health disorder and also are more likely to be an adolescent mother/father intensifies the need to have effective holistic mental health intervention amongst this at-risk population.

Program overview

The proposed program delivers psychotherapy to adolescent parents (14-19 year olds) in Nairobi, coupled with training on business and finance management. Psychotherapy is delivered by peer counselors, who are trained and supervised by the Nzumari Africa Youth Gathering Space's psychologist. This psychologist, in turn, is supported by a clinical psychologist with experience of working on peer approaches.

The 12-month program will:

- provide free psychotherapy to 200 young parents;
- train 20 peer counselors;
- deliver mental health literacy for adolescent mothers and fathers (in- and out-of-school setting);
- undertake mental health awareness campaigns using expressive arts and sports to mobilize and engage community members on the importance of adolescent mental health, and;
- challenge mental health stigma.

This is coupled with training for 100 adolescent parents on entrepreneurship and financial literacy over the same period (this number can increase to support all 200 if more parents require it and funding permits). The training is provided in-house by Nzumari Africa's experienced trainers.

Possible outcomes

Payments could be linked to a number of outputs and outcomes including:

- each young person completing psychotherapy support;
- each young person who has improved wellbeing as a result (pre-post survey);
- each peer counselor trained; and then retained six months later;
- functional outcomes, linked to business and finance training for example: each business set-up; each employment secured, and; improved wages.

HBGI is keen to see the functional outcomes and impact of the psychotherapy sessions. Ahead of any contract award, HBGI would work with Nzumari Africa to determine what these could be and how they could be measured and evidenced.

Opa Mind

(voice technology application to support employees' wellbeing globally)

Provider

Opa Mind is a newly established organization with a core team of twelve. Established in Ireland, its Founder and CEO, Martin Lawlor, has spent 22 years in the Emotional Wellness space and on the back of this domain experience, Opa Mind has spent four years in Research & Development supported by Dublin City University and The Science Foundation of Ireland.

At the time of EoI submission, Opa Mind was pre-revenue.

As this is a mobile phone application, proposed geography is open. It will eventually be available on all digital apps.

Need being met

Nearly nine out of ten people with mental health problems say that stigma and discrimination have a negative effect on their lives (source: mentalhealth.org.uk). Opa Mind seeks to address the issue around stigma and emotional health globally in which people suffering from poor emotional health are unable to be open about it. They are scared of sharing how they feel and therefore not accessing the support they require, be it from family and friends or a professional. In particular, Opa Mind is focusing on employees in the workplace who are not addressing their poor levels of emotional health.

Program overview

At the time of submitting their proposal, Opa Mind was in the final stages of developing their voice technology application. As such, HBGI recognizes that this will need testing and piloting before it can be considered for potential contracting.

In summary, the Voice Technology App platform allows people to speak into the Opa App and express how they feel at any given time. Opa listens to the input and analyzes it, sending back various metrics based on the recognized Emotional State and Vocal Bio-Markers. The support element of the platform will personalize positive content for the user, to support and help them towards self-empowerment to eventually reach out and engage with various support structures and loved ones.

The Opa App is completely anonymized and user anonymity is central to the work of Opa Mind.

Possible outcomes

At current stage clear, measurable, and verifiable outcomes have not been identified. HBGI would want to see this piloted first, to understand how the application delivers outcomes at the individual level including: showing link between the use of the app to individual then seeking professional support for their emotional wellbeing; an improvement in an individual's wellbeing, and; how use of the app impacts on employees' performance in the workplace, for example, in increased productivity and attendance and reduced turnover.

HBGI recognizes that some further work and support will be required to achieve this.

Pantang Hospital

*(improved mental health and rehabilitation of homeless people with poor mental health in **GHANA**)*

Provider

Pantang Hospital is the largest of the three psychiatric hospitals in Ghana. Commissioned in 1975, Pantang Hospital currently operates a 200-bed capacity facility catering for inpatient and outpatient psychiatric and general medical services (including internal medicine, obstetric, ophthalmological, dental, laboratory, and x-ray services). The hospital also operates a COVID-19 treatment center.

Need being met

The proposed program will support the high number of homeless people living on the streets, who also have poor mental health, including severe mental disorders such as schizophrenia.

According to a 2005 study by the Mental Health Authority (Ghana), there are around 1,600 people on the streets of Accra and Tema with severe mental disorders, and approximately 7,000 nationally. Currently, the authorities estimates 2,000 mentally ill people in Accra and Tema, as well as 10,000 country wide – a growing number. (Covid-19: "Mentally-Ill" on Our Streets Could Be Virus Storehouse - MHA — Starr Fm, n.d.).

Program overview

The 'Set the Captive Free' program identifies and then provides temporary shelter for homeless people experiencing poor mental health, whilst also providing them with mental health support and other interventions including: reuniting with family; referring to social protection schemes like enrollment onto the National Health Insurance Scheme, and; livelihood support. The program trains and provides additional community mental health officers to work with more homeless people who are experiencing poor mental health.

The program's current funding source is mixed (e.g., individual philanthropist, churches, and corporate bodies). This proposal is to secure stable funding which will allow the program to be delivered at scale, to more individuals.

Possible outcomes

Potential outputs and outcomes to which payments could be linked include:

- each person supported (registered on the program);
- each person with improved mental health (e.g., through self assessment/pre-post survey);
- each person who has enrolled on social interventions such as the National Health Insurance Scheme (NHIS), Livelihood Empowerment Assistance Program (LEAP), and Labour Intensive Public Works (LIPW);
- each person achieving a functional outcome, e.g., employment, secure housing, or rehabilitation with family;
- each community mental health officer trained, and; then retained at six months post training.

Partners In Health

*(strengthened care for people with severe mental health conditions in a number of **AFRICAN** countries)*

Provider & Proposed Geography

Partners In Health (PIH) works to expand mental healthcare from institutional treatment to community systems, meeting people where they live in the community. The proposed program focuses on service users with severe mental health conditions (diagnosed with chronic illness such as schizophrenia or bipolar disorder) in low-resourced, vulnerable and rural locations including Rwanda, Liberia, Sierra Leone, Lesotho, and Malawi. PIH, whilst operating in these African countries, is open to which geography service is delivered in and can focus on one particular country if required.

Need being met

Mental healthcare remains at the margins of global health delivery, with up to a 90% treatment gap and low- and middle-income governments typically spending less than 1% of their limited resources on mental health. Severe mental health conditions affect more than 4% of the global adult population. Specifically, in Africa, mental illness accounts for 18% of a life lived with disability. If an individual has a mental illness for 10 years, the person will be utterly dependent for 730 days (two years) of his/her life. Schizophrenia accounts for on average 4-5% of disability adjusted life years and years lived with disability in Rwanda, Lesotho, Liberia, Sierra Leone, and Malawi. (Daniel Vigo and Partners In Health, 2016, Cross-Site Mental Health Meeting, Beverly, MA). Moreover, there is a 40–60% chance of premature death in people with schizophrenia (source).

Program overview

The proposed program will strengthen and scale a rights-based and recovery-oriented care pathway and psychosocial rehabilitation (PSR) package to support people living with the most severe mental health conditions, working within existing facilities (e.g. primary care, hospital) by:

1. training and mentoring non-specialist health workers on person-centered integrated care (including strengthening skills-based training and supervision of frontline workers) in basic care packages for psychosis;
2. strengthening the early identification and uptake of treatment for severe mental health conditions through community engagement;
3. promoting psychosocial rehabilitation and family resilience through self-help groups for peers and caregivers;
4. engaging with local communities to enhance capacity for supporting treatment for people living with severe mental health conditions, social inclusion, vocational training, and employment opportunities, and;
5. strengthening procurement processes to increase access to psychotropic medication and reduce stock-outs of essential medication.

The target population focuses on service users with severe mental health conditions, their caregivers, and healthcare workers. Inclusion criteria will be used to ensure there is consistency in the cohort across sites and that service user outcomes are clearly tracked over time.

Possible outcomes

Ahead of any contract award, HBGI would work with PIH to refine possible outputs and outcomes to which payments could be linked, including the weighting of payments so that focus was on impact, rather than outputs. However, examples of some of the possible outputs and outcomes include:

- each Health Worker (HW) trained in PSR, and; each HW still conducting PSR six months post training;
- each new person identified and diagnosed with severe mental health conditions, and; that person having a PSR recovery plan;
- each person provided with social support (e.g. food packages);
- each person with clinically significant improvement in symptoms and functioning using a validated scale appropriate to the local context (e.g. the Clinical Global Impression (CGI) scale and the WHO Disability Assessment Scale (WHODAS Brief);
- each person participating in income-generating activities (e.g. self-employment and/or formally employed);
- a reduction in medication stock outs (against a baseline).

PATH

*(perinatal depression screening and counseling in maternal child health services to improve wellbeing in mothers in **MOZAMBIQUE**)*

Provider

PATH is a global nonprofit dedicated to achieving health equity. With over 40 years' of experience forging multi-sector partnerships, and with expertise in science, economics, technology, advocacy, and other specialties, PATH develops and scales up innovative solutions to the world's most pressing health challenges.

The proposed geography is Mozambique, though this could be replicated in other similar geographies.

Need being met

The need for perinatal* mental health screening and follow-up in Mozambique is high due to well-documented risk factors for perinatal depression, including high adolescent pregnancy rate (45%) and one of the highest HIV prevalence rates during pregnancy in the region (15.8%). A study in Maputo Province found that the prevalence of depressive symptoms in postnatal women was nearly 18%. Fortunately, there is widespread agreement within the Ministry of Health that perinatal depression screening and counseling should be scaled up through primary healthcare. This is possible given that Mozambique has relatively high availability of mental health providers, with most urban and district-level hospitals having a mental health technician or psychologist in the team.

Program overview

In 2019–20, the Ministry of Health, with technical assistance from PATH, developed and piloted the first-ever national protocol for the screening and management of perinatal depression within routine postnatal care (PNC) services in the country. Over 70% of suspected perinatal depression cases referred by Maternal Child Health (MCH) nurses were confirmed by mental health providers, thereby suggesting that the simple frontline screening approach is reasonably accurate. The proposed program is a scale-up of this perinatal depression screening and counseling in MCH services.

MCH nurses will be trained and supported by mental health providers to conduct initial screening for perinatal depression using the short PHQ-2 form. Women suspected of being depressed will be provided with light-touch first-response counseling by the nurses and also referred to mental health specialists. They will be subsequently screened by mental health providers with the longer PHQ-9 tool to confirm initial diagnosis. The scale-up will include development and testing of a follow-up model consisting of supportive text messages and peer group support, facilitated by the mental health technicians, who are present in most district-level government hospitals. The proposed program will provide blanket coverage of all health facilities in three urban centers within three regions of the country: Matola City in Maputo Province; Quelimane City in Zambézia Province, and; Nampula City in Nampula Province.

Possible outcomes

Payments could be linked to the following possible outputs and outcomes:

- each MCH nurse trained in mental health screening;
- each individual pregnant woman screened;
- of those screened positively, each then accessing the follow-up intervention (e.g. peer support group);
- each woman then showing reduction in depressive symptoms (as measured using PHQ-9 form).

HBGI would also be keen to scope and determine how payments could be linked to 'functional outcomes' for the mother, and possibly child. HBGI would work with PATH to develop this ahead of any contract award.

*Perinatal is the period of time from when a woman becomes pregnant and up to a year after giving birth.

Red Dot 365

*(improved mental health awareness and management amongst school children, applicable **GLOBALLY**)*

Provider

Red Dot 365 harnesses the precision of data and technology with the understanding of people to improve their health and wellbeing. Red Dot 365 operates in the UK, USA, Australia, Switzerland, Portugal and Brazil. It operates in education, manufacturing, health, sport, and communities. The platform is Cyber Essentials+ accredited and available in all languages. The current business turnover is £2.9 million.

Proposed program can be implemented in any country of choice.

Need being met

Globally, one in seven 10-19-year-olds experiences a mental disorder, accounting for 13% of the global burden of disease in this age group.

Depression, anxiety and behavioral disorders are among the leading causes of illness and disability among adolescents. Suicide is the fourth leading cause of death among 15-29 year-olds. The consequences of failing to address adolescent mental health conditions extend to adulthood, impairing both physical and mental health and limiting opportunities to lead fulfilling lives as adults (WHO).

Program overview

The proposal is to rollout a digital platform for learners aged 11 – 18 to address mental health and wellbeing via a secure user portal. This is supported by an organizational portal to understand data, trends, demographic differences, demand, and what solutions work for teachers and educators. The program is designed to adopt a preventative approach to mental health. It operates in a learning institution (e.g., school) and runs for a minimum of two years, with an additional year of learning and evaluation.

Stage 1: capture data and insights into what the perceived goals, challenges, barriers and solutions are for students, with respect to their wellbeing, then use the data to design and implement evidence-based solutions (e.g., courses, training) at a school level.

Stage 2: measure the impact by understanding what works, where, and why. The information will further evolve the portal to inform policy, broaden the scope across all education provision (e.g., primary, secondary, further education, teachers' training), as well as providing a mechanism for safeguarding children.

The program is live in schools throughout Wales and also used on the Welsh Government's Jobs Growth Wales+ Program. Estyn (inspection body for Welsh schools) has rated the program as excellent in learner health and wellbeing.

Possible outcomes

Ahead of any contract award, HBGI would contract this first in a few schools within a defined geography, with a control group for comparison.

Payments could be linked to a mixture of outputs and outcomes including:

- an increase in mental health awareness amongst students and teachers (against control group or baseline, and the increase to be statically significant);
- an increase in young people engaged who understand how to manage their own wellbeing, reducing impact on statutory services (against control group or baseline, and increase to be statically significant);
- each child achieving a functional outcome (for example, improved school attendance, improved attainment - against a baseline);
- each Pastoral Care Lead (teachers) trained on how to manage the portal;
- a reduction of the number of suicides in young people and teachers (against baseline – and applicable in geographies where incident numbers are worryingly high).

Sangath

*(addressing depression and improving treatment and functional outcomes for people with diabetes in **GUJARAT, INDIA**)*

Provider

Sangath is a non-governmental, nonprofit organization. It is committed to improving health across the lifespan by empowering existing community resources to provide appropriate interventions for the prevention and care of mental health problems. Since its inception in 1996, Sangath has become one of the world's most recognized mental health implementation science NGOs. Headquartered in Goa and with hubs in Bhopal and Delhi, Sangath works in partnerships with state governments across India and has a number of longstanding partnerships with international institutions, notably Harvard Medical School.

Need being met

NCDs such as diabetes and depression often co-occur; people with diabetes are twice as likely to experience depression compared to the general population (India). A recent meta-analysis reported the prevalence of depression among patients with diabetes in India to be 38%. A scalable, person-centered, integrated approach to embed depression care in routine care, in particular within India's NCD program, is urgently needed. India's public health system has a well-defined structure comprising of sub-centers, primary health centers, community health centers, and district hospitals. Various cadres of health professionals work at the different levels of structure. Two key health professionals – the Community Health Officer (CHO) (comprised of both men and women) and the Accredited Social Health Activist (ASHA - all of whom are women) – are important actors in the proposed program.

Program overview

The proposal is to scale-up the Healthy Activity Program (HAP). This is a manualized, brief psychological intervention for depression for delivery by frontline providers in routine care and community settings (including patient's home) for patients receiving diabetes care. HAP consists of six to eight sessions, delivered in three phases in weekly or biweekly intervals, conducted face-to-face. The program will utilize the strategy of task-sharing by training, deploying, and supervising the CHOs and ASHAs (as the frontline providers) for treating depression in community settings in Gujarat, a state in Western India with over 60 million people. The program will use the EMPOWER digital platform which builds the capacity of CHO and ASHA who are managing NCD care, to learn, master, and deliver evidence-based, brief psychosocial interventions. The digital approach ensures that the same content is delivered in the same way for all who receive the training, eliminating the cost and complexity of repeatedly training new trainers and monitoring their fidelity across all training events and contexts. The EMPOWER approach accompanies providers through three broad stages of growth:

1. learning a new treatment through a competency based digital curriculum with the support of a coach;
2. mastering the treatment through case-based practice with supervision by an experienced provider, and;
3. following credentialing based on tailored competency assessments (based on the WHO's EQUIP tools), delivering the treatment with continuing quality assurance through peer-supervision.

Possible outcomes

Payments could be linked to a number of possible outputs and outcomes, including:

- each CHO and ASHA who is trained and achieves competency;
- each CHO and ASHA who begins delivering HAP, and then retained six months after training;
- each patient who completes the program;
- each patients who reports increased improvement in wellbeing using approved matrix (tbd);
- Patient-centered functional outcomes achieved by each patient, such as returning/retaining employment;
- outcomes related to comorbidity, for example, improvement in treatment adherence; reduction in disability; or diabetes control.

Save the Children: Program 1

*(improved caregiving, food security, child diet and maternal mental health in **MALAWI**)*

Provider

Save the Children is a leading independent organisation for children, with an international division responsible for the implementation of programs in nearly 120 countries. Save the Children works closely with partners, which include national governments, local and international NGOs, civil society coalitions, children's groups, and communities. The organization submitted proposals for two programs, both of which are detailed here.

Need being met

While the prevalence of child undernutrition in Malawi has decreased over the years, most recent data suggests that is still high at 36% (MICS 2019). Poor maternal, infant, and young child feeding practices, recurring infections and lack of access to key health and nutrition services are all causes of malnutrition, exacerbated by poverty, food insecurity, and gender inequality. Chronic malnutrition affects children's growth, health, brain development, and school performance with long-term consequences on a person's productivity, and consequences for the next generation (a stunted mother is more likely to have a stunted child). Access and use of essential health and nutrition services before, during, and after pregnancy, until the child is five years of age, will improve pregnancy outcomes and child growth by reducing the risk of disease, anemia, and improving maternal and child caregiving behaviors.

Program overview

The proposal is to scale and convert into an outcomes-based contract existing program in Malawi (MAZIKO) which combines maternal and child cash transfers with social and behavior change interventions to improve caregiving practices, food security, child growth and development. The current program works with circa 18,000 mothers via the social and behavioral change intervention and 5,500 women through the cash transfer element.

The program works with mothers and children during the first 1,000 days of life (pregnancy to age two years), providing:

1. maternal and child cash transfers and livelihood support, and;
2. counseling and social and behavior change interventions to improve caregiving practices, food security, child growth and development.

The program is delivered by trained community health workers and volunteers.

Possible outcomes

Ahead of any contract award, HBGI will work closely with Save the Children to define and further develop the scale-up to ensure best fit with outcomes-based contracting. This includes the need to define more clearly the target population and possible outcomes, including mental health outcomes for the mothers. Payments could be linked to both outputs and outcomes, including:

Outputs (benefiting from intervention):

- each woman receiving monthly cash transfers;
- each caretaker receiving counseling and support.

Outcome One (improved caregiving)

- each child less than six months who was exclusively breastfed in last 24 hours.

Outcome Two (improved children's diets)

- each child (six to 23 months) with minimum acceptable diet in last 24 hours.

Outcome Three (improved food security)

- each household not experiencing food insecurity in the last month (according to HFIAS tool).

HBGI would also like to see outcomes linked to weight gain in each child and will work with Save the Children to ascertain the viability of this.

Save the Children: Program 2

*(improved wellbeing and safety for school children in **NEPAL**)*

Need being met

Mental health issues for children and the low capacity to address them has been well documented in Nepal. An epidemiological study conducted in 2021 showed an 18.3% prevalence of mental health problems in school children aged 6-18 years and increased mental health problems in both boys (19.1%) and girls (17.6%). Fourteen percent of adolescents in grades 7-11 had suicidal ideation whilst 10.3% had attempted suicide.

Various studies from Nepal have also shown a lack of safe learning environments for children with studies showing a high prevalence of violence against children in the school system, with corporal punishment being a common practice in most schools. A Global School Based Student Health Survey (GSHS) in Nepal revealed that almost half of school students had been physically attacked, more than one in three were involved in a physical fight, and 12% had been victims of sexual violence.

Program overview

Safe Schools, Happy Lives program is a 'whole school approach' to improving the wellbeing of children by reducing school-related violence. The program focuses on several aspects: policies; legal framework; educators' capacity/knowledge, and; parents and children. It is delivered in partnership with local NGOs and government partners from child protection and education, including the Centre for Mental Health and Counseling Service Nepal (CMC Nepal).

The program will focus on:

- children (including peer-to-peer support; resilience building strategies);
- teachers and school managers (support in providing safe environment for children, as well as accessing support for their own mental ill health);
- parents (support to use positive parenting practices, and referral to mental health support if they require it), and;
- local government staff (whose capacity and ability to implement the national free mental health support services to school children will be enhanced to deliver quality services).

Possible outcomes

HBGI would work with Save the Children to define clear functional outcomes ahead of any contracting, however possible outcomes (and outputs) to which payments could be linked include:

- each child who records improvement in mental health/wellbeing and feeling safe (pre/post self-reporting);
- each child who records a functional outcome, for example, improved school attendance;
- each teacher and parent who completes a course on safety;
- functional outcomes achieved for each teacher, e.g., reduced absence/sickness or improved retention.

SEEK-GSP

*(addressing depression and improving income and treatment outcomes for rural communities in **UGANDA**)*

Provider

SEEK Group Support Psychotherapy Initiative Ltd (SEEK-GSP) is a newly incorporated and registered NGO based in Kampala, Uganda.
SEEK-GSP is an implementing partner of the Ministry of Health. It is responsible for Group Support Psychotherapy (GSP) training, mentorship, and supervision of facility- and community-based health workers in the ongoing integration of mental health screening and support within the HIV continuum of care.

Need being met

Uganda is ranked among the top six countries in Africa in rates of depressive disorders (4.6%; Miller et al., 2020), while 2.9% of the population lives with anxiety disorders (WHO, 2017). Whilst an estimated 35% of Ugandans suffer from a mental disorder, and 15% of Ugandans require treatment, it is likely that the incidence of mental illnesses and the need for treatment is much higher (Molodynski, Cusack, & Nixon, 2017). Communities in northern Uganda are facing multiple risk factors for depression including the COVID-19 pandemic, war trauma, sexual and gender-based violence, and extreme poverty. People affected by depression face stigmatization by their community largely due to misunderstanding and disconnect between traditional and modern medicine.

Program overview

The proposed SEEK-GSP's self-titled program (Social, Emotional and Economic empowerment through Knowledge of Group Support Psychotherapy) is an innovative mental health program which has proven highly successful and cost-effective in treating depression in people with HIV-AIDS across the three districts of Uganda it already operates in. Ninety-nine percent of patients on the program were free from major depression six months after completing the eight-week treatment. Follow-ups two years later found the same proportion of people free from depression, against a control group. More GSP than control participants reported improved viral suppression (96% versus 88%).

Other benefits of this intervention include improvement in poverty levels amongst participants as they were better able to engage in livelihood activities. In 24 months, around 94% of GSP patients from the lowest socioeconomic group reached a higher status, while in the control group the opposite occurred, with the number of people in the lowest socioeconomic group increasing by 85%.

The proposal is to roll the SEEK-GSP program out to the general population across 20 districts of Uganda. Specifically, the program will target rural communities who do not have easy access to health facilities or awareness around poor mental health, and depression in particular. The program will introduce depression screening and treatment to these isolated rural communities using a Train-the-Trainer model. A great advantage of GSP is that it does not require ongoing input from expert mental health practitioners. Health workers in government facilities will train existing primary healthcare workers in rural health centres to deliver GSP sessions. In turn, they train lay health workers who then identify individuals with depression and treat them in the villages through GSP. In this way, SEEK-GSP empowers local communities to take control of their own mental health needs.

The lay health workers will deliver information session on mental health in the isolated communities they are a part of, inviting members to undertake depression screening using the SRQ form. Those scoring six or higher will be invited to join group therapy sessions, which run weekly for eight weeks, facilitated by the trained lay health worker. Individuals with scores indicating severe depression are referred to mental health workers in nearby health facilities. SEEK-GSP also provides basic financial knowledge and livelihood/income generating skills, the success of which is measured through improved income, food security, asset possession and acquisition of savings.

Possible outcomes

Payments could be linked to the following outputs:

- each health worker trained as Trainers;
- each lay health worker trained, and; retained for six months as GSP facilitator;
- each person screened for depression;
- each person completing the GSP program.

And to the following outcomes:

- each person treated from depression post GSP (scoring more that six on SRQ form);
- for those with comorbidities, each person who adheres to and/or completes treatment post GSP completion (for example, for those who are HIV positive, each person with improved viral suppression);
- each functional outcome achieved, for example: improved income, food security, asset possession, and savings.

SELF Circles

*(developing skills to strengthen resilience in young people, **GLOBALLY** applicable)*

Provider & Geography

SELF Circles was incorporated in 2022 and registered for nonprofit status in the USA.
The SELF Circles model can be applied to any given geography once adapted for appropriate cultural and context fit.

Need being met

Before the COVID-19 pandemic, one in five young people worldwide was living with a mental health condition, and suicide was the third leading cause of death for teenagers between the ages of 15 and 19. Nearly 50% of all mental health conditions have their onset by the age of 14, and 75% by the age of 24. Since the pandemic, symptoms of anxiety, depression, and other mental health conditions have increased dramatically, putting young people at risk of full-blown disorders that disrupt their ability to successfully manage relationships, school, and work as they move into adulthood. SELF Circles is designed to intervene before mental ill health symptoms severely disrupt the transition into adulthood.

Program overview

SELF Circles is a strength-based, resilience-oriented program that reduces the effects of toxic stress, trauma, and oppression and is designed to harness participants' power in creating paths to wellness. It is designed to be culturally adapted and delivered by other organizations/programs as part of their overall program of activity. Staff of the hosting organization/program are trained on the adapted model, which includes weekly coaching during delivery and subsequent ongoing peer learning through participating in community of practice. These staff are then equipped to deliver the program.

SELF Circles is a 12 lesson program, which is generally offered on a weekly basis. While the concepts build on one another, it is not required that the lessons be delivered consecutively. They are typically offered within an organization, community space, or as part of a mental health promotion or substance misuse program within a larger system. Conversations are co-facilitated by health workers or other staff and include 10-12 young people. Each program is evaluated on completion in order to ensure that there is a continuous improvement cycle.

Self Circles is designed to assist young people in identifying their areas of concern and addressing the early signs of distress, potentially preventing mental ill health and shifting the trajectory of a lifetime of struggle.

Possible outcomes

HBGI would look for further evidence of delivery and potentially aim to pilot the program before rollout. As part of this, HBGI would also look to define outcomes more clearly, focusing on evidenced functional outcome for the young person (such as improved school attendance). In the meantime, the possible outcomes (measured using a range of globally recognized pre- and post-surveys) that could be achieved at the individual person level include:

- increasing agency, which refers to making decisions to influence events and circumstances of one's life;
- increasing emotional regulation;
- increasing problem-solving;
- improving self-care;
- reducing secondary traumatic stress symptoms.

Society for Pre and Post Natal Services

*(improved perinatal mental health for parents in **ZIMBABWE**)*

Provider

A voluntary organization established in 2010, the Society for Pre and Post Natal Services (SPANS) is a pioneering perinatal mental healthcare organization in Zimbabwe. SPANS provides mental health and perinatal care through a family-centered approach. This includes: training family mental health therapists; promoting mental health literacy; managing advocacy campaigns to promote sound mental health, and; organizing the International Conference on Maternal Mental Health in Africa.

Need being met

The global prevalence of antenatal depression is estimated at 15%, while in Zimbabwe a study conducted in Harare polyclinics found it to be at 23% of pregnant women (Kaiyo-Utete et al., 2020). Globally, 17% of women who give birth are affected by Postpartum Depression (PPD) while the prevalence in Zimbabwe is even higher at 27%, making PPD the most common psychological condition following childbirth (Wang et al., 2021). While much is being done to address this challenge, perinatal women have been largely left out or ignored in the face of the global mental health crisis. Failure to treat promptly may result in a prolonged, negative effect on the mother, the relationship between the mother and baby and on the child's psychological, emotional, social, spiritual, and educational development. There has not been enough support given towards strengthening mental health services towards pregnant and lactating mothers in Zimbabwe. According to the WHO Special Initiative for Mental Health (2020), 'Zimbabwe has a severe shortage of human resources for mental health, with an estimated 18 psychiatrists (17 of them in Harare) or approximately 0.1 per 100000 people. There are 917 psychiatric nurses (6.5 per 100000) and 6 clinical psychologists (0.4 per 100000).'

Program overview

The proposed program is the delivery of SPANS' main program of interventions to improve perinatal mental health through a family-centered approach. The program targets expectant mothers and fathers. Interventions are delivered in partnership with Primary Healthcare clinics and include:

- training of family mental health therapists through a SPANS-initiated diploma in Systemic Family Therapy and Developmental Counseling in Maternal, Paternal and Child Mental Health;
- providing family therapy/counseling sessions, and;
- improving community awareness around mental health (which includes campaigns, conferences, and literature production).

Possible outcomes

Payments could be linked to the following outputs and outcomes:

- each family therapist trained;
- each family therapist retained six months post training;
- each family unit attending and completing family therapy/counseling program;
- of those attending, each family reporting improved wellbeing and mental health through approved pre-post surveys;
- of those attending, identifying a family functional goal and achieving this (e.g., one parent returning to work or both parents living together).

HBGI would look to work closely with SPANS to develop program outcomes focused on results, including possible outcomes linked to the newborn achieving developmental milestones.

Stellenbosch University

*(reduction in depression/anxiety and improved academic achievement via digital interventions for university students in **SOUTH AFRICA**)*

Provider

The lead organization for this work is the Institute for Life Course Health Research (ILCHR) in the Department of Global Health within the Faculty of Medicine and Health Sciences at Stellenbosch University (SU) in South Africa. SU is one of Africa's leading research-intensive universities. ILCHR is a global public health research center. For over 10 years, ILCHR has worked across sub-Saharan Africa and in other LMICs on a large number of projects aimed at generating evidence about 'what works' to improve child and adolescent mental health and development.

Need being met

In LMICs, including South Africa, mental disorders are highly prevalent, particularly amongst youth. However, there are scarce resources for mental health services, and so a large mental health treatment gap exists (in excess of 90% in South Africa). Digital mental health interventions have potential to fill this gap. Evidence globally suggests that a range of digital mental health interventions can be effective to treat mental disorders among young people, particularly depression and anxiety. Importantly, the evidence also suggests that these approaches may decrease loneliness, improve health behaviors, and reduce suicide risk. However, digital interventions have also been shown to have low uptake and retention rates which may impede the ability for these emerging technologies to close the mental health treatment gap.

Program overview

The proposed program seeks to leverage innovative implementation science strategies to address barriers to uptake and maximize the scalability of digital interventions for youth (college students) with mental health problems in LMICs with a focus on achieving national scale in South Africa.

The proposed program will include:

1. personalized marketing strategies developed in collaboration with youth with lived experience (barrier targeted: enrollment);
2. developing menus of context-appropriate digital interventions to enable youth choice (barrier targeted: engagement);
3. developing an implementation science monitoring and evaluation component to the intervention which helps to understand the accountability levers which can be built into digital and online programs to improve retention/adherence (barrier targeted: retention), and;
4. using a stepped care approach within the menu of interventions to ensure that students are routed to increasingly higher intensities of intervention according to need and treatment response (barrier targeted: resource optimization).

Possible outcomes

This is a research program, which is different to the other programs proposed. Potential payments could be linked to the following outputs and outcomes:

- reduced symptoms of depression and/or anxiety (assessed using the PHQ-9 and GAD-7, possibly against baseline);
- improved academic achievement (assessed using rates of graduation and grades/academic performance, against baseline);
- improved quality of life and functioning (assessed using standardized quality of life measures, as well as engagement in social/leisure activities, number of social contacts, loneliness, securing gainful employment, and achieving other life goals);
- uptake of the digital platform and its adherence (assessed as number of new users, user retention, and duration/frequency of the usage of digital tools).

Teenergizer

*(trained peer-to-peer counselors and improved mental health of young people in **UKRAINE** via online counseling)*

Provider

Teenergizer is a youth-led organization which includes professional psychologists and trained peer-to-peer counselors. They provide free and confidential counseling on various topics including sexual and reproductive health and living with HIV to young people from the EECA region through their web platform.

Need being met

The cumulative effect of the COVID-19 pandemic and the 2022 Russian invasion of Ukraine has resulted in a surge of mental health disorders, including anxiety, PTSD, depression, and substance use disorders. More than 22% of conflict-affected people may end up with some form of mental health disorder. In the context of Ukraine, that would mean over 4.5 million people, of which over 1. 5 million are children.

In a rapid assessment of needs amongst displaced families in Ukraine, parents' biggest worry for their children was their mental health (45%). Worryingly, more than a quarter (26%) of parents in the same area had no knowledge of mental health services that they could make available to their children. Investing just US$50 per person now could prevent over one million people affected by the conflict from developing more complex mental health issues such as anxiety, depression, schizophrenia, bipolar disorder, and other mental health disorders (Source).

Program overview

The proposal is to provide psychological support to Ukrainian young people and adolescents affected by the Russian invasion, COVID-19, and other issues, by:

- training and supervising peer counselors in Ukraine to deliver counseling support, and;
- delivering psychological peer-to-peer online counseling support to youth and adolescents via Teenergizer online platform for counseling.

Peer counselors also receive training on the general principles of online counseling and its methods, including on policies designed to safeguard the young people, such as policies on sexual exploitation and abuse. Moreover, peer-to-peer counselors regularly attend group supervisions and individual supervisions where they discuss the cases of beneficiaries with professional, experienced psychologists to ensure the safety of both peer-to-peer counselors and the teenagers/young people who ask for help.

Possible outcomes

Payments could be linked to outputs including:

- each peer counselor trained;
- each peer counselors practicing six months post training.

In addition, before any contract award, HBGI would work with Teenergizer to identify and agree outcomes linked to individuals. This could include, for example:

- each young person who completes a series of counseling session (e.g., to be defined as x number of sessions);
- each young person who has improved mental health (e.g., through self-reported pre-and post- questionnaire);
- each young person achieving a functional outcome (e.g., remaining in education).

Trauma Resource Institute

*(reduction in post-trauma stress and improved school performance for educators and students in **UKRAINE**)*

Provider

The Trauma Resource Institute (TRI) is a nonprofit registered in the US which promotes individual and community wellbeing. TRI has developed two types of training: i) the Trauma Resiliency Model (TRM)® and; ii) the Community Resiliency Model (CRM)®. Both models are biologically based and teach wellness skills, cultivating wellbeing in mind, body, and spirit. While TRM is oriented towards mental health professionals, CRM takes on a public health focus and has been taught to non-health professionals and community leaders.

Whilst the proposal is to deliver this in Ukraine, the model can be adapted for other regions.

Need being met

COVID-19, followed by the 2022 Russian invasion and subsequent ongoing war has resulted in widespread interruptions to the educational process for many educators and students in Ukraine. For example, the war in Ukraine has resulted in more than six million Ukrainians fleeing to neighboring countries. This includes nearly 665,000 students (16% of total number of enrolled students) and over 25,000 educators (6% of total educators in the country). As of May 6, 2022, according to the Ministry of Education and Science of Ukraine (MoES), 1,635 schools and universities (5% of total) have been damaged from the war and 126 have been destroyed. TRI wishes to mitigate the impact of this on the mental health of educators and students in Ukraine.

Program overview

The proposal is to deliver a series of CRM Workshops and CRM Teacher Training (CRM TT) to help educators and students recover from trauma and build ongoing sustainable resources for improvement of mental health and wellbeing. CRM teaches wellness skills, cultivating wellbeing in mind, body, and spirit. CRM targets non-health workers and community leaders, including school staff. The CRM TT program has a 40 hour training format and follow-up consultation for one year. The CRM TT program is a combination of lecture, discussion, practice, and student teaching. During the course, the trainees learn the key concepts of CRM, the biology of traumatic/stress reactions, the skills of CRM, and teaching methods to enhance their teaching abilities, and support for the students.

Possible outcomes

HBGI appreciates that the success of this program will depend on strong buy-in from government and schools and would look to see that this is in place ahead of any contract award. HBGI would also work with TRI to ensure program is designed to deliver measurable impact on both students and teachers including functional outcomes for children, for example, improved performance at school or improved behavior, and to better understand the theory of change.

Payments could be linked to following outcomes:

- ***For educators:***
  1. a reduction in post-trauma stress response indicators (e.g., secondary trauma symptoms, somatic complaints);
  2. an increase in wellbeing indicators;
  3. reduced burnout (e.g., job retention indicators, reduced absenteeism, work engagement, improved teamwork/collaboration).
- ***For students:***
  1. a reduction in post-trauma stress response indicators (e.g., secondary trauma symptoms, somatic complaints);
  2. an increase in wellbeing indicators;
  3. improved school performance (e.g., reduced school dropout rates, reduced absenteeism, reduced referrals for behavioral problems, improved grades).

Both measured against baseline and/or pre- and post-training surveys.

TrustCircle

*(improved wellbeing using AI-based social-emotional learning platform for students in **CALIFORNIA**)*

Provider

TrustCircle is a for-profit public benefit corporation registered in the USA. It fosters emotional resilience and wellbeing at scale for children, adolescents, and youth globally, utilizing AI-driven social-emotional learning platform focused on prevention and early interventions. TrustCircle is now an official DigitalX solution for the United Nations Development Programme.

UNICEF India country office has joined forces with BringChange Foundation Inc. (a non-profit corporation in the USA) to empower one million individuals in India. BringChange Foundation is helping scale impact globally utilizing TrustCircle's Social-Emotional Learning Platform.

Need being met

COVID-19 pandemic has impacted the wellbeing of millions of students and youth who are facing this unprecedented crisis and need immediate help. In California, rates of anxiety and depression among children shot up by 70% from 2016 to 2020, according to an analysis by the Annie E. Casey Foundation. Suicide rates among Californian youth increased by 20% in 2020 according to the California Department of Public Health.

Globally, there is a 'state of emergency' in child and adolescent mental health. Mental health emergencies have risen 24% for age group 5-11 and 31% among age group 12-17. Suicide attempts amongst girls' age group 12-17 have risen by 51%. TrustCircle serves this immediate need with urgency and at scale – globally (Reference).

Program overview

The proposed program is a Social-Emotional Learning (SEL) platform that allows three minutes of self-reflection check-ins before a class starts. The SEL platform allows students to see trends in their own wellbeing and take proactive action. Proposal is to launch this SEL platform to six million students per year for three years in California, USA or in any other region.

The TrustCircle wellbeing technology platform, which is research-backed and supported by UNICEF, UNDP, NIHR, and the WHO Collaborating Center, is focused on fostering prevention and early interventions at scale. The TrustCircle SEL platform, whilst completely confidential, empowers individuals to understand their feelings, improve their behaviors, avoid mental health pitfalls that can lead to crisis (harm to self or other), and seek help when needed, even remotely from anywhere, anytime from any device - all this with just three minutes of self-reflection check-ins daily. The data generated by the activities enables individuals to see trends in their own wellbeing and take proactive action. In addition, TrustCircle empowers administrators and mental health 'Stewards' (e.g. school staff) to leverage TrustCircle's AI-driven wellbeing insights to see problems before they escalate into crises, help identify high-risk individuals/demographics, and take proactive action to promote health and wellbeing for children, adolescents, and youth at scale.

Possible outcomes

HBGI would suggest contracting this first in a small number of schools with a control group for comparison.

Payments could be linked to:

- each child utilizing the service regularly (to determine length of time where use of service is deemed regular and not a one-off, e.g., consistently for x days per week over x weeks);
- reported improvement in mental health/wellbeing of a given cohort (e.g., school year group against a control group or a baseline);
- reported number of 'seek help' requests from students, which are then followed-up.

HBGI would also want to see reported improvement in functional outcomes for individuals, such as improved attendance at school and reduction in sick days. Ahead of contract award, support would be provided to determine how these could be measured and verified.

UKOO

*(improved wellbeing and educational performance for young, queer people in **KENYA**)*

Provider

UKOO (Believe Mental Healthcare) is a registered feminist, community-based organization, founded in 2018. UKOO is committed to supporting the mental health and psychological wellbeing of queer young people (aged 10-35) and women in Uasin-Gishu County, Kenya. UKOO provides a range of services to support young queer people and women including: magazine publication, community dialogue, and community therapy sessions.

Need being met

Mental health is a growing area of concern in Kenya, with evidence suggesting that the burden of mental illness is high and increasing. An estimated 76% of people in the region with serious mental health conditions do not have access to the treatment they need. The WHO (2019) estimates Kenya's age standardized suicide rate to be 11.0 in 100,000. However, there is scarcity of data on suicide in Kenya. Suicide is the fourth leading cause of death among 15–29-year-olds . In LMICs, the male-to-female suicide ratio is 1.5 men to woman. Mental health illness amongst young queer people can be expected to be high given the social stigma associated with homosexuality in Kenya.

Program overview

Building on the existing relationship UKOO has with a number of Technical Vocational Education Training institutes (TVETS) in Eldoret, Kenya, the proposed program will support young people aged 19-25, focusing on queer young people, to address poor mental health by setting up peer group therapy sessions. Each peer group will have 12 sessions, which are facilitated and supervised by psychologists and counselors trained in mental health and behavioral science. The group therapy uses African storytelling tradition as well as information aids, and film screenings as tools to discuss mental health, build resilience, break cycles of violence, and contribute to both emotional and mental wellbeing amongst young people.

Possible outcomes

Ahead of any possible contract award, HBGI would work closely with UKOO to further develop the program, including its theory of change, proposed interventions, and outcomes. HBGI would look to pilot the program initially, in one or two TVETS before wider rollout. Possible outputs and outcomes to which payments could be linked include:

- each young person completing the peer group therapy sessions;
- each young person who records improvement in mental health (for example, via using quality of life tool);
- each further referral and take up of mental health service;
- improved student performance (for example, attendance and educational attainment) against a baseline.

YLabs

*(increased mental health literacy and access to psychosocial support for adolescents in **RWANDA**)*

Provider

YLabs is a global design and research organization based in Rwanda and specializing in adolescent mental health. YLabs designs, evaluates and scales technologies in partnership with youth to improve economic opportunity and health. YLabs' team includes product designers, behavioral scientists, physicians, nurses, mental health researchers, data scientists, as well as content writers and graphic designers.

Need being met

Rwanda is a young country, with 40% of the population aged under 15, and 2.2 million youth aged 15-24 years old. An alarming rate of 13% of Rwandans aged 10-17 report suicidal ideation or behavior. One in four youth meets the diagnostic criteria for depression. Mental health awareness and literacy are low among Rwandan youth, and there is reported societal shame in seeking help. Even though increased access to community mental health services, follow-up, and case management is a central component of the Rwandan Ministry of Health's 2018-2024 strategic plan, only 1% of the health budget is dedicated to mental health. Nationally, there are only two referral facilities, and five psychiatrists. Current healthcare resources are ill-equipped to meet the mental health needs of Rwanda's large youth population. Despite national efforts to build community-based mental health services, Rwandan youth lack knowledge of the symptoms of mental illness or where to access care. A recent systematic review found that the major barriers to seeking mental healthcare were perceived stigma and embarrassment, problems in symptom identification, and a preference for self-reliance.

Program overview

Tegura Ejo Heza (*Prepare for a Better Tomorrow*) is a youth-driven, holistic, offline/online digital learning, self-care, and peer support platform, designed to increase mental health literacy and psychosocial support for youth in- and out-of-school. This was designed in partnership with 158 youth and community members using a youth-driven design methodology. The platform helps address the lack of community-based mental health services by offering a first-of-its-kind resource for Rwandan youth, aged 10-19, to seek information on mental health, as well as receive support and referrals to seek additional care. Wellness Warriors – trained peers based in large urban youth centers, supported by older adult mentors – raise awareness and support referrals to services.

The proposed program will further develop and scale the online platform - with additional features including: interactive profiles of young people who manage their mental health; online/phone/message chats with trained peer counselors; self-screening of symptoms, and; service finder to increase self-efficacy to seek care.

The platform is designed to be used by youth centers and secondary schools.

Ahead of any contract award, HBGI would work closely with YLabs to understand the rationale behind the proposed development of the platform to ensure they are focused and linked to a clear theory of change.

Possible outcomes

Payments could be linked to the following:

- each school and youth center that adopts/uses the platform;
- percentage increase in platform users accessing psychosocial support services to improve their mental health (against a baseline);
- each platform user reporting changes in knowledge of mental illness and support services available (user survey);
- each platform user experiencing improvements in mental health and wellbeing score/effect size (e.g. WHO-5);
- each platform user experiencing improvements in functioning score (e.g., WHO-DAS 2.0);
- each platform user experiencing improvements in anxiety or depression symptom severity score/effect size (e.g., PHQ-9, GAD-7, RCADS).

HBGI would work with YLabs to identify additional functional outcomes that could be measured at the individual level.

Zvandiri

*(improved wellbeing and treatment outcomes for young people living with HIV in **NAMIBIA** and **SOUTH AFRICA**)*

Provider

Zvandiri is a private, voluntary organization, established in 2004 in Zimbabwe. It was formed following the request of a young woman living with HIV wanting a peer support group where HIV positive adolescents could learn from and share their experiences of living and growing up with HIV. Over the last 18 years, that first Zvandiri support group has evolved into a globally recognised, evidence-based, holistic model of peer-led, HIV and mental health services. Starting in Zimbabwe, it has been adopted and scaled in 10 countries and trained 2,690 peer counselors, called Community Adolescent Treatment Supporters (CATS).

Whilst current program regions are Angola, Ghana, Eswatini, Mozambique, Namibia, Nigeria, Rwanda, South Sudan, Tanzania, Uganda, and Zambia, the proposal is to scale-up in Namibia and open up in three provinces of South Africa.

Need being met

Over 1.5 million adolescents in Sub-Saharan Africa live with HIV. Despite significant advances in morbidity and mortality among adults living with HIV worldwide, adolescents continue to fall behind, with lower rates of viral suppression and treatment success. There is now increasing recognition that poor treatment outcomes among adolescents living with HIV is driven by high rates of poor mental health. Peer counseling focused on problem-based discussion must be utilized to improve CMDs. In 2021, the WHO strongly recommended that all countries integrate mental health interventions within their national HIV programs to improve the health and wellbeing of young people living with HIV.

Program overview

The proposal is to scale an evidence-based model which connects young people living with HIV (0-24 years) with trained, mentored peers - CATS (18-24 years). These trained, mentored peer counselors, themselves living with HIV, connect with their peers in their homes, clinics, support groups, and through mobile health clinics. CATS provide information, counseling and support services to promote their clients' physical and mental health and wellbeing. Supervised by health workers and Zvandiri Mentors, CATS identify undiagnosed young people and support them as peers to know their HIV status, start and remain on treatment whilst also supporting their broader health including mental and sexual and reproductive health and protection.

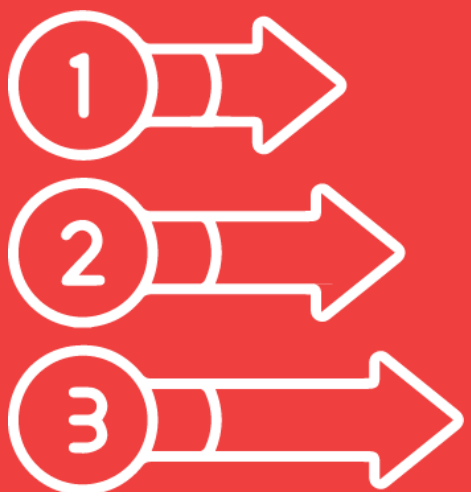
Three randomized controlled trials of previous programs have demonstrated that the Zvandiri model leads to significantly better HIV and mental health outcomes for young people living with HIV, with 42% of young people more likely to have a suppressed viral load and a reduction in poor mental health from 62% to 2%.

Possible outcomes

Possible outputs and outcomes to which payments could be linked include:

- each individual CATS trained on psychosocial support and CBT-based counseling, and retained at six months;
- each young person living with HIV accessing the support;
- each young person accessing the service being virally suppressed after one year;
- each young person who has scored positive for poor mental health then receiving counseling;
- each young person accessing the service who demonstrates improvement in mental health (pre/post survey);
- each young person who achieves their set functional goal (e.g., return to school, finish school, gain employment).

Ahead of any contract award, as with other potential providers and contracts, HBGI would work closely with Zvandiri to develop the payment structure for outputs and outcomes so that they are weighed to focus on the outcomes.



The Way Forward and Next Steps

WHAT THE PROVIDERS SAY

At CCI (Centre for Community Impact), we have found working with HBGI very interesting and helpful. Collaborating with HBGI has helped us to better understand the importance of delivering outcomes and functional outcomes at the individual service user level. Designing programs with an outcomes lens has been a critical shift which has helped us to think about our CCI programs differently as we had been focused on achieving inputs and outputs previously.

Sakumzi Ntayiya
Co-CEO and Chief of Party, CCI

CCI
CENTRE FOR COMMUNITY IMPACT

HBGI has learned a great deal through the production of this report, engaging and collaborating with the diverse range of organizations showcased here. Our partnership with the providers started at the launch of the Call, was developed during the process of co-producing the featured summaries, and will continue and strengthen as we develop and establish our Outcomes Funds.

We will disseminate this report as widely as possible, to raise awareness of the global growing mental health challenge and how mental health is a cross-cutting theme touching all our lives. We are also promoting the benefits of outcomes-based contracting, obviously with a particular reference to mental health programs but more widely, in challenging waste in public service funding and in international development. Targeting the service provider market, donors, researchers, global institutions, governments, policymakers and influencers, this report will be circulated through: our dedicated launch event; digital platforms including our website, social media channels, and direct mail to our existing and growing contact database; our Lived Experience Council and Board, and their extensive networks; other partners and supporters such as the Wellcome Trust and WHO AFRO and; mental health advocacy networks.

The funders/contractors of programs should always consider the significance of their role as market stewards. The wellbeing of our service users depends on the strength and capabilities of our providers. The impact of the programs depends on the capacity of the providers. We need to consider how to invest in building that capacity and enabling these organizations to perform at their best.

Following the publication of this report, HBGI is running **a series of virtual capacity building events,** open to service providers and others, including potential donors. The sessions, running over a number of months, will cover topics such as: understanding outcomes and outcomes contracting; building effective performance management systems; operational design considerations for an outcomes contracted program, and; understanding cashflow and working capital, including Impact Bonds. We will look to draw on the significant experience of many of the organizations in this report as co-designers and co-presenters of these events.

Details of each event will be circulated ahead of the session via email, our social media platforms, and on our website.

Beyond this report, HBGI has started to develop our first regional project with our Outcomes Fund for Africa. We are also working with donors and other stakeholders to establish a series of thematic Outcomes Funds which will focus on: sport and mental health; new brains (and new mothers); technology and mental health; veterans and mental health and; health system strengthening. Partnering with governments, we are working on: how to deliver empowering, sustainable outcomes for homeless people; a commercial model for shifting from hospitalization to community care, and; a challenge to the economically and socially destructive revolving door of reoffending.

As we launch each of these Outcomes Funds, we will issue a new Request for Proposals. These submissions will then be evaluated to select the programs to be contracted, with HBGI providing ongoing technical assistance and performance management support during mobilization and program delivery.

Finally, we will continue to work with our Lived Experience Council to ensure that the voice of service users informs service design and delivery. To learn more about our Lived Experience Council please read our report, which also details recommendations for integrating lived experience into organizations and services.

If you are interested in learning more about any of the programs or organizations featured, are considering donating to one of our Outcomes Funds, or want to discuss any other element of this report further, please get in touch with:

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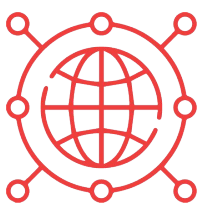

Acknowledgements

HBGI expresses sincere thanks to every one of the organizations who took the time, effort, and resources to respond to the Call for EoIs, particularly given that funding or contract award was not attached. We are grateful for the continued engagement with HBGI.

HBGI welcomes the commitment to the common goal of delivering greater impact on more individual lives and communities, delivering more for every dollar that funders and donors commit.

We look forward to working with you as we develop the Outcomes Funds.

We extend our thanks to partners who facilitated our engagement with a wide range of service providers, including Grand Challenges Canada and WHO Afro.

We also thank our supporters, including but not limited to: the Wellcome Trust, Otsuka Pharmaceuticals, and Johnson & Johnson.

In particular, we would like to thank Lundbeck, whose generous contribution has made this report possible.

Lastly, our many thanks to Daria Mukhina in Ukraine for designing this report (for more information, please refer to her portfolio here).

Appendix

Appendix A:
An overview of outcomes contracting in fragile contexts

WHY TO CONTRACT FOR OUTCOMES, NOT INPUTS

The following short paper sets out the characteristics of outcome-based contracting and contrasts these with the more common form of contracting – 'fee for service'. Outcomes-based contracting has the potential, when designed and managed well, to increase the efficiency and effectiveness of contracted services in many contexts. This paper further describes those characteristics which make this form of contracting also particularly suited to low resource or fragile country contexts.

THE CHARACTERISTICS OF OUTCOME-BASED CONTRACTING

If services are being contracted out to be delivered by another organization, the most common form of contracting model – in terms of how the service is paid for/funded – is a 'fee for service' model. Under this model, the purchaser (the organization who is contracting out the program, for example, a government department or a donor) carefully pre-defines the service – its content and how it will be delivered. The purchaser then may run a competitive tendering process to select a provider to deliver the service. Through this process, the provider is selected, often (usually in large part) on price, with those quoting a cheaper price winning the tender. Once selected, the provider is then paid for the achievement of the prescribed inputs or activities. In some instances, payments are also linked to outputs.

For example, in a training context: the purchaser defines the curriculum and assessment tools, the number of hours to be taught, and possibly the class size and the qualifications of the trainer; the would-be provider submits a proposal describing their capability to fulfil this requirement, and setting out their price; the selected provider is then paid for each trainee enrolled, each hour taught, each trainee completing the program, and possibly each examination passed.

Under an outcome-based model, the purchaser focuses on the desired outcome of the service, as opposed to its content. What are the results or impact that is being sought? The purchaser defines the outcome and determines a price for it. The provider is selected (at least principally) on the quality of their delivery proposal, not on price. They are paid for the number or magnitude of their outcomes or impact.

For example, in an employment context: the purchaser defines the outcome(s) as a job that is secured and that is sustained by someone who was previously unemployed; the purchaser stipulates the characteristics of this employment, possibly in terms of salary, hours of work and length of contract; the purchaser sets a 'unit price' to be paid for each job started and for each job sustained for the stipulated period; the would-be provider submits a proposal describing how many job starts and sustained employment outcomes they can deliver at that price, and how they will achieve this; the provider is selected on the technical strength of their proposal (and maybe the quantity of outcomes they commit to deliver); the provider is then paid every time they achieve one of these outcomes (each time a person secures a job, and for staying in work).

Outcome-based contracts are sometimes described as 'risk-reward'. The provider takes on the (financial) risk of delivery. The provider is rewarded for taking on that risk, and making upfront investments, with payments linked to performance. The level of the payments (the 'unit prices') must be set high enough to incentivise that investment, without allowing unreasonable profits/surplus. The purchaser setting the price in advance for an outcome-based contract is advised to think carefully about the relationship between cost and delivery, and arrive at the 'unit prices' on the basis of a commercially-informed costing of the potential service.

In a fee-for-service model the level of payments are left to the market to decide. It is argued that the use of price competition will mean the price settles at the most cost-efficient level. However, this does not take into consideration the possible perverse incentive for the provider simply to win the competition at any cost. The 'winner's curse' describes the instances when a provider secures a contract because they were cheapest, but at a price that is not actually deliverable.

Because of the transfer of (financial) risk to the provider in an outcome-based contract, it is argued that providers must be given control of the content of the service in order to manage that risk. The extent to which this control is handed over varies between contracts. In the most extreme variant, a 'black box" procurement model is followed.

In a 'black box' model the purchaser does not define any of the detail of the service content at all. In fact, even after contract award, the provider is allowed to vary their delivery as they choose, with little or no audit or quality assurance. The focus is purely on the outcomes. This creates a number of risks for the purchaser.

It is advisable for the purchaser to maintain some control and oversight of content of the service. In most cases the purchaser has a duty of care (i.e. an ongoing responsibility) for the service users (e.g. the trainees or jobseekers). The purchaser must, for example, ensure that no service users are discriminated against on the basis of gender or ethnicity. The purchaser may also want to define a baseline of basic service delivery that all service users must receive, and prescribe health and safety or security or complaints procedure requirements. In this case, a 'grey box' model is used, in which the provider has a large degree of control but the purchaser specifies service parameters and minimum standards, and then actively audits and quality assures during delivery.

Just as the box might be grey rather than black, most applications of outcome-based contracting actually use hybrid payment mechanisms. Not all of the money is attached to the outcomes. Under an employment program, for example, the provider might be paid for enrolments onto the service as well as for job outcomes.

Weighting payments on outcomes obviously creates an upfront cash requirement. The provider must take on premises, hire staff, purchase resources etc. prior to receiving enough income (from the outcomes payments) to cover these costs.

There are a number of ways to fill this cash gap. The provider could use their own reserves, but only larger organisations are likely to carry such sums, and NGOs may not be allowed to touch any reserves they hold. The provider could borrow from a bank, though this comes at a cost and NGOs are often limited in the debt they are allowed or are willing to take on.

The purchaser could choose to remove the upfront cash requirement or could find ways to facilitate external investment. An upfront 'mobilisation allowance' could cover the providers' early costs and then be repaid once outcomes start to be delivered, though this may leave too much risk with the purchaser if the services are large scale. Or a 'prime contractor' model could be used, in which the purchaser contracts with large 'primes' (with the necessary reserves or the borrowing capacity), who then subcontract to smaller, local providers, either using 'softer' payment terms down their supply chain or easing the cash requirement through breaking it into more manageable chunks. Alternatively, the purchaser could structure the deal such that third party investors bring the investment, with their repayments tied to the outcomes.

In a public service delivery context, the first application of such an outcome-based model may have been in Wisconsin in the 1990s. It was applied there as authorities looked to address endemic unemployment with a switch from input-based training programs to a 'work-first' approach. This was heavily influential in the subsequent development of employment programs in the UK (notably the Employment Zones) and Holland. In Australia, around the same time, the whole of the public employment service was outsourced on this basis.

The uptake in low resource country contexts has been slower. Possibly with a perception of risk, both by purchasers and providers, as well as an emphasis on external 'expert' advisors, there has been a preference for prescribed, paid-for inputs. This has possibly come at the cost of reduced service impact.

The use of Development Impact Bonds (DIBs) is also slowly increasing. These are not really 'bonds' in any true sense but are a variant of outcome-based contracting. In a DIB, the purchaser contracts a 'social' investor who provides the upfront financing needed by the provider and subcontracts the service provision to local providers. Payments to the investor by the purchaser are tied to achievement of predetermined/priced outcomes or impact. The advantages of this model are that: the investors relieve the upfront cash requirement, and; they bring an additional focus on performance (to protect their investment) which further strengthens service delivery and increases the chances of outcomes/impact being achieved. Examples include: diabetes prevention in Israel; maternal and neonatal maternity rates in Rajasthan; eye care in Cameroon; disability rehabilitation centres in Mali, Nigeria and the Congo, and; employment for highly vulnerable jobseekers in Columbia.

One of the reasons that outcome-based models have not had wider application is the inflexibility of institutional budgets. Most public institutions (as well as most donors) manage with annual budgets and find it hard, if not impossible, to budget across years. It is much easier for them to manage input-based payments against a fairly rigid timetable in which inputs are achieved within the given financial year, than plan for payments in future years linked to performance. This performance link also means that the final cost may vary up or down. It is actually easier to contract and manage a service that delivers poor social outcomes, but has a simple fixed cost, than a service that has the potential to deliver more but could exceed forecasts. This inflexibility in budgets is one of the reasons why such institutions have rigid procurement rules which further limit outcome-based models.

THE APPLICABILITY OF THE MODEL IN A FRAGILE ENVIRONMENT

The applicability of outcome-based contracting in fragile or conflict-affected countries is sometimes questioned, but it may be that certain characteristics of the model make it particularly suited to such fragile or simply low resource environments. Indeed, it may address a number of the weaknesses inherent in fee-for-service models.

Attaching money to outcomes, rather than multiple inputs, is potentially very attractive to government and to donors in these contexts. First of all, it demonstrates greater accountability, with payments tied direct to impact. This can increase the credibility of the government and contribute to social cohesion. It may also go some way to addressing 'donor fatigue'.

Secondly, it reduces the opportunity for corruption. The multiple payment points along the chain of a service paid according to inputs each represent an opportunity for fraudulent activity. The multiple points are replaced with just one or two payment triggers under an outcome-based model.

Far from being a model from London or Washington that is imposed on the distant country, an outcome-based contract shifts the contracting from the 'what' to the 'how'. The 'what' of the service content is not defined or imposed 'top down' as it is under a fee-for-service model. The contracting model becomes the tool that answers the question: how do we facilitate a 'bottom-up' design that is locally responsive and appropriate.

Because of the focus on outcomes, the service design and delivery are more likely to be demand-led. In order to achieve the outcomes, the provider must listen to the service users (e.g. jobseekers and employers) and adapt to meet their local, personal needs. The service cannot be 'one size fits all', with all service users pushed through the prescribed content. It must be individualized and is more likely to innovate.

A feature of a fragile or low resource context is that it may be subject to change. Under an outcome-based contract, the provider has the ability to flex delivery, whilst maintaining a focus on the outcomes. Under a fee-for-service contract, the provider must continue delivery of the prescribed content, even if the environment has shifted.

A fee-for-service contract may appear to be cheaper but this does not mean it is more cost-effective. The outcome-based contract is usually more cost-effective because it increases value for money through maximising the results. Indeed, the money is not paid if there are no results.

Appendix B:
A Call for Expressions of Interest

For programs to address poor mental health and/or its socioeconomic causes and consequences and/or to strengthen mental health systems – ***to be contracted and paid for on the basis of outcomes.***

Please note: We do not currently have the funding for these contracts. We are looking for Expressions of Interest to highlight what is out there and what could be achieved, selecting compelling examples to present to donors in order to establish these new mental health outcomes funds. We aim to run a further competitive Request for Proposals in 2023.

The context

The cost of mental and neurological health conditions is huge for individuals, families, communities and countries. It accounts for nearly 10% of the global disease burden. 70% of that burden originates between the ages of 11 and 24.

This represents an estimated US$4 trillion in annual cost to the global economy and has been exacerbated by the impact of COVID-19.

But it remains chronically unaddressed, virtually everywhere. It is the great challenge we all face, either personally or in our families, at some point in our lives, but that we try to hide from. Financial investments remain very low with countries spending less than 2% of their health budgets on mental health, and with mental health systems often barely functioning. In some places, people will tragically chain up family members with acute conditions, while in the USA nearly two thirds of adults with a mental illness receive no treatment.

The impact, inevitably, is exacerbated for vulnerable groups and in low resource settings (in low- and high-income countries). It is mixed up with a wide range of causes and consequences, from unemployment to child pregnancies, from homelessness to addiction, from domestic abuse to HIV patients dropping out of treatment, from environmental changes to the aftermath of conflict.

Healthy Brains Global Initiative

Creating new 'outcomes funds' with regional partners, to mobilize new programs at scale: addressing mental health and its associated socioeconomic impacts; giving donors a new mechanism to connect their funding more effectively with results, significantly increasing accountability and transparency; bringing in social or impact investment where needed to provide working capital; embedding research and learning from day one of delivery, and; working in concrete collaboration with donors, governments, researchers, service providers, and service users.

Healthy Brains Global Initiative

The Healthy Brains Global Initiative (HBGI) was founded in 2020, uniting world leaders across sectors to tackle this growing global issue. Over the past two years, HBGI has commissioned studies to develop its strategy, and brought in a wide variety of stakeholders through its Interim Board and Lived Experience Council. HBGI is now:

- ***establishing four new 'outcomes funds'*** (giving donors a new stand-alone mechanism to enable them to pay for results);
- ***contracting new programs and paying for them on the basis of outcomes*** (linking funding to clearly evidenced outcomes, at the level of the individual service user, maximizing the funding impact);
- ***learning from day one through generating and sharing data at scale*** (undertaking research to drive a change in the global understanding of mental illness, across populations, in its prevention and treatment, and its place in government policy).

This flexible, outcomes-based model, with embedded research, will support bottom-up approaches to improve mental health, to improve life chances, and to foster systems-level change. We will grow this in stages, starting with four regional funds: ***South Asia, Africa, California and Ukraine***. With an initial target of US$50m to be spent on outcomes over six years in each, with early 'proofs of concept' demonstrating the effectiveness and potential of the model.

Donors and multilaterals are all increasingly interested in performance/outcomes – they want to see and pay for results. But their systems are not geared up for this so they find it complex, with high transaction costs. HBGI, on the other hand, will be structured from the outset to contract, manage and pay for performance. This will be our function.

How it will work

1. We will work with governments, donors, investors, communities, people with lived experience and service providers to identify programs and other interventions.
2. We will define clear, measurable outcomes to contract each program, with pricing that takes account of actual delivery costs, and we will pay programs when they deliver these outcomes.
3. If the providers of these programs need working capital to cover their delivery costs before they receive any outcomes payments, then we will bring in social investors to cover this (a bit like Impact Bonds, where social investors take on the risk rather than the service providers).
4. We will closely manage the performance of these programs and look to generate rich data on the activities, the journey of the service recipients, the costs and the outcomes. We will fund local governments to co-manage these programs with us, to build capacity and influence policy.
5. We will not wait until programs are finished to evaluate impact. Implementation research will commence along with every program and our findings will be shared openly, globally.

Over the next 6 months, HBGI aims to mobilize US$8-14m of private capital, which will be used to develop the systems and to secure the outcomes funds that HBGI will then administer on behalf of our donors. We will launch a Request for Proposals in 2023 for our first programs to be paid for with these funds. These programs will go live in 2024.

Our call for Expressions of Interest

We would like to go to philanthropists and donors ***now*** with examples of the types of programs and other interventions that we could contract and pay on the basis of outcomes – that will deliver tangible impact on vulnerable people's lives.

We are calling for proposals of programs that you would like to run, to address clearly identified needs.

We are looking for around a dozen compelling examples that we will use in our dialogue with the decision-makers. We want to show that such programs exist, how outcomes can be defined and delivered, and that there is an appetite in the 'market' to use this model to unlock a new scale of impact.

We hope to generate a hugely diverse set of possible programs. We have already seen some of these in practice but some may be completely new or at least new to the idea of outcomes funding. These might include, but certainly not be limited to:

- Strengthening health systems, such as growing the skills of care workers or reducing staff attrition or improving access to pharmaceuticals or reducing hospitalization rates.
- Deploying peer counselors or case managers, possibly embedding employment advisors in mental health teams or enabling homeless people to secure stable accommodation.
- Delivering across physical health conditions, such as improving adherence to HIV or TB treatment or reducing incidences of diabetes.
- Perhaps with a humanitarian focus, improving the wellbeing of refugees in refugee camps or assisting disaster or conflict victims to deal with trauma and regain independence.
- Possibly focused on young people, maybe increasing school attendance for vulnerable groups or reducing incidences of bullying or self-harm or eating disorders.

We have a particular interest in low- and middle-income countries, and in young people who are suffering from anxiety and depression. Though we are not constrained by this and also recognize that there are many people in high-income countries who are currently in desperate need of mental health support.

Your proposed program could have been run already on a small scale, and you have a larger population that you would like to reach. It could have been run in one country and you would like to implement in a new context where there is evident need. You already have an evidence base, even if in a different context, of how well it has worked. You could be the provider, or part of a delivery partnership, or the manager of the program, or maybe an investor, though it will be clear who does what. We are thinking of programs that run for between three and five years.

There is, however, one vital criterion that all proposed programs must meet:

It must be possible to define a set of outcomes that can be measured and verified.

If you are interested in being involved in this and would like potentially to be one of the examples we cite at this time, then we would very much like to hear from you. Please tell us:

a) What your proposed program is;
b) What is the target population;
c) What is the need you are looking to address and how this is linked to mental health:
d) What are the (clear, measurable, verifiable) outcomes that you would aim to achieve;
e) How long the program would run and how many people it would reach and your estimate of the outcomes that could be achieved;
f) A high-level estimate of program cost;
g) Where this program has run before and any data you have on its performance;
h) Any existing government buy-in;
i) References/links to any public evaluations/reports on the program or something like it;
j) A little about your organization, including your mission, brief history, current geographical reach, usual sources of funding, number of staff and annual financial turnover.

We do not anticipate this taking more than ***four pages***. Please try to keep it as succinct and clear as possible.

In order to help us sift and select our examples, we will score these Expressions of Interest on the following basis:

- This is a population/community/system that is currently not reached by such a program (i.e. we are obviously going to be adding value) (15 marks);
- It is a concrete program in terms of the numbers to be reached, resources to be deployed, timeline, activities and overall cost (30 marks);
- There are clear, measurable, verifiable outcomes that we will be able to cost (i.e. attach a unit price to) (20 marks);
- There is an obvious link to mental health (15 marks);
- There is evidence of the proposed program/intervention working (e.g. performance data) (10 marks);
- The organization is credible, with a track record and capacity and stability (10 marks).

To be clear, we have no funding for these right now, but want to use the possible programs to raise the funding. We want to make the outcomes fund come alive with real examples.

We will acknowledge all proposals and, unless you request otherwise, keep you informed of all future developments of HBGI and the outcomes fund. We will choose around a dozen of the most compelling cases to include in our presentations to donors and compile an overview of the remaining proposals. All of these will be described on our website and to our social media contacts. You will be invited to consult with us on the best next steps, including on the process we follow when we move on in 2023 to a more formal Request for Proposals and a competitive selection of the first phase of funded programs. We hope you will consider submitting again at that time.

We regret that given current resource constraints, we are only accepting responses in English. Future Requests for Proposals will seek to be more inclusive and enable more diverse responses.

Please submit your Expressions of Interest as soon as it is ready and no later than the 6th September 2022 to: eoi.outcomes@hbgi.org

Please put 'Expression of Interest submission' in the subject line. If you have a question, please use the same address and put in the subject line 'Inquiry about Expressions of Interest'.

Thank you.

NEW VOICES, NEW SCIENCE, NEW FINANCE

The voice of the community.

Listening to the voices of people with lived experience, focusing on currently excluded communities, delivering programs that are centered on the needs of each individual service user.

Research to deliver impact.

Generating learning at scale, starting with implementation research, seeking constant performance improvement, working with populations that are usually ignored, sharing data and findings openly.

Making every dollar work harder.

Regional 'outcomes funds', in partnership with local stakeholders, giving donors the ability to connect funding with verified results, efficiently and effectively, bringing in social or impact investment where needed.

HBGI
Healthy Brains Global Initiative

Thank you for reading.

If you would like to discuss this report or find out more about the programs featured, please contact Shomsia Ali, Special Advisor (shomsia.ali@hbgi.org) or Richard Johnson, CEO (richard.johnson@hbgi.org)