NIHR Global Health Research Group on promoting children's and adolescent's mental wellbeing in sub-Saharan Africa Project Launch Minutes

Monday 03rd October 2022

Chair: Professor Agnes Binagwaho, University of Global Health Equity

Presenters: Professor Pete Edwards, University of Aberdeen; Professor Pamela Abbott, University of Aberdeen; Professor Graeme Nixon, University of Aberdeen; Professor Wenceslas Nzabalirwa, University of Rwanda; Dr Tsion Hailu, Addis Ababa University.

[Slide 1 - Welcome]

Professor Agnes Binagwaho (AB): Welcome to the project launch of the 'NIHR Global Health Research Group on promoting children's and adolescent's mental wellbeing in sub-Saharan Africa'.

[Slide 2 - Housekeeping]

AB: I will be chairing this launch today.

Please keep your microphones turned off whilst the presenters are speaking.

[Slide 3 - Agenda]

AB: We will hear from presenters from Rwanda, Ethiopia, and Aberdeen today.

[Slide 4 – Opening Remarks]

Professor Pete Edwards (PE): Thank you for welcoming me to today's launch, and to everyone for attending.

As the Vice-Principal for Regional Engagement and Regional Recovery at the University of Aberdeen, this project is a little out of scope to my usual work, so I was very interested to read about it and to be asked to attend today.

I am delighted that the University of Aberdeen is partnering with the University of Global Health Equity, Addis Ababa University, and the University of Rwanda. Collaborative partnerships are crucial to building a strong, vibrant academic network which transcends geographical boundaries, as evidenced by so many of us coming together today from across the world. Furthermore, collaborative partnerships allow us to create interdisciplinary solutions to transnational challenges drawing on our individual and institutional strengths, and to achieve our strategic goals. The launch of the "NIHR Global Health Research Group on promoting children's and adolescent's mental wellbeing in sub-Saharan Africa' project today is evidence of this.

In my current role as a Vice-Principal, I work on a variety of initiatives to support regional priorities and recovery. Education is a crucial element of long-term economic, social, and cultural progress – regardless of location. In this context, education refers to two elements:

firstly, the role of higher education institutes in advancing knowledge and progress to benefit communities and peoples' lives. Secondly, the importance of education from the earliest age in creating long-term impact at a local, national, and international level. A strength of this project is that it encompasses both.

This is a four-year project, but it's important to remember that the challenges this project is looking to address will not be solved in such a short amount of time. Supporting the mental wellbeing of our children and young people will remain an important task across the world and finding ways to support children and adolescents to thrive and live full, happy lives must remain a key priority for educators, policymakers, and communities. I hope this project will contribute to an important body of knowledge about child and adolescent mental wellbeing in sub-Saharan Africa. I also hope it will nurture the relationship with our colleagues at the University of Global Health Equity, Addis Ababa University, and the University of Rwanda, and develop an ongoing relationship with educators, policymakers and communities in Rwanda and Ethiopia which will thrive beyond this grant period.

Thank you everyone for attending and welcoming me this afternoon. I look forward to seeing what this project achieves over the next four years, and beyond.

[Slide 5 – Project Overview]

AB: Thank you, Professor Pete Edwards. That is an important point that this project will build on the existing relationships we have.

Professor Pamela Abbott, joint-lead principal investigator, will present an overview of the project.

[Slide 6 – The Research Consortium]

Professor Pamela Abbott (PA): The research consortium is made up of the University of Aberdeen, University of Global Health Equity, Addis Ababa University, and the University of Rwanda. We have received just under £2.9 million from the National Institute for Health Research (NIHR). Between August 2022 and July 2026, we will be working in Rwanda and Ethiopia to co-design, implement and evaluate a whole-school mindfulness intervention, that will benefit around 10,000 children and adolescents.

[Slide 7 – Context]

PA: The context of this project is that child and adolescent mental wellbeing is an under-researched area in sub-Saharan Africa. There is a lack of community awareness and few interventions to promote wellbeing.

Across sub-Saharan Africa as a whole, and particularly in Rwanda and Ethiopia, child wellbeing is poor and school attainment is low.

Mental health issues are a leading cause of illness, with around 1 in 7 children and adolescents having mental health problems. Left untreated, these children and adolescents are more likely to have mental health issues as adults. This impacts wellbeing, inequality, and economic outcomes.

COVID-19 has also had an impact, making this more urgent.

[Slide 8 – Our Aim]

PA: The aim of this project is to develop, implement and evaluate an affordable, effective, and trusted whole-school mindfulness intervention to improve child and adolescent mental wellbeing in sub-Saharan Africa, specifically Rwanda and Ethiopia.

This improves mental wellbeing but also school performance.

[Slide 9 – Our Team]

PA: Our team is made up of researchers from Ethiopia, Rwanda, and the UK. They include health experts, psychiatrists, social scientists, economists, gender experts and teacher educators.

We also have an International Advisory Board, made up of government officials from both countries, and world-leading experts on wellbeing, education, and mindfulness.

Communities will be directly involved, through community members, including parents, teachers, children, and adolescents helping to co-design and implement the mindfulness intervention. This will include training teacher educators and 'Mindfulness Champions' to deliver mindfulness in schools.

[Slide 10 – Theory of Change]

PA: This is our theory of change. Some of this has been covered already, but our inputs are 1) engagement with communities, parents, and teachers, 2) engagement with policy stakeholders, 3) developing a culturally relevant child and adolescent mental health intervention, 4) training teachers in mindfulness in schools, and 5) educating and training researchers in evaluation methodology.

The mechanisms of change for this are 1) a whole school mindfulness intervention, 2) engaging community and policy actors with the project, and 3) increased capacity for researchers to investigate and demonstrate outcomes from the intervention.

The outputs from this will be 1) child and adolescents completing a mindfulness course, 2) teachers completing training in mindfulness, 3) a validated professional diploma in mindfulness by the University of Rwanda, 4) evaluating and costing the intervention, 5) country and community ownership of the intervention, 6) peer-reviewed publications, 7) training materials, and 8) policy briefs.

The outcomes of this, in the short-term are 1 and 2) a perceived improvement in the mental wellbeing of children, adolescents and teachers, 3) embedding the intervention in national teaching qualifications, 4) communities and teachers recognizing the value of the intervention, 5) policy-makers committed to an evidence-based child and adolescent mental health whole-school intervention, 6) increasing the capacity for research leadership, and researchers in transdisciplinary mixed method wellbeing studies, and 7) cost-effect analysis as proof of concept.

In the medium-term, outcomes include 1) child and adolescent's experience of school and wellbeing improving, 2) teacher wellbeing improved in Rwanda and Ethiopia, 3) community engagement maintained and expanded, and 4) using this project as proof of concept to secure funding to test the intervention at scale.

In the long-term, expected outcomes are 1) improvement in child and adolescent mental wellbeing, 2) improvement in educational attainment, 3) because of this, improved

employment prospects, 4) reduced depression and anxiety amongst young adults, and a narrowing in the gender gap between boys and girls, as girls are more likely to experience mental health issues, 5) a reduction in poverty and inequality, including gender inequalities between boys and men, and women and girls, and 6) an increase in women and girls empowerment.

We've already touched on this, but this will occur in the context of certain challenges. This includes 1) economic barriers to increased investment in child and adolescent mental health, 2) regional political instability, 3) limited community engagement with low accountability between society and the state, 4) limited funding for research, leading to reliance on external support and overburdened researchers 5) limited organizational commitment to research, 6) under-resourced schools with large class sizes (exceeding 50+), and 7) teachers who are already overburdened.

However, there are also significant opportunities. There is 1) political support for child and adolescent mental health and policy commitments, 2) a commitment to evidence-informed policymaking, 3) a commitment to pro-poor and inclusive development, and 4) a commitment to enhance and build on existing research capacity.

[Slide 11 – Overview of the Work Packages]

PA: The project is made up of six work packages. The formative work has now been completed. Work packages one to three are the core research work.

Work package 1 is the context, situational analysis, community, and policy actors' engagement. This will include a political economy analysis, formative research on the context in which the intervention will be applied, and engagement with communities and policymakers.

Work package 2 will design and deliver the mindfulness training and intervention. This will involve co-designing a culturally appropriate mindfulness intervention with community advisory groups (children and adolescents, teachers, parents, community members, and policy makers) and training teachers to deliver it.

Work package 3 is the applied health research. This will evaluate the intervention using a controlled trial and will examine the cost-effectiveness of the intervention. The research will take place in three schools (pilot, intervention, and control) although all will be trained in the intervention, just at different points, so no-one misses out.

Work package 4 is the education and training. This includes the education of the four PhD students (two at the University of Global Health Equity and two at Addis Ababa University) and five post-doctoral researchers (two at the University of Global Health Equity, two at Addis Ababa University and one at the University of Aberdeen). There will also be training delivered by and for the researchers, drawing on the skills of the team.

Work package 5 is dissemination, advocacy, and sustainability. This is about disseminating the research findings as widely and relevantly as possible, and the long-term sustainability of the work.

Work package 6 is the overall management of the project.

[Slide 12 – Impact]

PA: We've mostly covered this on other slides, but this shows the expected impact of the project. The main grant objective is to demonstrate a cost-effective, scalable mindfulness intervention that promotes children and adolescent mental wellbeing. The grant outcomes are evidence of the intervention's cost effectiveness, a validated training programme for teachers, a manual for delivery, and 96 teachers to be trained in the intervention.

In the long-term, we hope this will be tested at scale and adopted into policy. The impact of this across 8-15 years is an acceleration towards the SDGs through a reduction in poverty through strengthening population health (SDGs 1 and 3), improved educational outcomes (SDG 4), an increase in productive employment (SDG 8), gender equality and the empowerment of women (SGD 5), and a narrowing of inequalities (SGD 10).

[Slide 13 – Innovation]

PA: We believe this project is innovative.

Community engagement and impact underpin the work. As previously mentioned, community advisory boards made up of children, adolescents, teachers, parents, and community members will help co-design the intervention, and it will be delivered by teachers in the community.

It is transdisciplinary – by this I mean it goes beyond interdisciplinary and crosses across multiple academic disciplines and international borders to create a framework incorporating all of them and learning from the interaction with each other.

It is gender transformative – women and girls have an equal representation on community advisory boards, data is disaggregated by gender, and we have policies in place to protect women and girls on the project.

Finally, it is a critical realist informed cluster control trial – a cluster control trial (as previously outlined) informed by critical realism.

[Slide 14 – Questions]

No questions.

[Slide 15 – Introduction to Mindfulness]

AB: Professor Graeme Nixon from the University of Aberdeen will now present an Introduction to Mindfulness.

Professor Graeme Nixon (GN): I am a Professor at the University of Aberdeen, Programme Director on the MSc in Mindfulness, and co-lead for WP2.

[Slide 16 – Work package 2]

GN:

1. Systematic reviews – scoping literature
2. Training teacher educators in mindfulness
3. Training teacher champions in mindfulness
4. Developing an appropriate mindfulness intervention for schools in Rwanda and Ethiopia

The overall aim of this work package is the fourth point. This project is happening at a good time because the results of the largest ever study of mindfulness in schools (MYRIAD) has just published its findings, and we can use this to inform our approach.

[Slide 17 – The years ahead]

GN: Teacher educators from Rwanda and Ethiopia will be trained in delivering mindfulness to adults from October/November 2022. From January 2023, they will be trained in how to train others in mindfulness. Completing the course on delivering mindfulness to adults first is important because it ensures a solid understanding of the mindfulness intervention and teacher 'buy-in' before training on how to deliver mindfulness to children. The MYRIAD project highlighted the importance of teachers and children both having 'buy-in' to the mindfulness intervention for it to work successfully.

From September/October 2023 (TBC) the teacher educators will train 'Mindfulness Champions' in the mindfulness intervention. These Mindfulness Champions will be primary school teachers. Once they have been trained in mindfulness, they will be trained in how to train others from January 2024.

There will be a mindfulness workshop in Rwanda in September 2023 about co-creating the mindfulness intervention.

[Slide 18 – An Introduction to Mindfulness]

GN: Kabat-Zinn defined mindfulness as "the awareness that emerges through paying attention in a particular way on purpose in the present moment to the unfolding of experience moment by moment" (Kabat-Zinn, 2003.)

It is 'observing thoughts and sensations, whatever they may be, with an attitude of kindness and curiosity'.

[Slide 19 – Three aspects of mindfulness]

GN: Mindfulness has three aspects – attention, intention, and attitude. Attention is to sit kindly and calmly with your experience. The attitude is to sit with self-compassion to your lived experience.

[Slide 20 – What mindfulness is not]

GN: Mindfulness is not religious or stopping thought or emptying the mind.

Whilst mindfulness practises can be found, in some way, in most religions and spirituality, it also has application in secular tradition. We are not taking mindfulness from a religious standpoint in this project.

[Slide 21 – Application in Multiple Contexts]

GN: Mindfulness has application in multiple contexts: education (as with the project), but other contexts are in healthcare, creativity, sport, social work, prison service and business.

[Slide 22 – A mindfulness practice]

A 5-minute practical demonstration of mindfulness, led by GN, was taken here.

Look up a guided breathing mindfulness practise if you would like to participate.

[Slide 23 – Questions]

AB: Thank you, Professor Nixon. Does anyone have any questions?

Question: how do people not fall asleep?

GN: It depends on the mindfulness practise taken – some, like body scan, do encourage a state of relaxation where some people may fall asleep. Others require more activity (such as watching the breath or movement). If people do fall asleep, it is about non-judgment, and creating a safe space where they can do what they need in that moment (which may be relaxing enough to sleep).

Question: how does this work with children?

GN: the mindfulness practise like we just did may be harder to do with children, but there are lots of other mindfulness practises which can be used with children and can be done in shorter spaces of time to prevent lapse in concentration. It is about adapting the practise to what is needed by the audience in that moment.

[Slide 24 – An overview of child and adolescent education in sub-Saharan Africa]

AB: Professor Wenceslas Nzabalirwa will present an overview of child and adolescent education in sub-Saharan Africa.

[Slide 25 - Overview of child and adolescent education in sub-Saharan Africa]

Professor Wenceslas Nzabalirwa (WN): I am a Professor at the College of Education at the University of Rwanda, and a co-I on this project.

[Slide 26 – Outline]

WN: Some of this has been covered by other presenters, but I will look at:

- The power of education
- The right to education in sub-Saharan Africa
- Primary school children contextualised data
- Challenges facing primary school children in sub-Saharan Africa
- Education for health and wellbeing
- Mindfulness

[Slide 27 – The power of education]

WN: Nelson Mandela said, ‘education is the most powerful weapon which you can use to the change the world’.

[Slide 28 – The right to education]

WN: ‘everyone has the right to education’ is stated in the Universal Declaration of Human Rights. The WHO Secretariat also says that all children and adolescents have the right to enjoy their childhood as well as being able to attain their full potential and lead productive adult lives.

SDG 4 works to ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.

This will accelerate the progress towards achieving the SDGs, including 3 (health), 5 (gender equality), 8 (economic development and employment), 10 (inequality) and 1 (poverty).

[Slide 29 – Primary school children contextualized data]

WN: This table compares indicators in Rwanda and Ethiopia. In 2017, children living in high poverty (less than $1.95ppp a day) was 60% in Rwanda and 26% in Ethiopia.

Compulsory primary school education is from 7-15 in Ethiopia, and 7-13 in Rwanda. Both countries have low completion rates and over-age students, and low academic performance of children with mental health issues.

The figures are from different places, but in 2018 Ethiopia had a 99.9% primary net enrolment rate, and Rwanda had a 98.9% primary net enrolment rate in 2021.

Both countries have large class sizes, with more than 50 children per teacher.

[Slide 30 – Challenges facing primary school children in SSA]

WN: 72 million children are out of school worldwide, 50% of them living in sub-Saharan Africa. Around 130 million primary school aged children in sub-Saharan Africa do not have basic numeracy and literacy skills.

Health issues, unemployment and illiterate problems contribute to out-of-school and drop-out rates. Other factors include the financial resources needed for school materials, creating schools and teacher training and retention.

Girls are majorly disadvantages by non-schooling – leading to increased gender inequality.

[Slide 31 – Education for health and well-being]

WN: ‘Education and health care significantly influence well-being and health outcomes, especially throughout adolescence’ (UNESCO).

Social wellbeing, mental wellbeing and physical wellbeing contribute to overall wellbeing.

[Slide 32 – Mindfulness: framework for promoting child mental wellbeing in school context]

WN: Education mindfulness can help cope with the pressures and uncertainty of life, connect with people and places, flourish through appreciating ourselves, others, and the world, and empower us to change what isn’t working.

[Slide 33 – Evidence for mindfulness: impact on the wellbeing and performance of the school staff (Katherine Weare, 2014)]

WN: Mindfulness increases:

1. Wellbeing
2. Mindfulness
3. Self-compassion
4. Attention
5. Emotional regulation
6. Teaching efficacy

It decreases:

1. Stress
2. Anxiety
3. Depression
4. Demotivation
5. Time-urgency
6. Burnout symptoms

[Slide 34 – Mindful teachers make difference]

WN: The image from Kevin Hawkins shows how mindful teachers create mindful schools. This improves wellbeing in teaching and learning.

[Slide 35 – Some references]

WN: This slide contains references from what was used in the presentation and additional reading.

[Slide 36 – Thank you for your kind attention]

WN: Thank you for listening.

[Slide 37 – Questions]

No questions.

[Slide 38 – Break]

Break skipped on consensus.

[Slide 39 – Overview of mental wellbeing in sub-Saharan Africa]

AB: Dr Tsion Hailu from Addis Ababa University will present an overview of mental wellbeing in sub-Saharan Africa.

[Slide 40 – Child and Adolescent Mental Health in Sub-Saharan Africa]

Dr Tsion Hailu (TH): I am a psychiatrist at a hospital outside of Addis Ababa, but am affiliated with Addis Ababa University, and the academic co-lead for Ethiopia.

[Slide 41 – Introduction]

TH: Children and adolescents make up a quarter of the world's population. 85% of them live in low and middle-income countries (LMICs)

[Slide 42 – Introduction…]

TH: Child and adolescent wellbeing is an under-researched issue in LMICs, and sub-Saharan Africa.

There is little reliable data on the prevalence and risk factors of mental illness, evidence of what works to promote mental wellbeing, and what strategies are cost-effective.

[Slide 43 – Evidence on Child and Adolescent Mental Health]

TH: Mental disorders are one of the leading causes of disability globally. About 20% of people experience mental health problems during their life.

50% of adults with mental health issues first experiences them before the age of 14.

[Slide 44 – Evidence…]

TH: The burden of mental health issues is higher in sub-Saharan Africa.

In sub-Saharan Africa, 1 in 7 people have mental health issues, and 1 in 10 have a specific psychiatric disorder.

[Slide 45 – Evidence…]

TH: Rwanda and Ethiopia have different national measures for mental health. In Rwanda, a national mental health survey found that 10% of adolescents aged 14-18 had a mental disorder.

The depression rate in HIV-positive and HIV-affected children and adolescents is higher, and for teenage mothers.

In Ethiopia, the children and adolescent prevalence rate of mental health issues was estimated to be between 12-25% in 2012.

[Slide 46 – Consequences]

TH: Childhood is a critical age for mental health. Poor mental wellbeing in children and adolescent is associated with:

- Lower school attendance and academic performance
- Increased involvement in risky behaviour
- Mental health issues which persist into adulthood
- And a poorer quality of life

[Slide 47 – Child and Adolescent Mental Health Service]

TH: There is a wide treatment gap in the child and adolescent mental health services.

[Slide 48 – Challenges]

TH: Challenges to improving mental health services include:

- A lack of clear plan for promoting child and adolescent mental wellbeing
- Low domestic spending and donor funding
- Lack of available, accessible, acceptable, quality services
- Shortage of qualified professionals – Ethiopia has 2 child psychiatrists and 2 specialist facilities in the whole country. Rwanda has no child psychiatrists or specialist facilities for mental health.

[Slide 49 – Challenges…]

TH: Other challenges include a lack of knowledge of health-seeking behaviour, stigma, and people preferring to seek help from traditional or religious leaders.

[Slide 50 – Conclusion]

TH: There is an urgent need to promote child and adolescent mental wellbeing in low- and middle-income countries. However, it needs to be culturally relevant, acceptable, and sustainable.

[Slide 51 – Thank you!]

TH: Thank you for listening.

[Slide 52 – Questions]

No questions.

[Slide 53 – Q&A]

No questions

[Slide 54 – Closing remarks]

AB: Thank you everyone for attending and listening today, and thank you to Professor Pamela Abbott, Professor Graeme Nixon, Professor Wenceslas Nzabalirwa, and Dr Tsion Hailu for their presentations today.

If no-one else has any questions, we will close here today.

[Slide 55 – Thank you!]

If you have any questions about this document or the project, then please email: nihrcmw@abdn.ac.uk.

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