NZAID EVALUATION & RESEARCH REPORT COLLECTION

Review of New Zealand's Development Assistance to the World Health Organization (WHO) Pacific Islands Mental Health Network (PIMHnet)

2005-2008

FINAL REPORT

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ACRONYMS AND ABBREVIATIONS

A&D	Alcohol and Drug
AM	Annual PIMHnet Meetings
CLO	Country Liaison Officer
CNMI	Commonwealth of the Northern Mariana Islands
FSP	Foundation of the Peoples of the South Pacific
FSPI	Foundation of the Peoples of the South Pacific International
KANGO	Kiribati Association of NGOs
MDT	Multi Disciplinary Team
MH	Mental Health
MHMS	Ministry of Health & Medical Services
MOH	Ministry of Health
NCD	Non Communicable Diseases
NCOPS	National Committee for the Prevention of Suicide
NFC	National Focal Contact
NGO	Non Government Organizations
NZ MOH	New Zealand Ministry of Health
NZAID	New Zealand's International Aid & Development Agency
PHC	Primary Health Care
PICs	Pacific Island Countries
PIMHnet	Pacific Islands Mental Health Network
PNG	Papua New Guinea
POLHN	Pacific Open Learning Health Network
SAMHSA	Substance Abuse and Mental Health Services of America
TOR	Terms of Reference
VANGO	Vanuatu Association of Non Government Organizations
VCH	Vanuatu Central Hospital
VIT	Vanuatu Institute of Technology
VPF	Vanuatu Police Force
VTC	Vanuatu Teachers' College
WHO	World Health Organization
WPRO	Western Pacific Regional Office of the World Health Organization
YMH	Youth Mental Health

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The WHO PIMHnet Secretariat and the NZ MOH gave generously of their time throughout the duration of the review. They shared an enormous amount of information that was not found and reports and documentation and this is greatly appreciated.

NZAID made this review possible. Quite a number of people within the agency made themselves available for interview before and after the field work, and have provided significant feedback on various drafts of the report, and I thank them for that. I would particularly like to acknowledge Ginny Chapman and Renee Simpson for their support and their friendship throughout.

EXECUTIVE SUMMARY

Background

The WHO Pacific Islands Mental Health Network (PIMHnet) was officially launched at the Meeting of Ministers of Health for the Pacific Island Countries in Port Vila, Vanuatu on 14 March 2007.

PIMHnet's broad objectives are to

Key components of PIMHnet's structure and operation are achieve improvements within countries and across the region in communication, co-ordination and co-operation, and capacity and capability in mental health service provision.the National Focal Contacts (NFCs), in-country mental health networks, the WHO Secretariat, the network Facilitator, and strategic partners.

Purpose and objectives of the review

The purpose of the review is to assess the extent to which the PIMHnet has met its major activity outputs and examine progress made towards achieving stated development objectives. Three specific objectives include:

(i) To assess PIMHnet project progress towards the stated objectives;
(ii) To assess the level of satisfaction and ownership from in-country stakeholders; and
(iii) To compare cost of interventions with the achievements of the project.

The review examined PIMHnet activities undertaken from October 2005 to June 2008, and the review was undertaken in November and December 2008.

Methodology

The review had three clear stages:

(i) *Desk study and NZ consultations*:

(ii) *Field study* in four PIMHnet member countries (Fiji, Kiribati, Tonga and Vanuatu) in which NFCs and strategic partners and key stakeholders were consulted.

(3) *Reporting,* with significant opportunity for feedback from NZAID, NZ MOH, WHO and the PIMHnet Secretariat.

A large amount of data was collected via reports, face-to-face and telephone interviews and questionnaires, generating qualitative and quantitative data that were entered into spreadsheets. Triangulation of data and verification of information followed. Where discrepancies in achievements were encountered the reliability of the data were verified with the Secretariat.

There were limitations in the methodology that included: limited number (4) Pacific island countries visited; ten out of the sixteen PICs have contributed to the review, either through a direct visit by the reviewer or by responding to the questionnaire sent out during the review process; and inability to undertake a detailed assessment of value for money due to financial information contractually required in project reporting being insufficient to allow this assessment to be made.

Key findings

Progress toward achieving stated objectives

The findings of the review suggest that a very successful project has been implemented and the interventions so far have been effective, measured at this early stage in outputs delivered. This is significant given the short period of time that the project has been in place and the number of Pacific Island countries (16) that are now benefitting. Some key achievements reflecting effectiveness include:

- Appointment of National Focal Contacts in all countries
- Generally satisfactory support to NFCs by the Secretariat through dedicated communication channels, given the challenges that the Pacific presents with communications technology
- Technical support visits by the Secretariat to six countries

- Provision of standard briefing documents and resource materials to countries, including small amounts of funding to support workplans
- Just over half of in-country networks are operating well; a barrier to network functioning in some countries is a lack of funds to resource meetings.
- The excellent progress with the development of MH policy and workforce plans is indicative of the high priority that countries have attached to these two areas:
- A MH information/resource kit targeting health professionals and the social sector/NGO sector has been provided to all NFCs, and has been very well received.
- MH legislation has not yet progressed to the same extent as policy and workforce planning, having been sensibly put on hold while the former are addressed.
- An NGO workshop in New Zealand in February 2008 brought together country specific and regional presenting an opportunity to advocate for PIMHnet and identify how these groups could support the in-country networks.

Achievement of development objectives

At this point in time *sustainability* of the network is not assured, but important precursors are in place: MH is on the political agenda in many countries and well supported at the highest levels in the Ministries of Health. Countries have ownership of the initiative. And some countries indicate the likely appointment of in-line positions dedicated to MH.

While it is difficult to report on *efficiency* of the initiative due to lack of details of funding allocations within the project, information gained through consultations suggests that the model that has been implemented is a cost efficient one.

Capacity building is reported to have been built in the following areas: ability to lobby and advocate for MH, confidence to be more outspoken, policy development, workforce planning, information sharing.

Satisfaction with the Project

The review found that stakeholders are generally very satisfied with PIMHnet to date. This included satisfaction with the technical support that was being provided and overall satisfaction with the nature of the project. Overwhelmingly the project is meeting country expectations and expressed MH needs:

Views were mixed about the ownership of PIMHnet by the member countries, but overall they consider they do have ownership, because they are identifying the priorities and the strategies to support MH in their country and these are country specific.

Value for money/efficiency

Funds have been received by WHO for three financial years to 2007/08, and has achieved outputs described in Annex 10 developed by the consultant and Annex 11 (MOH achievements). While broad categories of expenditure were not available to the review on which to make an informed judgement about value for money, the evidence in Annexes 10 and 11 suggest that the project has provided good value for money thus far.

Appropriate location and structure for the PIMHnet:

Examining various options for future delivery of PIMHnet, it is recommended that PIMHnet be funded through the NZAID regional program, contracting WHO directly to implement. This would need to continue for quite some years at least. It will ensure essential elements of the project continue to be progressed, with minimal disruption to the current structure and its functioning. The strengths and weaknesses of the all options are discussed.

Discussion

The findings of the review suggest that a very successful project has been implemented and the interventions so far have been effective, measured at this early stage primarily in outputs delivered with just a few early outcomes apparent in relation to human rights. The achievements are significant given the early stage of development of PIMHnet. The membership of PIMHnet has grown from an initial twelve countries, to now having eighteen countries that are benefitting. This is significant given the challenges of working regionally in the Pacific, and yet demonstrating continued engagement, with all countries making progress.

PIMHnet has a role in the wider regional strategies of strengthening social and behavioural aspects of people's lives and broader community wellbeing. The cumulative strengths of this with other programmes is consistent with the objectives of NZ and AusAID.

The project presents an interesting model that has ownership at its core. This increases the likelihood of sustainability as countries determine how and at what pace initiatives will be rolled out. While the WHO Secretariat facilitates and supports countries in this process, the final responsibility is with the countries themselves.

An evidence-based approach to identifying interventions that are needed has been adopted, and further studies need to be resourced in pharmacology and nursing to continue this approach.

Gender and human rights are very clearly embedded in the program, and WHO guidelines used for MH policy and legislation development ensure that these issues are addressed. However, this needs to be better documented.

Project documentation presents an area for improvement. It is now timely to bring the separate project documents (framework, 10-year objectives, monitoring matrix) together into one framework/design and carefully articulate just what the objectives of PIMHnet are, what key activities are needed to achieve those objectives, and how achievement of those objectives will be measured. This exercise would not detract from the ownership that the membership countries have, and any re working should at some point be done with country input, or be presented for endorsement and confirmation. A process should be initiated that facilitates discussion and further development of an integrated performance and monitoring framework that will work for NZAID (and any other donors), PIMHnet and its member countries.

A challenge ahead is implementation of the workforce plans. Countries will need to be supported in how those plans are realised, maintaining the principle to keep the training in the Pacific to minimise the risk of losing people to nearby developed countries. Support to implementation of workplans is going to require significantly more funds than has been required to date. It is now timely for NZAID to facilitate this by actively seeking partnerships with other funding agencies working in the region. Efficiencies will be achieved if that is secured in time for the next phase of implementation, with one single pool of funds eliminating the need for the Secretariat to be continually expending energy and time on trying to find funds for discrete "projects" within the whole. This would also give other donors the opportunity to support a model that has demonstrated its feasibility to contribute to addressing the needs of one of the key groups that constitute the disabled – the mentally ill.

The review process itself was seen as beneficial to the NFCs in three of the four countries that were visited. What emerged was greater understanding in some cases by the NFC of PIMHnet, ideas for further activities, identification of opportunities for seeking funding, and a list of "things to do"! It also highlighted that the review *process* itself could be beneficial as a supportive intervention to implement perhaps yearly, between AMs, with in-country visits to all PIMHnet countries by an appropriate person (e.g. from MOH) to visit with NFCs and government and non-government stakeholders, reviewing progress and identifying opportunities. It is important to consider that "*you don't know what you don't know*", which means some countries will never ask for assistance through in-country visits, yet will miss out as a consequence.

Lessons learned

(i) Ownership and responding to country needs: The approach adopted in this project is an excellent example of a model that facilitates ownership and can at the same time reach many countries and respond to their different stages of development.

(ii) It is important to encourage continuity in NFCs; there are benefits if the primary/active NFC attends all AMs.

(iii) Good linkages to the WHO CLO or other in-country WHO officer (where they exist) are beneficial, given their own linkages and networks; they can also assist in monitoring good governance and adherence to human rights.

(iv) In country support visits can have enormous intended and unintended benefits for NFCs and other stakeholders.

(v) Weaker NFCs can be supported/strengthened by building other supports around them e.g. NGOs, CLO, churches.

(vi) Timely dissemination of draft reports overcomes the constraints of WHO publication protocols that would hinder the timely dissemination of important project outcomes and results.

(vii) There is value in developing a structured mechanism for each country to do its own self-monitoring against project objectives; using this each country can contribute to the updating of the overall project monitoring framework and the furthering of their own action plan.

(viii) NGOs have a significant role to play in the provision of MH support; some good examples exist where they are part of the overall formal referral system.

(ix) NZ MOH has demonstrated the value of it having a key role in the implementation of the project; and highlights exploring the benefits of their inclusion in further projects of this kind, using various mechanisms.

(x) If there is any uncertainty about the ability to use new and complex templates then they need to be piloted, at least with countries that are not so well developed and may find this type of exercise challenging.

(xi) Sound NZAID reporting and accountability structures for GAF activities will contribute to better knowledge about the success or otherwise of NZAID supported activities.

Recommendations

Recommendation 1: Continue to encourage greater inclusion of the in-country WHO office/CLO in stakeholder meetings/partnerships.

Recommendation 2: The implementers need to clarify regularly for member countries how and where funds are available that are identified under Objective 2, and identify if there is a process for obtaining funds; make this clear to NFCs; encourage NFCs to identify other sources of funding in their own country.

Recommendation 3: Pilot templates for acceptability and usability before distributing to those filling them in.

Recommendation 4: The PIMHnet Secretariat establishes a mechanism for monitoring the outcomes of the NGO meeting in Wellington.

Recommendation 5: NZAID (or donor) ensures MOUs are explicit about reporting for financial accountability that will permit value for money/efficiency analysis in future funding agreements.

Recommendation 6: Reassess the communications strategies to determine if all strategies are cost effective and are accessible by most members.

Recommendation 7: NZAID actively pursue additional funding from other donors for whom MH (disabilities) is a priority to increase the pool of funding for all elements of a comprehensive program; WHO cost the total funding needed for the next 3-5 years minimum.

Recommendation 8: Bring together all documentation that has been developed that describes PIMHnet into one concise PIMHnet framework/design document, with the assistance of a consultant whose expertise is in the development of logframes and monitoring and evaluation matrices. This should be worked jointly with the WHO Secretariat and NZ MOH, and subsequently with member countries to maintain the ownership and the original intent of the network framework. It is recommended that this is done in preparation for the next phase of funding. It is essential that the next phase of the project/programme be taken forward with a strong description of its design and a strong, measurable M&E framework.

Recommendation 9: In conjunction with the development of a concise PIMHnet framework/design document (Recommendation 8) develop a systematic, concise M&E framework including data collection tools to support regular monitoring and eventual evaluation of the project. Along with the standard M&E requirements at all levels of the program implementation (activity, outputs, objectives/outcomes) this must:

- include a mechanism to monitor policy implementation, and measure the outcomes of the training identified in the workforce plans;
- identify indicators to measure that gender and human rights issues are being met, primarily through changes that are occurring in practice compared with practices at the start of the project.
- Provide simple but sound matrices (developed by this review) for the PIMHnet Secretariat to use annually to review country performance.

Recommendation 10: Once the M&E framework has been developed dedicate part of an AM to workshopping M&E for the project; this should increase compliance with provision of information.

Recommendation 11: Identify strategies to strengthen those NFCs who struggle in their role.

Recommendation 12: Consider a Phase 2 that has a duration of five years; schedule an independent review at the end of two years maximum i.e. 2011.

Next Steps

(i) Address documentation limitations.

(ii) Define studies that need to be done and bring into an updated design document (e.g. nursing and pharmaceuticals).

(iii) Pursue support to self monitoring - create ownership of progress.

(iv) Convene a meeting with NZAID, WHO, NZ MOH and AusAID to discuss further support to the project.

1. BACKGROUND

1.1 Background to development of the PIMHnet

At the meeting of Ministers for Health for the Pacific Island Countries (PICs), held in March 2005 in Apia, Samoa, the idea of a Pacific Mental Health Network was discussed as a means of overcoming geographical and resource constraints in the field of mental health. Based on findings from a situation analysis (see Annex 1 for details) and extensive consultations with Pacific Island countries, a final funding proposal for establishing and operating the network was developed and the World Health Organization (WHO) has received three years of funding from the New Zealand Ministry of Health (NZ MOH) and the Overseas Development Agency of the Ministry of Foreign Affairs and Trade (NZ International Aid Agency - NZAID) to support the network activities. Following success with funding, two planning meetings were held with Pacific Island country representation: in Tonga in 2005 to develop a draft framework for the Network and in Auckland in 2006 to develop an implementation plan. The WHO Pacific Islands Mental Health Network (PIMHnet) was officially launched at the Meeting of Ministers of Health for the Pacific Island Countries in Port Vila, Vanuatu on 14 March 2007. Significant dates and events are presented below.

Date	Event	Activity
2003	Pacific Health Ministers' Meeting, Tonga	Mental Health on agenda
2004	Mental Health Situational Analysis	Report
March 2005	Pacific Health Ministers' Meeting, Samoa	Recommendation to establish WHO WPRO Mental Health Network
2005	NZAID'S Government Agency Fund successful bid	3-year funding for Mental Health Network
August 2005	Tonga planning meeting – 5 countries participating	Developed draft framework for Network
May 2006	WPRO meeting in Auckland, NZ	Develop an implementation plan for PIMHnet
March 2007	Pacific Health Minister's meeting - Vanuatu	Launch of Network

1.2 Aim of the network

PIMHnet's ***vision*** is "*the people of Pacific Island countries enjoying the highest standards of mental health and well-being through access to effective, appropriate and quality mental health services and care*".

To achieve this vision, PIMHnet's ***mission*** is "*to facilitate and support cooperative and coordinated activities within and among member countries that contribute to sustainable national and sub-regional capacity in relation to mental health*".

Given its vision and mission PIMHnet has as its broad ***objectives*** improvements within countries and across the region in:

- Communication;
- Co-ordination and Co-operation; and
- Capacity and Capability.

1.3 Description of the program

The operational structure of PIMHnet is the result of various consultations on a draft proposal drawn up by WHO Geneva and WPRO that described what the network would look like and how it would function. This was circulated to twenty Pacific Island countries for comment.

Several key components make up PIMHnet and are integral to its structure and operation. These are National Focal Contacts (NFCs), In-Country Networks, the WHO Secretariat, the Network Facilitator, and Strategic Partners.[1]

[1] A more detailed description of the structure and organisation of PIMHnet is found in the Review TOR at Annex 2

National Focal Contacts are key to the operation of PIMHnet and are appointed by each country's Minister of Health as the focal person for that country. They are people who hold a senior position within government or the public service with responsibility for and a strong involvement in mental health.

The NFCs have responsibility for fostering ***in-country mental health (MH) networks***, whose members could include: mental health clinicians and professionals; those involved in mental health legislation, policy, financing and planning, and programme management; relevant professional organisations; NGO and other relevant provider organisations; service users and/or service user organisations; family representatives and/or family organizations; educators and academics in the field of mental health; and representatives from community and church (e.g. elders, leaders, traditional, healers). These groups vary and fluctuate in size and composition.

NFCs are responsible for facilitating activities, relationships and communication between individuals, groups and organisations with a role or interest in mental health in their country.

The WHO (Geneva, WPRO) serves as the ***WHO Secretariat*** and is responsible for: the development, management and dissemination of information and resources; fundraising; the preparation of materials (e.g. discussion papers and reports); the maintenance of a database of contacts and activities; and the overall management and co-ordination of meetings and activities.

The ***Network Facilitator*** is contracted by WHO as a key member of the Secretariat[2] to ensure the ongoing operation of PIMHnet. Key aspects of the Network Facilitator's role include administration, co-ordination and communication with PIMHnet countries.

Strategic Partners are individuals or organisations (government, non-government and private) that can provide relevant expertise, resources and support in a wide range of areas and ways (e.g. funding, education and training, policy and legislation, service development and delivery, clinical practice, etc).

NZAID as the donor maintains regular contact via the MOH. NZAID staff at Post have some (mostly limited) contact with the project in country.

2. PURPOSE AND OBJECTIVES OF THE REVIEW

The Terms of Reference (TOR) for the review are found in Annex 2. Dr Alison Heywood was engaged as the independent consultant to undertake the review.

2.1 Purpose

To assess the extent to which the WHO Pacific Island Mental Health Network has met it major activity outputs to date and examine progress made towards achieving stated development objectives.

2.2 Objectives

Three objectives are articulated for the review.

Objective 1: To assess PIMHnet project progress towards the stated objectives (including use of the key performance indicators as detailed in the project proposal).

Objective 2: To assess the level of satisfaction and ownership from in-country stakeholders.

Objective 3: To compare cost of interventions with the achievements of the project.

2.3 Scope of the review

The review took place in November/December 2008 and examined PIMHnet activities undertaken from October 2005 to June 2008 which are outlined in Years 1 and 2 of the PIMHnet 10-year workplan. The details of key activities for each program objective for the ten years are found in Annex 3. The review has examined progress toward achieving objectives of the project, although this is constrained by a number of factors noted in Section 4.2 below.

[2] The Facilitator is based in New Zealand and is contracted part time and employs a part time analyst to assist.

The review involved field research in the following PIMHnet countries: Fiji, Tonga, Vanuatu and Kiribati. The sequence and timing of activities are described in Annex 4. Further details of the scope of the review are presented in the next Section 3: Review Methodology.

3. REVIEW METHODOLOGY

3.1 Approach

The review had three clear stages: Desk study and NZ consultations; field study; and reporting. A detailed methodology and workplan was developed prior to commencing the assignment, and is found at Annex 5.

(1) *Desk study and NZ consultations*: The desk study was conducted in New Zealand prior to the in-country visits to review available documentation, to identify key informants and potential field sites, and to plan the field work component of the study. Meetings were undertaken with NZAID, NZ MOH and the PIMHnet Secretariat. Relevant documents were examined and a list of all documents consulted is found at Annex 6. The consultant engaged in teleconferences to discuss the review and identify people to meet. Based on key planning and strategy documents a data matrix was developed and evaluation questions were derived (Annex 5).

(2) *Field study:* Four PIMHnet member countries were visited: Fiji, Kiribati, Tonga and Vanuatu. These were jointly chosen by NZAID and the PIMHnet Facilitator to provide a representative sample of countries (Melanesian, Micronesian, Polynesian) at different levels of progress. NFCs in each of these countries were consulted as were strategic partners and key stakeholders where available. The discussion guides for interviews are found in Annex 5.

A short questionnaire was developed and e-mailed to NFCs in those countries not visited by the consultant. This questionnaire is found in Annex 5.

A brief questionnaire was e-mailed to all participants who attended the Partnership meeting held in Wellington, New Zealand, in February 2008 (Annex 7).

A list of people consulted and respondents to the questionnaires are found in Annex 8.

(3) *Reporting:* Analysis and reporting were conducted during and following the field visits. A draft report was distributed to NZAID, NZ MOH, WHO and the PIMHnet Secretariat prior to returning to New Zealand for de-briefing meetings. In New Zealand preliminary findings were presented to NZAID, NZ MOH and the PIMHnet Secretariat. These meetings provided opportunity to comment on preliminary findings and offer further information. Stakeholders were again invited to provide comments on the final draft report. A final report was provided to NZAID a week after the New Zealand meetings. Further opportunity for comment was provided and feedback incorporated into a final report submitted on 23rd January to NZAID.

3.2 Methods for assessment of results

A large amount of data was collected via reports, face-to-face and telephone interviews and questionnaires. While the project reports focus largely on outputs, as does the framework, the review sought to report not only on the quantity of outputs (in table form for completeness country by country in Annex 9) but on the quality of those outputs from the perspective of the key stakeholders.

Quantitative and qualitative data were entered into spreadsheets. Identifying the sources of information permitted triangulation of data and verification of information particularly where discrepancies occurred. Quantitative data taken from these spreadsheets were presented in table form in the report.

Where discrepancies in achievements were encountered (and this related primarily to country self-reporting on achievements) the reliability of the data were verified with the Secretariat.

3.3 Limitations of the methodology

Only four of the Pacific island countries were visited. These tended to be easily accessed and with generally good communications, compared to others. It could be said that three were "performing" well. It might have been useful to include at least another couple of countries, among them one/some that were not performing so well or who were more challenged with communications/access issues.

To date ten out of the sixteen PICs have contributed to the review, either through a direct visit by the reviewer or by responding to the questionnaire sent out during the review process. The views of six countries have not been able to be considered. Attempts by the reviewer to follow up by phone, email or fax have been unsuccessful, mostly because the lines of communication have been "down". This significantly limits the generalisability of the findings.

The ability to undertake a detailed assessment of value for money to include making comparisons with other similar activities has not been possible for two reasons. (i) There is insufficient financial information in project reporting to allow this assessment to be made; and (ii) the consultant is unaware of similar programs in the region stating similar outcomes with budgets of similar size for a comparison to be made.

The inadequacy of project documentation has quite significantly affected the ability to undertake a systematic review of the project. Project documentation lacks cohesiveness, and inadequate outcome indicators against one consistent set of objectives limits the extent to which there can be an acceptable discussion about effectiveness.

4. FINDINGS OF THE REVIEW

4.1 Progress towards planned outputs

The PIMHnet 10-year Objectives document (see Annex 3) (not attached to the official Framework document) articulates six discrete objectives and key activities for each of those objectives over a 10-year period. For this review, progress was assessed for the key activities listed against framework objectives using a combination of approaches (described above in Section 3.1). The line of enquiry addressed both quantitative and qualitative aspects of progress, by quantifying the outputs in detail (see Annex 9) and probing for qualitative comments on those outputs, as well as on the technical inputs that have been provided.

Annex 9 structures the information on achievements against each framework objective, taking note of the key activities outlined for Years 1 and 2. It is structured in a way that clearly presents the achievements of the Secretariat and each country to date. The activities that are presented here are those identified by the project to be achieved against the stated objective.

Objective 1: Improved awareness of human rights & reduced stigmatisation

There are now eighteen countries participating in the network. These include: American Samoa, Australia, Cook Islands, Fiji, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, New Zealand, Niue, Northern Commonwealth of the Northern Mariana Islands (CNMI), Palau, Papua New Guinea (PNG), Samoa, Tokelau, Tonga, Vanuatu, Solomon Islands. Membership of PIMHnet occurs only by request of the government to WHO.

Secretariat support to NFCs occurs on a number of levels, and overall appears to be highly satisfactory. Regular contact is occurring with NFCs by email, telephone or fax and this is reported by NFCs to be satisfactory. Communications throughout the Pacific Islands is variable and often unreliable, and the Secretariat reported that it follows up by phone any non-response by NFCs to communications that require acknowledgement. This was confirmed by the NFCs interviewed.

Visits to some countries have occurred on request, providing direct and specific technical support:

- Vanuatu March 2007 - assistance with data for country information and beginning plan;
- Samoa June 2007 - assistance with policy, legislation review;
- Cook Islands November 2007 - assistance with country information and plan;
- Kiribati January 2008 - assistance with initial policy workshop, formulation of funding proposal and direction re current mental health problems in Tarawa;
- Solomon Islands June 2008 - discussion re review of outdated policy, plan and policy process-stakeholder meeting;
- Fiji September 2008 - First policy stakeholder meeting.

The Secretariat has prepared a number of standard briefing documents for use by NFCs, for example, to use when briefing their ministers. These were reported to be extremely useful. Regional resource materials relevant to PIMHnet are also sent to NFCs and have been well received.

Very early on materials were distributed for use during Mental Health Week.

A number of activities have been supported to address stigma, including its integration into policy and legislation development. While this has occurred, feedback during consultations suggested some further focus on human rights and stigma would be valuable as a focussed component of another AM.

Objective 2a: The profile of mental health as a key health issue within countries & region is raised

The ***PIMHnet framework*** was ratified by member countries at the inaugural AM in Samoa in June 2007 and is now finalised and can be found on the PIMHnet website.

NFCs have been appointed (by governments) for each country. In some countries two NFCs have been appointed with one identified as the primary contact. The PIMHnet Secretariat has a database of all NFCs and their contact information, including preferred means of communication. E-mail is the most preferred method for communication. This database is updated when and if NFCs change.

The capacity of NFCs is variable. About 60% (10/16) are reportedly well motivated and active. This was confirmed in the four countries visited. All NFCs have a responsibility for MH in their countries, and work in this area at the government policy or clinical level. It is the project's expectation that if NFCs change, the incoming NFC will be adequately informed about the network and about progress within his/her own country. Some informants reported that this has not always occurred, and it was also confirmed during in-country consultations and observations.

"New NFCs need to be properly briefed, and particularly when they come to the AM."

The extent to which ***in-country networks*** are operating is (not unexpectedly) variable. Two countries already had a very active mental health network prior to PIMHnet. Four countries now have an active network that is meeting regularly. Three countries have an active network but it does not hold regular meetings. The network is in an embryonic stage of development for three countries, and four have no network at all. In summary, the in-country network situation can be presented as follows:

Status of in-country networks	Countries	
	N	%
Active before PIMHnet:	2	12%
Active and meeting regularly	4	25%
Active but no regular meetings	3	19%
Embryonic	3	19%
No network	4	25%

Regularity of meetings does not appear to be a critical issue in terms of the effectiveness of the networks. Some countries met as the need arose rather than on a regular basis, and maintained impetus this way. What does appear to be critical is the nature of the relationship between the NFC and the stakeholders who make up the network, and the commitment generated to address mental health.

Strong links to the WHO Country Liaison Officer (CLO) or other in-country WHO officer appeared to benefit MH networks, because of that office's own linkages and networks. However, it should be noted that not all countries have a WHO CLO within their country.

Recommendation 1: *Continue to encourage greater inclusion of the in-country WHO office/CLO in stakeholder meetings/partnerships.*

The in-country review consultations identified outstanding networks in three of the four countries visited. Each of the three worked quite differently to one another, but appeared nevertheless effective particularly in supporting mental health care through the primary health care system or at the community level supported by NGOs. It is difficult for the review to know in the same way how strong the networks are in the remaining countries that were not visited.

For some countries formation of in-country networks has proved to be challenging, and different strategies have been used by PIMHnet members in order to engage them (for example, providing a lot of information to potential members and hoping this will prompt action). A barrier to network functioning in some countries was a lack of funds to resource meetings, irrespective of whether those meetings were to be held regularly or not.

While in-country networks are significant in some countries, "networking" effectively with NGOs and other stakeholders is problematic for some. This was very clear to the reviewer. Some informants stated openly that they had not appreciated the importance of the in-country networks, and did not realise that they were a significant element of PIMHnet.

The PIMHnet ***logo*** was developed through a competition that was won by a school in PNG. The intent of the logo is to raise the profile of and give recognition to mental health as a health issue in participating countries. The logo is on all documentation, on the website, and on caps and T-shirts. It is attractive and distinctive.[3] ***Caps and T-shirts*** were distributed to all countries. However there were some problems with appropriate distribution of those supplies. This presents a challenge for the Secretariat who try to engage the WHO CLO in an oversight role.

Not all countries have accessed ***in-country funding for communications***. Some dissatisfaction was expressed about this aspect of the project, which may relate to the guidelines for what will and will not be funded, and wanting items that are outside of these guidelines.[4] At least one country reported that on two occasions requests for funds for specific activities have been made, but nothing has been forthcoming. It is possible that some countries are unclear or have forgotten the procedures for getting funds. It was difficult to verify some of this information.

Country funds for communication were announced and discussed at both AMs, and documented in the meeting reports. It has also been discussed in at least one teleconference (although not every country participates in these), and numerous emails have been sent out about this from the Facilitator. Efforts by the Secretariat to inform countries about the process and guidelines are considerable. NFCs also need to be encouraged to explore other sources of funds in their own country. The review consultation process highlighted opportunities in at least one instance that was unknown to the NFC.

Recommendation 2: *The implementers need to clarify regularly for member countries how and where funds are available that are identified under Objective 2, and identify if there is a process for obtaining funds; make this clear to NFCs; encourage NFCs to identify other sources of funding in their own country.*

Objective 2b: Communication process to engage in discussion on key issues

A communication protocol with member countries was established early on in the project and includes: E-mail, phone, fax, mail, newsletters, teleconferences, website and annual meetings. This is addressed in greater detail in Section 4.6 below.

Objective 3: Public policy & legislative development in mental health that is reflective of international guidelines & human rights

Developing **Mental Health policy** is a priority for the all partners. This work is progressing well, and shows similar variability as for in-country networks. The findings in summary are shown below:

Status of policy	Countries	
	N	%
Policy endorsed and costed	1	6%
Finalised, awaiting approval	1	6%
Final draft, not yet approved	3	19%
Progressing well	8	50%
No policy, or needs review	3	19%

[3] This reviewer introduced herself to the WHO Nutrition and Physical Activity Officer (having never met him before) when disembarking at Suva airport, because he was wearing the PIMHnet T-shirt!

[4] All countries have had access to this fund; the process is to apply through their Department or Ministry of Health directly to Dr Wang RA in WPRO Manila. Funds then go through to Ministry or Department; they are tagged for MH to assist with in-country network support.

Considering that policy development takes time and involves stakeholder consultation processes, 81% of countries are progressing well or have final or endorsed policies. The Secretariat has provided significant support to policy development. It has provided WHO guidelines to all countries. The 2007 AM workshop was devoted to policy development and included showcasing countries that were well progressed with this activity. At least four countries, as the result of a direct request to the Secretariat, have received in-country support by way of a technical visit to assist development of its policy. Comments have also been provided on different drafts of policy documents. This support has reportedly been invaluable.

MH **legislation** has not yet progressed to the same extent as policy, and progress can be summarised as follows:

Status of legislation	Countries	
	N	%
Acceptable legislation in place before PIMHnet	1	6%
Finalised & in law	1	6%
Final draft, not yet approved	2	12%
Needed but not yet commenced	9	57%
None/NZ by default	3	19%

This slower rate of development can be explained by policy work rather than legislation having been identified as a high priority and an urgent need, and thus the focus of the early support by the Secretariat.

WHO guidelines that have been made available for the development of legislation ensure human rights issues are addressed within the legislative framework.

Objective 4: Increased skill & knowledge of workforce that interfaces & cares for people with mental illness

To achieve this objective member countries are being supported to develop MH human resource and training plans. The technical component of the 2008 AM was devoted to this activity. An initial workforce plan template was developed that proved to be too difficult for most countries to use. A second simpler template was therefore developed and this has been valuable in progressing this work. However, at least one country complained about starting with the first template then having to re-work their plan with the second.

Recommendation 3: *Pilot templates for acceptability and usability before distributing to those filling them in.*

Progress with these plans is progressing very well, given the relatively short timeframe since the new template has been in use and can be summarised as follows:

Status of workforce planning	Countries	
	N	%
Completed under PIMHnet	4	25%
Well progressed	8	50%
Progressing slowly	2	13%
Very slow/dropped off	2	12%

Seventy five per cent of plans are completed or well progressed. This achievement can be attributed partly to the focus on this activity in the most recent AM and is an indicator of the success of that process within the AM. It can also be attributed to the high priority that is placed on MH workforce training in all countries.

An activity within this objective is the development and distribution of a MH information/resource kit. This was developed with significant comment provided by the member countries during the process. This has been provided to all NFCs, in hard copy and on memory stick to facilitate distribution to relevant stakeholders.

Feedback indicates it is highly acceptable, appropriate, is written in simple language, and is easily used. It is in two sections targeting two audiences: (i) health professionals and (ii) the social sector/NGO sector. Those who contributed to the review (interview, questionnaire) rate the resource as very good to excellent.

The focus on a primary health care (PHC) model in member countries means that training and development around mental health of the associated workforce is clearly important to improving care and MH outcomes. This is perceived as a high priority by countries, and is a priority within the WHO guidelines. It is too early in the development of this objective to see evidence of how people in rural and remote communities will benefit from this intervention, except that training of the PHC workforce is a priority in plans. While much can be achieved through the training of general health staff in mental health, it is also evident that an optimal mix of services also requires a specialist workforce. Achievement of these elements will need to be monitored as plans are implemented.

Objective 5: Greater lobbying and strategic influence with organisations involved in key mental health issues

To progress this objective PIMHnet has been developing strategic partnerships with NGOs and has an extensive database in place. This includes country specific and regional NGOs, and international organisations. An NGO workshop was facilitated in New Zealand in February 2008 that brought together some of these groups to identify how they might contribute to PIMHnet achieving its objectives. Draft action plans emerged from this meeting for: advocacy, human resource development, and service delivery, in which the groups in attendance identified the actions that they would take responsibility for progressing.

The meeting presented an opportunity to advocate for PIMHnet and identify how these groups could support the in-country networks. Some participants were contacted as part of the review and without exception reported on how valuable this meeting had been:

> *"Terrific meeting … got all the people together who could have an impact … (it was) well organized and facilitated, with plenty of time for people to have input."*

However, while the meeting is considered to have been an important activity giving momentum to the network, limitations were identified. The action plans appear rather ambitious, and it was unclear how they will be progressed. This view was shared by some of the Secretariat as well as participants, but was qualified by saying:

> *"A lot of work was brainstorming … some of it is aspirational … is it too ambitious? … aspirational plans usually are; then it is up to those (employed) to do the work to make recommendations on how to move forward … but it is not a problem having aspirations."*

The Secretariat will need to establish a mechanism for monitoring the outcomes of that meeting i.e. that the NGO action plans have been progressed.

Recommendation 4: *The PIMHnet Secretariat establishes a mechanism for monitoring the outcomes of the NGO meeting in Wellington.*

The draft meeting report and action plan was provided to meeting participants and PIMHnet in the first week of April 2008, five weeks following the meeting. Many participants who attended the meeting loaded copies of presentations on their USBs and used these to brief their respective stakeholders on return to their countries.

While NFCs had input into identifying which organisations should be invited to this meeting, a number of stakeholders queried the NGO representatives finally selected to attend the meeting. It was noted that some of these had no involvement in mental health work in their country. In some instances (though not all) requests for a more appropriate representative to attend were not considered. While WHO had good justification for the final selection of attendees, there was nevertheless dissatisfaction expressed about this.

There was also a perception that there may be two separate arenas for PIMHnet: one for NGOs and one for GOs.

> *"Not good to have separate meetings of NGOs, other governments, professional organisations – looks like there are two separate arenas for PIMHnet – one for GOs and one for NGOs – PIMHnet needs to find a way to merge them".*

While this is clearly not an intended outcome, the perception and possible unintentional outcome needs to be considered.

Objective 6: Sustained change and support

Continuous support to NFCs is being provided through regular provision of resources and through the already identified communications channels.

The network has grown from the twelve initial member countries (American Samoa, Australia, Cook Islands, Fiji, Kiribati, New Zealand, Niue, Papua New Guinea, Samoa, Tonga, Tokelau, Vanuatu) and now includes Palau, Marshall Islands, Commonwealth of the Northern Mariana Islands, Nauru, Micronesia (joined 2007) and Solomon Islands (joined 2008).

An ongoing activity is continued preparation of proposals and pursuit of potential donors to enhance the sustainability of the Pacific Islands Mental Health Network.

4.2 Achievement of project objectives

Two separate sets of objectives are presented in PIMHnet project documentation. Six are presented in the 10-year workplan (Annex 3), without indicators for their measurement but with activities that are precursors for their achievement. Five are presented in the PIMHnet Monitoring Framework, within the Monitoring Schedule, together with indicators (Annex 10). The latter objectives are derived partly (though not wholly) from the PIMHnet Framework document. There is some consistency between the two sets of objectives, though not a lot. The last "objective" in this second set is in fact a higher level *goal*. It will be impossible to measure PIMHnet's contribution to it's achievement in the absence of very robust information systems.

These documentation limitations therefore make reporting on achievement of project objectives particularly challenging. At this early stage most of the achievements have been at the activity and output level. One therefore needs to draw the logical link between achievement of outputs and likely achievement of stated objectives. It is the opinion of the review that the link is sound, but it also apparent that some indicators at the objective level (Annex 10) are imprecise (therefore possibly unmeasurable), and some are output/activity level indicators (e.g. mental health legislation and policies that reflect human rights) and don't reflect the *outcome* of legislation and policies being in place e.g. improved human rights practices.

Despite documentation weaknesses, the review was told of changed practices that had already occurred in relation to improving human rights of the mentally ill, as a result of the focus on legislation. The project needs to find a way of reporting achievements at the objective level particularly if they are a sensitive. Overall it has to be said that there has not been a focus on how the project will collect information and report at the objective level.

4.3 Achievement of development objectives

(i) Sustainability

In the context of donor-funded development programs and projects, sustainability can be defined as measuring *whether and to what extent the benefits can be sustained after the end of the development assistance*.[5] The following questions are considered:

- To what extent will the benefits of a programme or project continue after donor funding ceases?
- What were the major factors which influenced the achievement or non-achievement of sustainability of the programme or project?

For this project it requires an examination of the capacity of the PICs, without further external assistance, to continue to have a functioning network that supports the provision of appropriate health care to members of their population with MH problems. In the words of one NFC:

> *"PIMHnet needs to be Pacific owned and Pacific managed."*

At this point in time sustainability is not assured. However, ownership is critical to sustainability, and ownership has been paramount to the model. Sustainability will also only be assured when governments make a

[5] *NZAID Evaluation Policy Statement*

commitment to dedicated budgets for MH, and ensure that MH project officers or advisors are appointed. PIMHnet has been able to build on previous activities commenced with other donor support e.g. workforce planning, as well as put MH on the political agenda. This latter factor is quite possibly one of its greatest achievements. Some countries have demonstrated significant political commitment in support by senior people in their Health Ministries (See Annex 9 for details), and some report positively about appointments specific to MH as likely in the near future.[6]

The project will need to monitor closely how it is working towards a sustainable outcome. Developing a set of project specific indicators for sustainability may assist this process.

(ii) Capacity building

Through direct consultations and questionnaires informants reported capacity having been built in the following areas: ability to lobby and advocate for MH, confidence to be more outspoken, policy development, workforce planning, information sharing.

Informants indicated further capacity building was wanted in lobbying and networking. As for sustainability, the project will want to document achievements in this area.

4.4 Value for money/efficiency

Efficiency measures *the extent to which the programme could have been implemented at less cost without reducing the quality and quantity of the activities.*[7] It asks the question: has the most efficient process has been adopted and considers whether the activities were cost-efficient, were the objectives achieved on time and was the programme or project implemented in the most efficient way compared to alternatives?

Detailed budgets are needed to assess efficiency adequately. Financial documentation available for the review for the three years to date has not contained the detail to identify how the funds have been allocated/expended[8], so it is not possible to look at even broad categories of expenditure. However, based on discussions with the NZ MOH and the WHO Secretariat (potentially biased in favour of the model), and the exposure of the (independent) reviewer to a significant number of project implementation models, and considering the information provided in Annex 11, and in Annex 9 that was developed by the consultant, it is considered that the model that has been applied for the implementation of PIMHnet is a cost efficient one. Eighteen countries (including New Zealand and Australia) are now members of the network and benefitting from the assistance being provided by WHO and NZ MOH. This is a large number of beneficiaries for the amount of funding provided. Sixteen countries are now making significant progress implementing the key elements of the project, with ownership at the core. Thirteen MH policies are completed or well progressed; four legislative frameworks are in place or well developed; twelve workforce training plans are completed or well progressed; and nine MH in-country networks are well established.

One of the potential risks to efficiency in a model of this kind is the temptation to send numerous technical experts to meetings. This is appears to have been kept under control, and for any future phase could be monitored by the proposed Management/Steering Committee.

It is important to note that whilst funds are provided to NZ MOH, that agency receives none of the funding despite quite significant contributions to the project - it is all passed on to WHO as the Implementing Agency.

Significant goodwill and altruism has been created by the project, resulting in substantial support/contribution that is external to the donor resource envelope. Some of this can be quantified (NZD 21,000 for the Vanuatu scholarship to India). The informal contribution[9], while difficult to quantify could be as much as 10% (or more) of

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[6] Cook island is a case in point: it had no budget for MH in 2005 and now it has a small one, but is a line item in the country budget

[7] *NZAID Evaluation Policy Statement:*

[8] However the documentation has been in line with reporting requirements of the first MOU.

[9] Includes: donations from the big NGOs (strategic partners) in response to country requests, gifting of resources (workbooks), Trans-cultural centre of NSW contributions (materials, guidelines on how to establish networks/support groups), planned training clinical inputs where the clinicians' time is on a voluntary basis, memory stick funded by the project then loaded with huge amounts of information. NZ

the donor budget. This contribution should not be underestimated, and will be a significant factor in terms of long term sustainability of the network.

However, more information on the activity's cost structures is needed to identify whether there are areas for more cost effective allocations of funding to activities, to know if funds could be better directed. This is important given the feedback from NFCs indicating a greater need for resources for translation, the need for country visits by WHO/Secretariat and assistance with consultant inputs. This analysis can't be done in the absence of more detailed financial acquittals.

Recommendation 5: *NZAID (or donor) ensures MOUs are explicit about reporting for financial accountability that will permit value for money/efficiency analysis in future funding agreements.*

4.5 Relevance of the project to the challenges of the mental health situation in the Pacific Region

Relevance examines *whether and to what extent the activity has addressed the needs and priorities of the target groups and is aligned with the partner's policies and priorities*.[10]

Target group and beneficiaries

Mental health disorders contribute significantly to the total disease burden in the Pacific Region. While there have been improvements in physical health over the last 50 years in this region, the situation has worsened with respect to mental health and the region has a higher burden of mental and neurological disorders relative to other parts of the world[11].

In the Pacific region mental health is often assigned a low priority, competes for scarce resources, and frequently struggles to be recognised at all levels of government and society. Because of the numerous and competing demands on already limited country resources and budgets, achieving effective outcomes rests on a reduction in unnecessary duplication and fragmentation of activities, and working towards achieving greater cooperation and collaboration to build sustainable national and regional capability and capacity in relation to mental health.

The strategy proposed by PIMHnet reflects the priorities identified in the WHO Regional Strategy for Mental Health (WHO 2002) in which two key strategic directions are proposed that are designed to lead to improved mental health and relief from the economic, social and individual costs of mental illness and mental disorders. These strategic directions are:

(i) *Taking an intersectoral approach to mental health promotion and the prevention and treatment of illness*, drawing together the relevant agencies and organizations to provide a supportive environment for diagnosis, treatment and prevention of mental disorder, and

(ii) *The integration of treatment for mental disorders into general health services and a more informed understanding of mental health in the wider community*. Such integration will involve addressing stigma and community attitudes which stand in the way of access and service provision and increasing support for family and consumer advocacy and self-help groups.

The strategy identifies six key approaches including: advocacy, service provision, mental health promotion, policy and legislation, encouraging the development of a research culture and capacity; and suicide prevention.

The situational analysis of mental health needs and resources undertaken in Pacific Island countries in 2004 identifies needs country by country against each of these dimensions.[12] The findings provide very clear evidence of a need for an intervention that supports the development of mental health services and supporting frameworks in the region.

MOH specific contributions include: occasional meetings with NZAID and within NZ MOH, e-mail/letters with network countries, in-country development of the NZ network (in its infancy), attempts at aligning PIMHnet and IIMHL (International Initiative of MH Leadership) for the benefit of the network leadership, regular meetings with the PIMHnet Secretariat (x3 weekly), chairing PIMHnet meetings, etc,

[10] *NZAID Evaluation Policy Statement*

[11] *Regional Strategy for Mental Health*: World Health Organization – Western Pacific Regional Office, 2002.

[12] University of Auckland Centre for Mental Health Research, Policy & Service Development, 2005: *Situational analysis of mental health needs and resources in Pacific Island countries*

Donor

NZAID's Policy Statement "Towards a safe and just world free of poverty" has as one of its key strategic outcomes to achieve "safe, just and inclusive societies", working with a wide range of partners to achieve poverty elimination. These partners include regional and multilateral agencies, as well as civil society, especially NGOs, community groups and private sector organisations. A central focus of the policy is on poverty elimination, including poverty of opportunity, where opportunities to participate in economic, social, civil and political life is seriously limited. The poverty analysis that informs this program takes into account human rights and gender issues, amongst other things.

NZAID supports multilevel activities, working with a civil society and communities at the grassroots, to support for the development of national, regional and international policy frameworks.

Operating principles include protecting and promoting human rights and achieving equitable development benefits for women and men, girls and boys. Sustainability will only be achieved through the development of effective partnerships that are based on trust, openness, respect and mutual accountability.

The elements of the policy statement are clearly in line with the underlying principles of PIMHnet.

Two of the three key areas of focus for NZAID's Health Policy include improving access to and provision of primary health care, and promoting a multidimensional view of health through collaboration across sectors. PIMHnet is focused on strengthening the capacity of the primary health care system to support people with mental health problems, and is taking a multisectoral approach to addressing the needs of this target group.

It is evident that PIMHnet clearly supports the needs and priorities of both the target groups and beneficiaries, and the donor.

4.6 Effectiveness of the PIMHnet communication strategy and networking

Communications occurs on two levels: (i) regular management and operational communications that might occur on a weekly or even daily basis; and ii) mechanisms for communicating information, reports, resources, and the like.

For the first of these a transparent system of communication has been identified to allow each participating country equal say and opportunity without unnecessarily delaying action/activities. The basic structure for this is:

- establishing a dedicated email address for PIMHnet;
- PIMHnet communications are managed through the Network Facilitator using the dedicated email address or alternative fax number or postal contact (for countries that may experience difficulties with internet and email access);
- Each NFC is that country's contact point for all such communications and acknowledges receipt of communications to the Network Facilitator; and
- The Network Facilitator maintains full contact details and a preferred communication protocol for each NFC: e-mail, phone or fax.

This appears to work satisfactorily for most NFCs, but there are exceptions for those countries where communications is extremely problematic. It was evident that the Secretariat makes every effort to ensure that communications ultimately occurs and communication attempts are followed up, but it is also quite apparent that some countries pose extreme challenges in this regard. There is often no solution. During the review it was evident that some emails listed as current were obsolete, and perhaps a system to encourage continuous updating is needed, although ensuring compliance is often in itself challenging.

NFCs have indicated their preferred means of communication, and for most it is e-mail. However for some this appears not to be very effective as they do not have e-mail access at their desks.

The second of these communications strategies includes: newsletters (about quarterly), teleconferences (3-6 monthly), PIMHnet website, and annual meetings. Feedback on the acceptability of each of these as communications channels can be summarised as follows[13]:

	Acceptability/satisfaction (N=10)		
	Less than acceptable/useful	Average	Very good/excellent
Newsletters:	1	2	6
Teleconferences	7		2
Annual Meetings (AM)	1		9
Website	4	1	4
Overall satisfaction with communications		1	9

Newsletters are a mechanism to showcase initiatives of the countries, initiatives which would otherwise be invisible. The less than average degree of satisfaction with newsletters was explained by saying that they were only as good as members' contributions to them. Those who were very positive liked to hear what other countries were doing and were challenged to catch up or exceed.

There was generally less satisfaction with teleconferences as a means of communication. The main reasons for this were difficulties with phone lines, poor quality connections, no teleconferencing facilities and excessive cost to PIMHnet, inferring that those funds could be used in more effectively. Given it is a costly exercise and not everyone benefits, its continued use may need to be re-considered in terms of its cost effectiveness, even if the few that benefit do find it useful for networking and sharing information.

Since PIMHnet was launched in Vanuatu in March 2007, two annual PIMHnet meetings have been held (Samoa June 2007, Fiji September 2008). These meetings are fully funded by PIMHnet, and are attended by the NFCs, WHO, NZ MOH. These meetings commence with an Annual General Meeting (AGM) (one day) and the remainder of the meeting is a technical workshop. During the workshop support is provided from WHO HQ and WPRO, and the network Facilitator to progress developments that have so far included policy, legislation and human resource/training plans. These meetings are also used to share/inform participants of regional resources, update on country progress, and achieve the regional networking that is an essential element of the PIMHnet. The significance of the networking that occurs at the AM cannot be underestimated:

> "*People are driven by the progress of their neighbours … (PIMHnet) is building competition."*

But it not only inspires healthy competition:

> *"Hearing from other countries inspires the idea that we have to reach out …"*

With only one exception NFCs who provided feedback on the AMs were overwhelmingly positive about their value. The opportunity to meet face to face with other NFCs, hear what people were doing and of progress being made (being challenged to catch up or exceed), and the opportunity for informal gatherings and opportunistic learning/sharing were all reasons for rating annual meetings highly. They are particularly important for those countries whose access to other forms of communications (reliant on various forms of technology working) is limited or compromised.

> *"We realize that since (country) is so far away, it will be difficult for onsite visits and technical assistance. We appreciate the follow up that PIMHnet provides by e-mail and the opportunity to attend the annual meeting where we can share with other Pacific Island nations".*

The one negative comment suggested that perhaps the funds spent on these would be better spent on direct technical support to countries through visits by the Secretariat.

[13] These numbers are based on responses from 10 countries – those visited and questionnaires from the remainder received at the time of writing the draft

The PIMHnet website sits within the WHO Mental Health website under Mental Health/Policy. Low scores for the website were primarily attributed to poor Internet access or being too busy to access. However even those indicating it was very good stated they didn't have time to use it. As this is the location for many resources, the project needs to ensure that other strategies for sharing resources do need to be continued. While the website promotes the activities of PIMHnet, it was suggested by some that it should be a website in its own right. This is an important comment in terms of the long term view that the network should be self sustaining run by the PIMHnet countries, and not be perceived as a WHO initiative but rather a PIC initiative. These comments were not made as a solution to overcoming the accessibility issues.

While overall satisfaction with the project's strategies for communications was very good to excellent, the feedback from member countries identified strengths and weaknesses in the different elements of the strategy.

Recommendation 6: *Reassess the communications strategies to determine if all strategies are cost effective and are accessible by most members.*

4.7 Country satisfaction with the project to date

The review found that stakeholders are generally satisfied with PIMHnet to date. Findings on a number of dimensions are presented in the following table:

	Acceptability/satisfaction (N=10)		
	Less than acceptable/useful	**Average**	**Very good/excellent**
Technical support to policy development	-	-	9
Technical support to workforce planning	-	-	7
Overall technical support	-	1	8
Meeting expressed needs	2	1	7
Overall satisfaction	-	2	8

Some views are captured in the following statements:

> *"… we (PIMHnet members) progress differently…. the Secretariat is not judgemental."*

> *"PIMHnet is extremely useful because it has served as a driving force for much needed areas in mental health that is identified as a need in my country but has been overlooked and commonly pushed back as last need. With the existence of PIMHnet, it supports the needs for country leaders to make it a priority. The area of focus that PIMHnet as identified are areas that is needed in order to have a more coordinated and directed services."*

Overwhelmingly the project is meeting country expectations and expressed MH needs:

> *" has helped to raise profile of MH, and if it can assist with workforce training then it is good"*

> *"… important to have this base so we can benchmark against what is going on in the region, as well as knowing what is out there"*

> *"PIMHnet is meeting our needs very well, we are trying to integrate it with U.S. federal assistance opportunities. It provides us with a fresh set of ideas and ways to approach policy, manpower planning, etc. issues. The WHO policy guidelines are excellent resources".*

There were mixed views about the ownership of PIMHnet by the member countries, but overall member countries consider they do have ownership, because they are identifying the priorities and the strategies to support MH in their country and these are country specific.

> *"Of all the WHO stuff imposed upon us this is probably one of the most beneficial."*

The review acknowledges that satisfaction ratings from beneficiaries will be biased in a positive direction, and that this indicator has somewhat limited utility. However the qualitative comments do provide some valuable information.

4.8 Opportunities for the PIMHnet mechanism to provide momentum/benefit to in-country capacity development & activities

There is evidence that this is occurring to a significant degree. PIMHnet is working with the Human Rights Alliance to include MH on its agenda. Relationships are being developed between NGOs and government. Support and education is being provided to in-country NGOs, and PIMHnet materials (e.g. training materials) are available to both groups. MH is being included in training curriculums outside health e.g. education, theology. This can be directly attributed to the activities of PIMHnet and the NFC. It was not possible to gauge the extent to which this was happening across all member countries, but it was evident that the education sector in particular had become generally very involved in many MH initiatives via PIMHnet.

Most of the human resource needs for MH come from the non medical workforce. PIMHnet is currently engaged in discussion with the Royal College of Psychiatrists in the UK to place trainees/registrars in the Pacific. Capacity is being built in Pacific nursing schools.

It needs to be noted that PIMHnet has become a vehicle/broker for other organizations and networks (WHO, NGOs, RANZCP-RACGP, IMNHL, NZ Mental Health Foundation) to provide resources (scholarships, places for PIMHnet countries to attend conferences, MH leadership development). The Facilitator communicates with member countries, refers to their developed plans to assess whether opportunities would assist with progress against identified action plans and uses a transparent process to put names up to organizations.

New advocacy groups have been formed as a spin off of the project and are addressing some un-met needs.

4.9 Appropriate location and structure for the PIMHnet

PIMHnet is currently funded through the GAF (Government Agencies Fund) within NZAID. The funds are provided to the NZ MOH as the Partner Agency. These in turn are provided to WHO as the Implementing Agency.

WHO has responsibility for delivering against the Aims/Objectives/Annual Plan of PIMHnet, and facilitates implementation, with the WHO PIMHnet Secretariat taking the main responsibility for this process. NZ MOH acts as a conduit between WHO and NZAID, and provides an accountability point for WHO activities.

GAF funding is usually available for small projects that are time limited. PIMHnet is a long term initiative, the full achievements of which will not be evident for probably 8-10 years. Its sustainability will take as many years and realistically it may not be entirely sustainable because of its regional nature. The GAF may therefore not be the most appropriate location for the project within NZAID.

Structurally, the mechanism that is in place appears to work well. However there are areas that need strengthening. A continuing or new structure should continue to ensure:

- Documentation is strengthened;
- The bulk of the funds directly benefit the member countries by continuing to support meetings and to provide ongoing technical assistance to countries;
- Accountability, including financial accountability, is strengthened through MOUs that specify the detail required to achieve this;
- Continuing to report back to member countries and stakeholders occurs in a timely fashion.

To achieve this a small Management/Steering Committee which has membership that is external to the Implementing Agency should be part of any option that is considered. .

Options to be considered for future delivery of PIMHnet could include but not be limited to the following[14]:

1. Continuation of the current PIMHnet location and structure;
2. Fund through the NZAID regional program, contracting WHO to implement;
3. Fund through the NZAID regional program, contracting SPC to implement;

[14] All options were raised during the consultation process and are included here for that reason. Their inclusion does not mean that they are necessarily appropriate.

4. Fund through the NZAID regional program, contracting WHO and SPC jointly to implement;
5. Fund through the NZAID regional program, contracting one of the member countries to implement.

Option 1: Continuation of the current arrangements

Model: The funding is provided through the NZAID GAF, with NZ MOH as the Partner Agency, and WHO as the Implementing Agency. The PIMHnet Secretariat and Facilitator would maintain current roles and responsibilities.

STRENGTHS	WEAKNESSES
• Proven successful delivery of the project with clear deliverables • Has built a strong relationship between NZ MOH and WHO • WHO have demonstrated technical expertise in MH • NZ MOH have significant contacts and professional linkages to contribute to the project • Has achieved good communications with all member countries • The model is recognised in the region	• GAF funding is historically time limited, thus inappropriate for a longer term initiative • GAF funded projects are traditionally small value projects • Subject to bureaucratic constraints of WHO • Some aspects of accountability are weak • No oversight management group

The model has worked well. NZ MOH have important contacts e.g. in relation to pharmacological issues, with professional groups in the region, that benefit the project, and have entrée to high levels of government in the participating countries. WHO have significant and respected technical expertise in MH. The PIMHnet Secretariat and Facilitator do the bulk of the work, are respected and trusted by the participating countries. Its main disadvantage is that the project is a long term initiative, requiring significant funds at least in the early years. This is inconsistent with the GAF program. In addition, financial accountability is very weak.

Option 2: Fund through the NZAID regional program, contracting WHO to implement

Model: The funding is provided through the NZAID Regional program, contracting WHO to implement and manage. Establish a Management/Steering Committee that includes NZ MOH.

STRENGTHS	WEAKNESSES
• Continued successful delivery of the project still achievable • Continues to utilise the technical expertise of WHO • Takes a longer term view of the project • The amount of funding required is not at odds with the NZAID Regional program • Continuity of Secretariat inputs • Administrative costs remain the same • The PIMHnet reputation in the Pacific likely to remain unchanged and still attract outside contributions • Could strengthen accountability and lead to improved documentation • Fits with NZAID Regional program focus around disabilities and MH	• Risk losing the significant contribution of NZ MOH • Subject to bureaucratic constraints of WHO e.g. reporting requirements that contribute to delays in production of final reports

This model streamlines the delivery of funds and appears to fit with the objectives of NZAID's regional program. It could naturally sit within the disability and general NCD focus of the regional program. The implementers (WHO PIMHnet Secretariat and Facilitator) remain the same, thus providing continuity to the project. The

Management/Steering Committee will strengthen accountability and governance, and together with the implementers provide a mechanism to jointly ensure that activities maximise benefits to the member countries.

Option 3: Fund through the NZAID regional program, contracting SPC to implement

Model: The funding is provided through the NZAID Regional program, contracting SPC to implement and manage. Establish a Management Committee that includes NZ MOH

STRENGTHS	WEAKNESSES
• Takes a longer term view of the project • The funding required is not at odds with the NZAID Regional program • Brings the management within the region • Demonstrated capacity to implement regional programs??	• Potential to interrupt the current smooth rollout of support • SPC does not have specific MH technical expertise • SPC do not work in the whole region • Need for member countries to establish new relationships • Possible need to establish a new management unit within SPC • Unknown management costs

At this early stage of the project this is considered to have too many negative consequences for the project. The current relationship between member countries, the WHO and NZ MOH are very strong and positive. To change these dynamics while many key activities are being implemented and are at various stages of development is considered high risk.

Option 4: Fund through the NZAID regional program, contracting WHO and SPC jointly to implement

Model: The funding is provided through the NZAID Regional program, contracting WHO and SPC jointly to implement and manage. Establish a Management Committee that includes NZ MOH

STRENGTHS	WEAKNESSES
• Utilises the MOU between WHO and SPC • Continues to utilise the technical expertise of WHO • Takes a longer term view of the project • The funding required is not at odds with the NZAID Regional program • Takes a longer term view of the project • Continuity of Secretariat inputs • Could contribute to greater accountability and improved documentation	• Potential to interrupt the current smooth rollout of support • SPC does not have specific MH technical expertise • Need for member countries to establish new relationships • Possible need to establish a new management unit within SPC • Unknown management costs, with the potential to be higher than current costs • Potential for less streamlined management • Increased administrative costs and an unwieldy management structure might be required

This is something of an unknown, without the details of the WHO/SPC MOU.

It may provide a strategy for the future once key elements of the project are bedded down under WHO leadership. In the short term it is not a preferred option.

Option 5: Fund through the NZAID regional program, contracting one of the PIMHnet member countries to implement

Model: The funding is provided through the NZAID Regional program; one of the PIMHnet member countries is contracted to implement and manage the project

STRENGTHS	WEAKNESSES
• Perceived greater ownership of the project by the	• Possible risks in terms of governance and accountability

STRENGTHS	WEAKNESSES
region • Reduced cost of administration • Builds capacity in one country to administer a regional program	• Lack of capacity, and risk of failure • Competition between some countries for the management could jeopardise the project • Risk support by some countries

This is a possible long term option. Its feasibility, design and management structure could only be articulated when the environment was considered ready.

At this stage the recommended option is **Option 2** and this would need to continue for quite some years at least. It is considered this has the best development potential. There are still some essential elements of the project to be progressed, and PIMHnet needs to continue with minimal disruption to the current structure and its functioning. To change this would jeopardise the significant achievements that have already been made. In addition, the structure that has been put in place is one that was proposed and agreed to by member countries. It is important to remember how central WHO Geneva and WPRO are to the network and to the provision of technical expertise and other supports to countries. Many of the benefits of WHO input are intangible: they have the ear of the ministers; know other work of WHO into which they can link; work one on one with the countries; bring international best practice to the table; can influence the scholarship money in the countries with the potential to ensure funds are earmarked for MH.

It is equally important to recognise the significant role of the PIMHnet Secretariat and Facilitator. They do the bulk of the work, and are respected and trusted by the participating countries. Removing the support of WHO and its Secretariat would put at risk the network's ability to achieve what is still needed. It is important that support of WHO continues to be through MH WHO personnel, not through regional generic officers.

Equally important is the continued involvement of NZ MOH. NZ MOH has probably the most significant experience with the Pacific (together with the WHO Secretariat which includes the PIMHnet Facilitator) and understands best how the Pacific Islands function. This understanding cannot be underestimated in terms of implementing approaches that are compatible with Pacific Island culture. In addition to this they have provided an oversight function together with the WHO Secretariat to ensure that funds are appropriately allocated to support the Pacific Islands, and ensure that the project adheres to this principle in full. This governance oversight needs to remain strong.

Inclusion in the NZAID Regional Program would complement an existing package of assistance. Discussion would however be needed within NZAID about funding arrangements and resource implications for management, as would discussion about the eligibility of providing funds to WHO Geneva and WPRO.

Whatever option is chosen, governance, systems and reporting all need to be strengthened.

It is unlikely that NZAID can sustain this programme on its own, its own funding pool not being large enough. This does need verification. As it moves toward supporting the implementation of workforce plans and training much more resource intensive support is going to be needed. Given the success so far, the demonstrated commitment and ownership of countries and governments to these initiatives, it is essential that the realisation of this is supported adequately. Anything less would be unacceptable.

Recommendation 7: *NZAID actively pursue additional funding from other donors for whom MH (disabilities) is a priority to increase the pool of funding for all elements of a comprehensive program; WHO estimate the total funding needed for the next 3-5 years.*

4.10 Cross-cutting issues in the program

The Programme has initially had and can continue to have a significant wider sectoral impact, thus impacting on the health of women and children, gender issues, and other areas of priority such as HIV. Its challenge is to document that this is happening. To date this has not been done.

Women

According to the World Health Organization, there are considerable gender disparities in mental illness, particularly in relation to common mental illnesses such as depression, anxiety and somatic complaints, all of

which constitute a serious public health problem[15]. Even when women are not over-represented in terms of illness (e.g. there are no marked gender differences in relation to illnesses such as schizophrenia), women and children are particularly vulnerable to the impact of mental illness. When a family member has a mental illness, it is often women who are the main caregivers. Women are often at risk of gender-related violence as a result of substance abuse and may need to act as providers/income earners if the man is unable. The discrimination against people with mental illness may affect women and children, by isolating them from other forms of support such as churches or village activities. Shame may also deter women from seeking help for themselves or other family members.

The WHO also notes that up 20% of women attending primary health care in developing countries suffer from anxiety or depressive disorders[16]. Such illnesses are often related to social factors, including sexual violence, domestic violence and escalating rates of substance abuse among women, and are poorly recognised and treated. WHO's focus on women's mental health specifically includes an emphasis on enhancing '*the competence of primary health care providers to recognise and treat mental health consequences of domestic violence, sexual abuse and acute and chronic stress in women'*[17].

Children and young people

Young people have particular mental health needs, including needs related to: suicide, trauma as a result of conflict (i.e. Solomon Islands) and alcohol and substance abuse. WHO has a focus on reducing suicide in young people and this is especially pertinent to the Pacific, where there are indications that suicide among young people is increasing. Recognition and treatment of alcohol and substance abuse can also make a significant contribution to a decrease in suicide among young people.

Reducing vulnerability to HIV and emerging infections

There is a close relationship between risk-taking behaviour (such as alcohol and substance abuse) and the spread of HIV. In addition, people with HIV/AIDs may be more susceptible to mental health problems such as depression and AIDS-related dementia[18]. The burden of caring for a family member with AIDS may give rise to mental health problems and needs to be addressed in this context. The WHO notes that mental illnesses affect and are affected by chronic conditions, including HIV/AIDS.

Untreated mental illness can impact adversely on compliance with medication, diminished immune function and overall poor outcomes. In addition, people with mental illnesses are often particularly vulnerable to sexual abuse/assault and the consequence of sexually-transmitted disease. A diagnosis of HIV/AIDs in a person with mental illness can present a 'double stigma' and may limit access to treatment for one or both conditions. Pregnant women with HIV/AIDs must have their mental health needs met to enable them to be deal with their own health and the health of their child, and to be effective mothers.

Gender

Gender is built into the MH policy framework and legislative framework of WHO. A checklist accompanies the policy development guidelines, ensuring gender issues are addressed. Groups that represent men and women are invited to the policy development workshops. Gender is addressed in the MH information/resource package, and spelt out in treatment guidelines. Service and consent guidelines draw attention to gender issues. Consultations in country confirmed that gender issues were high on their agendas, with countries facing different challenges in addressing these issues.

Human Rights

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[15] World Health Organization. www.who.int/mental_health/prevention/genderwomen

[16] ibid

[17] ibid

[18] *What is the relevance of mental health to HIV/AIDs care and treatment programmes in developing countries? A systematic review*, Collins PY, Holman AR, Freeman MC, Patel V, 2006. AIDS, 20, 1571-1582

Non-discrimination and equality are fundamental human rights principles and essential components of the right to health.[19] The International Covenant on Economic, Social and Cultural Rights (1966), widely considered as the central instrument of protection for the right to health, recognizes *"the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"*. This covenant gives both mental health (often neglected) and physical health equal consideration. The right to health is achieved through articulation of the right in specific policies, and this is occurring for MH. It must also be complemented by ensuring everyone's right to appropriate health care is met.

In PIMHnet human rights is explicitly addressed in the development of MH legislation and policy. It is also being addressed in the PIMHnet workforce planning which intends to ensure that people requiring care get appropriate/correct care as a result of the workforce being adequately trained. If workforce plans are successfully implemented then this should be a natural consequence.

PIMHnet recognises that ensuring human rights are respected is challenging. Some countries have treated (and still do treat) their mentally ill badly and historically there has been a tolerance of violence and abuse not deemed to be acceptable by human rights advocates. When people become isolated from their community (as locked up in-patients) they are vulnerable to abuse. This issue has to be addressed tactfully and carefully. WHO guidelines do not tolerate exclusion of human rights in policy. Policy workshops require a commitment to address this issue. During the process human rights is defined often to ensure it becomes routine thinking. Technical support in country by the Secretariat and the Facilitator involves direct discussions with Secretaries of Health and Ministers regarding their commitment to improve rights of the mentally ill. Without this commitment policies and plans cannot be progressed.

Anecdotal evidence emerged during the review demonstrating that informal mechanisms are being used that are outside the standard Western approaches to involve stakeholders in addressing serious human rights issues. Documenting the details of this is often difficult because of cultural sensitivities and the shame that would be engendered. It must be noted that the in-depth knowledge of the way these cultures work that is embodied in the Facilitator has contributed to what some may term innovative approaches to getting the government system and the NGO network involved in addressing some of these situations and taking control. *It will be important for the project to find appropriate ways to report on these achievements that reflect positively on the government and the NFC.*

Inherent in the human rights discussion is discussion about stigma and access to services. This has been addressed within MH policy, during which the consultation process raised awareness about stigma. In addition, focused MH awareness raising activities in member countries have specifically tried to address stigmatising attitudes, and clinicians in the hospitals are engaging in discussions with patients and carers.

It was suggested during the consultation process that a focus of the technical component of an AM could be on both of these issues.

PIMHnet has been able to secure funding to send one person key to developing legislation in Vanuatu to India on a Human Rights Diploma. The funding for this has been secured outside of the PIMHnet budget.

The project will be strengthened if there is a mechanism in place to monitor policy and workforce plan implementation, and to measure the outcomes of the focus on both gender and human rights. This can be done quite simply and can be incorporated into the consolidated design and M&E framework that will be recommended for a future phase of the project.

These cross-cutting issues are all important. However, the project needs to establish mechanisms for monitoring achievements against these. Some information is already being collected, largely through the review process than through project documentation. Others are harder to monitor than others, and there is scope to include in the monitoring framework qualitative "story telling" that may meet these requirements. The challenge is to keep it simple, but the challenge is also to document the successes.

4.11 Project documentation

[19] WHO & Office of the United Nations High Commissioner for Human Rights, 2008

Project documentation on a number of levels could be improved. This includes documentation that describes the project itself, and documentation that describes achievements.

Project description

The PIMHnet Framework document (see Annex 12 for outline) was developed jointly by the WHO, NZ MOH and member countries, and is a conceptual framework. It does not provide detail about the design/content of PIMHnet. This detail is found in the 10-year objectives document (see Annex 3) which presents the six objectives of the project and key activities against each of those. Yet another document presents the monitoring framework for PIMHnet. These are all disconnected and there are inconsistencies between them, for example in the description of objectives. The PIMHnet monitoring schedule is said to be embryonic and at this stage of the project it could be fully developed, and improved. In brief there are problems with:

- clear articulation of objectives;
- clear description of activities;
- duplication/repetition between objectives and activities;
- confusion between activities, outputs and outcomes; and
- consistency between documents in the description of PIMHnet objectives.

The way the documentation is currently developed the logical flow from inputs to outputs to outcomes is missing. While the development of the10-year plan is very useful, it does not identify that progress will be variable.

The development of a concise design document for PIMHnet with a logframe would greatly enhance understanding the above, and distinguish between the key outputs, which are the necessary precursors to achieving outcomes, and the outcomes themselves. The question needs to be asked: did all these activities/outputs make a difference, and how? Indicators at every level need to be carefully articulated to ensure that they are measurable. The means of measurement (data collection) need to be presented. It would be timely to develop this for the next phase of funding.

Developing this detailed documentation clearly will present the intervention logic and articulate detail of inputs activities outcomes and impacts.

Recommendation 8: *Bring together all documentation that has been developed that describes PIMHnet into one concise PIMHnet framework/design document, with the assistance of a consultant whose expertise is in the development of logframes and monitoring and evaluation matrices. This should be worked jointly with the WHO Secretariat and NZ MOH, and subsequently with member countries to maintain the ownership and the original intent of the network framework. It is recommended that this is done in preparation for the next phase of funding. It is essential that the next phase of the project/programme be taken forward with a strong description of its design and a strong, measurable M&E framework.*

Project achievements

Project documentation does not do justice to actual project achievements. A challenge for the review was the limited detail in some reports on exactly what progress had been made against the PIMHnet objectives, the only guiding document describing what was to be achieved. This was particularly problematic until the draft report of the second AM was made available. Consequently the consultant developed a matrix that would allow achievements to be recorded in more detail (Annex 9). This summarises very concisely the significant achievements made by WHO and the Secretariat, and each of the participating countries. This was used during in-country consultations, where the consultant worked with the NFC to complete the detail in this matrix for their country.[20] An interesting outcome of that exercise was a request by the NFCs concerned to have a copy of this matrix for their country alone, for them to use to do their own self-monitoring, but also more importantly to be able to attach to proposals or submissions to their government when requesting extra resources or reporting up on PIMHnet progress. It demonstrates the value of concise summaries of this type of information.

[20] Initial documentation of achievements against this matrix was commenced with WHO Geneva and the PIMHnet Facilitator, and confirmed through face-to-face interview and via questionnaires

Systematic documentation of support and progress against each objective is needed. It would also facilitate more systematic recording by the Secretariat of some achievements that are not very well detailed. For example, there were discrepancies in what was reported about receipt of funding by countries, but project records of funding provided were not presented (in summary form) *in documentation available for the review*[21]. Six countries had received in-country visits to support particular activities, but this was not recorded in any summary of achievements available for the review. It is quite likely that in the future requests for these visits will increase. The project needs to keep systematic documentation of provision of this support to be available to the donor(s) or subsequent reviews. This is needed for accountability purposes, and to also decide if funds need to be allocated differently in response to expressed needs of member countries. A well-designed M&E framework can address these issues. The matrix developed by the review is a useful tool that could guide the development of the M&E framework that would accompany a detailed design document.

Recommendation 9: In conjunction with the development of a concise PIMHnet framework/design document (Recommendation 8) develop a systematic, concise M&E framework including data collection tools to support regular monitoring and eventual evaluation of the project. Along with the standard M&E requirements to capture achievements at all levels of the program implementation (activity, outputs, objectives/outcomes) this must:

- include a mechanism to monitor policy implementation, and measure the outcomes of the training identified in the workforce plans;
- identify indicators to measure that gender and human rights issues are being met, primarily through changes that are occurring in practice compared with practices at the start of the project.
- Provide simple but sound matrices (developed by this review) for the PIMHnet Secretariat to use annually to review country performance.

5. DISCUSSION

The project presents an interesting model that has ownership at its core. Countries request to participate in the network, the request coming from the highest level of government. In doing this they make a commitment to progressing their country's needs for an improved mental health service. As such the likelihood of sustainability is increased as countries determine how and at what pace initiatives will be rolled out. The WHO Secretariat facilitates and support them in this process, but the final responsibility is with the countries themselves.

The project takes an evidence-based approach to identifying interventions that are needed. It has been informed in the first instance by the findings of the Situational Analysis (2005). Further interventions and support will be informed by pharmacology and nursing studies, planned to be undertaken as soon as funding is secured. It is critical that these studies can proceed in a timely manner, as both areas have been identified as priorities needing assistance, but needing to be informed by these studies.

Gender and human rights are very clearly embedded in the program, and WHO guidelines used for MH policy and legislation development ensure that these issues are addressed. However, to date this has not been well described in *project documentation*. Nor have *simple* systems been established that will assist the implementing agency to report regularly against indicators that measure how they are being rolled out in each country. This can be done within project M&E documentation and the project will be strengthened when this has been developed. The recommendation to improve project documentation will be the opportunity to bring these to the fore, not only describing where in the project they are occurring, but also providing each country with a mechanism to monitor how they are responding to these needs. The review process identified some early human rights progress being made, but this was nowhere to be found in project documentation. Discussions about training plans that are expected to be put in place clearly show that opportunities for women in particular will be increased. As a matter of routine these achievements need to be recorded systematically as they happen. It may also be useful to use an AM at some point to workshop M&E so that there is a better appreciation of the value of systematic recording of achievements but also a better understanding of the indicators that measure achievements for both human rights and gender.

[21] It is understood that WHO Secretariat does keep records of funds provided to countries from PIMHnet funding sources as well as from its own sources.

Recommendation 10: *Once the M&E framework has been developed dedicate part of an AM to workshopping M&E for the project; this should increase compliance with provision of information.*

It is evident that there is significant variability between countries in achievements that have been made. This is not unexpected and can be attributed to a number of factors is including: the stage of development of the countries MH program at commencement of PIMHnet, capacity of NFCs, political environment and commitment, etc. However, given the short timeframe since the network was launched (almost 2 years) these achievements can be considered quite outstanding. However, given this variability the project needs to monitor and report on this for each country.

The NFC has changed in some countries, and this has resulted in those countries not being represented consistently by the same person at the AM. It was apparent that some new NFCs were not adequately briefed about the network and in particular about the activities within their own country in the network. Thus they performed poorly at the AM when reporting on their country's progress to the AM audience. In addition, it is important that where the primary NFC changes, and particularly if that person has not been involved in all AMs, that the individual is appropriately briefed about the intention of the network. This is probably best done by the Secretariat to ensure adequacy of that information.

Recommendation 11: *Identify strategies to strengthen those NFCs who struggle in their role.*

It has been noted that development of in-country networks is quite variable. In-country networks are quite embryonic in some countries, and it is expected that in some countries building a suitable in-country network will be challenging. In some there are really no mental health stakeholders that could form an in-country network and for those it will probably not ever be a reality. PIMHnet Annual Meetings are clearly very useful. Reports of these meetings also indicate that the Secretariat is willing to reflect upon how it is supporting the member countries, to identify barriers and be receptive to suggestions for improvement. It is noted that comments in the most recent AM draft report were repeated/confirmed during review consultations.

WHO protocols and approval processes are acknowledged and respected, and mean that final reports take many months before they are disseminated. But all countries have access to working drafts until they are published by WHO. It is important that WHO Secretariat maintains its practice of disseminating draft reports in a timely manner.

A challenge ahead is implementation of the workforce plans. Countries will need to be supported in how those plans are realised. Considerations should include:

- Short term options to “get the ball rolling” that do not remove people from the workplace for significant periods of time e.g. in country support (Vanuatu), short term placements, etc.
- Long term options: twinning arrangements, use of the Pacific Open Learning Health Network (POLHN), other medium to long term training, strategies to back fill positions while people go away to train, etc

An underlying principle should be to keep the training in the Pacific to improve retention – to minimise the risk of losing people to nearby developed countries. It is also evident that support to implementation of workplans is going to require significantly more funds than has been needed to date. The Secretariat invests significant time preparing proposals and pursuing donors to support continued implementation of PIMHnet. NZAID funding does not fully support what is needed to implement the project in a comprehensive and sustainable manner. It is now timely for NZAID to facilitate this by working with other aid agencies in the region to secure funding to supplement the NZAID pool of funding. Efficiencies will be achieved if funding is secured in time for the next phase of implementation, so as to have one single pool of funds and thus eliminate the need for the Secretariat to be continually expending energy and time on trying to find funds for discrete “projects” within the whole. This is not an efficient way of managing a project, and instead would allow Secretariat resources to be better directed to supporting the network members. This would also give other donors the opportunity to support a model that has demonstrated its feasibility to contribute to addressing one of the key groups that constitute the disabled, now a key policy area for numerous donors working in the Pacific and elsewhere.

Assessing efficiency has been compromised by the financial information available to the review. NZAID acknowledges that the reporting requirements of the first MOU did not request sufficient information to enable full assessment of expenditure, although subsequent MOUs were much more detailed. Due to an oversight, WHO

never received copies of the MOU between NZAID and MOH and therefore were unaware of the reporting requirements and level of detail required by NZAID. The arrangement of the MOU being between NZAID and MOH (and WHO not seeing the MOUs) and having three different administrative systems to deal with complicated the situation but it is now understood that the three parties (WHO, NZAID, MOH) will work together in future to agree what reporting is required and to agree who will provide the necessary information.

Assessing effectiveness[22] was and will be difficult unless project documentation is improved. It is now timely to bring the separate project documents (framework, 10-year objectives, monitoring matrix) together into one framework/design and carefully articulate just what the objectives of PIMHnet are, what key activities are needed to achieve those objectives, and how achievement of those objectives will be measured. At the moment there are two different sets of objectives: those presented in the 10 year work plan (without indicators for their measurement), and those presented in the PIMHnet Monitoring Schedule (with indicators). The latter objectives are taken directly from the PIMHnet framework document.

Associated with this will be a process that facilitates discussion and further development of an integrated performance and monitoring framework that will work for NZAID (and any other donors), PIMHnet and its member countries. This exercise would not detract from the ownership that the membership countries have of the project objectives, and any re-working should at some point be done with country input or be presented for endorsement and confirmation. Apart from the framework document, the other documents (10-year workplan, monitoring framework) don't seem to have gone through an endorsement process.

As each country varies in its progress, it would be more appropriate to summarise all the key activities to achieve each objective but not allocate them to a specific year. Countries will engage in these activities at different times. It is probably appropriate now to have each country develop its own plan against a "master plan".

An interesting outcome of the review process was the obvious benefit of the process itself to the NFCs who in three of the four countries that were visited accompanied the consultant to all meetings. What emerged was greater understanding in some cases by the NFC of PIMHnet, ideas for further activities, identification of opportunities for seeking funding, and a list of "things to do"! It was very clearly beneficial for the NFCs concerned. It also highlighted that the review *process* itself could be beneficial as a supportive intervention to implement perhaps yearly, between AMs, with in-country visits to all PIMHnet countries by an appropriate person (e.g. from MOH) to visit with NFCs and government and non-government stakeholders, reviewing progress and identifying opportunities. It is important to consider that "*you don't know what you don't know*", which means some countries will never ask for assistance through in-country visits, yet will miss out as a consequence.

6. CONCLUSION

The findings of the review suggest that a very successful project has been implemented and the interventions so far have been implemented well, measured at this early stage primarily in outputs delivered. The achievements are significant given the short period of time that the project has been in place and the number of countries that are now benefitting.

Given that significant changes to documentation are being recommended, and there will be increased requirements to report on achievements, it is recommended that Phase 2 has a duration of 5 years and is independently reviewed after 2 years maximum.

Recommendation 12: *Consider a Phase 2 that has a duration of five years; schedule an independent review at the end of two years maximum i.e. 2011.*

There are numerous lessons that can be learned from this model and recommendations that can be made as an outcome of the review.

6.1 Lessons learned

[22] *NZAID Evaluation Policy Statement:* Effectiveness is the measure of the extent to which the programme and/or activity has achieved the desired outcomes.

(i) Ownership and responding to country needs: The approach adopted in this project is an excellent example of a model that facilitates ownership and can at the same time reach many countries and respond to their different stages of development.

(ii) It is important to encourage continuity in NFCs; there are benefits if the primary/active NFC attends all AMs.

(iii) Good linkages to the WHO CLO or other in-country WHO officer (where they exist) are beneficial, given their own linkages and networks; they can also assist in monitoring good governance and adherence to human rights.

(iv) In country support visits can have enormous intended and unintended benefits for NFCs and other stakeholders.

(v) Weaker NFCs can be supported/strengthened by building other supports around them e.g. NGOs, CLO, churches.

(vi) Timely dissemination of draft reports overcomes the constraints of WHO publication protocols that would hinder the timely dissemination of important project outcomes and results.

(vii) There is value in developing a structured mechanism for each country to do its own self-monitoring against project objectives; using this each country can contribute to the updating of the overall project monitoring framework and the furthering of their own action plan.

(viii) NGOs have a significant role to play in the provision of MH support; some good examples exist where they are part of the overall formal referral system.

(ix) NZ MOH has demonstrated the value of it having a key role in the implementation of the project; and highlights exploring the benefits of their inclusion in further projects of this kind, using various mechanisms.

(x) If there is any uncertainty about the ability to use new and complex templates then they need to be piloted, at least with countries that are not so well developed and may find this type of exercise challenging.

(xi) Sound NZAID reporting and accountability structures for GAF activities will contribute to better knowledge about the success or otherwise of NZAID supported activities.

6.2 Recommendations

Recommendation 1: Continue to encourage greater inclusion of the in-country WHO office/CLO in stakeholder meetings/partnerships.

Recommendation 2: The implementers need to clarify regularly for member countries how and where funds are available that are identified under Objective 2, and identify if there is a process for obtaining funds; make this clear to NFCs; encourage NFCs to identify other sources of funding in their own country.

Recommendation 3: Pilot templates for acceptability and usability before distributing to those filling them in.

Recommendation 4: The PIMHnet Secretariat establishes a mechanism for monitoring the outcomes of the NGO meeting in Wellington.

Recommendation 5: NZAID (or donor) ensures MOUs are explicit about reporting for financial accountability that will permit value for money/efficiency analysis in future funding agreements.

Recommendation 6: Reassess the communications strategies to determine if all strategies are cost effective and are accessible by most members.

Recommendation 7: NZAID actively pursue additional funding from other donors for whom MH (disabilities) is a priority to increase the pool of funding for all elements of a comprehensive program; WHO cost the total funding needed for the next 3-5 years minimum.

Recommendation 8: Bring together all documentation that has been developed that describes PIMHnet into one concise PIMHnet framework/design document, with the assistance of a consultant whose expertise is in the development of logframes and monitoring and evaluation matrices. This should be worked jointly with the WHO Secretariat and NZ MOH, and subsequently with member countries to maintain the ownership and the original intent of the network framework. It is recommended that this is done in preparation for the next phase of funding. It is essential that the next phase of the project/programme be taken forward with a strong description of its design and a strong, measurable M&E framework.

Recommendation 9: In conjunction with the development of a concise PIMHnet framework/design document (Recommendation 8) develop a systematic, concise M&E framework including data collection tools to support regular monitoring and eventual evaluation of the project. Along with the standard M&E requirements at all levels of the program implementation (activity, outputs, objectives/outcomes) this must:

- include a mechanism to monitor policy implementation, and measure the outcomes of the training identified in the workforce plans;
- identify indicators to measure that gender and human rights issues are being met, primarily through changes that are occurring in practice compared with practices at the start of the project.
- Provide simple but sound matrices (developed by this review) for the PIMHnet Secretariat to use annually to review country performance.

Recommendation 10: Once the M&E framework has been developed dedicate part of an AM to workshopping M&E for the project; this should increase compliance with provision of information.

Recommendation 11: Identify strategies to strengthen those NFCs who struggle in their role.

Recommendation 12: Consider a Phase 2 that has a duration of five years; schedule an independent review at the end of two years maximum i.e. 2011.

7. NEXT STEPS

(i) Address documentation limitations including the development of an M&E framework.

(ii) Define studies that need to be done and bring into an updated design document (e.g. nursing and pharmaceuticals).

(iii) Pursue support to self monitoring - create ownership of progress.

(iv) Convene a meeting with NZAID, WHO, NZ MOH and AusAID to discuss further support to the project.

ANNEX 1: SUMMARY OF SITUATIONAL ANALYSIS

OF MENTAL HEALTH NEEDS & RESOURCES IN PACIFIC ISLAND COUNTRIES

Situational analysis (SA) background[23]

The countries targeted for the situational analysis were: Commonwealth of Northern Mariana Islands, Cook Islands, Federated States of Micronesia, Fiji, Guam, Kiribati, Republic of Marshall Islands, Nauru, New Caledonia, Niue, Palau, Papua New Guinea, Samoa (Western), Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, and Wallis and Futuna.
The information was gathered using three main approaches: a desk-based audit of various forms of documentation; interviews with, or surveys completed by, key informants; and a workshop run at the South Pacific Nursing Forum. Information from these sources was collated in an ongoing fashion into country profiles that were the basis of a gap analysis/needs assessment.

Mental health services are the means by which effective interventions for mental health are delivered and through which the burden of disease can be reduced or ameliorated. However, the success that mental health services have in fulfilling this function often depends, in large part, on certain conditions such as the legislative and policy frameworks that those services operate in, and how they are planned for, funded, organized and delivered. Hence the goal of this SA seeks to target these areas by equipping people with the expertise to determine the exact mix of different types of mental health services that their country should have, and to develop and implement a plan to deliver that optimal mix of services. Many obstacles and issues confront the programme however.

The overview and analysis indicate that most Pacific countries have a health structure that lends itself to an optimal mix model – that is, they already have a system orientated towards primary health care. However, mental health care does not necessarily fit easily or well into this structure. Reasons for this are many but include the infrastructure needed to develop and support an optimal mix of mental health services, including: governance; financing; health services delivery and organisation; legislation; policies, plans and programmes; workforce; services and facilities; and the involvement of non-governmental organisations (NGOs). The complex interrelationship between areas and issues is evident in countries where facilities and services are developed but cannot be staffed because of workforce problems, or where staff exist but there is insufficient expertise or funding to develop services/facilities.

Although governance is not always clear from available data all countries have a government ministry or department responsible for health, though not necessarily a dedicated mental health section, staff or focus within it. Many countries do not have a dedicated mental health budget and often spend very small percentages of their overall health budget on this area.

There is variation across the region in the nature, comprehensiveness and quality of legislation in relation to mental health. While a small number of countries with legislation are engaged in a review and updating process, or have done so in the last decade, many have legislation that is dated. Thus, a key function of the programme will involve supporting countries in reviewing legislation to produce legal frameworks that, while reflecting the unique circumstances and culture of each country, are comprehensive, contemporary in nature, and mindful of international obligations.

There is inconsistency across the region in relation to the presence, make up and status of mental health policies, plans and programmes. It would seem that not only the development but the operationalisation and often the actual implementation of policies, plans and programmes can be highly problematic for countries. This is clearly an area where skilled technical assistance and support may be crucial. Current priorities in the planning of many countries include:

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[23] University of Auckland Centre for Mental Health Research, Policy & Service Development, 2005: *Situational analysis of mental health needs and resources in Pacific Island countries*

- Increasing the size and expertise of specialist workforces (almost universal).
- Improving training for the general health workforce (very common).
- Improving understanding and awareness of mental health in the community.
- Improving the organisation and management of mental health services.
- Developing mental health policies and legislation.
- Developing/improving community based care.

Regardless of their status, content and coverage, the existence of policies, plans, programmes and other such initiatives in various countries can be built upon for this programme.

The skewing of health services towards primary health care means that training and development around mental health of the associated workforce is clearly important to improving care and outcomes. This is perceived as a high priority by countries. However, while much can be achieved through the training of general health staff in mental health, an optimal mix of services also requires a specialist workforce. The small size of such workforces in most countries raises a number of issues such as those around recruitment and retention (including the loss of specialist staff when training occurs overseas) and providing appropriate and ongoing training for this group. In relation to these issues, a more co-ordinated and co-operative approach among groups of countries may be useful. Similarly, ongoing distance learning and support programmes in specialist staff development are clearly important but these need to be carefully structured.

Workforce issues must also consider the best utilization of staff. Thus, the organisation and structure of services and facilities must be considered in close relationship with workforce issues and along with the wider country context and the place and fit of mental health more generally.

The often limited and frequently variable nature of information regarding services and facilities has implications for analysis in those areas. From the available data some general observations can be made about services and facilities:

- Large dedicated institutions often only provide less than optimal care and place a heavy drag on resources.
- Despite strong primary health care orientated systems, for a variety of reasons many countries do not integrate mental health into those systems
- The involvement of, and reliance on, primary health care workers, outside agencies, communities and families necessitates a strong education programme.
- Delivery of services is often hampered by the geography of countries (e.g. widely dispersed islands) and limited resources (e.g. reliable, maintained transport). Thus, developing services and facilities needs to incorporate considerations well beyond those centred around mental health and be open to innovative thinking.
- Geography can also influence mental health service and facility development directly – e.g. the need to replicate services and/or facilities when transport makes centralisation problematic.
- There is the need to consider provision for particular groups (e.g. children and adolescents) and needs (e.g. around suicide) as well as generic services and facilities
- As well as providing support, networking and sharing among Pacific countries may highlight similar problems and throw up innovative solutions.

NGO involvement is variable across countries and, again, precise information is limited by data available for analysis. In a number of countries there is expressed interest by NGOs and governments in expanding the roles and involvement of such organisations.

In terms of responding to these issues, the report offers an overview and analysis of education and training in the countries under consideration and from a regional perspective. This examines health education more broadly across various areas (e.g. clinical and management), and with a particular focus on mental health.

As clinical training, especially in terms of health workers, nurses and doctors, is seen as a high priority in all countries, it is positive that most have, at the least, programmes around nursing. However, there is variation in the nature and significance of mental health content in these and efforts in addressing this need to be made. It is argued that this programme will make a valuable contribution to extending the interest in clinical training to

management, policy and leadership areas. Also considered important by countries were more general programmes around mental health education, promotion and prevention for workers and the public.

The primary health care system is important in relation to mental health care. However, the mental health training for this workforce varies considerably in terms of existence, type, frequency, coverage, and quality and again this is an area that needs attention. Any clinical training around mental health should take account of the predominance of nurses and health workers in the specialist and generic workforces.

It is apparent that many countries use courses run in neighbouring countries for basic and/or specialist training and there is a clear and expressed desire for more collaboration of this kind. Such networks and collaborative approaches are obviously of value and interest since they can play an important role in training and support initiatives. Indeed, improved and expanded networks are a key goal in this programme. Existing Pacific education collaborations, networks and relationships vary in size, nature and structure and one country can belong to a number of these for a variety of different motivations or purposes. Apart from SPC, networks and organisational collaborations tend to be associated with smaller regional sub-groupings.

Future collaborations could be made up of a set of countries grouped around a key provider, based on more local relationships and particular needs. Each collaborative centre of training or learning would provide a focus for shared and concentrated investment of human and financial resources to ensure quality training. It could also develop a 'train the trainers' approach and encourage a flow on effect to other groups of workers. Collaborations would allow for training to reflect the cultural and other needs of Pacific Island nations and could well reduce the loss of staff that often happens when training is made available in Australia or New Zealand.

Technical support in various forms would clearly be beneficial in developing and maintaining collaborations of this sort and in promoting shared and ongoing training and education. Most countries have developed external or strategic partners (in Australia and New Zealand), but there still needs to be more linkages at regional level with efforts made to utilise, support and develop the leadership roles of existing providers. For instance, although USP is the leading distance education provider in the Pacific, it does not teach health or medicine programmes. Thus, it needs to link productively with providers that have such an orientation. Ongoing support should favour models that contribute to the goals of building capacity and capability and a lasting infrastructure in the region through viable and sustainable networks and organisations.

It is clear that the internet and other electronic media, including telehealth initiatives, offer some potential in relation to collaborations and networking around education and training. However, heavy emphasis was placed on the oral culture in Pacific countries, the preference for a face-to-face approach for training, and the need for close engagement with neighbouring countries. Ongoing support and mentoring was recognised as important but the approaches adopted needed to be appropriate and reflect the above factors. Thus, electronic media should be viewed as an adjunct rather than mainstay of any programme, though consideration must still be given to availability, access, reliability, costs, skills, knowledge, experience and preferences. Even if technology is available in countries, in-country variability could mean that more mundane approaches such as ordinary mail and the like may still be necessary.

Finally, it was evident from interviews that any proposed programmes be well piloted. In addition, in order to give credibility and ongoing support to particular training programmes, significant members of the community and church (e.g. elders or leaders) should be involved alongside administrators, managers, clinicians and workers. This will ensure greater buy in and sustainability of programmes.

ANNEX 2: TERMS OF REFERENCE FOR THE REVIEW

Review of New Zealand's Development Assistance to the World Health Organization (WHO) Pacific Islands Mental Health Network (PIMHnet) – 2005 - 2008

Background

Establishment of WHO PIMHnet

The Pacific Region comprises a large number of countries spread across a considerable geographical area with a wide variation in cultural practices, socioeconomic status, and access to health care. Mental health disorders contribute significantly to the total disease burden. While there have been improvements in physical health over the last 50 years in the region, the situation has worsened in respect of mental health and the region has a higher burden of mental and neurological disorders relative to other parts of the world[24].

Mental health in the Pacific region is often given a low priority, must compete for scarce resources, and frequently struggles to be recognised at all levels of government and society. Particularly in the Pacific, innovative approaches are needed to achieve improved mental health among populations through the development of mental health services, policy, and planning, as well as better treatment and care. Because of the numerous and competing demands on already limited country resources and budgets, achieving effective outcomes rests on a reduction in unnecessary duplication and fragmentation of activities and greater cooperation and collaboration and build sustainable national and regional capability and capacity in relation to mental health.

The idea of a Pacific mental health network as a means of responding to these issues and challenges was raised and discussed at the Meeting of Ministers of Health for the Pacific Island Countries held 14-17 March 2005 in Apia, Samoa. This emerged from an earlier Pacific Health Ministers' meeting in Tonga in 2003, which had placed mental health on its agenda and generated interest in and commitment to this important area. The recommendation was made from the 2005 PHMM, to establish a WHO WPRO Mental Health Network to support countries to profile and improve mental health. With support from the New Zealand Ministry of Health, WHO consulted with Pacific Island countries to establish a situational analysis for the region in relation to mental health. This situational analysis was completed in 2004. In 2005, PIMHnet successfully bid for funding via NZAID's Government Agency Fund to support the work of the network for three years.

WHO consulted with counties on "what this network would look like and how it would function". 20 Pacific countries were initially consulted and 11 countries expressed interest in the proposal. Six countries were able to meet in Tonga in 2005 to develop up a draft framework. Twelve countries expressed strong support for the proposal and nominated a country representative via their government to be part of the network.

PIMHnet was officially launched during the Pacific Health Ministers' Meeting in Port Vila, Vanuatu in March 2007. The network has expanded from the 11 initial country members, and now a total of 18 countries[25] form part of the network. It had its inaugural meeting in Apia, Samoa in June 2007.

The work of PIMHnet is envisaged to take place over a period of at least ten years, since much of the work is centred on developing sustainability which includes growing member countries' ability to build capacity and capabilities and appropriate legislative frameworks for improvement in mental health. In many countries and regions within the network there are no mental health policies and legislation, and therefore no protection of human rights of people with mental illness and limited access to appropriate services. Development of the necessary policy framework can only take place over the long term and with consistent support from organisations such as the World Health Organization whose credibility in international health has raised the profile of mental health on the political agenda of PI countries.

The Ministry of Health New Zealand role is twofold. Firstly it has been the sponsor for the proposals to NZAID's Government Agencies Fund; secondly it is represented on PIMHnet by Dr David Chaplow- Director of Mental

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[24] *Regional Strategy for Mental Health*: World Health Organization – Western Pacific Regional Office, 2002.

[25] American Samoa, Australia, Cook Islands, Fiji, Kiribati, Marshall Islands, Micronesia (Federated States of), Nauru, New Zealand, Niue, Northern Mariana Islands, Palau, Papua New Guinea, Samoa, Tokelau, Tonga, Vanuatu, Solomon Islands

Health for New Zealand as New Zealand's National Focal Contact for the network. The Ministry has had an active role in the preparation of the Terms of Reference for this review. The Ministry recognises the importance of providing input and advise where needed to NZAID in relation to, stakeholder interview selection, draft report and suggested recommendations.

Vision, Mission, Objectives and Principles of PIMHnet

PIMHnet's vision is the people of Pacific Island countries enjoying the highest standards of mental health and wellbeing through access to effective, appropriate and quality mental health services and care.

In order to achieve this vision, PIMHnet's mission is to facilitate and support cooperative and coordinated activities within and among member countries that contribute to sustainable national and sub-regional capacity in relation to mental health.

Given its vision and mission, PIMHnet has, as its broad objectives, improvements within countries and across the region to:

- Assist countries to improve mental health services in countries
- Reduce unnecessary duplication and fragmentation of activities in this area
- Encourage more cooperation and collaboration
- Build sustainability, capacity and capability
- Deliver on Millennium Development Goals through a greater mental health contribution.

The function of PIMHnet is guided by a set of principles:

1. A desire by its member countries to actively engage in improving mental health in their own countries and across the region as a whole
2. A willingness of members to work cooperatively and collectively as demonstrated by a commitment to network development both in countries and among countries
3. A recognition by members that PIMHnet serves as:
    a. The primary vehicle for developing and implementing mental health initiatives within and among participating countries in the region
    b. The key mechanism for coordinating financial and technical resources associated with such initiatives.

(see attached 10year PIMHnet objectives – annex 3)

Structure and organisation of PIMHnet

The key components of PIMHnet and are National Focal Contacts, In-Country Networks, the WHO Secretariat, the Network Facilitator and Collaborative Partners. The following paragraphs will detail the various roles.

National Focal Contacts (see appendix 1 for contact details) are people who hold a senior position within government or public service with responsibility for and a strong involvement in, mental health. The National Focal Contacts are appointed by the government via the Minister of Health in each country. The Minister of Health and the Ministry or Department of Health, and are key to the operation of PIMHnet. The National Focal Contacts have two primary roles: to be the primary contact for WHO and the Network Facilitator for all PIMHnet related business and communications; and to foster and engage with an in-country mental health network that will assist them with their work.

The World Health Organization serves as the secretariat for the network. The Network Facilitator is the liaison with National Focal Contacts(NFC) within countries, identifying issues with WHO, providing assistance with resolution to countries accessing resources, providing direct in country support where requested by PIMHnet governments, administration, coordination and communication with PIMHnet countries. Liaison with NGO groups in countries occurs in conjunction with NFCs.

Collaborative partners are individuals or organisations that can provide relevant expertise, resources and support to the network such as funding, education and training, policy and legislation, service development and delivery and clinical practice. Examples of collaborative partners include WONCA, FSPI, MHF(NZ), WFMH, Regional Pacific NGOs.

Workplans and activities

Consultation with the network has identified key areas for action which include:

- Advocacy
- Policy, legislation, planning and service development
- Human resources and training
- Research and information
- Access to psychotropic medications.

Annual workplans are the mechanism to guide activities and are selected according to the priorities of countries and PIMHnet's capacities and capabilities. Work to date has included the following:

- The development of detailed mental health training plans for each member country. The plans provide a situation analysis of current mental health and general workforce, workforce required to provide appropriate mental health services and training requirements;
- An information package providing detail about mental health and mental illness aimed at two levels – first general health professionals (predominantly nurses who are often the first point of contact for people with mental illness in many areas of the Pacific); and second the social services (such as teachers, police, church) in order to provide them with an understanding of mental health and mental illness, how to respond and how and to whom to refer people with mental illness;
- Sharing of information and assistance with in country communications regarding mental health as required;
- Facilitation of access to technical in-country support;
- A policy and planning workshop for PIMHnet member countries to assist them develop their own mental health policy, plans and legislation in Apia, Samoa in June 2007. Ongoing support is being provided to countries by the network in terms of developing their own mental health policies and legislation;
- A workshop in Wellington, NZ in February 2008 involving participants from international organisations and Pacific non-government organisations to build support and collaboration for mental health in the region;
- A dedicated home page for PIMHnet was established on WHO website; all information and activities on PIMHnet will be housed on this site for wider access
- Development of communication protocols with each country to establish the most reliable means of communicating with each country

Purpose of Review

To assess the extent to which the WHO Pacific Island Mental Health Network has met it major activity outputs to date and progress made towards achieving stated developmental objectives.

Key Outcomes for the Review

WHO and the NZMoH will have the information to assess whether the current arrangements under which PIMHnet has operated are the most efficient and effective way to achieve the objectives. NZAID will have the information to inform future funding decisions for PIMHnet.

Information gained from the review will be used to enable ongoing improvement to PIMHnet's delivery of key activities and thereby contribute to greater development impact.

Scope of the Review

This review covers PIMHnet activities undertaken from October 2005 to June 2008 which are outlined in 'years 1 and 2' in appendix two (attached). The reviewer will be expected to consult with a selection of NFC's (to be determined in consultation with MoH).

The evaluation will take place in September/October 2008. The review should involve field research in the following PIMHnet countries: Fiji, Tonga, Vanuatu and Kiribati.

Objectives of the Review

The following review objectives should be met in order to achieve the overall purpose of the review:

Objective 1: To assess PIMHnet project progress towards the stated objectives (including use of the key performance indicators as detailed in the project proposal).

Objective 2: To assess the level of satisfaction and ownership from in-country stakeholders.

Objective 3: To compare cost of interventions with the achievements of the project.

Review Methodology

The review team will develop the methodology and include this in a review plan submitted to NZAID and MoH. The review will involve the collection and appraisal of both qualitative and quantitative information in the process of evaluation, and may involve

- a desk review of key documents, including workplans, reports, training materials,
- face-to-face and telephone interviews with a representative sample of key stakeholders

Review Questions

The following key questions will guide the review:

1. What progress has been made towards the planned outputs and development objectives of the project?
2. To what extent does the initiative represent value for money? The total amount of money spent on the programme should be compared qualitatively with the broad outcomes, impacts or changes brought about by the work[26]
3. What is the relevance of the project to the challenges of the mental health situation in the Pacific Region?
4. How effective is PIMHnet communication strategy in providing/disseminating information, improving knowledge and enabling networking across the pacific region?
5. How satisfied are countries with the project to date? How does this fit with their expectations? To what extent do countries consider this is meeting their expressed needs with regards to mental health?
6. What opportunities are emerging where the PIMHnet mechanism could provide momentum or benefit to in-country capacity development and activities?
7. What is the appropriate location and structure for the PIMHnet? Make recommendations for what this might be.
8. How well have cross-cutting issues, particularly gender and human rights been considered in the design and implementation of this programme?

Tasks

1. Meet with NZAID and MoH in Wellington at the outset of the review for a briefing.
2. Submit a review plan, including a timeline to NZAID and MoH for assessment (substantive work on the review should not start before the Plan is agreed).
3. Review would.
4. Review the available documentation (principally proposals, financial authorities, contracts and reports)
5. Conduct in-depth interviews with key stakeholders in New Zealand and PIMHnet, including NZAID and MoH staff, the Network Facilitator and National Focal Contacts.

- If possible, comparisons of value for money should be drawn with experience or norms in other activities (in the same country/region or internationally), where similar outcomes or impacts have been aimed for and/or achieved.
- The activity's own cost structures should be analysed to identify cost effectiveness issues, including whether savings could have been made (without disproportionately compromising outcomes) through different methods of management, procurement, prioritisation, design, etc."

6. Prepare and circulate a draft report of findings, conclusions and recommendations that addresses the review objectives and key questions.
7. Prepare and present a final report, incorporating feedback and comment from NZAID, MoH and WHO.
8. Undertake debriefing with NZAID and MoH in Wellington, if required.

Review Outputs

1 Pre-review briefing in Wellington with NZAID and MOH

2 Submit a draft Review methodology and implementation plan to NZAID and MoH for assessment

3 Submit a draft study report including:

a. a title page;

b. contents (including figures and tables)

c. abbreviations and glossary

d. an executive summary of 2-3 pages;

e. a clear and concise body no longer than 20 pages detailing:, timing of study, literature reviewed, discussion, lessons learned and recommendations for guiding the future policy and operations of the PIMHnet and key stakeholders activities with regard to the assistance to mental health activities, and conclusion; and

f. appendices including the review TOR, methodology utilised, references to background materials or papers, an itinerary, a list of people consulted and a summary of the main costs and benefits of the project (including noting any non quantifiable costs and benefits).

4 Oral presentation of research findings to relevant stakeholders

5 Final study report

Review Milestones

- Pre-research briefing in Wellington
- Presentation of a comprehensive review plan (to be agreed by the Contract Manager)
- Review of relevant studies
- Preparation of final draft report
- Presentation to stakeholders in Wellington
- Finalisation of report – the contractor should allow enough time to ensure that the report meets the Terms of Reference and NZAID's evaluation standards.

Specification of the Reviewer

The reviewer will have the following skills and competencies:

- Considerable experience with reviewing and evaluating development activities and institutional structures.
- Good cross-cultural communication and interpersonal skills
- Experience of and skill in participatory approaches to review/evaluation, ideally in the Pacific.
- Proven ability to work effectively in a cross-cultural environment
- Analytical skills
- Demonstrated skill in verbal and written communication– especially report writing

Management of the Review

- NZAID and MoH will jointly manage the review but NZAID will have responsibility for the management of the contract.
- NZAID and MoH will jointly approve the review workplan/methodology
- The consultant will provide progress reports to MoH copied to NZAID. Content and timing of progress reports are to be included in the review workplan/methodology.
- MoH will take the lead on briefing the consultant prior to commencing work on the review. MoH will also take responsibility for provision of background documents.
- MoH will take the lead on reviewing the draft report and providing comments. NZAID may also provide comment.
- MoH may assist the consultant with travel arrangements and facilitation in setting up interviews/meetings, particularly with in-country stakeholders.
- MoH will take responsibility for communicating review plans with stakeholders and reporting back results of review to stakeholders.

Time frame and reporting

The review should take place in September/October 2008, with a draft report submitted to NZAID by 15 November 2008

Follow-up

Meeting/s with NZAID and the Ministry of Health as project sponsor, in November or December 2008.

ANNEX 3: PIMHNET 10-YEAR OBJECTIVES

Objectives	***Year 1***	***Year 2***	***Year 3***	***Year 4***	***Year 5***	***Year 6***	***Year 7***	***Year 8***	***Year 9*** *Handover*	***Year 10*** *complete*
	KEY ACTIVITIES	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*
Improved awareness of human rights and reduced stigmatisation	Support for NFC Awareness raising network profiling occurring	Drafting of materials for countries to assist in briefing ministers and wider community on MH Network officially launched	Network becoming engaged with wider pacific groups	Advocacy + training, material available thru collaborative parties/network.	In country organisations Conducting wider training with community groups	Increased awareness, public campaigns, service and resources cited in wider community Greater integration of those with MI in the general community	Increased awareness, public campaigns, service and resources cited in wider community Greater integration of those with MI in the general community	Gap between Health status of those with MI and general population is lessening Greater articulation within community of regards for HR	Gap between Health status of those with MI and general population is lessening Greater articulation within community of regards for HR	International agencies cite examples of PIC in regards to strategies and awareness of HR and reduction of stigma
The profile of mental health as a key health issues within countries and region is raised Communication process to engage in discussion on key issues	F/W discussion + scope – awareness raising NFC appointment by governments In-country network Need for Communication & Framework for network identified by countries	F/W established and approved In country funding given for communications and in country activities Logo, slogan, T shirts. Mental health day resources Assistance provided to NFC - drafting papers - co-ordinate liaison Annual meeting - work plan - teleconferences - newsletter	Website established In-country activities occurring, support given re resources – print materials, provide advice and assist with information to NFC	Wider personnel + organisation become involved. Continued advice and support to in-country NFC and teams Wider access to technology for interaction with network	Ministers become advocates for mental health improvements NCD plans start incorporating MH Continued advice and support to in-country NFC and teams Wider access to technology for interaction with network	Mental health on agenda of Pacific Health Ministers meetings Continued advice and support to in-country NFC and teams Wider access to technology for interaction with network				
Public policy and legislative development in mental health	Awareness raising Needs identified	Policy workshop - initial policy work	Work plan policy work occurring in countries	Policy + in-country workshop	Cabinet process occur re MH plan Continued policy	Legislation reviewed and drafted	Legislation Time given to MH policy	Legislation	Enacted	

Objectives	***Year 1***	***Year 2***	***Year 3***	***Year 4***	***Year 5***	***Year 6***	***Year 7***	***Year 8***	***Year 9*** *Handover*	***Year 10*** *complete*
	KEY ACTIVITIES	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*
that is reflective of international guidelines and human rights					advice provided	Continued policy advice provided	Continued policy advice provided New mental health policy areas identified and developed	New mental health policy areas identified and developed. Countries starting to become more skilled and able to access support in differing ways	New mental health policy areas identified and developed. Countries starting to become more skilled and able to access support in differing ways	PIC developing new models of regional policy frameworks to assist in MH response
Increased skill and knowledge of workforce that interfaces and cares for people with mental illness	Identification of problem	Human Resource (workforce) - plan and need analysis Plans 2/11 begin Mental health info and Resource kit scoped	Plans 5/12 occurring Mental health info and Resource kit developed, submitted to countries	10/17 plans complete	In-country training and support occur	In-country training and support occur	Countries developing new approaches to workforce need through greater collaboration with regional groups and NGOs In-country training and support provided as required	Countries developing new approaches to workforce need through greater collaboration with regional groups and NGOs	Continuing education and support	Continuing education and support
Greater lobbying and strategic influence with organisations involved in key mental health issues		Establish collaborative/ strategic partners Database established Ongoing NGO meeting held	Increase sharing with collaborative partners. Joint work programmes established. Resources identified and accessed by countries.	Ongoing assistance and support from secretariat to work with governments	Ongoing assistance and support from secretariat to work with governments	Ongoing assistance and support from secretariat to work with governments	Ongoing assistance and support from secretariat to work with governments at national and regional level	NGO and wider in country agencies are developing lobbying skills and successful strategies are occurring.	NGO and wider in country agencies are developing lobbying skills and successful strategies are occurring	
Sustained change and support	Establishing and identification of support for NFC Funding for in-country support provided	NFC support and advice provided 5 new countries entered Identification of Regional Projects and future donors	NFC support and advice provided Nursing project scoped, finalised and submitted to AusAID Potential donor database established	NFC support and advice provided Seek funding from donors for PIMHnet projects Meeting with potential donors	NFC support and advice provided In country teams are strengthening Review current needs Work with collaborative parties on ongoing activities in country and	NFC support and advice provided. In country teams are strengthening Increased activity Projects are scoped and agreed to by all members Donor identified	NFC support and advice provided . In country teams are strengthening Increased activity PIC provide some contribution to regional projects PIC budgets identifying MH	NFC and . In country teams are providing strong leadership	NFC and . In country teams are providing strong leadership	PIC country budgets include MH and are contributing to in country improvement of mental health

Objectives	***Year 1***	***Year 2***	***Year 3***	***Year 4***	***Year 5***	***Year 6***	***Year 7***	***Year 8***	***Year 9*** *Handover*	***Year 10*** *complete*
	KEY ACTIVITIES	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*	*KEY ACTIVITIES*
			Pharmacy project scoped New country entered Process for engaging remaining PI countries		regionally Consider facilitation of telelinks between regions for clinical support and mentoring	and successful funding occurs	projects			

ANNEX 4: SEQUENCE AND TIMING OF REVIEW ACTIVITIES

Dates	Task
3-7 Nov	Review of NZAID and project documentation Briefing with NZAID Interviews with key NZAID staff about PIMHnet and NZAID funding mechanisms Prepare review methodology Interviews with project Secretariat (Wellington, Geneva) Interviews with NZ MOH
8-13 Nov	Fiji Briefing with NZAID post Interviews with NFC, MOH (Central & Eastern Division), NGOs, WHO
13-18 Nov	Kiribati Briefing with NZAID post Interviews with MOH, NGOs, other strategic partners including other sectors Visit to Mental Hospital
19-24 Nov	Tonga Interviews with NFC, MOH, NGOs, other strategic partners
26 Nov-3 Dec	Vanuatu Interviews with NFC, MOH, NGOs, other strategic partners
4-14 Dec	Analyse returned questionnaires Finalise and submit draft report
15-18 Dec	De brief in Wellington Present review findings
19-23 Dec	Finalise report and submit by email

ANNEX 5: PIMHNET REVIEW METHODOLOGY

Background to the review

At the meeting of Ministers of Health for the Pacific Island Countries, held in March 2005 in Apia, Samoa, the idea of a Pacific Mental Health Network was discussed as a means of overcoming geographical and resource constraints in the field of mental health. Based on findings from a situation analysis and extensive consultations with Pacific Island countries, a final funding proposal for establishing and operating the network was developed and WHO has received three years of funding from the New Zealand Ministry of Health and the Overseas Development Agency of the Ministry of Foreign Affairs and Trade to support the network activities. Following success with funding, two planning meetings were held: in Tonga in 2005 to develop a draft framework for the Network and in Auckland in 2006 to develop an implementation plan. The WHO Pacific Islands Mental Health Network (PIMHnet) was officially launched at the Meeting of Ministers of Health for the Pacific Island Countries in Port Vila, Vanuatu on 14 March 2007. Significant dates and events are presented in the Table below.

Date	Event	Activity
2003	Pacific Health Ministers' Meeting, Tonga	Mental Health on agenda
2004	Mental Health Situational Analysis	Report
March 2005	Pacific Health Ministers' Meeting, Samoa	Recommended establishing WHO WPRO Mental Health Network
2005	NZAID'S Government Agency Fund successful bid	3-year funding for Mental Health Network
August 2005	Tonga planning meeting – 5 countries participating	Developed draft framework for Network
May 2006	WPRO meeting in Auckland, NZ	Develop an implementation plan for PIMHnet
March 2007	Pacific Health Minister's meeting - Vanuatu	Launch of Network
June 2007	First PIMHnet meeting, Samoa	Finalise PIMHnet framework, policy and planning workshop
September 2008	Second PIMHnet meeting, Suva	Review progress, support implementation of policies and plans

PIMHnet's ***vision*** is the people of Pacific Island countries enjoying the highest standards of mental health and well-being through access to effective, appropriate and quality mental health services and care.

To achieve this vision, PIMHnet's ***mission*** is to facilitate and support cooperative and coordinated activities within and among member countries that contribute to sustainable national and sub-regional capacity in relation to mental health.

Given its vision and mission PIMHnet has, as its broad ***objectives*** improvements within countries and across the region in:

- Communication;
- Co-ordination and Co-operation; and
- Capacity and Capability.

Several key components make up PIMHnet and are integral to its structure and operation. These are National Focal Contacts (NFCs), In-Country Networks, the WHO Secretariat, the Network Facilitator, and Strategic partners.

National Focal Contacts are key to the operation of PIMHnet and are appointed by each country's Minister of Health as the focal person for that country. More than one person may be nominated. As a general guide, NFCs are people who hold a senior position within government or the public service with responsibility for or strong involvement in mental health. Alternatively, they might have a strong background in and knowledge of mental health. NFCs have pivotal functions and responsibilities in respect of PIMHnet in relation to both inter-country and intra-country activities. Therefore, they must be in a position that enables them to attend to both these dimensions. The former involves being the primary country contact for WHO and the Network Facilitator for all PIMHnet related business and communications. The latter involves actively fostering and engaging with an in-country mental health network.

The NFCs have responsibility for fostering ***in-country mental health networks***, whose members could include:

- mental health clinicians and professionals;
- those involved in mental health legislation, policy, financing and planning, and programme management;
- relevant professional organisations;
- NGO and other relevant provider organisations;
- service users and/or service user organisations;
- family representatives and/or family organizations;
- educators and academics in the field of mental health;
- representatives from community and church (e.g. elders, leaders, traditional, healers).

NFCs are therefore responsible for facilitating activities, relationships and communication between individuals, groups and organisations with a role or interest in mental health in that country.

The ***WHO Secretariat*** is responsible for:

- the development, management and dissemination of information and resources;
- fundraising;
- the preparation of materials (e.g. discussion papers and reports);
- the maintenance of a database of contacts and activities; and
- the overall management and co-ordination of meetings and activities.

The ***Network Facilitator*** is contracted by WHO to ensure the ongoing operation of PIMHnet. Key aspects of the Network Facilitator's role includes administration, co-ordination and communication with PIMHnet countries.
Strategic Partners are individuals or organisations (government, non-government and private) who can provide relevant expertise, resources and support in a wide range of areas and ways (e.g. funding, education and training, policy and legislation, service development and delivery, clinical practice, etc).

The project has developed a framework identifying six key objectives, and at 10 year plan that identifies key activities to be achieved against each of those objectives. These are key documents to the review.

Review purpose and objectives

Purpose

The purpose of the review is: *To assess the extent to which the WHO Pacific Island Mental Health Network has met it major activity outputs to date and progress made towards achieving stated developmental objectives.*

Objectives

There are three key objectives to the review:

> Objective 1: To assess PIMHnet project progress towards the stated objectives (including use of the key performance indicators as detailed in the project proposal).

Objective 2: To assess the level of satisfaction and ownership from in-country stakeholders.

Objective 3: To compare cost of interventions with the achievements of the project.

The review covers PIMHnet activities undertaken from October 2005 to June 2008 which are outlined in Year 1 and Year 2 of the PIMHnet 10 Year Objectives. The reviewer will be expected to consult with a selection of NFC's (to be determined in consultation with MoH).

The evaluation will take place in November/December 2008. The consultant will undertake field research in the following PIMHnet countries: Fiji, Tonga, Vanuatu and Kiribati. Remaining countries in PIMHnet will be e-mailed a brief questionnaire to complete as their contribution to the review.

Detailed review questions

Detailed review questions include the following:

1. What progress has been made towards the planned outputs and development objectives of the project?
2. To what extent does the initiative represent value for money? The total amount of money spent on the programme should be compared qualitatively with the broad outcomes, impacts or changes brought about by the work.
3. What is the relevance of the project to the challenges of the mental health situation in the Pacific Region?
4. How effective is PIMHnet communication strategy in providing/disseminating information, improving knowledge and enabling networking across the pacific region?
5. How satisfied are countries with the project to date? How does this fit with their expectations? To what extent do countries consider this is meeting their expressed needs with regards to mental health?
6. What opportunities are emerging where the PIMHnet mechanism could provide momentum or benefit to in-country capacity development and activities?
7. What is the appropriate location and structure for the PIMHnet? Make recommendations for what this might be.
8. How well have cross-cutting issues, particularly gender and human rights been considered in the design and implementation of this programme?

Review data sources

Data sources for the review will include:

1. NZAID policy documents
2. WHO policy documents
3. PIMHnet documents including proposals, financial authorities, contracts and reports
4. In-depth face-to-face interviews with stakeholders:
    - in New Zealand: with government agencies (NZAID, NZ MOH), the PIMHnet facilitator
    - in four PIMHnet countries (Fiji, Kiribati, Tonga and Vanuatu): with the NFCs, country government agencies, NZAID, AusAID, WHO, NGOs, others
5. In-depth telephone interviews with the WHO/PIMHnet Secretariat (Geneva, Manila)
6. Questionnaires emailed to the NFC in those countries not visited by the consultant

The following table aligns review questions with data sources.

Review question	NZ interviews				In-country interviews				
	NZAID	NZ MOH	PIMHnet Facilitator	WHO PIMHnet Secretariat	NZAID post	NFCs	Strategic partners	Partner govt agencies	WHO Country office
Progress towards planned outputs and development objectives		✔	✔	✔		✔	✔	✔	
Value for money		✔	✔	✔		✔			
Relevance of project to MH challenges in the Pacific Region		✔	✔	✔	✔	✔	✔	✔	✔
Effectiveness of PIMHnet communications strategy		✔	✔	✔		✔	✔	✔	
Satisfaction with project to date; meeting their expectations & expressed needs with respect to mental health						✔	✔	✔	
Opportunities for PIMHnet mechanism to provide momentum/benefit to in-country capacity development		✔	✔	✔		✔	✔	✔	
Appropriate location and structure for the PIMHnet	✔	✔			✔				✔
Consideration of cross-cutting issues (gender, human rights) in the design & implementation of PIMHnet		✔	✔	✔		✔	✔	✔	

Review Methodology

A range of data sources are being used to collect information to address the review's objectives and key questions.

Documentation analysis

Documents will be reviewed to assess achievements against the PIMHnet framework and objectives, comment on the quality of the work done so far, and examine alignment with NZAID and WHO strategies/policies. These will include but not be limited to:

1. Meeting Report: First meeting of the WHO Pacific Islands Mental Health Network, Apia Samoa June 2007. WHO 2007
2. Meeting Report: Meeting on Partnership for Mental Health in the Pacific. Wellington New Zealand February 2008. WHO 2008
3. Report to NZAID, Pacific Islands Mental Health Network (PIMHnet). Dr David Chaplow, Chief Advisor Mental Health, Director of Mental Health, NZ MOH. March 2008
4. PIMHnet Annual Report to NZAID. August 2008
5. WHO Pacific Islands Mental Health Network (PIMHnet) – Framework Document May 2007. WHO 2007
6. Situational analysis of mental health needs and resources in Pacific Island countries. University of Auckland Centre for Mental Health Research, Policy & Service Development, January 2005

7. PIMHnet Newsletters (x4)
8. MOU/29/5/GACF NZ Official Development Assistance Government Agencies Contestable Fund. August 2006
9. MOU/29/8/GACF NZ Government Agencies Fund. December 2007
10. MOU/29/9/GACF NZ Government Agencies Fund. January 2008
11. Regional Strategy for Mental Health. WHO WPRO Manila 2002
12. WHO Resource Book on Mental Health, Human Rights and Legislation. Geneva, WHO, 2005.
13. Achieving Gender Equality and Women's Empowerment NZAID May 2007
14. Ending poverty begins with health NZAID undated
15. Human rights policy statement NZAID undated
16. Policy statement NZAID June 2002

Stakeholder analysis

Stakeholder	Interest	Type of stakeholder
NZAID staff in NZ	Contracted the review. Manage and oversee GAF, knowledge of GAF systems and process. Knowledge of funding programs in NZAID.	Primary
NZAID staff (post)	Knowledge of different funding options in NZAID. Appropriateness of GAF for this project	Primary
NZ MOH	Recipient of GAF funding. Knowledge of implementation and progress of project. Interest in/view of long term options for the project.	Primary
PIMHnet Secretariat, NZ	Experience of implementing the project. Knowledge of progress, limitations, challenges of project View of long term nature of project	Secondary
PIMHnet Secretariat Geneva, Manila	Experience of implementing the project. Manage the project budget. Knowledge of progress, limitations, challenges of project View of long term nature of project	Secondary
PIMHnet NFCs	Experience in implementation of project. Knowledge of progress. Views on performance/support of Secretariat. Areas in which capacity is being built	Secondary
MH service providers – formal and informal sector	Views on progress of project. Views on support from project. Areas in which capacity is being built	Secondary
Strategic partners – NGOs, other govt sectors	Knowledge of project. Views on implementation, inclusion, collaboration, cooperation. Views on achievement of a network. Areas in which capacity is being built. Views on limitations, areas for improvement, further opportunities.	Secondary

Interviews with key stakeholders

Feedback from stakeholders will be sought addressing all elements of the Terms of Reference. This will be achieved through face-to-face interviews, telephone interviews and emailed questionnaires. At this stage the number of interviews is not known as schedules for meetings have not been completed. Much of this will not happen until arrival in country.

Discussion guides and draft email questionnaire

Discussion guides have been developed for in-country interviews with NFCs and with key stakeholders including NGOs. A questionnaire has been developed to be e-mailed to NFCs in countries not being visited by the review. These are attached at the end of this document

Analysis of information

While the project reports focus largely on outputs, as does the framework, the consultant will also seek to report on not only the quantity of outputs (in table form for completeness country by country) but on the quality of those outputs from the perspective of the key stakeholders. This will also include a line of questioning that explores the extent to which capacity and skills have been built that did not exist before PIMHnet.

The consultant will pay attention to views that are expressed, particularly those that are contested. As this becomes apparent, clear examples will be sought, and the issue validated against other sources if that is possible.

Verification of information gathered will be undertaken through triangulation of data. This will be done by confirming during face-to-face interviews, in e-mailed questionnaires and through telephone calls statements in documents, for a select number of dimensions of the review. Conflicting points of view will be noted and reported.

Review Timing

Dates	Task
3-7 Nov	Review of NZAID and project documentation Briefing with NZAID Interviews with key NZAID staff about PIMHnet and NZAID funding mechanisms Prepare review methodology Interviews with project Secretariat (Wellington, Geneva) Interviews with NZ MOH
8-13 Nov	Fiji Briefing with NZAID post Interviews with NFC, MOH (Central & Eastern Division), NGOs, WHO
13-18 Nov	Kiribati Briefing with NZAID post Interviews with MOH, NGOs, other strategic partners including other sectors Visit to Mental Hospital
19-24 Nov	Tonga Interviews with NFC, MOH, NGOs, other strategic partners
26 Nov-3 Dec	Vanuatu Interviews with NFC, MOH, NGOs, other strategic partners
4-14 Dec	Analyse returned questionnaires Finalise and submit draft report
15-18 Dec	De brief in Wellington Present review findings
19-23 Dec	Finalise report and submit by email

Ethics and Risk Mitigation

Ethics

The consultant is a member of the Australasian Evaluation Society and as such operates under the code of ethics of that society.

The consultant has extensive experience in undertaking evaluations and reviews in developing countries, and is cognisant of the potential for these exercises to create stress for participants. Inclusion of all stakeholders is a priority, and listening to all viewpoints adhered to.

Participants are assured of confidentiality of information collected, and where interviews are recorded this procedure is undertaken in the most professional manner, with opportunity to terminate recording if the

participant wishes, and an assurance that data is kept in a secure place and only used by the consultant. Where questionnaires are collected, information is de-identified, and reports do not attribute comments to any one in particular.

Risks

1. People not available for interview: can't do anything if they are not in country; identify alternate informants
2. Ability to verify assertions being made and adequately triangulate data due to a limited number of informants available: follow up with e-mails or phone calls where possible
3. Value for money – no comparisons available; lack of data forthcoming from WHO: it will be just about value for money, and looking at WHO expenditure items, insisting on the costings being made available.
4. Limitations of documents/reports for information: develop a template and undertake intensive process of completing those with support from PIMHnet Secretariat and NFCs, demonstrating the value of the template to encourage compliance.
5. Attributing success/capacity building achievements to PIMHnet - with other capacity building support occurring in these countries it will be difficult to attribute capacity building to PIMHnet: the line of questioning will attempt to make this distinction.

Limitations of the review

The ability to undertake a detailed assessment of value for money to include making comparisons with other similar activities: the consultant is unaware of similar programs in the region stating similar outcomes with budgets of similar size.

There are now 16 countries in PIMHnet (excluding New Zealand and Australia). Only four of those countries are to be visited (25% of the total) which is a fairly small sample size. Every effort will be made to have the remaining countries complete the questionnaire that will be sent to them, but the risk is the response rate will be low and a questionnaire does not allow the same amount of exploration for information as face-to-face interviews.

Discussion guides for in country interviews, NFCs and stakeholders

Questions to NFCs:

1. Describe your role in/involvement to date with PIMHnet. Do you have a MH background?

2. The word "Network":
    - What's your understanding of what a network should be trying to achieve?
    - What does "networking" mean?
    - What are the necessary qualities of a "networker"?
    - What have you been able to do (if anything) to get the network operating in country?

3. How engaged are you with senior management, the Minister?

4. Main activities/achievements so far (against each objective of PIMHnet, country workplan)

5. **Extent of support** from WHO, PIMHnet facilitator, NZ MOH, others –
    - adequacy of that support/best features
    - anything you would not do/you want to get rid of
    - scope for improvement/additional support you would like to see?

    Using a scale of 1 to 5, with 1 = not at all satisfied, 5 = extremely satisfied, overall how would you rate that support?

6. **Sustainability and commitment:**
    - how will this happen?
    - Your country's MH budget situation
    - NFC appointment – access to highest level in Ministry

7. Specifically, has the support for **developing MH policy and plans** been adequate & appropriate? 1 to 5

8. Specifically, has the support for **developing MH workplans** been adequate & appropriate? 1 to 5

9. How useful is the **information package/kit**?
    - What's the evidence that it is being used?
    - Can it be improved?
    - Rate on a scale of 1 to 5

10. How useful are the **annual meetings**?
    - Rate on a scale of 1 to 5
    - Have you seen the report of the first meeting?
    - Do you fill in an evaluation at the conclusion of the AM?
    - Is there anything you would do differently during the AM?

11. How effective is the network in **bringing member countries together**?
    - Achieving collaboration and cooperation, sharing resources?
    - Any challenges in trying to do that?

12. Involvement of **other government departments/sectors** with PIMHnet:

- none, some (list them);
- describe perceived degree of commitment

13. Extent of involvement of **NGOs, strategic partners**:
    - good, fair, non-existent
    - Who are they?
    - Evidence of participation

14. PIMHnet has a **communications strategy** to facilitate sharing of information - e-mail, phone, fax, teleconferences, newsletters and website. Which of these work well/best for you?
    - Email: does it work for you?
    - Fax
    - Telephone
    - Newsletters – have you seen them?
    - Teleconferences: are there problems with these?
    - Website use: don't go to it, difficult to use, good, etc.
    - How useful is the website? Rate on a scale of 1 to 5:

    Overall how effective is this strategy in providing/disseminating information and, improving knowledge and enabling networking across the Pacific region. Rate on a scale of 1 to 5

15. Overall, how **satisfied** are you with the project to date? 1 to 5 rating
    - Does it fit with your expectations?
    - To what extent is it meeting your expressed needs with respect to mental health (relevance of the project)?

16. Do you think your country has **ownership** of the PIMHnet activities occurring in your country, or is there a sense of activities being imposed upon you from outside?

17. Do the activities of PIMHnet and the network mechanism provide benefit to other capacity development and activities in your country?
    - Skills you can use elsewhere in the health sector?
    - Skills you now have that you didn't have before PIMHnet?

18. **Stigma & access** issues due to stigma:
    - describe developments in this area
    - what (if anything) is PIMHnet doing to assist?

19. **Human rights and gender**:
    - What is your understanding of how is PIMHnet assisting with addressing these issues?

Anything else

Questions to NGOs, other stakeholders

1. Explain what you or your organisation does?

2. Do you have a formal in country mental health network?
   How does it operate?

   Does it meet, regularly - how often?

3. What (if any) has been your organisation's involvement been with PIMHnet?

4. Have you received any materials, resources from PIMHnet?

5. Overall, are you benefiting at all from PIMHnet? Use rating scale of 1 to 5.

6. What could PIMHnet do to support you?

Emailed Questionnaire to NFCs: **Country _____**

1. **Mental Health (MH) legislation**: describe progress since the start of PIMHnet e.g. not applicable (legislation already in place), needed but not yet started, progressing, completed.

2. What MH **awareness raising activities** have occurred with PIMHnet funding?

3. How useful is the PIMHnet **information kit/package**? (**rate using a scale of 1 to 5**, with 1= not useful, 5= excellent)

   Could it be improved? If yes, how?

   To whom have you distributed the package so far? (Not distributed yet, distributed to … name groups)

4. **Other sectors:** Indicate involvement of other government departments/sectors with PIMHnet: none, some (list them). Describe degree of commitment

5. **In-country MH network**: do you have a formal network Yes, No) – if yes, list members. Indicate the active ones if you can.

   If you have an in-country MH network, does it meet regularly: no, yes (how often). If no, why not?

   If yes, was this network in place before PIMHnet, or has PIMHnet been influential in this being established?

   How would you describe the extent of involvement of NGOs: good, fair, non-existent.

6. Have any **MOUs/agreements** (or equivalent) been developed to support a collaborative approach to MH since the start of PIMHnet? No, Yes – describe

7. How would you rate the **effectiveness of communications channels** within PIMHnet (rate on a **scale of 1 to 5** with 1=not effective or useful, and 5=excellent). Provide comment against each one, particularly if it is not very useful or has problems.

   Newsletters:
   Teleconferences:
   E-mails:
   Fax:
   Mail:
   Website:
   Annual Meeting:

8. Please rate (**using a scale of 1 to 5, or N. A. if not applicable**) the **quality of the technical support** that you have received from PIMHnet for the following:
   MH policy and plan development
   MH workforce planning
   Development of legislation
   Assistance provided for: drafting papers, coordination, liaison
9. **Capacity building**: what skills (if any) have you acquired as a result of PIMHnet activities? What can you now do better than you could before PIMHnet?
10. **Overall, how satisfied** are you with PIMHnet to date? Rate using a **scale of 1 (not at all satisfied) to 5 (extremely satisfied).**
11. How well is PIMHnet **meeting your country's expressed MH needs**? Rate using a **scale of 1 (not at all) to 5 (extremely well).**

ANY FURTHER COMMENTS ARE WELCOME, PARTICULARLY IDENTIFYING AREAS FOR IMPROVEMENT

Thank you for your response: Dr Alison Heywood

ANNEX 6: DOCUMENTS READ

1. University of Auckland Centre for Mental Health Research, Policy & Service Development, 2005: *Situational analysis of mental health needs and resources in Pacific Island countries*

2. PIMHnet Report May 2006. *Report on WHO Meeting to Develop an Implementation Plan for Mental Health Network in the Pacific.*

3. WHO July 2007. PIMHnet Report June 2007. *First Meeting of the WHO Pacific Islands Mental Health Network.* Apia, Samoa June 2007.

4. WHO 2008. *PIMHnet Mental Health Information Package– Part 1 – Health Professionals*

5. Tonga 2001. *Mental Health Act 2001.*

6. WHO 2007. *Meeting Report: First meeting of the WHO Pacific Islands Mental Health Network.* Apia Samoa June 2007.

7. WHO 2008. *Meeting Report: Meeting on Partnership for Mental Health in the Pacific*. Wellington New Zealand February 2008.

8. MOH New Zealand, March 2008. *Report to NZAID, Pacific Islands Mental Health Network (PIMHnet).* Dr David Chaplow, Chief Advisor Mental Health, Director of Mental Health,

9. MOH New Zealand 2008. *PIMHnet Annual Report to NZAID*. August 2008

10. WHO 2007. *WHO Pacific Islands Mental Health Network (PIMHnet) – Framework Document May 2007*.

11. University of Auckland Centre for Mental Health Research, Policy & Service Development, January 2005 *Situational analysis of mental health needs and resources in Pacific Island countries*.

12. PIMHnet Newsletters (x4)

13. MOH New Zealand 2006. *MOU/29/5/GACF NZ Official Development Assistance Government Agencies Contestable Fund.* August 2006

14. MOH New Zealand 2007. *MOU/29/8/GACF NZ Government Agencies Fund.* December 2007

15. MOH New Zealand 2008. *MOU/29/9/GACF NZ Government Agencies Fund*. January 2008

16. WHO WPRO Manila 2002. *Regional Strategy for Mental Health.*

17. WHO Geneva, 2005. *WHO Resource Book on Mental Health, Human Rights and Legislation*.

18. NZAID May 2007. *Achieving Gender Equality and Women's Empowerment*

19. NZAID undated. *Ending poverty begins with health*

20. NZAID undated. *Human rights policy statement*

21. NZAID June 2002. *Policy statement*

22. WHO & Office of the United Nations High Commissioner for Human Rights, 2008. *The Right to Health. Fact Sheet No. 31*

ANNEX 7: E-MAILED QUESTIONNAIRE TO PARTNERSHIP MEETING PARTICIPANTS

Kia ora,

I am reviewing the PIMHnet for NZAID, and examining its progress to date. The review is intended to report on how the PIMHnet is rolling out, and is seen as a constructive exercise that reports on successes and identifies areas for improvement.

As part of the review process I would like to get feedback from those of you who participated in the Wellington meeting in February 2008, and ask you to respond to the following questions:

1. Have you been able to brief people yet about the meeting?
2. What have you been able to progress back in your country (if anything) as a result of that meeting?
3. Is funding required to progress anything that you plan to do – if YES, where would you get it?
4. Did PIMHnet set up a mechanism for reporting back on progress against the Action Plans from that meet?
5. Is the Action Plan too ambitious?
6. Did you receive the report of the Wellington meeting in a timely fashion?

Answers to these questions, and any further comments, will be much appreciated. Just include your response to each question by return email.

The information will be used in confidence and no comments in the review report will be attributed to any one country or person. Countries will only be identified if there is positive information about them that is worth sharing with everybody else.

Can you please complete this and return it by email to me by **Wednesday 10th December** so that your views can be incorporated into the review report.

Could you please also let me know that you have received this email?

With thanks

Dr Alison Heywood

ANNEX 8: PEOPLE CONSULTED

NZAID

Ms Virginia Chapman	Manager, NZAID GAF Pacific Group
Ms Renee Simpson	Development Programme Administrator, Pacific Regional Growth & Governance
Ms Megan McCoy	Development Programme Officer
Ms Christine Briasco	Health Advisor
Ms Marion Quinn	Health Advisor

MOH New Zealand

Dr David Chaplow	Director, Mental Health & Chief Advisor
Ms Wendy Edgar	Manager, Global Health

WHO PIMHnet Secretariat

Dr Frances Hughes	Facilitator
Dr Michelle Funk	Coordinator, Mental Health Policy & Service Development, Department of Mental Health and Substance Abuse, WHO (telephone)
Dr Xiangdong Wang	Regional Adviser Mental Health WPRO

Suva, Fiji

Dr Odille Chang	NFC, Acting Medical Superintendent, St Giles Hospital, MOH
Ms Liebling Marlow	Psychiatric Survivors' Association
Ms Margaret Leniston	Regional Health Programme Manager, FSPI
Dr Temo Waqanivalu	Nutrition and Physical Activity Officer, WHO
Mr Simione Tumi	Mental Health Project Officer, MOH
Mr Meli Vakacabeqoli	NCOPS
Ms Millicent Kado	Development Programme Coordinator, NZAID

Tarawa, Kiribati

Mr Koorio Tetabea	NFC, Principal Nursing Officer, MHMS
Sr Mariateretia Tabakea	Alcoholics Anonymous Resource Centre
Mr Marea Itaia	YMH Coordinator, FSP Kiribati
Dr Kautu Tenaua	Honorable Minister for Health
Ms Reina Timau	Secretary, MHMS
Dr Terairo Bangao	Director, Hospital Services, MHMS
Ms Tanimahin Nootii	A/Director Nursing, MHMS
Ms Roko Timeon	Executive Secretary, KANGO
Ms Alicia Afuie	Deputy High Commissioner, New Zealand High Commission

Nuku'alofa, Tonga

Mele Fohe	NFC (primary), Mental Health Social Worker, Vailoa Hospital & MOH
Dr Mapa Puloka	NFC, Lead Mental Health Clinician, Vailoa Hospital & MOH
Paula Pateta	Training Clinical Psychologist, Mental Health Ward, Vailoa Hospital
Halamehi Ata	Clinical Nurse, Mental Health Ward, Vailoa Hospital
Solomoae	Clinical Nurse, Mental Health Ward, Vailoa Hospital
Lola Tukuafu	Registered Nurse, Mental Health Ward, Vailoa Hospital
Sitiveni Kaufusi	Psychiatric Assistant, Mental Health Ward, Vailoa Hospital
Emeline Pupunu	Registered Nurse, Mental Health Ward, Vailoa Hospital
Mele Fone	Registered Nurse, Mental Health Ward, Vailoa Hospital
Dr Villiami Tangi	Minister of Health, Deputy Prime Minister
Dr Litili 'Ofanoa	Director of Health, MOH
Ms Nauna Paongo	Computer Operator, Health Statistics Department, MOH
Ms Keasi Pongi	Program Manager, Civil Society Forum

Ms Emeline Ilolahia	Executive Director, Civil Society Forum
Mr Simione Silapelu	President, Tonga Association for Non-Government Organisations
Lette Siliva	Counsellor/Trainer, Tonga National Centre for Women and Children
Vika 'Aonga	Sexual Health Counsellor & Clinic Coordinator, Tonga Family Health Association
Mr Sione Faka'osi	Executive Director, Tonga Trust
Mr Uikelotu Vunga	Mental Health Coordinator, Tonga Trust
Filifai'esea Lilo	Coordinator, Lifeline
Tapavalu Takaii	Lifeline
Hepisipa Mauae	Australian Youth Ambassador, Lifeline
Ms Sisilia Lilo	Lifeline
Ms Barbara Tu'ipulotu	Program Manager, AusAID
Dr Pratap Jayavanth	A/CLO WHO

Port Vila, Vanuatu

Mr Jerry Iaruel	NFC, Assistant National NCD Coordinator, Public Health Department, MOH
Ms Myriam Abel	Director General, MOH
Mr Len Tarivonda	Director, Public Health Dept, MOH
Mr Graham Tabi	In-Country Coordinator (NCP) Pacific Action for Health Project, MOH
Dr Sereana Natuman	Junior Registrar, Medical Ward & Mental Health Team, VCH
Mr Barry Sawiel	Registered Nurse, Medical Ward & Mental Health Team, VCH
Mr Peter Kaloris,	Coordinator, Youth Mental health Project, Vanuatu FSPI
Mr Henry Vira,	Secretary General, VANGO Office
Mr Sandy Maniuri	Technical Education Officer, Secondary Education Department
Mrs Leisel Masingiow	Technical Education Officer, Curriculum Department, Education Department
Mr Jim Knox Allanson	Education officer, Community Secondary, Vernacular and Inclusive Education, Education Department
Ms Mereisi Shem	Chief Executive Officer, Ministry of Justice & Social Welfare
Mr Arthur Caulton	Deputy Commissioner, Vanuatu Police Force (VPF)
Mr Alick Ishmael	Force Administrative Officer, VPF
Mrs Laurina Liwuslili	Social Worker, Correctional Services
Chris King	Psychologist, Correctional Services
Mrs Angeline Soul	Parliamentary Counsel, State Law Office
Ms Jane Jereva	State Counsel, State Law Office
Ms Lynette Pirie	Senior Program Officer, AusAID

NFCs contributing by questionnaire

Ms Keti Fereti	Niue
Dr Imaculada Gonzaga-Optaia	FSM
Ms Frances Brebner	Samoa
Dr Sylvia Wally	Palau
Mr William Same	Solomon Islands
Dr Umadevi Ambihaiphar	PNG

In Australia

Professor Helen Herrman	World Federation of Mental Health (Oceania) (telephone)
Professor Michael Kidd	Discipline and General Practice, University of Sydney (telephone)

ANNEX 9: SUMMARY DOCUMENTATION OF ACHIEVEMENTS

Table 1: Summary of progress against framework – PIMHnet Secretariat contribution

Objectives	*Years 1 & 2*	*Progress*
	KEY ACTIVITIES	Overarching activities
1. Improved awareness of human rights & reduced stigmatisation	**Year 1** • Support for NFC • Awareness raising network profiling occurring **Year 2** • Drafting of materials for countries to assist in briefing ministers & wider community on MH • Network officially launched	• **Supporting the NFC:** o this is happening regularly: ongoing day-to-day one-on-one contact by email, telephone, fax for major activities and individual support; annual PIMHnet meetings (combined AGM, technical meeting), quarterly newsletters, resources on website, visits to some countries providing direct technical support as requested(e.g. Kiribati January 2008; Vanuatu, Cook Islands Fiji 2007) o Have prepared a number of briefing documents to be used by NFCs when briefing their ministers; standard briefing document available to all NFCs; information materials relevant to PIMHnet found in the region are sent off to the NFCs, gathering what's been done in the region and making it available PIMHnet countries o the Annual PIMHnet Meetings consist of a half day AGM, plus 2½ day technical meeting with specific focus(Inaugural meeting June 2007 Apia, Samoa; second meeting 9 - 11 September Nadi, Fiji) o Very early on had materials distributed for use during mental health week • **Raising awareness, profiling of PIMHnet:** o August 2006 funded PICs to attend a scoping meeting in relationship to establishing a MH network, to discuss ideas for the framework including: identify geographical scope, NGO involvement or not, etc; o PIMHnet launch - March 2007 in Vanuatu at PIC Health Minister's Meeting all ministers signed up and endorsed the network; media covered the event o Media activity – use all opportunities to include PIMHnet in a media release e.g. RACGP meeting in Australia 2008 o Promotional materials: flyer distributed at all meetings; other promotional material (caps, t-shirts), distributed to the countries and within country e.g. during MH awareness raising events; website profiling tool, o Presentation: ➢ Pacific Medical Association delegates (2006) and members about the concept of a network ➢ SAMHSA (August 2007) ➢ Transcultural Mental Health Sydney (2007) ➢ World Federation of Mental Health (August 2007) ➢ National Council of Mental Health Colleges, Australia (2007) ➢ World Psychiatric Association (Hong Kong 2007) ➢ WHO Health Promoting Schools (October 2007) • **Addressing human rights and stigma:** o All countries have been supplied with WHO Mental Health Guidelines- HR, Services, Legislation & policy o PIMHnet Annual Meeting Samoa 2007 addressed policy development, human rights and stigma: assistance to developing MH policy has used a human rights framework within WHO guidelines, consisting of a 14-module package step-by-step guide on how to improve the MH system, relevant to developing plans, focussed on the policy about human rights and stigma o One key person from Vanuatu sent to undertake a one-year diploma in India on MH law and human rights; intention is to send at least one person each year; the cost of this training is being sourced outside of the PIMHnet budget o Provided materials very early on in the project to organisations in the region to use with mental health survivors

Objectives	*Years 1 & 2*	*Progress*
	KEY ACTIVITIES	Overarching activities
2. The profile of mental health as a key health issue within countries & region is raised Communication process to engage in discussion on key issues	**Year 1** • F/W discussion + scope – awareness raising • NFC appointment by governments • In-country network • Need for Communication & Framework for network identified by countries **Year 2** • F/W established and approved • In-country funding given for communications & in-country activities: Logo, slogan, T shirts, Mental Health Day resources • Assistance provided to NFC: drafting papers, co-ordinate, liaison • Annual meeting: work plan, teleconferences, newsletter	**Raising the profile of MH:** ○ PIC Health Minister's Meetings (HMM): ➢ 2003 March (Samoa) – PIMHnet on agenda; result: identified need for the network; ➢ 2006 May (Auckland) – to develop implementation plan for PIMHnet, followed by pre-PIMHnet meeting ○ In 2006 ran a logo slogan competition – money put up for in-country competitions from Year 1 PIMHnet budget ○ PIMHnet framework development and ratified by PIMHnet members at the inaugural PIMHnet meeting in Apia, Samoa June 2007. • **Support for in country communications** ○ Countries were offered funding to support them in building own in-country team – to have meetings, venues, fax machines, etc ○ Communication a big issue; often unreliable; communications strategy identified for each country; PIMHnet has identified country one-on-one strategies (email, mail, phone); • **broader communications and publicity about PIMHnet:** ○ Submission to AusAID on its draft Disability Strategy ○ Interviews with Pacific ABC ○ developed talking points for individual to do radio interviews, ○ youth awareness week – managed to get MH as part of that and picked up by ABC in Australia; ○ assisted countries to get articles into their local papers; ○ Assist with writing briefings for Ministers ○ Publications currently in press for Pacific Dialogue (a peer refereed health research journal) on MH and PIMHnet ○ Presentations to World Federation of Mental Health, the World Psychiatric Association, World Congress for Mental Health – all Oceania
3. Public policy & legislative development in mental health that is reflective of international guidelines & human rights	**Year 1** • Awareness raising • Needs identified **Year 2** • Policy workshop - initial policy work	• In 2005-06 identified common issues – advocacy, workforce, legislation, policy, pharmaceuticals • Did Situational Analysis on policy, legislation, human rights for each country first • 2006 June Samoa PIMHnet meeting – focus on development of policy • The work is ongoing in each country with technical support from WHO and PIMHnet Facilitator • Have used the WHO guidelines into which are built guidance on the issue of full consent • In country budgets there was no dedicated budget for advocacy so it was neglected; with this budget countries are able to engage in advocacy activities
4. Increased skill & knowledge of workforce that interfaces & cares for people with mental illness	**Year 1** • Identification of problem **Year 2** • Human Resource (workforce) - plan & needs analysis • Plans 2/11 begin • Mental health Information & Resource kit scoped	• **Workforce planning** ○ Situational Analysis done, and ongoing, will be further developed in each country working on own workforce plan; includes identification of problems ○ Developed a template to collect workforce information – various versions developed to improve understanding and assist countries to complete workforce analysis ○ The Fiji 2008 PIMHnet Annual Meeting used identified needs of the countries; the workshop was on the workforce development ○ This work is ongoing • **MH Information & Resource kit** ○ Information kit/package developed, exceedingly knowledge-intensive of every major category of illness/disorder at 2 levels: nurse level, and others (police, lay people, NGOs); addresses de-stigmatisation;

Objectives	*Years 1 & 2*	*Progress*
	KEY ACTIVITIES	Overarching activities
		○ feedback from 2nd PIMHnet Annual Meeting in Fiji was that it was useful; ○ written in simple terms
5. Greater lobbying and strategic influence with organisations involved in key mental health issues	**Year 1** **Year 2** • Establish collaborative/strategic partners • Database established (ongoing) • NGO meeting held	• **Strategic Partners:** ○ Recognizing that NGOS play an important role in relation to MH, NGOs aren't necessarily doing the things needed or using international best practice – identify NGOs in the PI countries, bring them together – ○ PIMHnet developed a list of significant NGOs, and facilitated a meeting of Pacific Island NGOs and collaborative partners in February 2008 in Wellington NZ and invited the NZ NGOs in, together with regional NGOs e.g. WONCA, Royal Australian and NZ College of Psychiatrists, World Federation of Mental Health, World Fellowship for Schizophrenia and Allied Disorders ○ Important outcome – letting the NGOS know that PIMHnet exists; ○ some in-country NGOs have now joined the in-county network, ○ WONCA has indicated a commitment to cover the cost of supporting Vanuatu for implementation of a training plan; process is such that NGOs respond to countries needs, not the other way round – brokering role of PIMHnet to ensure this is the process ○ Database of potential collaborative partners is developed and will be added to as more NGOs and other organisations ask to join ○ There are a number of networks trying to link in: the Human Resource Pacific Alliance (based in WHO in Suva office, PIMHnet in contact with them to work out how to make sure parallel processes are not set up), Healthy Schools ○ Another – disability network – part of PIMHnet workplan for 2009 – focus on HR development, advocacy, including PIMHnet into the major networks
6. Sustained change and support	**Year 1** • Establishing & identification of support for NFC • Funding for in-country support provided **Year 2** • NFC support & advice provided • 5 new countries entered • Identification of Regional Projects & future donors	• Providing continuing support to the NFCs • Network has grown from initial member countries (American Samoa, Australia, Cook Islands, Fiji, Kiribati, New Zealand, Niue, Papua New Guinea, Samoa, Tonga, Tokelau, Vanuatu) and now includes the following: • Solomon Islands (joined 2008) • Palau, Marshall Islands, Commonwealth of the Northern Mariana Islands, Nauru, Micronesia (joined 2007)

ANNEX 10: PIMHNET MONITORING SCHEDULE

Objective	Stakeholders	Indicators
Assist countries to improve mental health outcomes in countries i.e. improve services, reduce stigmatisation, improve human rights of those suffering from mental illness	All PIMHNet member countries. Government agencies and NGOs concerned with mental health. Funders and service providers. People with mental health needs and their families.	**Improved services** • Health services identifying and delivering treatment for mental disorders, and promoting self care • More community-based services identifying and delivering treatment for mental disorders, and promoting self care • Good practice guidelines / protocols available and in use. • Budget allocation for mental health services **Reduced stigma** • More organisations active on mental health issues • More people seeking help **Improved human rights** • Mental health legislation and policies that reflect human rights. • Services that provide for treatment in the least restrictive environment.
Reduce unnecessary duplication and fragmentation of activities in the region, and maximise the opportunities to work together on mental health issues	All PIMHNet member countries. Government agencies and NGOs concerned with mental health. People with mental health needs and their families.	**Reduce duplication/fragmentation** • Evidence of collaborative approach through PIMHNet and agreements/MOU at country level. • NGOs and development organisations in established partnerships to forward PIMHnet goals **Maximise opportunities** • Member countries taking opportunities to co-ordinate activities. • Collaborative projects (including sharing of information, technical collaboration) under way between member countries.
Encourage more co-operation and collaboration	All PIMHNet member countries	• Member countries fully informed of and able to be involved in activities. • Collaborative projects funded, facilitated and under way.
Build sustainability, capacity and capability through	All PIMHNet member countries.	**Stronger workforce** • Training/guidance developed and implemented, to

strengthening the workforce and in-country and regional infrastructure	Government agencies and NGOs concerned with mental health. People with mental health needs and their families.	build strengths in current workforce, • Strategies to build workforce, including sustainable mentoring and supervision system in place **Stronger infrastructure** • New/better relationships in-country and regionally. • More complete range of services in-country and regionally.
Deliver on Millennium Development Goals through greater mental health contribution Note: These goals are far-reaching and difficult to measure. Therefore, this objective can best be described as an 'aspirational objective'.	All PIMHnet member countries. Governments, their agencies and NGOs concerned with mental health. People with mental health needs and their families.	Identifiable contribution to all UN Millennium Goals, but particularly goals: 3: Promote gender equality & empower women 4: Reduce child mortality 5: Improve maternal health 6: Combat HIV/AIDS, malaria and other diseases

ANNEX 11: SUMMARY OF ACTIVITIES AND FINANCIALS

PACIFIC ISLANDS MENTAL HEALTH NETWORK – SUMMARY OF ACTIVITIES FOR EACH OF THE YEARS 2005/06, 2006/07, 2007/08 and FINANCIALS

Activity	2005/06	2006/07	2007/08
The profile of mental health as a key health issue within countries and regions is raised	a. Scoping meeting in Tonga with 12 countries to discuss how to progress the network as a result of the Pacific Health Ministers Meeting in 2005 –countries were consulted on drafts of framework document which will describe how PIMHnet is to be operationalised including principles of how we would work, role of WHO, vision and objectives. This was then sent to National Focal Contacts (NFCs) for further consultation. b. Secretariat (2005) and Facilitator (2006) established c. Logo and slogan competition with PIMHnet countries for use on PIMHnet posters, stationery and future website.	a. Four countries in addition to the original 12 PIMHnet countries join the network (American Samoa, Commonwealth of the Northern Mariana Islands, Marshall Islands and Palau) b. Official launch of PIMHnet during a special session of the Meeting of Pacific Island Health Ministers in Vanuatu on 14 March 07. It was attended by Pacific Island Ministers, the WHO Regional Director, WHO Secretariat, PIMHnet Facilitator as well as invited speakers. All PIMHnet NFC were assisted in briefing their Minister prior to the event. It was the first time a mental health consumer was invited to speak at PIMHnet	a. First inaugural meeting of PIMHnet in June 2007, Apia, Samoa to discuss operational matters and develop and agree on a programme of work for PIMHnet for 2007/08. The inaugural meeting was attended by the 16 PIMHnet member countries, WHO Secretariat and PIMHnet Facilitator. b. New member countries actively engaged in PIMHnet (Palau, Commonwealth of the Northern Mariana Islands, Marshall Islands, American Samoa). Technical support is being provided to these countries to undertake core PIMHnet work c. Solomon Islands request to join the network
Communication process to engage in discussion on	d. Draft of initial communication strategy for PIMHnet members –	c. Establishment and endorsement of PIMHnet framework by PIMHnet	d. Major website for PIMHnet has been established which provides the background to

Activity	2005/06	2006/07	2007/08
key issues	including the development of a newsletter, teleconferences, communication protocols for individual countries and promotional materials for PIMHnet	countries. The framework describes the main objectives of PIMHnet, its management and organisational framework, how it operates and its priority areas of work. This involved meetings and consultation with the 16 PIMHnet countries. d. Ongoing communication with PIMHnet members to collect information, support country work around the PIMHnet priorities and keep country members informed of PIMHnet activities and progress. Communication is happening on a daily/weekly basis with many countries. Regular newsletters are being created and disseminated electronically.	PIMHnet, descriptions of its major aims and objectives, its launch in Vanuatu, other major meetings as well as profiles of PIMHnet member countries. Work on this website is ongoing.
Improved awareness of human rights and decreased stigmatisation	e. Providing support to NFC and assistance with in-country support networks. NFC provided with direct support including briefing materials for their governments on mental health issues in the Pacific. Countries were provided with initial funding to support the development of their in-	e. Drafting of materials to assist in briefing ministers and wider mental health community. f. Countries assisted to access resource materials, eg journals g. PIMHnet T-shirts and caps provided to all PIMHnet member countries. These were provided in bulk and were used by various in-	e. Network becoming engaged with wider Pacific groups, presentations and discussions to establish common interest in raising profile of mental health and assistance in addressing need for human rights and stigma. Groups included – other WHO collaborative centres in mental health; centres for rural mental

Activity	2005/06	2006/07	2007/08
	country network and ability to communicate with the network. Countries provided with WHO guidance packages to assist them in awareness activities within their own governments and networks.	country network groups to profile mental health awareness at mental health day activities and other similar events	health (Australia); World Federation of Mental Health, World Psychiatric Association, US Peace Corp, Foundation for the Peoples of the South Pacific etc
Public policy and legislative development in mental health that is reflective of international guidelines and human rights	h. Policy workshop planned for mid 2006 was postponed due to country unrest in Tonga until April 07 in combination with the Inaugural PIMHnet meeting	h. Mental health policy and planning workshop in June 07 to provide PIMHnet member countries with information and training on mental health policy and plan development and to formulate strategies for regional cooperation in promoting mental health policy reform i. WHO Guideline Packages and training resources provided to enable each NFC to have basic tools to commence policy work in country. Facilitator contacted regularly to provide phone or email support. j. In country support provided – for example, Fiji visited by Facilitator and assistance given in relation to policy development. Fiji currently developing suicide policy.	f. Support to policy and planning for mental health – direct country assistance has been provided on an individual basis to countries to support them develop their own mental health policies and plans. This involves travelling to countries, reviewing policies and plans, providing comments, discussing comments with country focal points and helping with the revisions. Workshops have been held in Vanuatu and Kiribati to help facilitate stakeholder meetings around the policy and plan and to work with the drafting committees.
Increased skill and	i. Identification with network	k. Comprehensive Information	g. Institutions / organisations

Activity	2005/06	2006/07	2007/08
knowledge of workforce that interfaces and cares for people with mental illness	members of their needs. This was the beginning stages of what was needed to go into a workplan for PIMHnet and the development of human resource planning for mental health.	Package on Mental Health for Pacific Island Countries developed which provides best practice treatment guidelines for mental health treatment, care and support. Development of the package has involved the background research of regional materials, technical writing, consultations as well as the establishment of a working party made up of PIMHnet members to review and provide regular input on the document. l. Human resource development – plans being developed for each PIMHnet country. The first stage has been to carry out a detailed situational analysis followed by specific human resource development plan for training and supporting workers. The training plan includes concrete actions and timeframes.	with specific expertise for training primary health care workers have been contacted in order to negotiate on the ground training and mentoring of primary health care workers in PIMHnet countries h. Human resource development – human resource development plans are still being progressed for each Pacific Island country. The first stage has been to carry out a detailed situational analysis, followed by a specific human resource development plan for training and supporting health workers. Countries are now developing their training plan, which includes concrete actions and timeframes. These plans will form the basis of requests for assistance with collaborative partners.
Greater lobbying and strategic influence with organisations involved in key mental health		m. Development of a database with organisations that may become future collaborative partners n. Contracts made, presentations given to NGO groups in Australia, New	l. Building of alliances between NGO groups in the Pacific Island countries and PIMHnet has been a core focus of PIMHnet work. NGOs and other strategic partners involved in providing

Activity	2005/06	2006/07	2007/08
issues		Zealand and Asia in relation to the network by the Secretariat and Facilitator	mental health or related services in Pacific Island countries have been identified and entered into a database of NGOs which now includes key focal points, contact details, priority areas of work, and potential areas of contribution to mental health and PIMHnet. j. PIMHnet facilitated a forum of Pacific Island NGOs and international organisations in February 2008 to discuss how these organisations could collaborate on mental health in the region and contribute to the work of PIMHnet. An action plan was developed which outlined key activities each organisation considered it could contribute to k. Meeting with other WHO Pacific Island networks on Health Promotion in Schools – the Facilitator attended and presented PIMHnet at a Brisbane meeting in August 2007 and is now engaged in wider network.
Sustained change and support		o. Ongoing activities to explore additional potential donors and prepare funding proposals to enhance the	l. Identification of regional projects and future donors. A review of all donors has occurred, analysis of process

Activity	2005/06	2006/07	2007/08
		sustainability of the Pacific Islands Mental Health Network	of application has also occurred. m. Contact has been made with International Mining Companies who work in the Pacific by writing, phone and face to face meetings n. Nursing project proposal developed with NFCs and submitted for consideration to AusAID, however declined due to Disability Strategy currently under development. In discussions with NFC in Australia and AusAID over this priority proposal o. Pharmaceutical project currently being scoped.

ANNEX 12: PIMHNET FRAMEWORK DOCUMENT OUTLINE

1. BACKGROUND

2. ESTABLISHMENT OF THE PACIFIC ISLANDS MENTAL HEALTH NETWORK (PIMHNET)

   2.1 Vision

   2.2 Mission

   2.3 Objectives

   2.4 Membership

   2.5 Guiding Principles

   2.6 Structure and Organisation

      2.6.1 National Focal Contacts

      2.6.2 In-Country Mental Health Networks

      2.6.3 WHO Secretariat

      2.6.4 Network Facilitator

      2.6.5 Strategic Partners

   2.7 Operating Principles

      2.7.1 Communication

      2.7.2 Decision Making