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let's end mental health discrimination

Conversations change lives

Global anti-stigma toolkit

“When I keep quiet, stigma wins, and I can’t let that happen.”

Edwin, Kenya

Before I was diagnosed with depression, anxiety and severe ADHD, I was quite oblivious to mental health issues. Since then, I have gained a much deeper insight on how society views and deals with these issues. I have also come to realise how my words effect the way people interact with me, and how they view me as a person. Words are powerful. Which is why I have said publicly, “when I keep quiet, stigma wins – and I can’t let that happen”.

Stigma is something I have had to deal with on an almost daily basis – especially in the workplace. Over time, you learn to deal with it, but the scars stay with you. They act as a reminder that the stigma attached to mental illness is real.

I would say the biggest drivers of stigma in my country are a lack of awareness / information and harmful stereotypes. In Kenya, common misconceptions include ideas that people with mental health issues cannot recover, that people with mental health issues are violent, that we are incompetent and that we are to blame for our illness.

There are many negative economic and social ramifications attached to having mental health conditions – which can serve to further add to the stigma.

I am naturally a very vocal person. Before becoming a Champion with this global anti-stigma programme, I had spoken out about mental health on social media and I had also taken part in mental health advocacy. However, now, I am part of a group of Champions who are challenging stigma on mental health issues. It feels like being in a big family that understands you – during bad times and good.

> **“Stigma is something I have had to deal with on an almost daily basis."**

What is even more encouraging is the knowledge that in other countries the same thing is happening. I had the chance to meet with Champions from Ghana, India, Nigeria and Uganda. This event in my home city of Nairobi brought together five different cultures and languages, but the most inspiring thing was that we all found a common language, the language of anti-stigma.

This language knows no race, religion, gender, creed, or political allegiance. This common drive to end mental health stigma, bound us together as Champions and friends. We are moving forwards together to change the world.

For everyone reading this toolkit, I hope you can share this common language too. I think one thing we all need to embrace is that learning never stops. Amazing work is happening around the world to end mental health stigma.

Exchanging ideas and sharing the challenges faced in different countries will make all our work stronger.

The one thing I would love everyone reading this to know is this: Stigma hates conversations that challenge its' existence. So, let us start having raw and candid conversations about mental health conditions and the stigma we are facing.

When we all start to do this, we will see a world where people with mental health problems are treated as human beings.

Edwin, Basic Needs Basic Rights Kenya

"Sharing the challenges faced in different countries will make all our work stronger."

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Introducing the global anti-stigma toolkit

"The experience of mental illness… the burden to the individual is enough already. For the community to make this even harder is total injustice. We need to change our beliefs. We need to change our thinking."

Martha, Champion, Ghana

Globally, too many people face discrimination, exclusion and other restrictions on their human rights because of their mental health problems.

As well as restrictions in accessing quality and affordable mental health care where it is needed, many people are excluded by families, friends, communities, employers and schools.

Such exclusion restricts their right to education, work and employment, amongst other things.

Additionally, many people experience exploitation and abuse, violence, inhumane treatment and even torture, because they have a mental health problem.

Stigma is a major cause of this wide-scale discrimination and it keeps people with mental health problems shut out from their communities.

"I want to share my experience because I believe it's going to help me heal myself and others. I want to be a trailblazer for people struggling in silence to get help."

Allan, Champion, Uganda

Mental health problems know no boundaries; nor does discrimination. They affect people of all ages, all income groups and all cultures.

That is why in 2018, we launched Time to Change Global – a programme which challenges mental health stigma and discrimination in Ghana, Nigeria, Kenya, Uganda and India.

The programme is a partnership between UK mental health charities Mind and Rethink Mental Illness, international disability and development organisation CBM and five country-level partners: Mental Health Society of Ghana (MEHSOG), Grameena Abyudaya Seva Samsthe (GASS), Gede Foundation, Basic Needs Basic Rights Kenya (BNBR) and Mental Health Uganda.

"I had a relapse at the prayer camp, and I was tied like a sheep. They tied my legs together, like a pig or an animal at a butcher to be carried home."

Bernard, Champion, Ghana

In these five countries and around the world, the drivers and underlying causes of stigma and discrimination can be linked to:

- Damaging stereotypes, cultural norms and practices
- Limited knowledge of mental health issues, fueled by harmful myths and negative attitudes and behaviours
- Lack of understanding of the value people with mental health problems bring to all areas of society and respect for their human rights
- Insufficient focus, resources and support for people with experience of mental health problems to effectively challenge stigma and discrimination and lead change.

All of these issues are compounded by weak legal frameworks that do not sufficiently protect individuals rights (and in some cases may reinforce harmful stereotyping), and by insufficient resource provision for mental health services and support.

Using the toolkit

> **"Speaking up about mental health is the surest way to end the stigma and create more safe spaces for anyone going through a hard time."**
>
> Sandra, Champion, Kenya

While mental health stigma may be present in almost every community around the world, the realities of stigma and the related discrimination look very different for each individual – based on who they are, their experiences and on the community and context in which they are living.

In this toolkit, we want to capture a snapshot of what stigma looks like in the five programme locations – Accra in Ghana, Doddaballapur in India, Abuja in Nigeria, Nairobi in Kenya and Kampala in Uganda. This toolkit is also a way for us to share some of the tools, materials, ideas and approaches that are helping to tackle stigma in those locations and elsewhere – both within the mental health space and beyond.

This toolkit is rooted in the voices of people taking action to end mental health stigma and discrimination.

The voices of people who know only too well what stigma and discrimination looks like – because they face it every day. We hope you will be inspired by their words, their stories and the work they are doing.

We know there is no one-size-fits-all approach to tackling stigma and discrimination. The toolkit is not here to present a 'right way' to take on anti-stigma work – instead, we hope it will help you to consider different approaches and new solutions. You will be able to explore some of the emerging evidence gathered from the pilot programme. We hope the toolkit will help you to put people with lived experience at the heart of your work.

The toolkit covers four areas:

1. What stigma and discrimination looks like in the five pilot locations
2. How to talk about mental health
3. How to include people with lived experience
4. How to identify and reach the right audience(s)

Each section will share learning and reflection, tools and materials and case studies and examples from the five locations. The toolkit is an important way to share formal and informal evaluation data and lessons-learned throughout the pilot programme.

As we continue to update the toolkit, we will share examples from other organisations working to tackle stigma.

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What stigma and discrimination looks like... in Accra, Ghana

What mental health stigma looks like… in Accra, Ghana

> **"The stigma is everywhere. In this part of the world, when you have a psycho-social disability, the respect given to you diminishes. For a long time now, when I see my family and I open my mouth to speak, everybody turns their face in the opposite direction. They don't want to listen to me."**
>
> Bernard, Champion, Mental Health Society of Ghana

The World Health Organisation (WHO) estimates that of the 21.6 million people living in Ghana, 650,000 are suffering from a severe mental disorder and a further 2,166,000 are suffering from a moderate to mild mental disorder. Further data from the Mental Health Authority of Ghana shows that 1 in 5 Ghanaians experiences a mental heath problem.

Read the WHO country profile for Ghana to find out more about mental health in the country.

Mental Health Society of Ghana (MEHSOG) is working in partnership with Time to Change Global and CBM to help end mental health stigma and discrimination in Accra.

Mental Health Society of Ghana (MEHSOG) is a grassroots association for people with personal experience of mental health issues and their care-givers. They work with like-minded organisations and with the Government of Ghana to advocate for mental health.

Since March 2019, MEHSOG has supported a group of 20 people with personal experience of mental health problems to plan and run events to engage the public, change perceptions and get more people talking openly about mental health. Events have taken place in local markets, shopping malls, lorry stations, universities and other community spaces across Greater Accra.

Through personal interaction and conversation these 20 'Champions' are helping to change attitudes and stop mental health stigma.

Alongside these events, in September 2019, the #ItCouldBeYou campaign was launched in Accra, aimed at a target audience aged 18-34. The adverts featuring the voices and stories of some of the Champions, reached 630,000 people in Accra via Facebook. This online activity was supported by radio and outdoor ads. You can find out more about this and the other 'social marketing' campaigns delivered as part of the pilot programme in the toolkit section, 'How to identify and reach your audience.'

Public perceptions of mental health in Accra, Ghana

To build understanding of each context and to inform the messaging of the social marketing campaigns in Ghana, Nigeria, Kenya, Uganda and India, qualitative research was commissioned. This research provides a snapshot of public perceptions of mental health problems.

Four focus group discussions took place in Accra in May 2019. This research by Consumer Insights Consult Africa showed that the public's knowledge of mental health problems was minimal. It was mostly associated with violence, drug/alcohol abuse and spiritual possession.

> **"If a family member has a mental illness, people will not even want to marry from your home"**

Spontaneously people in these focus groups associated mental illness with "madness" and brain dysfunction. The discussions highlighted other harmful stereotypes and misconceptions – and highlighted how these beliefs can ultimately lead to people with mental health problems facing barriers to employment, family, education and other basic rights.

> **"Mad people are not supposed to appear in public… we don't see them as humans"**

As well as highlighting misconceptions, stereotypes and harmful beliefs, the focus groups highlighted potential tactics and approaches for tackling stigma by building empathy and improving knowledge in Accra.

Most focus group participants recognised the need to show love and support to people in their lives living with a mental health problem.

They believe living with, continuing a relationship with, or working with someone with a mental health problems is possible since they are responsible for showing love and support to help aid their recovery.

> **"In Africa we are brought up in a way that we should care for each other… so you see such a person you will feel for them."**

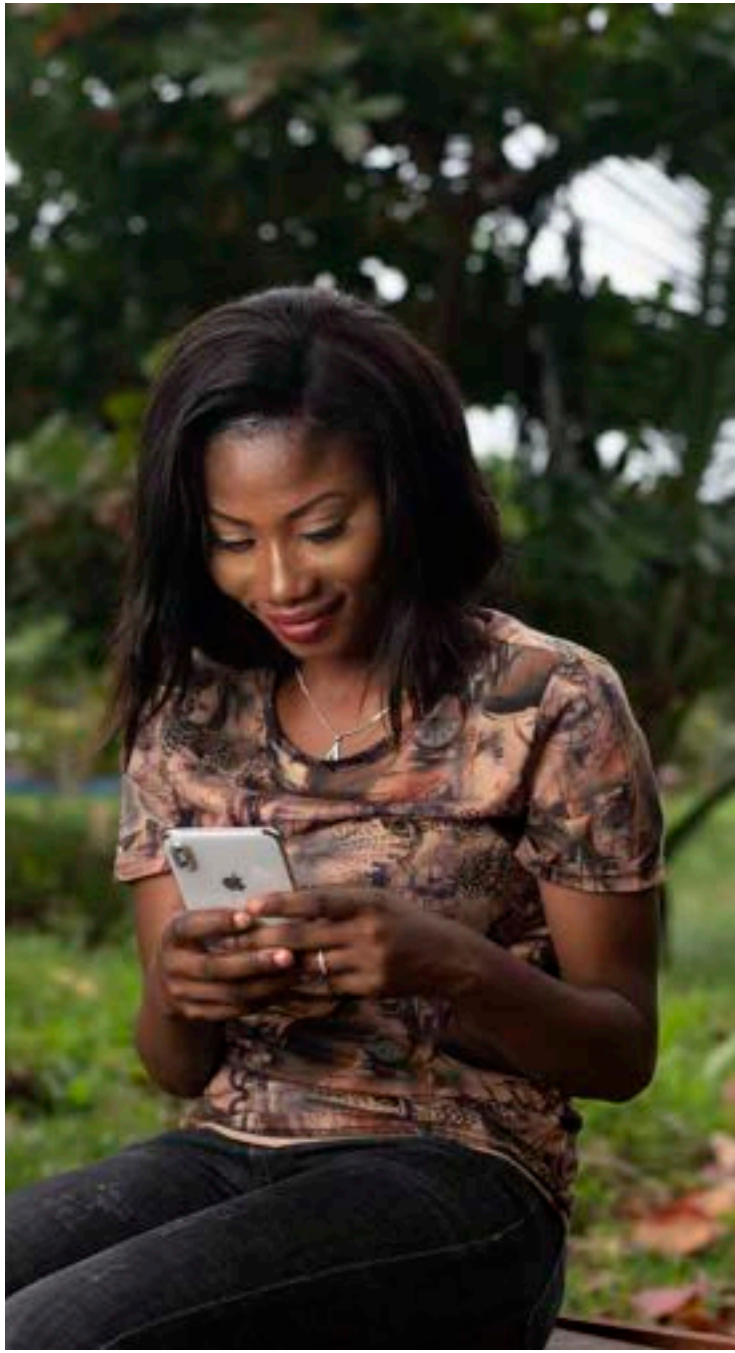
> **"You know sometimes what comes to my mind is that what if it were to be me? It can happen to anybody sometimes it not their doing."**

Empathy and strong family ties were other key factors in Accra which the research showed could help influence positive behaviour towards people with mental health problems.

As well as focus group research in each country, in Ghana and Kenya further quantitative research was carried out to benchmark levels of knowledge, attitude and intended behaviour regarding those with experience of mental health problems. In Accra, 500 adults were surveyed face-to-face using a questionnaire. Read the full baseline report for Ghana.

Key findings from the baseline report:

- 78% agree there is a need to adopt a far more tolerant attitude toward people with mental illness in our society.
- However, there is a judgmental attitude attached to the tolerance. About 60% think mental illness comes from a lack of self-discipline and will power. As a result, 26% agree people with mental illness don't deserve sympathy.
- 46% hold the idea that people with mental health problems represent far less of a danger than most people suppose. However, the fear and stigma can be shown in the 42% agreeing that people with mental health problems should not be given responsibility.
- Close to 80% agreed that mental health problems can spring from a curse.
- More than half believe that mental illness is genetic.
- Over 50% believe in the use of medication to recover from a mental health problem. 85% agree that psychotherapy can be also an effective treatment for people with mental illness and 86% would advise a friend to get professional help.
- 7 out of every 10 agree that treatment can bring a full recovery.



Martha's story

Martha was unable to graduate from High School after first experiencing mental illness aged 15.

With support from the Mental Health Society of Ghana (MEHSOG), she is now a passionate advocate for people with mental health problems. As a Champion with the Time to Change Global programme, she is showing people there is hope for anyone living with mental illness.

"When you experience mental illness, people should give you support and encourage you. Instead, they see everything like it's your fault."

"I was first diagnosed with a mental health problem in my second semester in High School. Soon after, I was admitted to Accra Psychiatric Hospital for about six months."

"My mother was my only hero. She stood by me through thick and thin. She never let go of me. She never failed to say, "we will pass through this". She was the only source of light in a dark tunnel."

"With my siblings, friends and neighbours, the story was different. Everyone made derogatory comments about me. The things they said made me not want to be in this world anymore. Today, I realise people treated me this way because of ignorance."

"In Ghana we have some social myths and beliefs about certain problems. People try to attach spirituality and certain forms of bad omen and aura to mental health problems."

"The experience of mental illness, the burden to the individual is enough already. For the community to make this even harder is total injustice. We need to change our beliefs. We need to change our thinking. We have to realise things happen and it's no one's fault."

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What stigma and discrimination looks like... in Doddaballapur, India

What mental health stigma looks like… in Doddaballapur, India

> **"Whatever we say, people don't listen to us, because of the stigma."**
>
> Champion, GASS

> **"Everybody stays away from you if you have a mental health problem."**
>
> Champion, GASS

According to the latest National Mental Health Survey of India, around 15 per cent of the adult population currently require support for one or more mental health problems. That amounts to approximately 150 million people. This survey recognises that a systematic understanding of their prevalence, disease burden, and risk factors is not readily available for each state of India.

Read the WHO country profile for India to find out more about mental health in the country.

Grameena Abyudaya Seva Samsthe (GASS) are working in partnership with Time to Change Global and CBM to help end mental health stigma and discrimination in Doddaballapur, a rural town near Bangalore in Southern India.

GASS is an organisation offering community-based rehabilitation and development for people with disabilities and all marginalised groups including women and children. GASS want to see a world where all marginalised groups are empowered to have equal opportunities, equal access to justice and equal ability to enjoy their human rights. Through all their work, they ensure the people they support can fully participate in society and lead a quality life.

Since March 2019, GASS has supported a group of 20 people with personal experience of mental health problems to plan and run events to engage the public and get more people talking about mental health.

Events have taken place in rural villages and towns around Doddaballapur. GASS have brought people in these communities together in creative ways - including through community tea parties and by inviting local dancers and actors to perform. Through personal interaction and conversation after these performances, the 20 'Champions' are helping to change attitudes and stop mental health stigma.

Public perceptions of mental health in Doddaballapur, India

To inform our work in each of the five countries, we carried out focus group discussions with members of the public. This research gives a useful snapshot of public perceptions.

Unlike the four African countries, where the pilot projects took place in capital cities, in India, the project was implemented in rural villages around Doddaballapur. It is important to consider how this rural context – and other cultural or geographical factors may influence public perceptions – especially in comparison to the four other pilot areas.

Alongside four focus group discussions, research agency Kantar also conducted four in-depth interviews with individuals that had proximity to someone with lived experience of a mental health problem – either their family member, friend or colleague having direct experience of mental health problems.

This approach was used as it became apparent in the Doddaballapur context that due to stigma, respondents were unlikely to open up in a group discussion with others.

The research showed that mental wellness and stress-free living were seen as important and were understood to be linked to better physical health, healthier relationships, good education and a better ability to fulfil family and job roles.

When it comes specifically to "mental health problems" however, knowledge was low with limited understanding of the range of conditions and experiences people might face. Understanding of symptoms was limited to perceptions of 'normal behaviour' versus 'abnormal behaviour'.

The research also showed surface level knowledge of different types of mental health conditions and their symptoms, with most mental health issues described as 'depression'.

Mental health problems were understood to be caused by external factors such as stress related to work, children, property and finances, drastic incidents or an accident. Demon possession was also considered a cause of mental health problems. The research revealed other negative perceptions and stereotypes towards those diagnosed with a mental health condition. People were described as:

- Unreliable, unstable and erratic
- Having broken away from societal norms
- Unkempt with no sense of personal hygiene
- Avoided and excluded
- Not having worthwhile opinions.

The research highlighted other widely held beliefs and misconceptions – which lead to stigmatising attitudes and discriminatory behaviour. Full recovery from a mental health problem was not seen as possible. A person experiencing a mental health problem is deemed unfit to work or lead a normal life. They are not considered as a functioning part of society.

The research showed that the public believe mental health is an area of expertise for priests and shamans, rather than doctors and psychiatrists. They believe that a person experiencing a mental health problem is possessed and therefore to be feared.

"My grandmother never used to sleep and used to remove her clothes. Then we went to the temple and did a puja and she is alright now. She does her own work. I have seen it in my own home. There is medical science and also God's science."

Older Female

Accessing support from a doctor or psychiatrist, was seen to be highly shameful. Participants felt this would mean the condition was 'beyond repair' and therefore the individual would be labelled as inherently defective and abnormal. Another common belief was that mental health problems are genetically transferrable and contagious. This brings with it the idea that a person experiencing a mental health problem or any of his or her family member is not suitable for marriage. It was also felt that a person experiencing a mental health issue should not be allowed to mingle with others, especially children.

"In a situation like this people first go to God, then to black magic, if that doesn't work, then if someone says that there is an elderly person who looks into such things, they will take them there, even if that doesn't work, only then they go to doctors."

Younger Male

Despite very stigmatising and negative perceptions of mental health, the research also looked to understand how positive attitudes and behaviours could be promoted.

The focus group participants shared that strong family ties would ensure that families provide support for people with mental health problems. For many people, friends are also a valuable source of support – especially for young men who spend less time in their family home. For women, community is a vital support system – after marriage, many women will find solace in sharing their worries and concerns with other women from their community.

"We like to share things. By sharing and talking, solutions can be found. But if she keeps it within herself and thinks of committing a suicide, how will we be able to stop her?

Older Female

There is a strong sense of care and concern shown towards others living in their area. Finally, a respect for elders was seen as a key driver of empathy towards people with mental health problems.

Venkatesh's story

Venkatesh N. was living with his wife and three children in Doddaballapura when depression gradually began taking over his life. After his brother died, things took a turn for the worse and Venkatesh started to isolate himself, and eventually stopped going to work.

Now, as a Champion with Grameena Abyudaya Seva Samsthe (GASS), he has found creative ways to share his experience and get people in his community talking about mental health.

“I was getting older and losing strength, which added to my worries. Owing to my mental illness, I was struggling to find work.”

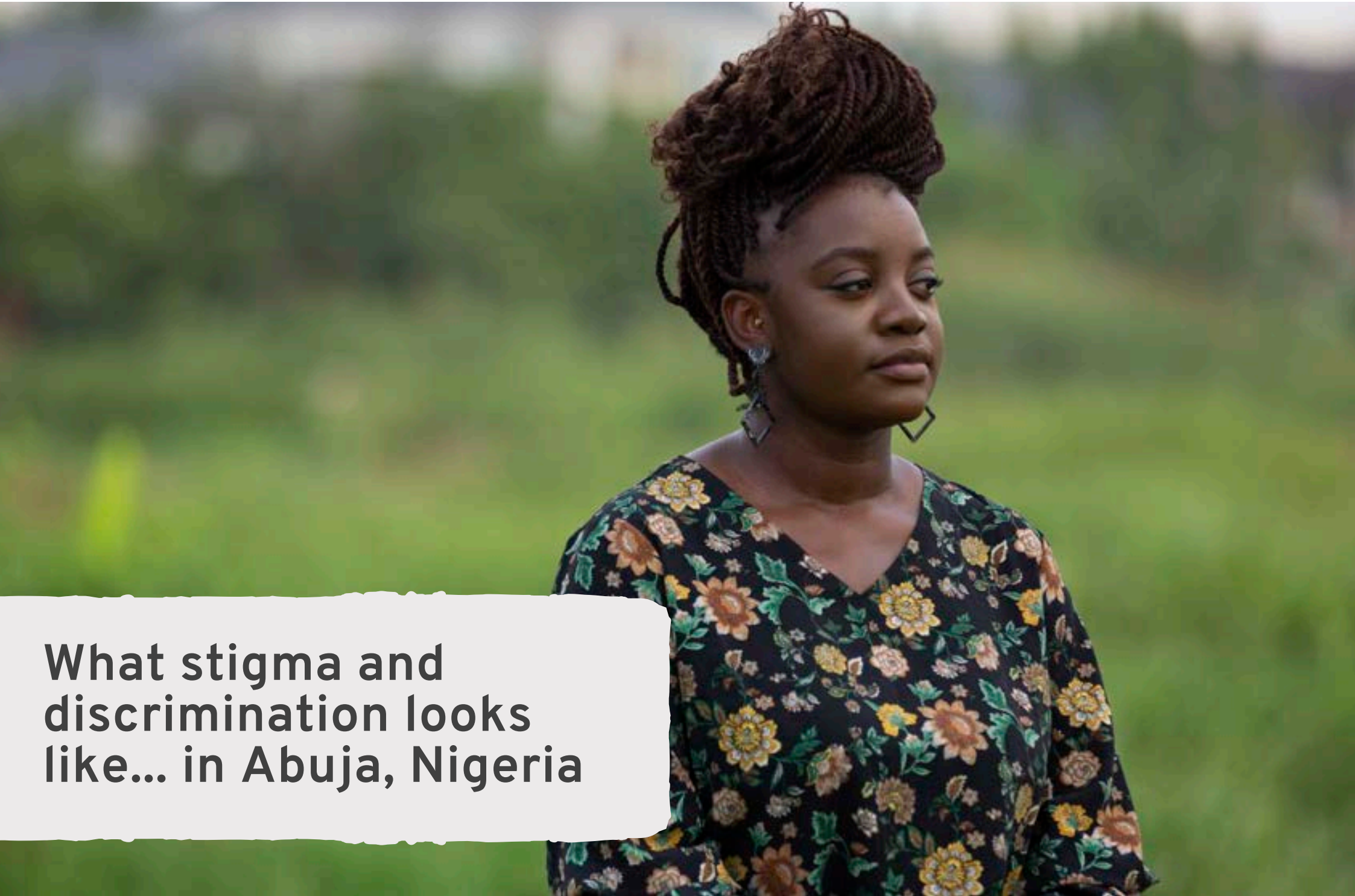
“Finally, when I got in touch with medical assistance, my life improved."

"I reached out to a local organisation called GASS (Grameena Abyudaya Seva Samsthe), a community-based rehabilitation service. "

"They helped me in raising my confidence, finding work, and leading a good life. I opened a shop and managed to educate my children well.”

“People’s reactions to my mental health problems have ranged from pity to apathy. But I don’t care what people think."

"I write and sing poems to express the things that I have been through, and to help people in my local community to talk about mental health.”



What stigma and discrimination looks like... in Abuja, Nigeria

What mental health stigma looks like… in Abuja, Nigeria

> **"I used to always ask myself, “what is wrong with me?”, “Am I demon possessed?”, “Do I need deliverance?” You’re just constantly asking these questions to yourself, because how do you explain these things to other people? I chose to keep it all in because I felt ashamed"**
>
> Tirnom, Champion, Gede Foundation

In Nigeria, it is estimated that around 30% of the population have a mental health condition. Mental health services are not readily available to the public and according to WHO data, people pay, mostly or entirely from their own pocket for services and medicines.

Read the WHO country profile for Nigeria to find out more about mental health in the country.

Gede Foundation are working in partnership with Time to Change Global and CBM to help end mental health stigma and discrimination in Abuja, the capital city of Nigeria.

Gede Foundation believe all members of all societies have the right to good health.

That is why they work with those who are impacted by underserved and stigmatised health burdens to achieve long term positive change. Their work specifically focuses on HIV-AIDS and mental health.

Since August 2019, Gede Foundation has supported 20 people with personal experience of mental health problems to plan and run events where they are sharing their stories to engage the public.

These 20 ‘Champions’ are helping to change attitudes and stop mental health stigma. Events have taken place across Abuja - in parks, at schools and a local arts and craft fair.

Alongside this Champion-led activity, in January 2020 the #ItCouldBeYou social marketing campaign was launched in Abuja, featuring the voices and stories of some of the Champions.

The campaign was aimed at residents of Abuja aged 18-34 years old. On Facebook alone, the campaign messaging reached nearly four million people. This was complemented by radio advertising and editorial content.

Public perceptions of mental health in Abuja, Nigeria

To build understanding of each context and to inform the messaging of the social marketing campaigns in Ghana, Nigeria, Kenya, Uganda and India, qualitative research was commissioned. This research provides a snapshot of public perceptions of mental health problems.

Four focus group discussions took place in Abuja in August 2019. This research, carried out by Consumer Insights Consult Africa showed how high levels of stigma are entrenched in society. It revealed low knowledge and understanding of mental health, with mental health problems strongly associated with violence, superstition and 'madness' or 'insanity'. The research showed religion played a key role in the lives of focus group participants, with some participants praying never to encounter mental illness in their families.

Overall, a majority of participants reported they would be willing to live with and continue a relationship with someone living with mental health problems if related by family ties – but they would choose to walk away from friends. The groups also felt people would not want to marry someone if they knew they had a mental health problem.

Participants showed very little support for the statement, 'I would be willing to work with someone with a mental health problem', this reaction was fueled by fears around their productivity levels.

The research shows perceptions of violence and stigma are the key drivers behind the fear surrounding mental health.

Participants were asked to consider factors that could help to drive sympathy towards people with mental health problems. It was felt that personal connection to the issue would be key to driving empathy. Similarly, increased understanding or better clarity around risk factors was seen as important.

> **"In Nigeria, if the person is someone you want to marry, even your family will tell you it will not work because madness runs in their family. Do you want to have mad children? You say no."**

> **"They should not be working, they should be on medication.. Working and mental problems don't go together."**

> **"We are all human and they were not born with it, it can happen to me so I will live with them to give them support."**

> **"They are not lazy, they are just having a problem."**

Kabati's story

As someone living with a mental health problem and HIV, Kabati has faced stigma and discrimination throughout her life.

After a mental health crisis in 2006, Kabati received financial support from Gede Foundation which allowed her to start her own business. Now she is speaking out with Gede Foundation to ensure her son can grow up in a world free from stigma, where everyone is treated equally.

“I have been treated very differently because of my mental health problem. I lost my business. I lost everything. I lost my comfortable accommodation. When people saw I was unwell, they started insulting me and calling me; ‘mad woman’."

"In Nigeria people think once you have a mental health problem, you must have done something bad. Or they assume you went to see a native doctor and the charms went bad for you. So, you are paying for your sins."

"People don’t realise mental health problems can be treated. The religious people will take you to a prayer house. Some of them will tie you, beat you, or even use chains."

"Nigeria is all about stigma. I was stigmatised because I was born out of wedlock. People stigmatise against mental health and they stigmatise against HIV. They stigmatise if you don’t have a legal marriage certificate. The stigma is all intertwined."

"I’m sharing my story so my child can have a better future. I want him to grow up in a world free from stigma."

"Every human being is important. We can all help to make the environment comfortable for each other. We all deserve equal treatment.”

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What stigma and discrimination looks like... in Nairobi, Kenya

What mental health stigma looks like… in Nairobi, Kenya

> **"For my generation, it was very difficult for us to talk about mental illness. Even today, if you go to your dad or your mum and say, "hey I'm depressed". They'll just laugh. As a society, we need to unlearn negative ways of thinking"**
>
> Charlene, Champion, Basic Needs Basic Rights Kenya

The 2011 Kenya National Commission of Human Rights report on the Mental Health System in Kenya estimated that up to 25% of outpatients and 40% of inpatients in health facilities in Kenya suffer from some form of mental health condition. The report also stated, "Legislation governing the mental health sector is outdated and narrowly focused on in-patient admission."

Read the WHO country profile for Kenya to find out more about mental health in the country.

Basic Needs Basic Rights Kenya (BNBR) are working in partnership with Time to Change Global and CBM to help end mental health stigma and discrimination in Nairobi, Kenya's capital city.

Basic Needs Basic Rights Kenya (BNBR) was founded in 2005 to support people with mental disorders, those at risk and their care-givers to live and work successfully in their communities. BNBR has a long history of developing proactive approaches to mental wellbeing, as well as delivering reactive mental health services to those in need.

Since August 2019, BNBR has supported a group of 20 people with personal experience of mental health problems to plan and run events to engage the public. Through personal interaction and conversations, these 'Champions' help change attitudes and challenge mental health stigma.

Events have taken place at conferences and exhibitions, in outdoor spaces like the Nairobi Arboretum and other community spaces across Nairobi.

Alongside these events, in January 2020, the #SpeakUp social marketing campaign was launched in Nairobi, featuring several Champions. The campaign was aimed at people aged 18-34. It reached 1.6m people across Facebook and Instagram alone (which equates to around 50% of all those aged 18-34 in Nairobi).

The campaign achieved engagement rates of nearly four times the Kenya benchmark. BNBR's Facebook fan base grew by 50% and hundreds of messages of support were received.

Public perceptions of mental health in Nairobi, Kenya

To build understanding of each context and to inform the messaging of the social marketing campaigns, qualitative research was commissioned. This research provides a snapshot of public perceptions of mental health problems.

Four focus group discussions took place in Nairobi in August 2019. This qualitative research showed a low level of knowledge about mental health among participants.

When asked to think about mental health, participants spontaneously leapt to an image of "the madman living on the street".

> **"Some of them are very much disturbing, some of them can even kill you. You are always afraid of them."**

Many expressed fear of those with mental health problems owing to a perception of violent and unpredictable tendencies, as well as from spiritual beliefs such as "being bewitched", "spiritual attacks" and "evil spirits".

The risk of social stigma by association was also highlighted as a barrier to engaging with someone with a mental health problem.

Depression and anxiety were the conditions referenced most often. Participants felt that both conditions were a possible result of economic development in the country.

While the majority of participants in the Nairobi focus groups claimed they would still live with someone that developed a mental health problem, the reason they gave for this was because they would "have no choice".

A significant number of younger respondents stated that they would cease their relationship with a partner if they developed a mental health problem – particularly if they were not yet married or were recently married.

Another reason given for rejection was the costs associated with treatment.

One difference between the Kenyan focus groups and those in Ghana and Nigeria was that living in the same neighborhood as someone with a mental health problem was seen as less of an issue. Kenyan participants also seemed more willing to work with colleagues with mental health problems.

There was consensus among participants that opening up about mental health problems was part of the healing process. Empathy was favoured over isolation.

> **"You can try to support them because if they are going through depression and you leave them it's a big stress to them. But being supportive to such a person is very important in their healing process."**

As well as focus group research in each country, in Kenya and Ghana further quantitative research was carried out to benchmark levels of knowledge, attitudes and intended behaviour regarding those with experience of mental health problems. In Nairobi, 500 adults were surveyed face-to-face using a questionnaire. Read the full baseline report from Nairobi.

Key findings from the baseline report:

- 44% of Kenyan survey respondents have experienced mental health problems either directly or through someone close to them.
- On average, 52% of the adult population in Nairobi wouldn't want people with mental health problems too close to them.
- Young people are generally more prone to discriminating against those with mental health problems. Young women in the sample were more discriminatory than the males.
- 80% of the adults surveyed in Nairobi acknowledge that people with mental illnesses deserve their sympathy.
- 7 in every 10 participants admit to currently not having a tolerant attitude towards people with mental illness in their society.
- Even with the high prevalence of discrimination against people with mental health problems, only 1 in 10 adults in the survey believe that being part of a normal community isn't the best therapy for many people with mental illness.
- More than other respondents, the older male generation hold traditional myths and beliefs regarding mental health problems as being "caused by a curse".

Brian's story

Brian faced stigma and discrimination from classmates and teachers due to his depression and self-harm.

As a Champion with Basic Needs Basic Rights Kenya, he wants to help demystify mental health and get people talking more.

“In high school, I didn’t know what was wrong with me. I was always depressed. I was self-harming. I made several suicide attempts."

"The other children at school started saying, ‘he’s in a cult’, or ‘he’s worshipping Satan’. I was listening to rock music, so they made those assumptions. They beat me up."

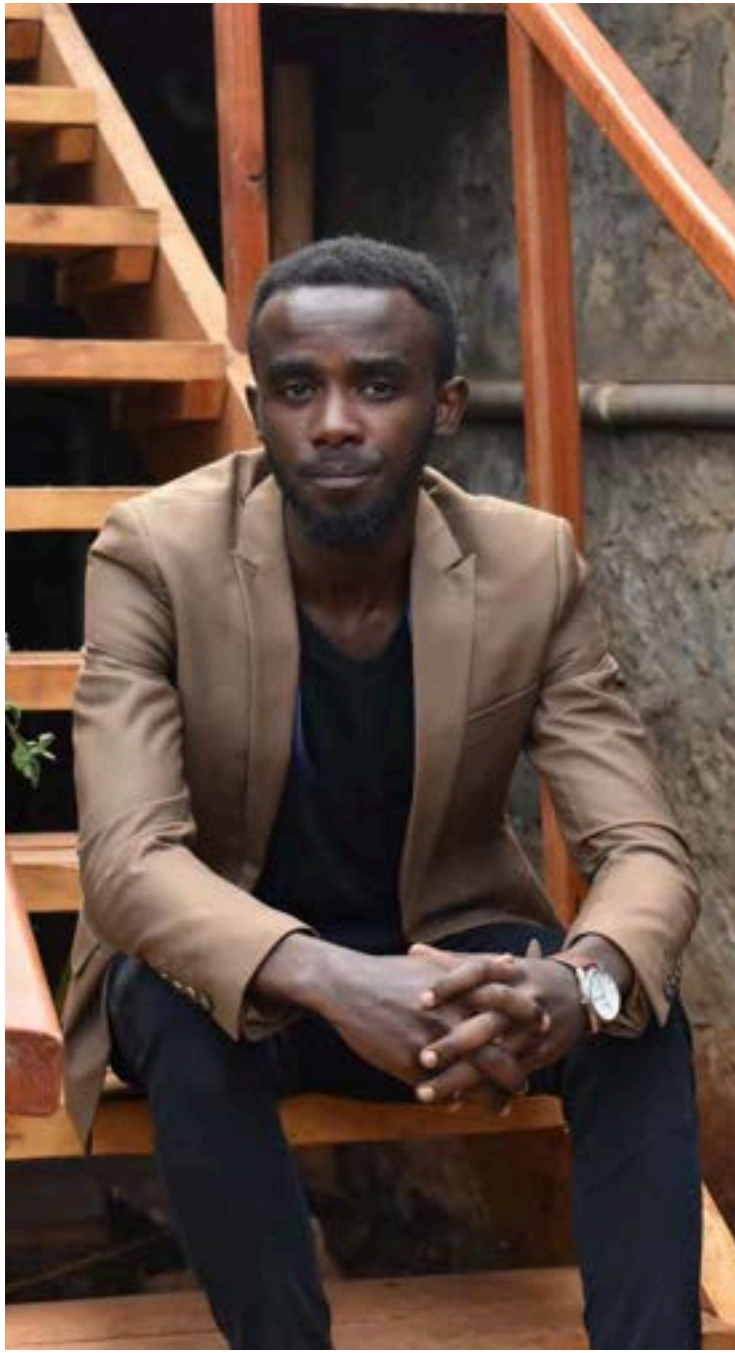
"There was a lot of stigma from the teachers too. The stigma is mostly due to ignorance. Those teachers called me a devil worshipper, they said I was possessed because they didn’t know about self-harm."

"The main challenge is information. People need to know what mental health actually is. We can create change by demystifying mental health. Generally, when you talk about mental health, people think about madness. That’s not the case."

"It doesn’t help that mental health is treated like a side show in Kenya. It only gets mentioned on our TV stations when an incident happens. It gets sensationalised."

"We need to change the whole conversation around mental health. People should be open minded to thinking when a person experiences mental illness, it’s not their fault."

"I think it’s about time people listened more. They should just take time and really understand.”



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What stigma and discrimination looks like... in Kampala, Uganda

What stigma looks like… in Kampala, Uganda

> **"The majority of Ugandans are of the opinion that mental illness is largely incurable or, at any rate, unresponsive to orthodox medical practices. People's attitudes towards mental illness are strongly influenced by traditional beliefs in supernatural causes and remedies."**
>
> Godfrey, Champion, Mental Health Uganda

Uganda passed a new Mental Health Act in 2018. Before this, the act dated back to 1964. According to the Ministry of Health, amongst a population of over 40 million people, the country has 33 psychiatrists, 259 psychiatric clinical officers and about 500 mental health staff in general nursing.

You can read more about mental health provision in Uganda in the World Health Organisation Mental Health ATLAS.

Mental Health Uganda are working in partnership with Time to Change Global and CBM to help end mental health stigma and discrimination in Kampala, Uganda's capital city.

Mental Health Uganda (MHU) was established in 1997 in response to the overwhelming marginalisation, isolation and abuse of rights of people with psycho-social disabilities, users of psychiatric services and their families.

As a Disabled People's Organisation, MHU seeks to create a unified voice that influences the provision of services and opportunities, in favour of people with personal experience of mental illness. They do this through capacity building, networking, advocacy and partnerships.

Since August 2019, Mental Health Uganda has supported a group of 20 people with lived experience of mental health problems to plan and run events to engage the public. These 20 'Champions' are helping to change attitudes and stop mental health stigma. Events have taken place in local markets and other community spaces across Kampala.

Alongside these events, in January 2020, the #Kyogereko social marketing campaign was launched featuring the voices and stories of some of the Champions. Kyogereko means, 'Speak Up' in Lugandan, Content was secured on popular youth TV and Radio, complemented by a social media campaign that reached 580,000 people aged 18-34 and generated over 210,000 engagements.

Public perceptions of mental health in Kampala, Uganda

To build understanding of each context and to inform the messaging of the social marketing campaigns in Ghana, Nigeria, Kenya, Uganda and India, qualitative research was commissioned. This research provides a snapshot of public perceptions of mental health problems.

This research gives a useful snapshot of public perceptions of mental health problems in each of the five countries.

Four focus group discussions were held in Kampala in September 2019. This research by Global Research Insights on behalf of Time to Change Global showed a lack of accurate information among the public when it comes to mental health.

The focus groups also highlighted commonly held beliefs among respondents, for example that mental health problems result in violence and that mental health problems occur a result of being bewitched.

> **"They may actually be dangerous especially when you have kids around."**

> **"If the experts determine the cause of their illness is not witchcraft, then it means they can be treated and I can live with them"**

Compared to some of the other countries, the Kampala focus group participants (and particularly the younger participants) showed a greater understanding of the nature of mental health and the range of mental health experiences. These groups also showed slightly higher levels of empathy and willingness to live and work with someone with a mental health problem.

> **"If you distance yourself from them you are definitely going to make them worse but if you are close to them they are most likely to recover from that state."**

> **"They are human and require our help. With love and care they can recover."**

Male participants in particular, spoke of a lack of “safe spaces” where they can speak openly about issues in their lives – including mental health problems. Women in the groups expressed that most social issues are resolved through social groups.

Another theme which emerged from the focus groups was concern about the financial burden of becoming responsible for care if living with someone with a mental health problem.

Christine's story

For Christine, stigma not only means isolation from friends and family – it is also a major barrier to accessing health services, medication and other support. This is why, as a Champion with Mental Health Uganda, she is taking action to end stigma and challenge harmful stereotypes and misconceptions.

“It’s not easy having a mental illness in Uganda, but what makes it worse is seeking help and facing stigma from the people who are meant to heal you. Friends say, “just because you have a mental health problem, you don’t have to be alone”. But in reality, they don’t offer to be with you every step of the way – and sometimes they don’t support you at all. One of the hardest things has been going for health visits alone."

"When it comes to mental illness, families do not bother to learn more about your illness so they can help you."

"In my country, someone diagnosed with a mental illness is seen very differently from someone hospitalised for a physical condition such as heart disease or a broken leg. Many people don’t understand that schizophrenia is an illness that can be treated like any other."

"Most people learn what they know about mental illness from the media. In Uganda, we are exposed to radio, television and newspaper accounts that present people with mental illness as violent, criminal, dangerous, comical, incompetent and fundamentally 'different'. These images perpetuate negative stereotypes. This leads to the rejection, marginalisation and neglect of people with mental illnesses. There is a perception that it is a person’s own fault if they suffer from mental illness."

"The stigma towards mental health conditions – the negative stereotypes and harmful ideas also result in limited resources assigned to mental health in the health budget."

"When you do take steps to seek help, it creates further pain to be prescribed drugs that are always out of stock in the public health pharmacies. It is so hard to have a medical need that consumes 70% of your monthly earnings – because the medicines you need are not available for free or at an affordable price."

"I want other people experiencing mental health problems to know, even if you feel you are fighting this alone, don’t give up on yourself. Showing up for yourself and fighting will help you heal – and it will help end stigma too.”

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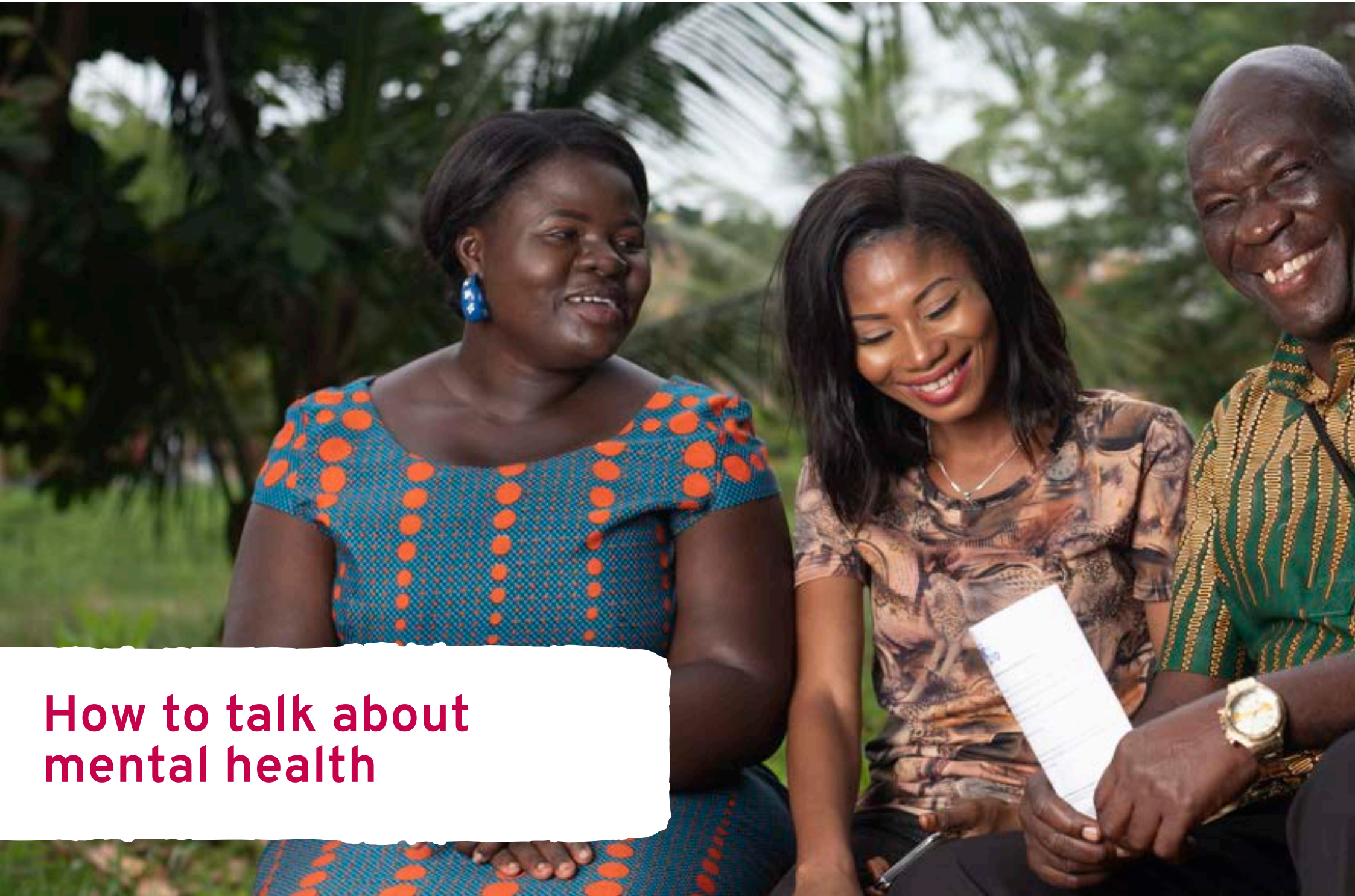

How to talk about mental health

"Mental health is still spoken about really badly in Kenya. We have a Swahili expression, ‘mwenda wazimu’, which means mad man or mad person."

Wairimu, Kenya

Why words matter when it comes to mental health

When it comes to tackling stigma and discrimination, words are powerful. How people talk about mental health matters. Language can exclude people with lived experience of mental health problems. Words can add to, or reinforce, stigmatising attitudes, stereotypes and harmful social norms.

However, language also has the power to inspire, include and empower people with lived experience of mental health problems.

As well as enabling inclusion, finding the right words and approaches is vital for engaging people in conversations about mental health. If we can find appropriate and accessible ways to talk about mental health, tailored to fit our audiences, we can challenge misconceptions and transform understanding and behaviour.

That is why people-focused stories are central to all elements of the Time to Change Global programme. We know the voices and stories of people with lived experience of mental health problems are incredibly powerful.

While language, terminology and communication methods may differ between the five locations, the focus on personal stories and Champion-led language cuts across the programme.

Our aim is not to suggest a ‘best way’ or a ‘right way’ to talk about mental health. What works well in rural Doddaballapur will be very different to what works in Kampala, for example.

We cannot simply translate and adopt existing materials from one context to use in another. Instead we need to ensure people with lived experience lead the development of the language to be used in any anti-stigma activities.

Whether at events, on social media, or through any other activity, it is essential people with lived experience can safely share their stories and experiences in the words that work best for them.

In this part of the toolkit, you can read about some of the creative approaches being taken in local communities to talk about mental health.

You can explore tools and suggestions from the five programme countries and you can find guidance on things to consider as you create and translate or adapt materials to address mental health stigma.

“The more we talk about it, the more we can reduce the stigma. The more people share their own stories, the more accepting people will be. When these stories hit close to home… then it will be easier for people to accept.”

Tirnom, Champion, Nigeria

Things to consider when we talk about mental health

In all the five locations of the pilot, Champions have repeatedly said conversations about mental health are uncommon, unwelcome, or they simply don't happen. Over 100 Champions with lived experience are speaking out in Ghana, India, Kenya, Nigeria and Uganda to change this.

Through regular community and other events, thousands of conversations with members of the public have been taking place.

Social marketing campaigns and other communications activity is also getting more and more people talking about mental health.

Through these activities, NGOs are building on their knowledge of what works well when it comes to talking about mental health in order to address stigma within local communities

This section will suggest some helpful things to consider when it comes to talking about mental health.

We want to share what is working well in the five pilot locations, as well as other helpful learning from the programme.

As we continue to update the anti-stigma toolkit, we will share further tips and guidance on how to talk about mental health, from the current programme and beyond.

1. Find language that works for people with lived experience of mental health

While it might seem obvious, a key part of finding inclusive language is simply to ask people with lived experience of mental health problems what works for them. When they explain their experiences to others, what words, phrases or descriptions do they find helpful?

As part of their training, Champions were invited to reflect on some of the words and phrases used by people in their communities that increase or reinforce stigma. For many, this was the first time they had come together with others with mental health problems to talk about their experiences. Creating a safe space to acknowledge stigmatising language and the words people use, can help people realise they are not alone. It also shows this language is not acceptable and can lead to discrimination.

While it is helpful to get an understanding of stigmatising words and how they make us feel, we have found it incredibly important to also think about positive words and descriptions, identifying empowering language we can use when it comes to mental health.

In fact, this part of the Champion training was adapted to put a greater focus on positive words.

In pairs, Champions wrote down one stigmatising word and then ripped up the paper to symbolise that these words are not okay. Champions then wrote down a positive word instead – these positive words were pinned onto a board for the whole group to see.

> **"I started to see I could accept myself – and maybe see myself as having bipolar powers... these apparent flaws can be a strength."**
>
> Abena, Programme Coordinator, Ghana

Basic Needs Basic Rights: Positive words hub

At our social contact events, we use something we call a "positive words hub". We ask the people we are having conversations with to think of something positive they could say to a person who is having a tough time. They then write it down and we encourage them to remember the same words for themselves if they ever need to.

2. Consider creative approaches to get people talking about mental health where these conversations might be uncommon

To help build knowledge and awareness of mental health, in communities where such conversations are rare or taboo, it can be helpful to find creative ways to describe and explain personal experiences of mental health problems.

In this part of the toolkit, we are sharing some of the creative approaches used across the five countries in talking about mental health.

Champions and other programme staff told us what works for them:

"People sharing their own lived experience and life experiences has been so important."

"We don't use 'NGO language', mental health terms or medical definitions. Instead, we explain how we feel, how we act and react."

"It is really important to define and explain using simple terms."

"When we're deciding on what language to use, we think about the age group and the words that are appropriate to them. Formal language often works best for older audiences. But for younger people, a mix of English and Pidgin can be really effective."

"Using real life examples – what it's like for someone with mental health problems waking up, sleeping, eating, socialising. It helps people understand these things can be difficult for people with lived experience."

"Poems, short stories, one of our Champions has played the flute."

"Performing arts and role-plays have helped us to explain the issues in our community."

"Using illustrations or photos has been really helpful. Especially when the photos show people with mental health problems being active."

"Avoid using too much formal English – people like materials and conversations to happen in a mix of local language and English.

3. Ensure you have time and resources to properly translate and adapt activities and materials.

Training with Champions was delivered in five very different contexts. Within each group of 20 champions, individuals came from different communities, speaking different languages and with different levels of education.

In many languages there are limited words when it comes to talking about mental health – and often no words at all to describe specific mental health diagnoses.

The training delivered in each of the pilot locations was translated into an agreed local language. All PowerPoint slides were delivered in the agreed language and in English. Training was delivered by programme staff alongside a professional interpreter. Despite working with translators and interpreters, it was a challenge to describe different mental health conditions, symptoms or experiences in languages where direct translations were not available.

Things to consider:

- Ensure there is enough time to agree key terminology with interpreters in advance – it may take time to find the right words to describe a condition or generally talk about mental health in accessible, clear language
- Limit the number of words you use – images and symbols can be a helpful way to explain mental health – as we adapted our training materials we made sure to use fewer words
- Make sure to budget properly for any translation you will need – and remember that translation of materials takes time
- Adapt your language for your audience – in contexts where a national language is used alongside local languages, consider which would be most appropriate for the audience you are trying to reach.

> **"For older generations, there is still be an expectation formal materials are produced in English. For younger audiences, a mix is best. Pidgin could be a great way to explain mental health to people."**
>
> Champion, Ghana

> **"We speak about 'the state of one's mind' because 'mental health problems' can be mistaken for headaches in some languages."**
>
> Champion, NIgeria

> **"Indian languages hardly even have terms to express mental health. There are not terms to express words like depression, anxiety or bipolar disorder."**
>
> Sanchana, India

4. Think about the power of visuals when it comes to mental health. Alongside the words we use to talk about mental health, imagery also has power -either to reinforce stigma, or to challenge and change how people think about mental health.

All too often, the same types of images are used to illustrate and explain mental health. People are shown alone, looking sad, often with their head in their hands.

Images like this can reinforce stereotypes and create a one-dimensional idea of people with lived experience of mental health problems.

Whatever materials you are creating, consider how the imagery you use could help you to change perceptions, challenge stereotypes and reduce mental health stigma.

Brand guidelines have been developed for the Time to Change Global programme, which include the following guidance on the use of photography:

- Wherever possible use photography featuring real people in real settings. People with mental illness are ordinary people from all backgrounds and communities. Photography should reflect this. It is important to ensure images represent the diversity of our communities.
- We recommend photography is bright, colourful, engaging and real, capturing real-life moments in a positive way.
- This programme is based on bringing people together. Images should bring this to life by showing people in conversation in everyday scenarios.
- Avoid using images which could reinforce stigmatising ideas and assumptions about mental health.

Useful tools and materials

Throughout the pilot, each NGO has thought about the language that will work best to engage people in their local communities.

We want to share some of the tools that have been developed, along with materials and examples which have helped partners to talk about mental health in their communities.

We also want to share tools and materials from beyond the programme – from other organisations taking action to end stigma. As we refine and update this toolkit, we will add more case studies from other initiatives.

Here are some of the phrases, words and slogans teams across the five countries have found most helpful when talking to the public about mental health stigma:

Ways to describe mental health	"In India, we use the metaphor of a peacock to represent and explain mental health when we talk to local people."
	"In Nigeria, malaria is given as an example of a physical health condition – the comparison is made to mental health to show that physical and mental health issues should be treated with the same levels of concern."
Successful slogans	"Kyogereko" or "Speak Up" – people like that we are using a slogan in our local language, Luganda (Uganda)
	"It could be you / Be more kind" (Nigeria and Ghana)
	"Mental health problems can be treated" / "Recovery is possible"
	"Mental health problems are not a sign of weakness"
Conversation starters	"In Nigeria, asking "How far?" is a great conversation starter."
	"In Ghana, our audience respond well when we use slang – so we open conversations with the phrase, What's up, Chale?"
	"Mambo ni different kwa ground" – In Kenya, the Champions have also found using slang or a mix of English and local language is a good way to engage younger audiences.

Finding creative ways to talk about mental health in Doddaballapur

In 1963, the peacock was declared the National Bird of India because of its rich religious and legendary involvement in Indian traditions. There were many reasons for this choice – the bird is well-distributed within the country and is recognisable to everyone.

At GASS, we use the symbol of the peacock to help explain the role of our incredible Champions. Peacocks attract others through their gorgeous courtship dance and colourful feathers. Like peacocks, our Champions attract people to take part in bright, colourful social contact events.

As the feathers of the peacock have many different colours, our Champions have different skills and experiences to attract and engage the wider community.

Because they are a part of the communities where they are speaking out, Champions are recognised by everybody through their good work to help end stigma and discrimination.

Mythri, Programme Coordinator, India

This section of the toolkit will help me to talk about mental health

- Agree
- Not sure
- Disagree

See results

Over the coming months we will be adding further case studies on ‘how to talk about mental health’.

Email us at global@time-to-change.org.uk if you’d like to share any examples from your own work.

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How to include people with lived experience

"People with lived experience of mental illness are essential when it comes to challenging stigma and de-mystifying mental health in the community. Those who have suffered from mental illness understand it best. We provide important testimony for the community."

Godfrey, Champion, Uganda

Why inclusion matters when it comes to mental health

With incredible passion, energy and dedication, a group of 111 'Champions' – people with lived experience of mental health problems – are helping to end stigma in Ghana, India, Nigeria, Kenya and Uganda.

They are making a difference in their local communities and beyond. They are sharing stories and speaking out to drive change. They are challenging negative stereotypes and misconceptions and changing how people think and act when it comes to mental health.

Inclusion is essential when it comes to tackling mental health stigma. It is not a 'nice to have' or an addition – but a right. The UN Convention on the Rights of Persons with Disabilities states that people with mental health problems have a right to meaningfully participate and be involved in all areas of society on an equal basis as those without experience of mental health problems.

People with lived experience are important advocates for change. Their voices can help others to understand mental health.

Their experiences and stories help bring the challenges and rights violations, facing people with mental health problems to life. They have a vital role to play in finding solutions to overcome these challenges.

By influencing policies, processes and other initiatives designed to address mental health they can help people with lived experience to be treated more fairly and to be more fully included in society.

Through our anti-stigma work, we must create environments which allow people with lived experience to meaningfully participate and engage in decision making and other processes that affect their lives.

That is why the programme has encouraged people with lived experience, across partners and locations, to take on Champion and staff roles to shape programme design and delivery.

There is no perfect way to build inclusion into your work. In this section of the toolkit, we want to present some key considerations that can help to ensure the effective inclusion of people with mental health problems. You can read some of the challenges, learnings and approaches from across the five pilot locations along with helpful tools and materials from the programme and elsewhere. By ensuring the inclusion of people with lived experience we can drive fair, equitable and sustainable change for all.

"Having contact with people who have gone through similar experiences and who have survived - who are still persevering and succeeding in life – it shows me I am capable. I can succeed."

Charlene, Champion, Kenya

Things to consider when it comes to inclusion

Inclusion is essential – but it does not happen overnight.

To deliver a successful pilot programme all partners delivered training and provided ongoing, tailored support, in order to ensure activities are designed and delivered by people with lived experience of mental health problems.

We have adapted and updated our approaches throughout the two-year programme to embed this.

Through ongoing learning, we have found better ways of working and of incorporating new ideas when it comes to including people with lived experience.

Here are some helpful things to consider when it comes to inclusion, as well as complimentary learning from across the five pilot locations.

As we continue to update the anti-stigma toolkit, we will share further guidance from this pilot programme and beyond.

1. Ensure people with lived experience are appropriately engaged and supported

- **Ensure inclusion for all**

Your activity should be open to participants irrespective of race, gender, religious belief, disability, sexual orientation or identity, age, socio-economic background, literacy level or any other characteristic or status. In the context of engaging people with lived experience in anti-stigma work, this means ensuring opportunities to participate are open to all with mental health problems.

Those responsible for engaging / recruiting people with lived experience should have a clear understanding of possible barriers to inclusion and take measures to address these. For example, by reaching out to participants using a variety of different channels and accessible formats. In the pilot programme, Champions were largely recruited through existing mental health and disabled persons networks and via social media platforms.

- **Clearly define and communicate roles and responsibilities**

People with lived experience must understand their own role in anti-stigma work. This enables them to choose how they would like to participate and helps to manage expectations. In the pilot programme the main responsibilities of a Champion were shared within a role profile, which also detailed expected commitment. For example, Champions were invited to participate in a voluntary capacity, in part to ensure that they were sharing their stories safely.

- **Support people with lived experience to understand, assess and manage risk**

Speaking out about our own mental health carries risk, particularly in contexts where mental health is not well understood, and where harmful social and cultural norms and practices exist. People with lived experience engaged in anti-stigma work must be supported to understand the potential risks, so they can make an informed decision about choosing to speak out.

It is important to ensure you have safeguarding policies and processes in place, and that everyone involved is aware of these and agrees to adhere to them. It is also vital that people with lived experience with whom you are working know where to get support if they need it.

Take a look at the consent form developed for Champions sharing their words and image as part of the programme.

- **Offer ongoing training and support**

Remember the importance of training and ongoing support for people with lived experience, to ensure they are equipped with the knowledge, skills and confidence they need to participate in, and sustain anti-stigma work.

Take time to understand the strengths and skills of the people you are working with and find ways to utilise these skills. This can help challenge negative perceptions.

How we did it:
In this programme, set up of the pilot projects involved training for Project Coordinators – a staff member within each NGO who work to support the group of Champions. After this, the Coordinators were supported to deliver two days of training to the Champions – to start to build their knowledge of mental health and their confidence to safely speak out and share their stories. The Project Coordinators continued to support the Champions to run events that provided a platform for them to share their stories and further build their confidence.

2. Project planning - lay the foundations for effective inclusion

Effective inclusion takes time and resources. When developing anti-stigma projects, it is important to consider all aspects of your project and how you will ensure people with lived experience can be meaningfully involved. Here are some important steps to consider:

- **Budget properly**

Provision for people with lived experience to be meaningfully involved in the planning, delivery, monitoring and evaluation of your work. Consider how and when people with lived experience will be involved in project tasks and ensure, where appropriate, that their time and expertise is compensated.

- **Collaborate and coordinate with other organisations**

Where relevant and viable, for the provision of services and equipment that may help promote inclusion.

- **Draw on existing learning and expertise**

Use the knowledge and technical expertise of other organisations with proven experience of working with and promoting inclusion of different groups. This expertise could come from beyond the mental health sector – what could you learn from organisations working with other highly stigmatised groups?

- **Ensure everyone is clear on the value of inclusion**

It might seem like a given, but it is important to ensure everyone involved in your anti-stigma work - whether that is project staff, people with lived experience or key stakeholders - are supported to understand basic rights and the importance and value of inclusion. Project staff should be mindful not to make assumptions about what is prohibiting or limiting the inclusion of people with lived experience.

3. Involve people with lived experience in identifying barriers and finding solutions

There are many barriers to inclusion for people with lived experience of mental health problems. While some similarities might be seen across countries and contexts – there will be unique challenges and barriers in every community and for every individual. To ensure inclusion, we need to first identify the barriers people are facing.

Asking people with lived experience what barriers they face and for solutions to address these is essential. It can be helpful to provide examples in accessible language to help illustrate different types of barriers. For example, barriers can be physical (no ramp access for wheelchair users; no provision made for people with visual and/or hearing impairments) or be financial (someone may be unable to meet the cost of getting to a workshop) or due to people's attitudes (someone doesn't think they have the skills to participate).

Identifying barriers and solutions will help inform the design of anti-stigma interventions and ensure the right people are targeted. It is useful to think about who can help promote inclusion as well as which groups might be creating barriers to inclusion.

We asked Champions and staff from MEHSOG, GASS, Gede Foundation, BNBR and Mental Health Uganda to consider some of the key barriers when it comes to inclusion of people with lived experience.

On the next page, you can take a look at some of their responses, grouped under the key topic areas raised.

Knowledge and awareness	“There is a lack of education and awareness when it comes to mental health” “Negative perceptions and attitudes”
Cultural and other beliefs	“Cultural and religious bias and beliefs – often there is an assumption or insinuation that religion is an alternative to mental health treatments.” “People are forced to go through traditional healing.”
Family and the wider community	“We can be excluded from family functions” “Stigma is a major barrier. People with mental health problems are ostracised. Some people are hidden in homes.” “Perception of limited capacity and value in family, community etc.”
Policy and legal frameworks	“Language used in legislation is discriminatory (e.g. imbecile)” “Legal provision – people with mental health problems cannot vote or be elected” “Government does not prioritise mental health (some ministers even laugh about the issue)” “There is not enough budget.”

As well as looking at barriers, programme teams were asked to think about solutions – ways to build inclusion for people with lived experience:

"We need public education on mental health - for family members, employers and religious institutions"

"Mainstream mental health services in all health facilities to remove stigma associated with “special” facilities"

"Need to build up the confidence of people with mental health problems – so they can speak up and claim their rights"

"Awareness campaigns should also be done in religious venues."

"We need to strengthen organisation of people with lived experience and lobby to make sure they can be a part of decision-making structures and conversations"

"Better mental health policies and proper implementation – as well as proper budget allocation"

"We need to see interventions that target rural areas"

"Awareness raising needs to start as early as kindergarten"

"Peer support – mental health groups."

4. Find ways to bring groups of people with lived experience together

One of the biggest strengths of this pilot programme has been bringing people together from different communities – with a shared goal of ending mental health stigma.

In each of the five projects Champions are a mix of genders, ages, faiths and backgrounds – they have different experiences – both of mental health problems and in all areas of their lives.

In communities where people with lived experience of mental health problems often face exclusion and many barriers to realising their rights, there is huge power and potential in bringing people together.

To ensure these groups have the right support and tools to work together, here are four helpful steps to consider:

1. It is important to establish boundaries within the group. A group agreement will help you to set out clear expectations for the group and for each other.

2. A group is made up of diverse individuals who need different conditions to thrive and be their best. Consider how you can maximise the strengths and skills of different members of the group. In each of the programme locations Champions have taken on different roles and responsibilities which reflect their skills – some help to plan and run events, others might lead on social media promotion, whilst others have been sharing skills such as singing and poetry to engage the public.

3. In establishing a peer group of people with lived experience, they should be supported to develop messaging, content and materials based on their experience and insights.

4. It is important to consider the mental health of the group. People with mental health problems could experience a relapse or other challenges during the programme. We would recommend putting steps in place at the start of your activity to help people with lived experience to consider how they would like to be supported if they are struggling with their mental health.

> **"When I heard about becoming a Champion, I was like, “Yep. Totally in. 100%!” Finally, I can meet with other people like me and hear their stories."**

Tirnom, Champion, Nigeria

Useful tools and materials

Throughout the pilot programme we have developed tools and training materials to foster greater inclusion of people with lived experience in all that we do.

We want to share some of these materials as well as helpful examples from beyond the pilot programme – from varied organisations taking action against stigma – both in the field of mental health and other areas.

Helping individuals and groups of people with lived experience to thrive

Within the pilot programme Champions said they would like further support in thinking about how to work and succeed as a group of people with lived experience, and how to identify and use strengths within the group. Over the next few pages we're sharing an activity which was designed in response.

The activity aims to encourage participants to reflect on how they can thrive as individuals and as a group of people with lived experience, in order to achieve the broader programme goals.

The activity also supports participants to develop their skills and confidence and to map individual strengths within their peer group.

When delivering this activity with people with lived experience and key project staff, remember to carefully consider how each participant could impact the comfort, safety and dynamic of the activity.

Session plan: Thriving as an individual

Introduction (10 mins):
Clarify understanding of the term 'thriving' and collectively agree a new term if needed - What do we mean by the word thriving? (e.g. to prosper, flourish, grow, develop, be successful)

Explain: *Thriving as individuals - Anti-stigma programmes are founded on the passion, skills and commitment of several individuals. For the programme to thrive, we need to support every individual within our programme to thrive.*

Individual reflection activity (15 mins):
Invite participants to reflect on what supports them to thrive as individuals, capturing their reflections through drawing or words on individual puzzle pieces, as they feel most comfortable. Prompt participants to consider, "What does thriving look like to you?" (e.g. I thrive when… I am given the opportunity to participate and make decisions… I am listened to…My mental wellbeing is supported etc.).

Sharing back to the group (20 mins):
Invite individuals to share back with the wider group, about what they included on their puzzle piece. They can present the information using creative methods of their choosing, such as acting or poetry.

Conclusion (5 mins):
Invite participants to reflect on what they have learnt / will take from the session. It is important to recognise that every individual is different and we all need different things to 'thrive'. We all have different experiences, skills and knowledge - our programme must find ways to support and celebrate these differences.

Session plan: Thriving as a group

Group reflection activity (25 mins):
Invite participants to find their corresponding puzzle pieces and form groups. In these groups, encourage them to first reflect on what supports each person within the group to thrive. Then invite participants to select a couple of these points and consider how these needs can be met and how individuals within the group of Champions can be supported to thrive.

Example: Someone shares, "I thrive when I am given the opportunity to participate and make decisions." You could consider this point in the group by discussing, "how can you ensure that you are giving all members of your Champion group the opportunity to participate and make decisions?" There are many ways, but one example could be ensuring that you share responsibility for the organisation of events across different individuals.

Here are some of the ideas that our Champions came up with during this activity:

- Saying Thank you
- Celebrating Champions' work
- Supporting the wellbeing of our teams
- Involve all Champions in decision making – distribute roles to reflect people's skills
- Set clear roles and responsibilities – ensure everyone understands and is happy with their role
- Peer support – finding ways to support each other and our Coordinator e.g. buddy system

Sharing back to the group (10 mins):
Invite each group to share feedback with wider group.

How we are supporting people with lived experience to share their story

Even when people with lived experience have made the decision that they are ready to share their stories publicly, they should be appropriately supported to speak out safely. Ahead of sharing their story, people with lived experience should be encouraged to consider:

- The possible risks associated with speaking out. It is vital that people with lived experience are given the time and space to consider these risks so that they can make an informed choice about speaking out.
- How much of their story they wish to share. This will help them to feel prepared and minimise the risk of them sharing more than they feel comfortable with during a conversation. Champions should be encouraged to take time away from, or stop speaking out, if they do not feel comfortable.
- How they will manage possible negative reactions or indifference to their story, whether this is shared online or in person. Sometimes the most difficult conversations can be the most powerful. In preparing to share their stories, it can be helpful to invite people with lived experience to reflect on how they will measure success.
- How they will manage challenging conversations, for example with members of the public or with journalists. Our Champions found it helpful to practice responding to difficult conversations through role play.
- How they will take care of their mental wellbeing. Even with the provision of appropriate support, people with lived experience may find speaking out for the first time quite overwhelming. This can be the case, whether their experience of sharing their story is positive or negative. It is therefore important to check-in with people after they have spoken out and ensure that they know where to go for support if they need it. As a group of people with lived experience, it can also be helpful to encourage the sharing of self-care strategies among peers

Considering stigma beyond the mental health space

No one is just a ‘person with lived experience of mental health problems’. This is not the only characteristic that defines us. Our age, gender, race, religion, sexuality, disability and many other factors can also create barriers to inclusion.

Gede Foundation work with those who suffer from underserved and stigmatized health burdens to achieve long term positive change. For over a decade, they ran one of Nigeria’s first one-stop clinics for people living with HIV-AIDS – a condition which has faced huge levels of stigma. In 2013, they expanded their work to look at the links between HIV-AIDs and mental illness.

> **"People stigmatise against mental health and they stigmatise against HIV. The stigma is all intertwined."**
>
> Kabati, Champion, Nigeria

This section of the toolkit will help me champion the inclusion of people with lived experience

- Agree
- Not sure
- Disagree

See results

We spoke to Anita, a Champion with Gede Foundation about some of the barriers facing a young woman affected by HIV.

In your experience, what are some of the barriers to the inclusion of people living with HIV - and in particular for women and girls?

"Self-stigma as well as societal stigma can mean that some people might be afraid that someone they know might see them in a hospital. The age of consent is a big obstacle in Nigeria. If you are below 18, you cannot go for family planning, safe abortion, distribution and usage of condoms, cervical and breast cancer services. Religion can also be a huge barrier. As far as adolescents and young women are concerned, having sex is a sin and there is a lot of shame attached to it."

"Marriage is also a barrier, especially in the northern parts of Nigeria. This is because the wife needs the man's consent to visit a hospital. Other harmful practices such as child marriage make it harder for people to access their rights – to security, social justice and to make decisions. Domestic violence or fear of domestic violence are other big challenges for young women affected by HIV."

"The cost of treatment is another huge barrier. Some drug regiments that are very expensive. Lastly, a lack of compassion from healthcare workers is an obstacle to inclusion."

What can be done to address some of these obstacles and to enhance inclusion?

"Education is important – not just for women and girls, but for adolescent and young boys too – everyone needs to understand these issues."

"We need to see advocacy around policy change on the age of consent. For instance, at the last review of this policy, adolescents and young people were not included in most of the interventions. Consistent advocacy will help push things forward. And then of course, we need more funding to go into adolescent and young people's HIV programming."

time to change global
let's end mental health discrimination

How to identify and reach the right audiences

"There is hope. Change is happening. More people are opening up about mental health..."

Brian, Champion, Kenya

Why personal stories are essential for tackling stigma

When people with lived experience of mental health problems speak out and share their stories, incredible things happen. Their voices can inspire and persuade. They can smash stereotypes, challenge misconceptions and change attitudes and behaviours.

Speaking out can also be hugely empowering and a confidence booster for people with lived experience.

As we saw in the toolkit section 'How to talk about mental health', personal stories are central to the Time to Change Global programme. This is true whether activities are happening face to face in local communities, online, or through campaigns to a wider audience.

These personal stories need to be shared with the right people. In the toolkit section, 'How to include people with lived experience in our work we looked at the importance of understanding barriers to inclusion.

This can help us identify who it is that we should be talking to and what messages they need to hear.

The pilot programme has focused on two main strategies for engaging the public in order to reduce mental health stigma:

1. Reaching the public at one to one level: Social contact

This part of the programme involved the 111 Champions in Ghana, India, Nigeria, Kenya and Uganda sharing their personal experiences of mental health problems through conversations with people in their local communities. This activity mainly takes place via events planned and delivered by the Champions. You can find out more about social contact as you explore this section of the toolkit.

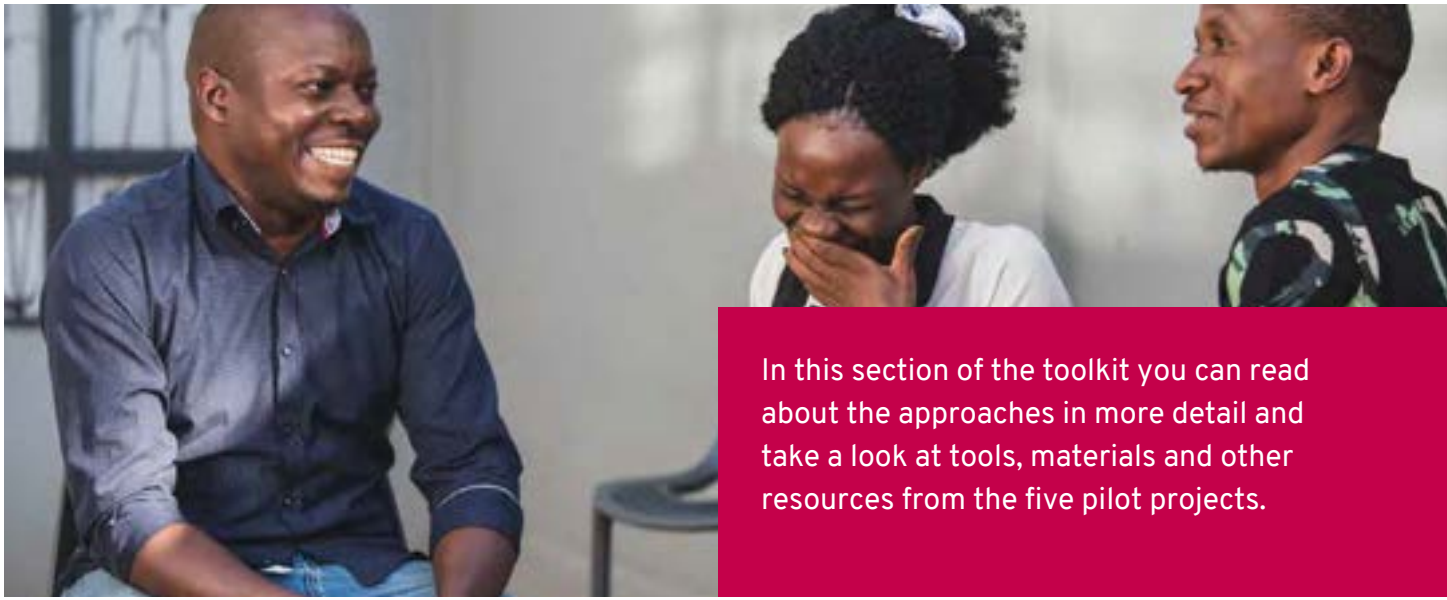
2. Reaching the public at a wider scale: Social marketing

This part of the programme saw the development of four marketing campaigns in Ghana, Nigeria, Kenya and Uganda. These campaigns have used the story-telling core of social contact activities to reach a wider audience through paid media channels. You can find out more about social marketing as you explore this section of the toolkit.

These approaches compliment each other, to help increase public knowledge and awareness and to change attitudes. The social contact activity and social marketing campaigns are also supported by other activity – such as; stakeholder engagement, media engagement and creation and distribution of Information, Education and Communications (IEC) materials.

Whatever your budget and whether you plan to engage members of the public through one to one or wider scale activity, it is essential to consider your audience and the messages that will most effectively engage them.

We are not suggesting social contact and social marketing are the only effective strategies for tackling stigma. Instead, we want to share what has worked for us, offering helpful tools to consider and provide a starting point for thinking about how to most effectively identify and reach your audience.



In this section of the toolkit you can read about the approaches in more detail and take a look at tools, materials and other resources from the five pilot projects.

"I want to share my experience because I believe it's going to help me heal myself and others. I want to be the trailblazer for people struggling in silence to get help."

Nsubuga Allan, Champion, Uganda

How to reach the public at 1-2-1 level: Social contact

What is social contact?

In this pilot programme, we define social contact as a two-way conversation between a person with experience of a mental health problem and a person without experience of a mental health problem.

Within the conversation, the person with lived experience will share that they have experience of a mental health problem. These two-way conversations may be one-to-one or they can take place in small groups.

These conversations will help people without personal experience of mental health problems to better understand the issues facing those with lived experience, building their power of empathy and changing their behaviour towards those with personal experience.

This helps to reduce the stigma and discrimination towards people with mental health problems.

Things to consider when engaging the public through social contact

During the pilot programme we have reached more than 11,000 people through social contact activities across the five pilot locations.

Using this experience, we have put together key things to consider which we can support you to take a similar approach in your own environments.

1. Create opportunities for people with lived experience to participate in the design, organisation, monitoring and evaluation of social contact activity

Across our pilot locations, people with lived experience have shared their ideas, knowledge and skills to influence the design and delivery of social contact activity, supported by local NGO project staff, as needed. Each Champion has contributed as far as they felt comfortable to.

Some Champions have taken on responsibility for coordination of activities and dissemination of information to peers, others have helped to foster relationships and secure relevant permissions from community leaders, whilst other Champions have been promoting activities to the public via social media platforms such as Facebook and Twitter.

It is important to allocate appropriate time and resources for everyone involved in delivering social contact activity, both to plan and reflect regularly. Thinking about what went well and what could be improved upon will help inform the design and delivery of future activities.

The 'How to include people with lived experience' section of this toolkit offers tips and tools to help ensure people with lived experience are meaningfully engaged in all aspects of your social contact activity.

2. Ensure conversations take place in an environment that feels comfortable for all

Social contact can take place online or offline in different settings, for example at community events, at school, on a bus, in workplaces or on social media. Wherever social contact takes place, it is important that conversations happen in an environment that feels natural and comfortable for all participants. This will help ensure that people are kept safe / well during the event and will create a reassuring space for more effective social contact.

During the Time to Change Global pilot programme, social contact took place at community-based events across the five pilot locations. Including events at markets, parks, transport junctions, shopping malls, temples, Universities and community meeting points. Alongside activities at larger events such as national trade fairs, business gatherings and community celebrations.

Some have been large group events, with up to 20 Champions engaged in planning, delivery, monitoring and evaluation. Large events can help attract big numbers of people which can raise the profile of anti-stigma work. You may wish to consider when your events are likely to have most impact. Organising large events during identified significant moments, for example a key local, national or global celebration such as, World Mental Health Day or International Day of Persons with Disabilities, can be a great way to maximise impact. Other events have been organised using a 'cluster approach', with smaller groups of Champions coordinating scaled down events in different geographical zones.

Benefits of organising specific events where social contact can happen:

- Project staff are present to support and ensure the safety of all participants
- Champions can support each other and manage any challenging situations together
- Effectiveness and impact of these conversations can be systematically evaluated

Other things to consider:

- People are likely to feel more comfortable to ask questions, be open and build a rapport in a one-to-one or small group discussion of 3-4 people, than in a larger group. One-to-one or small groups are more likely to encourage a meaningful two-way conversation.

- Power imbalances between those engaged in social contact need to be recognised and addressed. For example, by holding the conversation in a neutral setting where both parties (people with lived experience and members of the public) feel safe to share their experiences, ask questions and explain their perspective.

- Conversations, whether online or offline, should take place in locations / platforms that attract many people, including those who would not normally engage in 'mental health' conversations. It can be demotivating if there is limited footfall / traffic and no one to talk to, but equally it may be overwhelming and difficult to engage in meaningful conversation if there are too many people wanting to talk.

- Conversations should take place in locations / platforms where members of the public may be receptive to engaging in conversation with people with lived experience. Whilst we want everyone to hear our message, having conversations in places that are known to be very hostile could put Champions at risk, and / or be a demotivating experience for those speaking out.

3. Find ways to help people with lived experience open-up a conversation

It is not always easy starting conversations about mental health with people that you do not know. Whether conversations are happening online or offline, conversation starters can be a great way to draw people to your activity and encourage engagement. These could be materials, games or activities that help you to begin building rapport and start a conversation.

Across all five pilot locations, Champions found it helpful to use materials such as leaflets, banners, t-shirts and wristbands featuring anti-stigma messaging. In addition to activities such as popular traditional games, drama performances and tea parties, to start conversations with the public.

When considering conversation starters, here are a few things to think about:

- How do your activities / materials support you to open-up a conversation? It can be tempting to produce many different and exciting materials, but it is important consider the value added by each item which you intend to develop.
- Are your materials accessible to the public e.g. for people of differing literacy levels or languages, or persons with disabilities or other needs?
- What branding and anti-stigma messaging will you use on your conversation starters?

It might be helpful to look at the toolkit section 'How to talk about mental health' when considering your messaging.

Ahead of social contact activity, Champions have found it helpful to practice having conversations with peers in a safe environment.

This has helped support them to feel more confident and prepared ahead of an event. It has also helped them to practice speaking of their own experiences, rather than offering broader mental health advice and support.

> **"Through the programme I have come to realise there is a lack of proper in-formation on mental health that contributes to the stigma and discrimination. I have come to understand that speaking up about mental health is the surest way to end the stigma and create more safe spaces for anyone who might be going through a hard time"**

Sandra, Champion, Kenya

4. Consider ways to enhance the impact of social contact

There are a number of strategies that can enhance the positive impact of conversations in terms of contributing to a reduction in stigma.

The positive impact of two-way conversations can be enhanced by sharing information that replaces myths with correct information, thereby challenging negative stereotypes. This can be delivered in a range of ways including:

- Sharing real life stories and experiences
- Information materials in the form of pamphlets and leaflets
- Education materials online
- Media (TV, Radio, Social Media etc)

Bringing people together to actively co-operate, in pursuit of a mutual goal (for example planting trees; creating a community art work) is another useful strategy. By focusing people on what connects them instead of divides, such activity can help to break down stereotypes and harmful attitudes, ultimately reducing stigma.

5. Ensure you will appropriately support and safeguard everyone engaged in social contact activity

The safety and wellbeing of everyone participating in social contact activity is a priority. The 'How to include people with lived experience' section of this toolkit shares some tips on how to support people with lived experience to share their stories safely.

Additionally, it can be helpful to:

- Conduct a risk assessment ahead of each activity to identify potential risks and the measures that you need to take to mitigate and limit these. If you are running a community-based event for example, you may need to consider whether you have the relevant permissions or insurance required to deliver a public event? It is essential that everyone involved in delivering social contact activity clearly understands any potential risks so that they can make an informed choice about whether to participate.
- Ensure that you have safeguarding policies and processes in place, that everyone is aware of these and agrees to adhere to them.
- Conduct a briefing / debrief session at the beginning and end of each activity to ensure all relevant information is shared, making sure any immediate concerns are captured and addressed.
- Ensure Champions and other participants know where to go should they need to seek support for themselves or someone they know. We advise having 'signposting' information (guidance on where / how to access mental health services) kept within easy reach.

> **"Before this, I felt inferior about myself. I did not feel welcome in certain places. After the training and my involvement in social contact events, I feel confident to go anywhere I want to. I realise I can also do what other people are doing and be equally accepted."**
>
> Cecilia, Champion, Ghana

> **"A real positive thing in my community is that people are interested in learning more from people with lived-experience of mental health problems. At the social contact events, most people are receptive to hearing about mental health. They give me time to talk to them and ask a lot of questions."**
>
> Anita, Champion, Nigeria

6. Ensure people with lived experience are involved in monitoring and evaluation

People with lived experience should be given opportunities to meaningfully participate in the monitoring and evaluation of social contact activity. In the pilot programme, Champion groups held short debrief sessions after each event, followed by longer meetings (bi-monthly, or monthly) to reflect and capture any learning. Key things to consider:

- Are your monitoring and evaluation tools and mechanisms accessible to all e.g. for people of differing literacy levels or language, or persons with disabilities? Producing monitoring and evaluation tools in collaboration with people with lived experience will help ensure they are successfully understood and useful. It is important to ensure everyone involved in monitoring and evaluation is supported in how to use these tools.

- How will you monitor and evaluate the social contact activity? How will you know if your activities have been successful? Keeping a count of the number of conversations can help you to understand how many people you have reached, but this risks putting pressure on people to have conversations. People with lived experience should only ever have conversations where they feel comfortable to and should never be incentivised or pressured to achieve any number of conversations. In preparing your activity, it is helpful to invite Champions to reflect on how they personally will measure success.

- How will you share any useful learning more widely and for what purpose? In our pilot programme we have created opportunities to share learning within and across the five countries through learning events, online webinars and the toolkit. We also established platforms for peer groups to connect with each other to disseminate information, share ideas and learning, via channels such as WhatsApp and Slack.

"Giving the public facts about mental health helps challenge the negative attitudes and words. This information and myth busting backs up the physical interaction between a Champion and the public which also helps to break the negative attitudes that people with mental health problems are violent, unfriendly etc."

Judy, Programme Coordinator, Kenya

Useful tools and materials

While groups of Champions in Ghana, India, Nigeria, Kenya and Uganda are all delivering social contact activities in local communities, these activities look very different in each context.

In this section of the toolkit, we will share some of the specific approaches the different NGOs are taking when it comes to social contact activity.

In Uganda, they are taking a 'cluster approach'

Mental Health Uganda are using a 'cluster approach' to create opportunities for people with lived experience to meaningfully participate in the design, organisation, monitoring and evaluation of their social contact activities. A selected number of Champions have been chosen as 'cluster focal persons'. These individuals work with a small selection of Champions to deliver small-scale events in a specific geographical area. The focal persons liaise directly with the Programme Coordinator.

- **Positives aspects of this approach:** The small cluster groups have formed strong supportive relationships. Clusters allow for easier identification of well-being issues among Champions. This approach helps the focal persons to build their capacity and skills in areas including mobilization, coordination and communication. Oversight of clusters through the Champion focal person allows for easier communication and management of activity. This approach can allow for greater flexibility – for example if you have a group of Champions with different schedules (e.g. work commitments or childcare responsibilities).
- **Negatives / limitations of this approach:** As more events happen the Programme Coordinator is required to attend a greater number of events overall.

In Kenya, they have found lots of great ways to help people with lived experience open a conversation

Judy is the Programme Coordinator with Basic Needs Basic Rights Kenya. She shared some of the ways they get people talking about mental health.

"Our events are branded. We also wear branded t-shirts making it easier for people to see that something is going on. Passers-by are invited to take part in a trivia activity, or to join us for some soda. We also put up photos of famous people with the question, 'Who has mental health?' This attracts their attention and they wish to know more. Other times we put up a colourful banner that makes a very nice background for a photo or selfie then we wait for those who like taking photos and we start talking to them."

Teams in India and Ghana are ensuring conversations take place in an environment that feels comfortable for all

- Within rural villages in and around Doddaballapur, the GASS team have been holding community tea parties to bring people together in a safe, familiar way, before they begin discussions about mental health.

- On Time to Talk Day, run by Time to Change England every February, to get more people talking about mental health, MEHSOG ran an event at the Spintex Junction. They displayed a large banner over a motorway bridge and engaged people on the topic of mental health while they waited at the bus stop.

Support everyone involved

All five teams have developed signposting materials which they make available at social contact events to point to local mental health services. Having these materials on hand helps ensure Champions have a readily available list of local services which can be shared with members of the public.

This section of the toolkit will help me to identify and reach audiences at a 1-2-1 level

- Agree
- Don't know
- Disagree

See results

"It's really calming and enlightening when you go on social media and you realise someone went through this so maybe I can tackle my situation too. It strengthens you."

Charlene, Champion, Kenya

How to reach the public on a wider scale: Social marketing

What is social marketing?

In this programme, we define social marketing as "the delivery of behaviour change for social good by influencing an audience's behaviour towards others, by deploying content via paid media".

Within the wider context of the programme, the role of social marketing has been to deploy relevant messages and create channels to influence the public at scale. Social marketing campaigns are complementary to the social contact activities taking place in local communities.

We know social contact is a very effective way of driving behaviour change in order to reduce stigma. The social marketing campaigns harness the storytelling core of social contact to take anti-stigma messages to a much bigger audience via paid media channels.

The presence of these high-profile campaigns also helps to build the confidence of Champions who are sharing their stories – and can create useful links to local activity and events.

In this section, we outline our social marketing activities during the pilot phase, highlighting key things to consider alongside our learnings along the way.

Things to consider when engaging the public at scale

1. Understand your audience

Our starting point for campaign development was to understand the local audience's knowledge of mental health problems and what stigma and discrimination look like in each context.

Following this we could then develop relevant messaging and content in order to address these specific issues.

Existing available research in this area was extremely limited. Therefore, we commissioned qualitative research in order to inform our campaign development.

After a selection process to identify suitable research agency partners, we appointed Consumer Insights Consult for West Africa, Global Research Insights for East Africa and Kantar Bangalore for India.

20 focus group discussions were held across Accra, Abuja, Nairobi, Kampala and Doddaballapur. You can read a summary of the focus group findings here.

You can also access full reports from Ghana, India, Nigeria, Kenya and Uganda on the Time to Change Global website.

> "When people hear you have a mental health problem, they look at you with different eyes."

Hammond, Champion, Ghana

2. Consider the relevance and benefits of multi-country campaigns

During the pilot phase, we developed and ran social marketing campaigns in Ghana, Nigeria, Kenya and Uganda. Rather than develop a different creative approach for each country, we grouped into West and East African campaigns based on the following principles;

- Initial desk research suggested that knowledge, attitudes and behaviours are broadly similar in Ghana and Nigeria, and also in Kenya and Uganda, but with accentuated cultural differences between West and East Africa.
- We could spend more money on media reach per country if we did not spend on developing separate creative approaches for each country.
- Rather than running one single creative campaign across all countries, we could double the creative learnings from the pilot phase by grouping into two.

3. Work with expert partners

To maximise cost efficiency, we chose to appoint integrated creative and media marketing agencies to avoid incurring additional costs by working with two separate agencies.

Competitive agency selection and review was completed using the following process;

- Compilation of long list of agencies. Based on programme partner knowledge, recommendations and desk research.
- Request for Information issued to long list of agencies.
- Request for Proposal issued to no more than eight agencies.
- Meetings held to shortlist at agency office – a maximum of four per region.
- Contract negotiations and appointment of agency.

On completion of this process, we appointed Now Available Africa for West Africa, Scanad for East Africa.

Using the outputs from the qualitative research, a marketing brief was written for West and East Africa, setting out the objectives, insights, requirement, budget, timings and measurements expected.

The relevant local NGOs reviewed and input into each brief, then respective agencies responded with campaign proposals.

4. Develop a Media Strategy

We had defined campaign audiences for the four African countries as follows;

- 18 - 34 years old
- Equal male / female split
- Live within 30 km from centre of the capital city
- ABC1C2

These factors, alongside the capped budget, meant focused media strategies were devised in order to connect with our target audience and maximise awareness of our campaign messaging.

A similar strategy was used across all countries;

- Mobile centered. This demographic is glued to their mobile phone and so our connection points should be mobile led or at least mobile accessible.
- Social media first. Facebook, followed by Instagram is a key media channel for our audience in these four countries and is well suited to the campaigning, and conversation generation approach of our campaigns.
- Leverage radio for discussion opportunities. Focus on speech radio or speech segments to enable the Champions to tell their stories to broadcast audiences.
- Concentrate campaign to eight to ten week burst in order to maximise opportunity to see and remember.

A Social Media Tax in Uganda limited our ability to connect at scale with the target audience through such channels. Therefore, a youth programming partnership with NBS Television Uganda formed an important part of our media strategy in Kampala.

5. Develop a creative strategy

Design and produce content that will grab the attention of the audience and resonate with them. The focus groups revealed key approaches to engaging our audience:

West Africa

Make it personal
- Lead on commonality – “It could be you”
- Audience research showed empathy and engagement were triggered by an understanding of how common mental health problems are in Ghana and Nigeria

Leverage empathy cues
- Use real people with real stories
- Feature real Champions talking about their own personal experience

Educate
- Myth busting
- Tackle identified gaps in knowledge head on

Local
-Campaigns from MEHSOG and Gede Foundation, not 'Time to Change Global'

East Africa
Same as West Africa but instead of “Make it personal”, the findings suggested;

a) Prompt conversation around mental health
- Actively encourage people to “Speak Up!”
- Research showed an understanding talking about mental health is positive and therapeutic
- Local mental health prevalence data was not available for Kenya or Uganda

6. Think about signposting upfront

Any campaign that raises awareness on the subject of mental health, will invariably prompt your audience to seek out help for themselves or others. Signposting must therefore be an essential consideration.

As the campaigns were developed, each NGO was supported to prepare a list of referral points in their country. In Ghana, MEHSOG also collaborated with the Mental Health Authority to feature their new mental health crisis hotline.

A campaign website was created for each country to signpost those seeking help to the appropriate channels and provide basic information about a range of mental health problems. Explore the campaign websites:

- Ghana
- Nigeria
- Kenya
- Uganda

Ideally, campaign content would have been incorporated into the NGO's existing websites. During the pilot programme this was not possible due to the following factors:

1. Basic Needs Basic Rights Kenya did not have an existing website

2. Existing websites had been designed for stakeholders rather than our campaign audiences

3. It was more cost effective to build three similar campaign sites than to re-design and re-build three existing websites.

Every piece of campaign content featured the relevant campaign website URL. Radio stations also pointed their listeners to these websites as a reference point and resource.

7. Establish social media rules

Given that our campaign audiences were known to be mobile-led, habitual users of social media, we planned in advance to respond to questions and moderate content.

Each NGO partner was supported to set up an "out of hours" automatic response on Facebook that immediately gave mental health crisis information to the sender.

In advance of campaigns launching, a Social Media Moderation tool was provided for each NGO. This clarified content moderation responsibilities, included details of support channels and pre-prepared responses to anticipated questions.

Top tip: Take time to make sure those moderating social media have been provided with mental health awareness and resilience training. Inevitably, some contact and comments may be triggering.

8. Back up any claims with evidence

The campaigns in Ghana and Nigeria led on a "commonality" message – "It Could Be You".

To add weight to this message, it was important to highlight the prevalence of mental health problems in each country.

Rather than use WHO global estimations, we took responsibility to source local evidence of prevalence of mental health issues:

- In the case of Ghana, the Mental Health Authority directed us towards a research study published by the International Journal of Mental Health Systems from which we took our key message, "1 in 5 Ghanaians experience a mental health problem."
- For Nigeria, we also used a "1 in 5" prevalence figure based upon an academic paper by D E Suleiman published in the annals of Nigerian medicine.

9. Ensure people with lived experience are properly supported

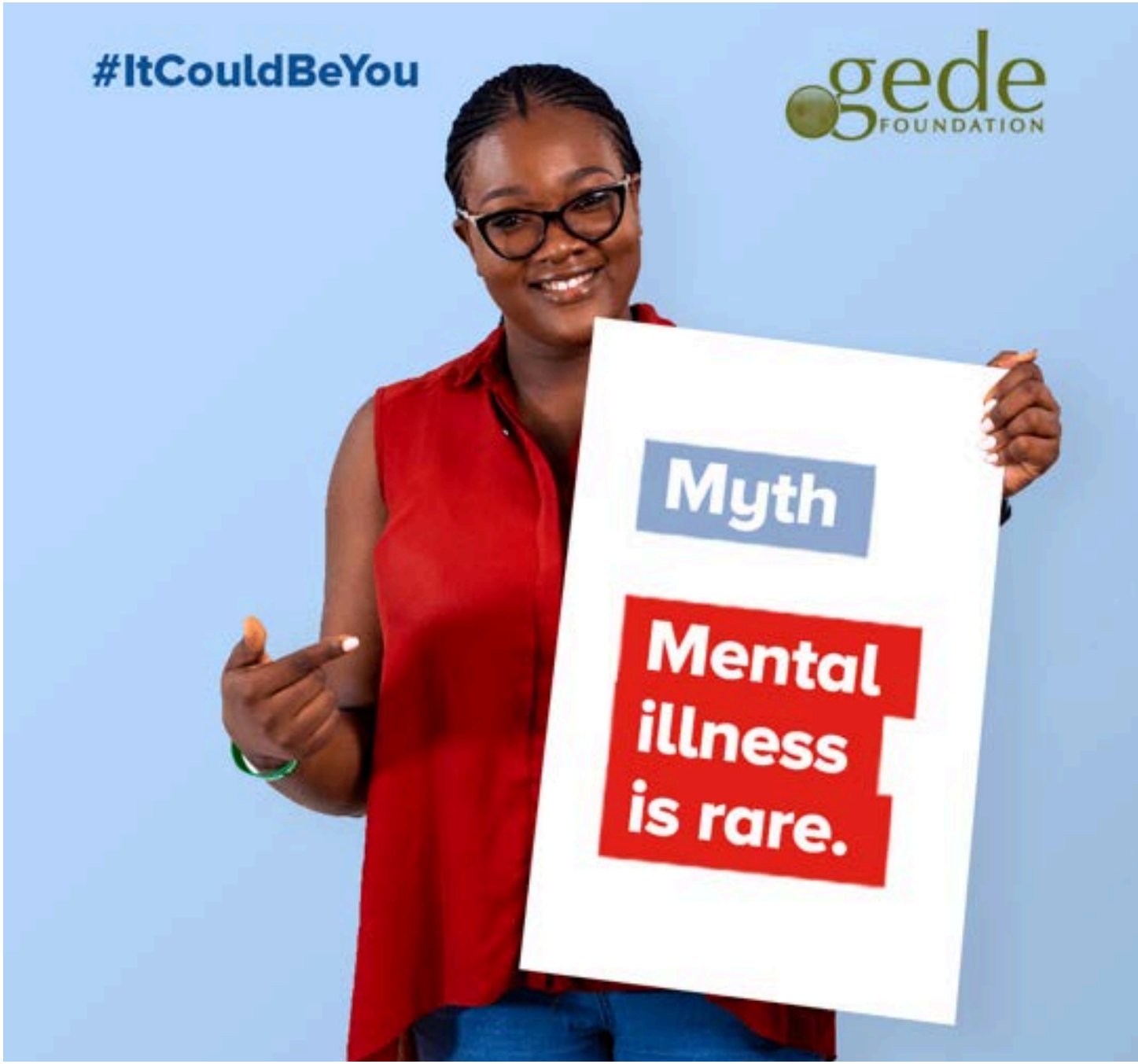
The creative strategy included the use of real people (Champions) telling real stories about their lived experience. Guidelines were developed for involving Champions in social marketing campaigns.

Media training	Featuring in a social marketing campaign will raise the profile of the participant. Their image or story could appear on billboards, on Facebook ads or on TV. While this can be exciting, it could also expose them to potential stigma and discrimination from the public. Champions must receive media training ahead of participation. This helps them understand potential consequences of participation and allows them to consider the parts of their story they are happy to share with a wider audience (and to practice doing this).
Open to all	All Champions were given the opportunity to participate in the social marketing campaigns. A Casting Brief sets out requirements and invites individuals to put themselves forward.
Without payment	To ensure remuneration does not unduly influence an individual's decision to participate, we only pay travel and subsidence costs.
Inclusion	All participants are given the opportunity to review and feedback upon the way in which they feature in the campaign before content is published

Useful tools and materials

In this section of the toolkit, we are sharing some of the creative content that was developed as part of the four social marketing campaigns.

You can also explore the campaign websites to find out more about each campaign and watch videos from inspiring Champions.

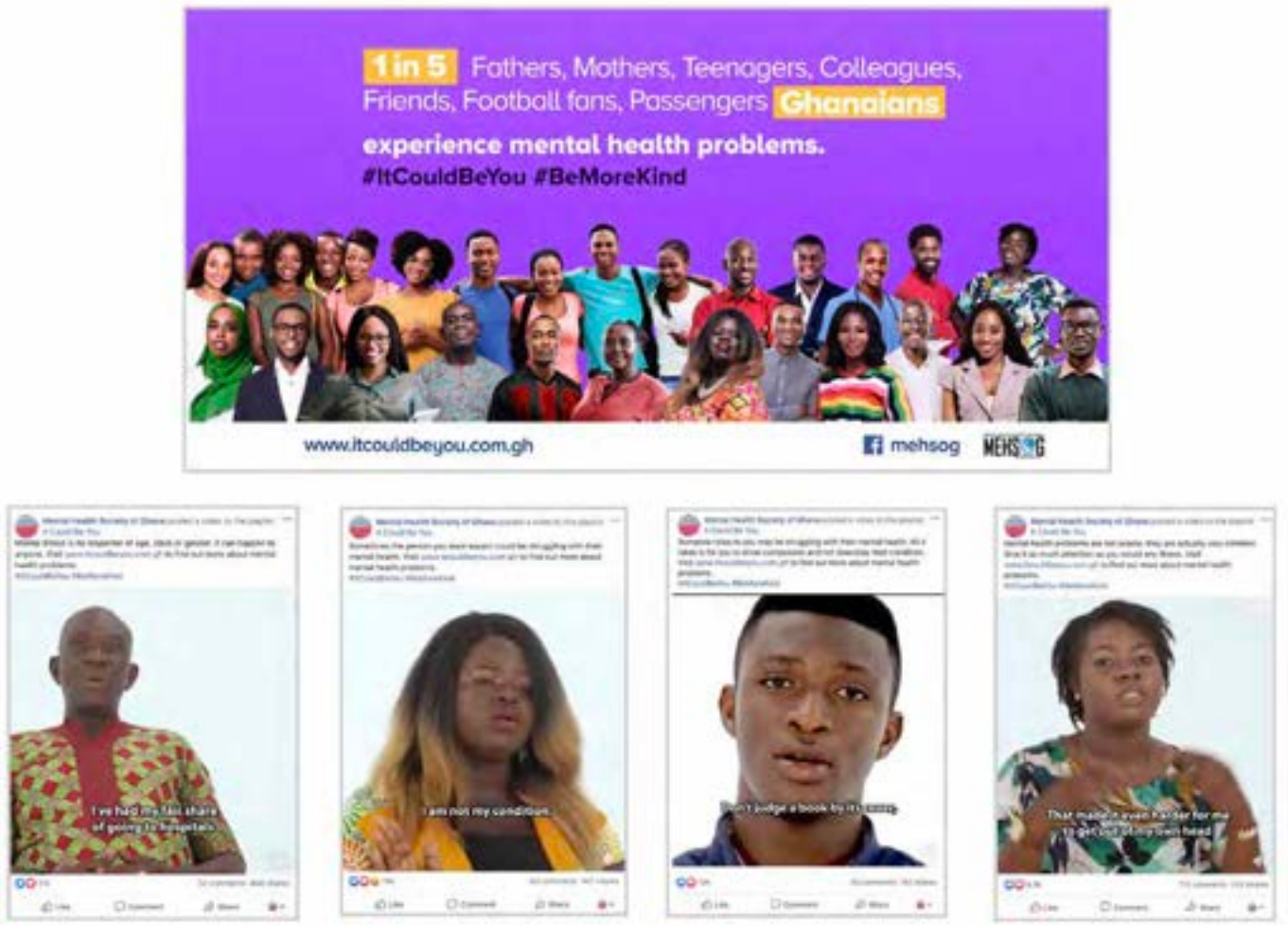


#ItCouldBeYou Ghana

Focus group research carried out in Accra, Ghana, showed empathy and engagement was triggered by an understanding of the commonality of mental health problems and an opportunity to “walk in the shoes” of those with lived experience.

Take a look at the 'What stigma looks like... in Accra' section to see more data from these focus group discussions.

Based on the focus group findings, a core message of “It Could Be You” was developed. This message was supported by the qualified claim of “1 in 5 Ghanaians experience mental health problems”. Champions from the Mental Health Society of Ghana shared their stories as campaign spokespersons.

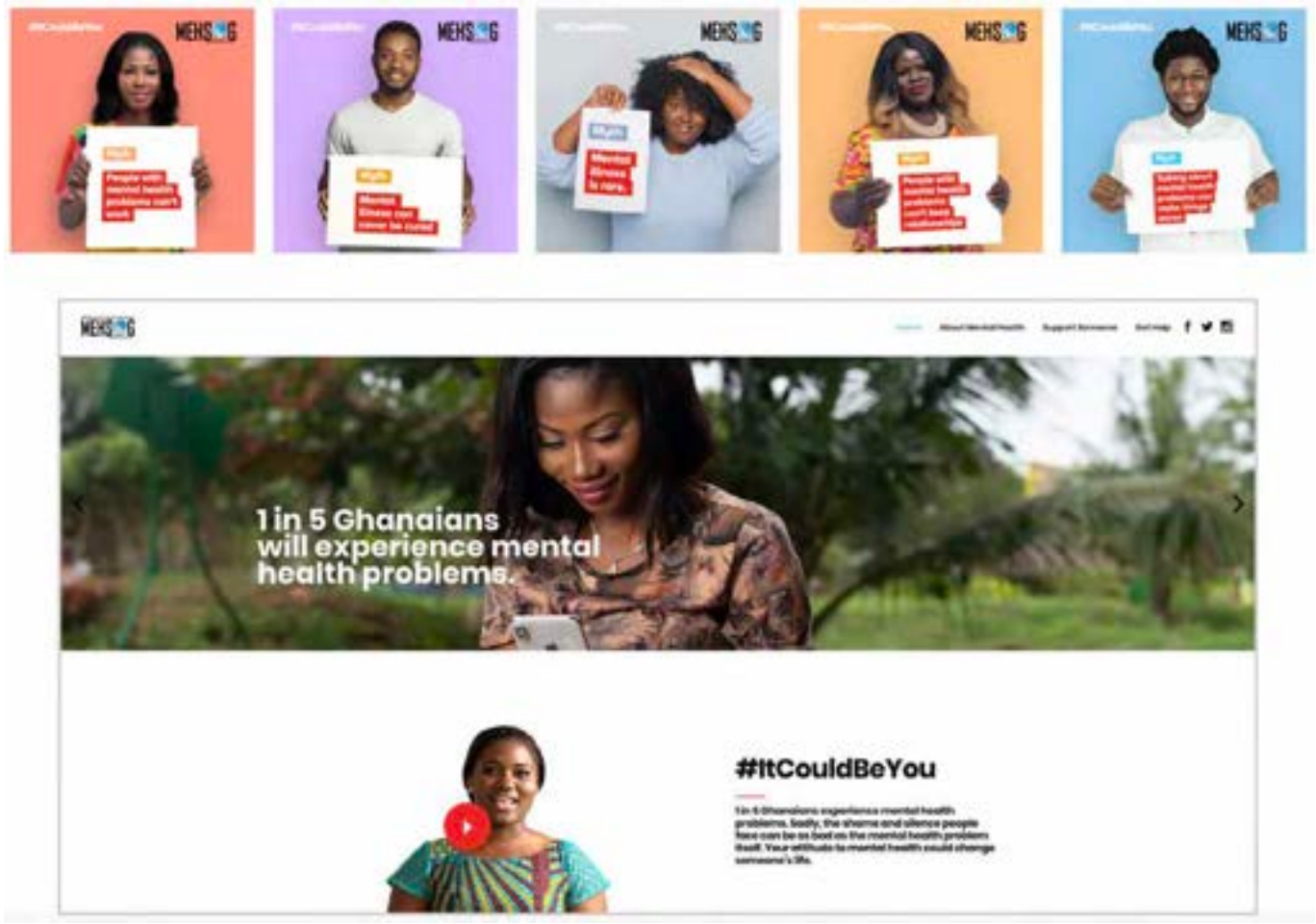


#ItCouldBeYou Ghana

The campaign launched in October 2019 with a “teaser” video. This was followed by a Facebook paid media campaign using video format ads featuring MEHSOG Champions talking about their experiences of stigma and discrimination as well as static ad formats designed to bust some of the myths regarding those with mental health problems.

Offline, a single poster site was deployed in central Accra to convey the campaign message and interviews were booked on local radio stations in order to raise awareness.

Explore the #ItCouldBeYou site to find out more about the campaign



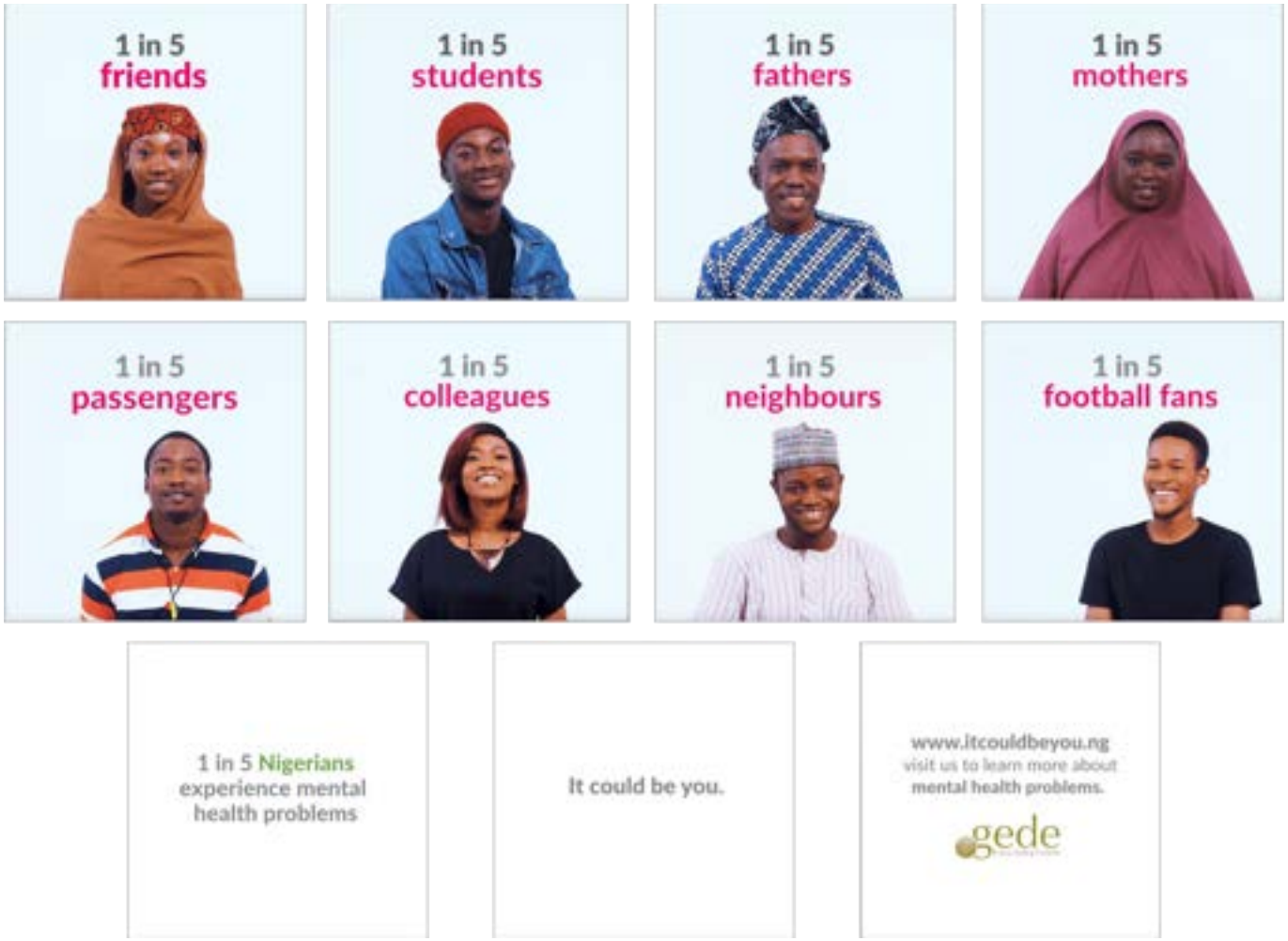
#ItCouldBeYou Nigeria

Focus group research in Abuja suggested strong similarities of knowledge, attitudes and behaviours between the Nigeria target audience and that of Ghana.

Take a look at the 'What stigma looks like... in Abuja, Nigeria' section to see more data from these focus group discussions.

Due to the close similarities, the same creative platform was used but adapted in production in order to feature Champions from Gede Foundation.

The campaign ran from January to March 2020 targeting 18-34 year old residents of Abuja. As with the approach in Accra, the campaign launched with a “teaser” video emphasising the commonality of mental health.

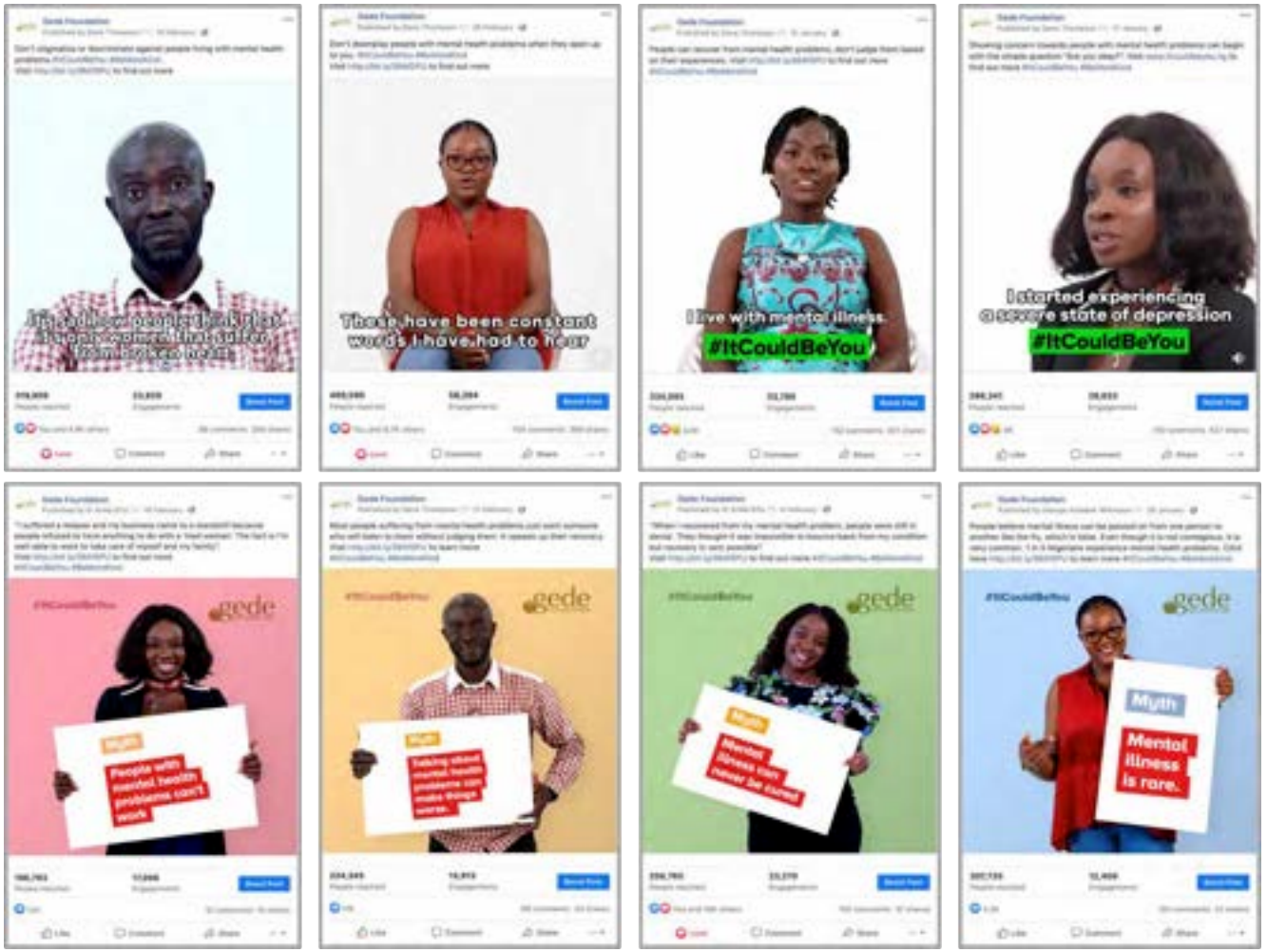


#ItCouldBeYou Nigeria

Facebook was selected as the prime paid media channel for the campaign in Abuja. On Facebook alone, the campaign reached 37 per cent of the available audience.

Radio advertising was used to support myth-busting messaging and our Champions also featured within radio and internet TV discussions.

Watch more stories from Champions on the campaign website.



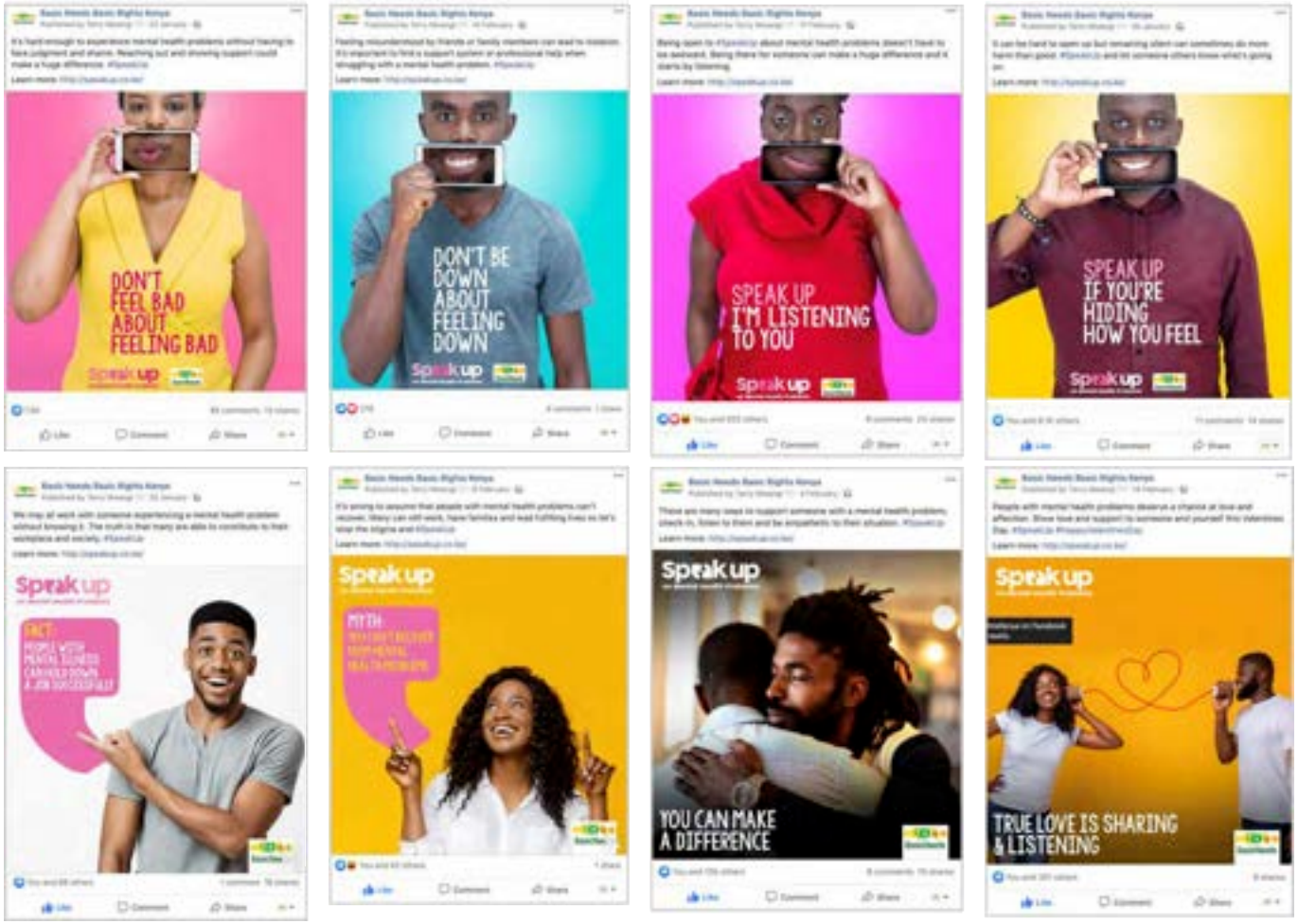
#SpeakUp Kenya

Primary research in Nairobi suggested that directly encouraging conversation around the subject of mental health and stigma would resonate with the target audience.

Take a look at the 'What stigma looks like... in Nairobi, Kenya' section to see more data from these focus group discussions.

The core campaign theme of “Speak Up” was spearheaded by lived experience Champions from Basic Needs Basic Rights who brought this theme to life across video interviews and static ads.

The #SpeakUp campaign ran from January to March 2020.

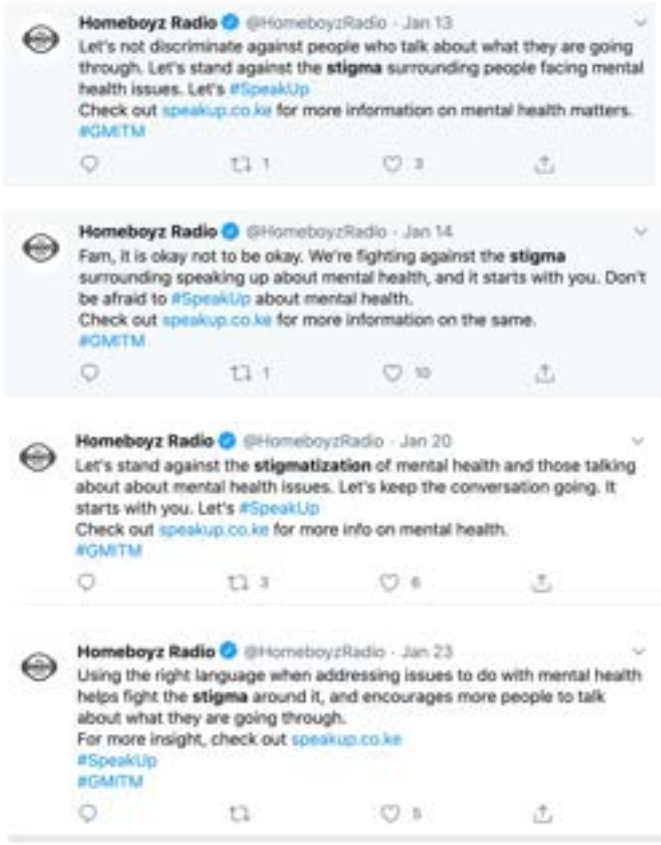


#SpeakUp Kenya

The campaign ran predominantly across digital channels – Facebook, Instagram and Twitter – owing to the heavy mobile usage of the audience and the conversational nature of these platforms.

Alongside this digital content, “presenter mentions” where also bought with a local youth-oriented radio station and supplemented by an interview feature with a mental health Champion.

Explore the #SpeakUp campaign site to find out more about the campaign in Nairobi



#Kyogereko Uganda

Focus group findings in Kampala showed many similar findings to the research in Nairobi. The same creative platform – Speak Up – was therefore used in Uganda as for Kenya, but adapted in production in order to feature Champions from Mental Health Uganda.

Take a look at the 'What stigma looks like... in Kampala, Uganda' section to see more data from these focus group discussions.

Kyogereko is a Lugandan translation of the term, Speak Up. This was used as the campaign title and hashtag.

Owing to government taxation on citizens' use of social media channels, greater emphasis was placed on TV and radio in order to reach a significant proportion of our target audience.

#Kyogereko Uganda

A commercial partnership with NBS TV enabled interviews with Champions and regular on air presenter mentions, both supported by onscreen branding “squeeze backs’.

Similar partnerships with Capital FM and Galaxy FM provided content integration, presenter discussions and interviews with Champions during breakfast and drive time shows.

Facebook and Twitter video format ads delivered both reach and engagement.

Explore the #Kyogereko campaign site to find out more about the campaign in Kampala

Evaluating social marketing activity

As a pilot programme working in five very different cultures and contexts, learning and evaluation is vital. This toolkit highlights this rich learning throughout - presenting both formal and informal reflections, lessons learned and evaluation findings. Data from a full programme evaluation will be made available on the Time to Change website.

In this final part of the toolkit, we are specifically sharing approaches and key findings from the social marketing evaluation. All four social marketing campaigns were evaluated using campaign metrics. In Ghana and Kenya additional budget was allocated in order to run in depth academic impact studies.

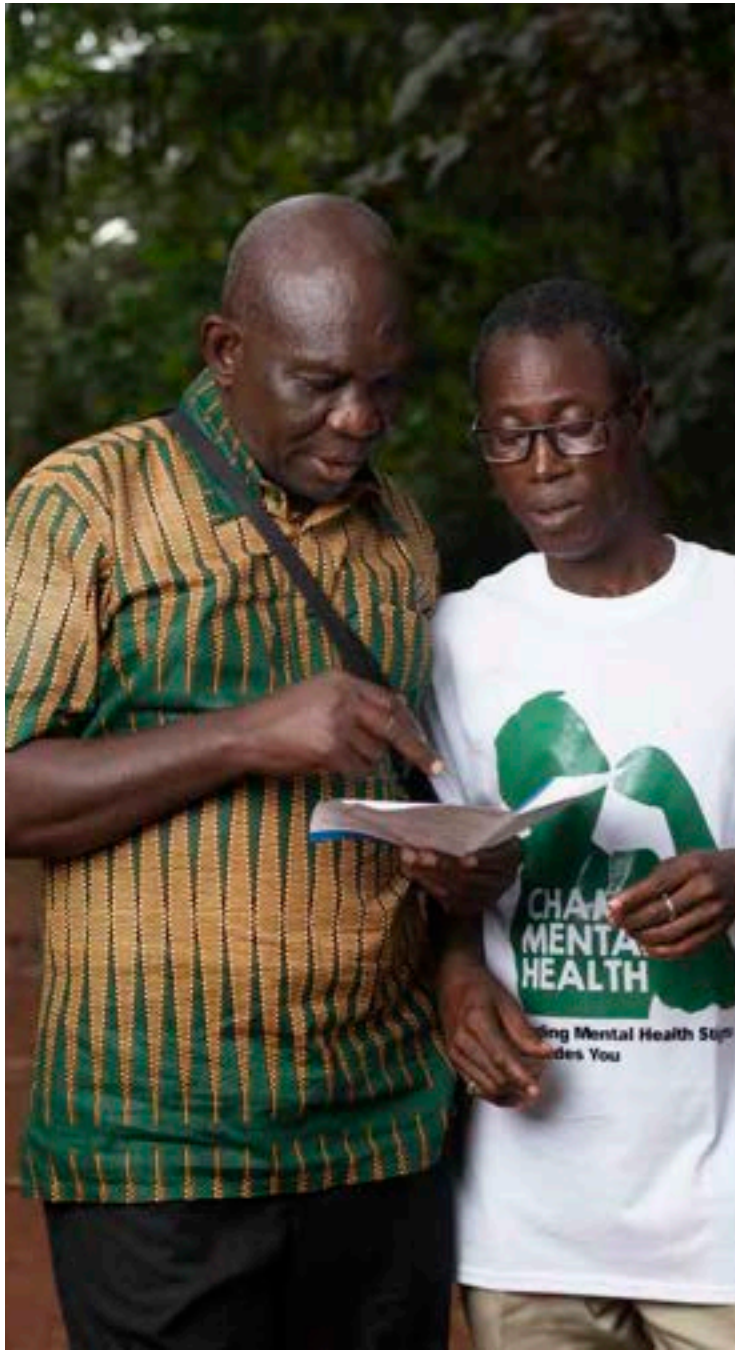
Campaign Metrics

At the planning stage of each social marketing campaign, Key Performance Indicators (KPIs) were set in order that they may be tracked for optimisation purposes during the campaign and for evaluation afterwards.

KPIs varied slightly by country but the key metric was “awareness” (reach) followed by “engagement” (social interaction, website visits). At the end of every campaign, the local marketing agency was charged with delivering a full evaluation report. Read the campaign reports for each of the campaigns:

- Ghana
- Nigeria
- Kenya
- Uganda

In summary, social media (Facebook in particular) proved to be a highly effective channel for reaching the target audiences. On average, approximately 50% of the total available target audience was exposed to the campaign content. Engagement rates were consistently above average based on comparative advertisers.



Impact Studies

In partnership with the Institute of Psychiatry, Psychology and Neuroscience (IOPPN) at King's College London a methodology was developed in order to measure the impact of the social marketing campaigns - specifically in Accra and Nairobi. This methodology looks at the knowledge, attitudes and intended behaviours of those exposed to the campaign messaging. Three tools were used, all validated for use in similar contexts. These tools have also been used for campaign evaluation in England and in other countries for many years.

The evaluation work revealed that the Ghana campaign led to a statistically significant increase in positive attributes relating to intended behaviour.

In Kenya, the campaign delivered a statistically significant increase in the levels of knowledge among the target audience.

Other notable findings were that having no religion was associated with more positive outcomes, as compared to Pentecostal or charismatic faith. Consistent with studies elsewhere, the findings also show that familiarity with mental illness through personal experience or a relationship was associated with all outcomes in Kenya and all in Ghana except for intended behaviour.

In both countries, a positive impact was found in relation to a statistically significant drop in reported belief that mental health problems may be caused by a curse.

Methodology

Working with IOPPN, a questionnaire was developed consisting of three key sets of questions;

1. Mental health-related knowledge (MAKS)
Mental health-related knowledge was measured by the Mental Health Knowledge Schedule. This comprised six items covering stigma-related mental health knowledge areas: **help seeking, recognition, support, employment, treatment, and recovery**, and six items that inquire about classification of various conditions as mental illnesses. The total of the first six items score was standardised. A higher standardised MAKS score represents greater knowledge.

2. Mental health-related attitudes (CAMI)
Public attitude towards mental health was assessed using 12 items from the Community Attitudes toward Mental Illness (CAMI) scale (Taylor & Dear, 1981) used in the Health Survey for England (HSE) 2014 (Ilic, Henderson, Evans-Lacko, & Thornicroft, 2014) and as part of the evaluation of the Phase 3 Time to Change England social marketing campaign (González-Sanguino et al., 2019). The standardised total score was used; a higher score represents less stigmatising attitudes.

3. Desire for social distance (RIBS)
Desire for social distance, i.e. the level of intended future contact with people with mental health problems, was measured using the Reported and Intended Behaviour Scale (RIBS) (Evans-Lacko et al., 2011). This assesses four areas relating to intended contact: **living with, working with, living nearby and continuing a relationship with someone with a mental health problem.** The standardised total score was used where a higher score indicates less desire for social distance.

In addition, the questionnaire captured responses to two further questions regarding beliefs that mental health problems are a) hereditary and b) the result of a “curse”.

Finally, the questionnaire also captured socio-economic data for each respondent.

Once methodology was established, local research agencies surveyed 400 respondents representative of the social marketing audience prior to the campaign commencing.

Within two weeks of each campaign ending, another 400 respondents were surveyed in each location with the same set of questions.

All data was anonymised, collated and provided to IOPPN who then investigated pre-post differences in stigma-related outcome measures: mental health related knowledge (MAKS), mental health-related attitudes (CAMI), and desire for social distance (RIBS). Socio-demographic data was also captured to control for differences.

This section of the toolkit will help me to identify and reach audiences at scale

- Agree
- Not sure
- Disagree

See results

time to change global
let's end mental health discrimination

Programme partners

The Time to Change Global programme is a partnership between UK mental health charities Mind and Rethink Mental Illness, international disability and development organisation CBM and five country-level partners: Mental Health Society of Ghana (MEHSOG), Grameena Abyudaya Seva Samsthe (GASS), Gede Foundation, Basic Needs Basic Rights Kenya (BNBR) and Mental Health Uganda.

Our work is possible thanks to our funders, Comic Relief and the Department of Health and Social Care.

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Thank you for reading

Conversations change lives

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