



Mental Health
Data Prize - Africa

Newsletter **2026**

Reflecting on Impact

Transforming Mental Health Data Insights into Action in Africa

Celebrating partnerships, lived experiences, and progress



**African Population and
Health Research Center**
Transforming lives in Africa through research



Editor's Note

Welcome to this special edition of the Mental Health Data Prize - Africa (MHDP-A) newsletter, highlighting achievements, partnerships, and lessons from Phase 1. This issue demonstrates how data, innovation, and lived experience have generated actionable insights to improve mental health outcomes across Africa. We invite you to celebrate the progress and collective efforts that are turning evidence into action.

A special shout-out to the entire Mental Health Data Prize - Africa team, without whom this newsletter would not be possible. Thank you for being part of this journey. Happy Reading!



Christine Ger Ochola
Communications Officer - APHRC



Editorial Disclaimer

The editorial content and opinions expressed here in are solely those of the authors and the publisher, the Mental Health Data Prize - Africa (MHDP-A) initiative. All rights reserved. Reproduction in whole or in part without permission is strictly prohibited.

Table of Contents

2.0 Project at a Glance	06 - 09
• The Challenge • Our Approach • MHDP-A Phase 1 Impact • Participants Reached • Data-driven concepts and prototypes • Workshops & Convening • Who MHDP-A Outputs Serve • Key Outputs • Early Impact • Partners • Project Status	
3.0 Project Highlights	10 - 23
• Digitizing Psychosis Care in Uganda • CO-LUMINATE: Youth Mental Health and Social Stress • Group Therapy and Depression in HIV+ Patients • Natural Language Processing for Mental Health Service Improvement in Africa • Digital Mental Health Solutions in the Western Cape • AfriCAT-DA: Adaptive Testing for Youth Mental Health • Understanding Mental Health in Rural and Urban Malawi • PAMHoYA: Mental Health Data Platform for Youth • Uganda's Digital Mental Health Leap: Harnessing DHIS2 for Data-Driven Insights Youth • Mental Health Innovation: Leveraging Data and Digital Tools for Scalable Impact	
4. 0 People with Lived Experience Highlights	24 - 25
5.0 Blog: Nothing About Us, Without Us	26 - 27
• Rethinking Mental Health Data in Africa	
6.0 Key Insights from the project	28 - 29
7.0 Photo Gallery	30 - 33
8.0 Acknowledgement	34 - 35



“Mental health data is most powerful when it inspires action. By bringing together innovators, policymakers, researchers, and communities, we can transform data into solutions that strengthen mental health systems and improve lives across Africa.”

Damazo Kadengye
Head of Data Synergy and Evaluation - APHRC

#MHDPA2026 #MentalHealthAfrica #DataForImpact

MHDP-A Principal Investigator's Remarks

As we reflect on Phase 1, I am proud and grateful for our shared progress. From the launch of MHDP-A, our goal was clear and ambitious: to transform mental health in Africa through data-driven solutions for anxiety, depression, and psychosis. We aimed to bridge gaps in mental health equity with scalable, evidence-based, and locally relevant solutions. This initiative enables us to better understand, diagnose, treat, and manage these common mental disorders.

Our progress is a result of the dedication of our entire community. I thank all partners for their commitment. The strategic partnership between APHRC, as delivery and learning partner, and Wellcome demonstrates a strong commitment to lasting change. This investment has established the foundation to bridge the care gap and ensure equitable access to effective treatment.

I am especially grateful to our participants and community members, whose dedication has turned data into real-world impact. To the researchers, data scientists, and policymakers, your rigorous work and innovation have been essential to our success.

My deepest gratitude goes to the lived experience experts, including young people and community members, whose voices have shaped our mission. Your voices have reminded us that each data point represents a person deserving care, dignity, and support. You have turned stories into solutions and lived realities into a powerful mandate for policy change.

I look forward to working together towards a future where everyone has the mental health support and treatment they deserve and a lasting impact. Thank you for your unwavering commitment to advancing mental health equity in Africa.



Sylvia Muyingo
Research Scientist - APHRC



Project at a Glance

The Challenge

Africa faces a high disease burden but contributes less than 2% of global research output. Mental health remains under-prioritized and under-resourced. Limited access to quality data, data science expertise, and collaborative platforms hinders effective understanding, prevention, and treatment of conditions such as anxiety, depression, and psychosis.

Our Approach

The MHDP-A initiative, led by the African Population and Health Research Center in partnership with Wellcome, established a continent-wide, multidisciplinary network to leverage existing data for mental health research. The project integrated capacity building, matchmaking, and a structured prize competition to support scalable, data-driven solutions tailored to African contexts.

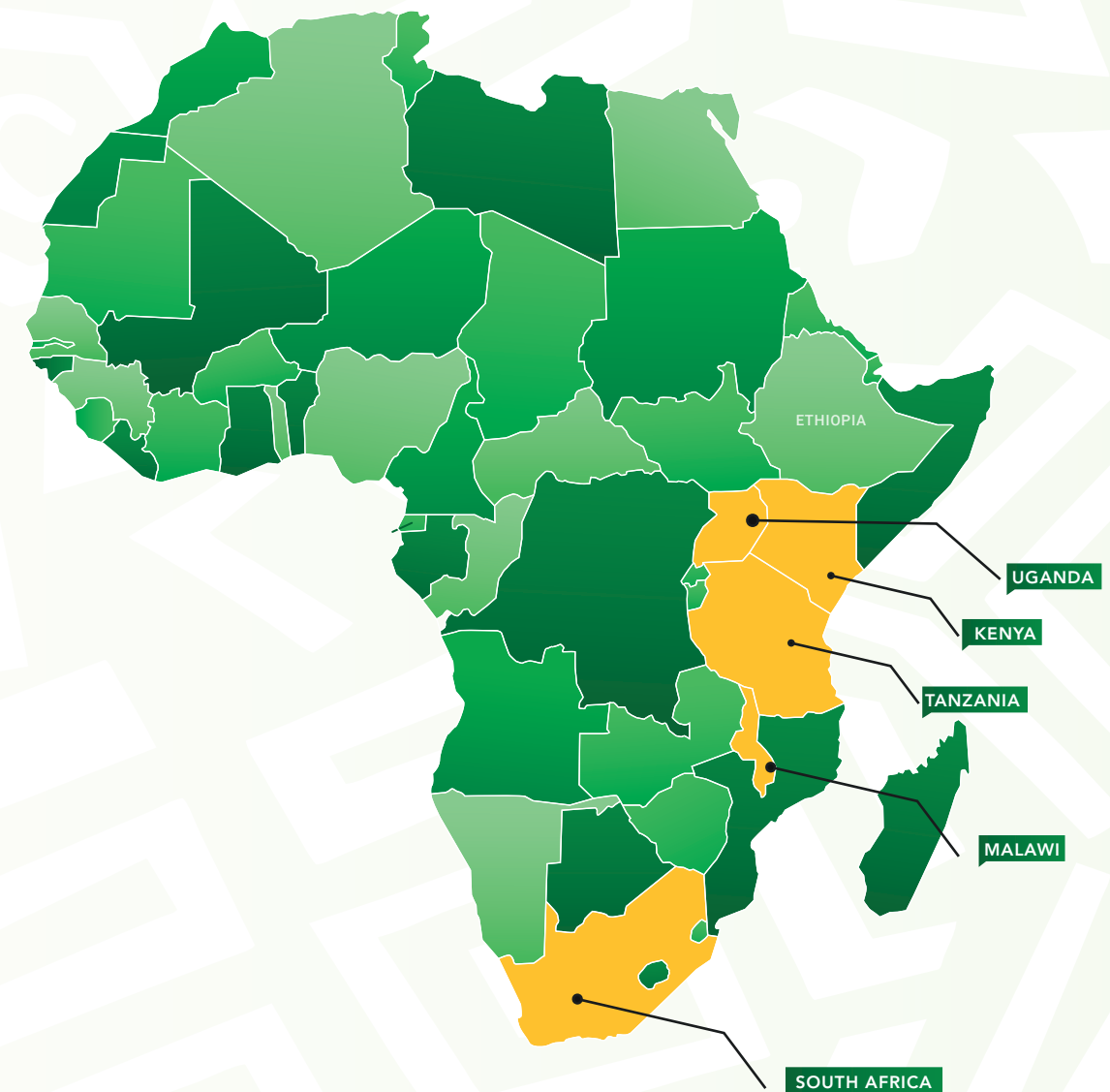
MHDP-A Phase 1 Impact

Participants Reached

More than 2,500 researchers, data scientists, clinicians, mental health experts, people with lived experience (LE), and innovators from across Africa took part in the initiative. Matchmaking platforms and collaborative events helped form multidisciplinary teams that combined skills in data science, mental health, policy, and lived experience to create new solutions.

Data-driven concepts and prototypes focused on:

- Tools for early detection and risk prediction using AI and machine learning models
- New methods for data visualization and decision-support tools
- Evidence generation for anxiety, depression, and psychosis





Workshops & Convening

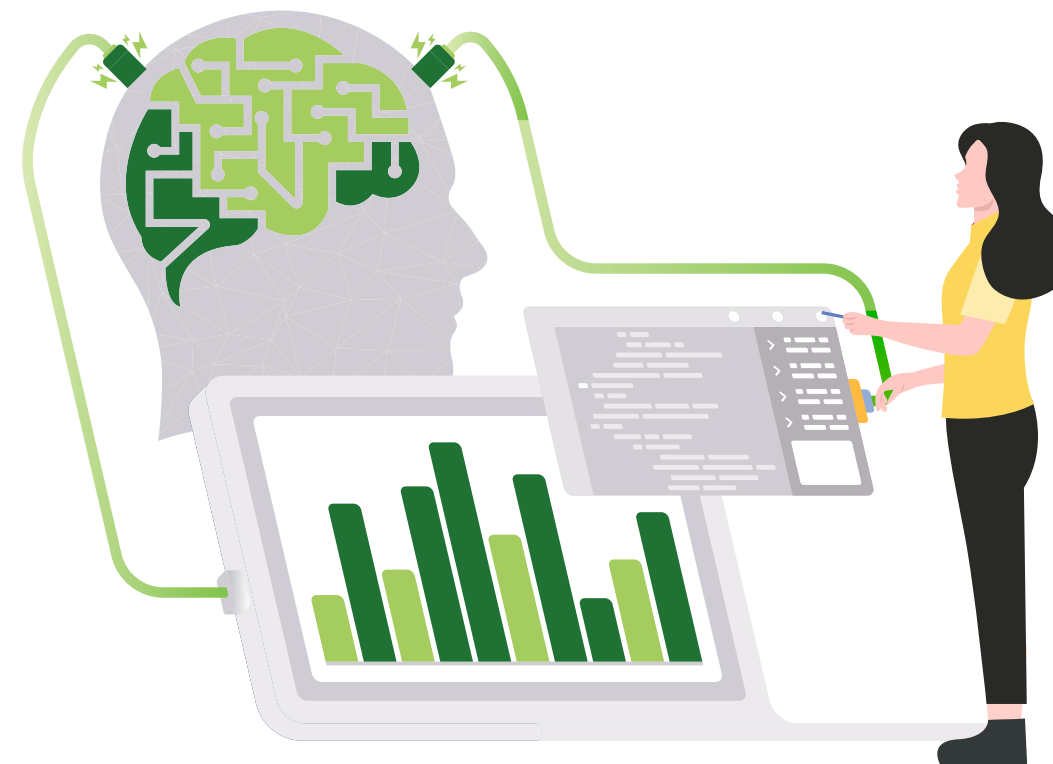
- 20+ structured online training courses
- Multiple expert-led webinars
- 14 matchmaking and networking events
- 1,300+ member Community of Practice established
- MHDP-A hosted an Awardee Workshop in November 2025, followed by its final convening in June 2026.

Who MHDP-A Outputs Serve

- African researchers, innovators, and data scientists
- Policymakers and health system actors
- Clinicians and frontline health workers
- Communities, including people with lived experience of mental health conditions

Key Outputs

Strengthened technical and research capacity for over 2,500 participants through training in data science, AI, open science, mental health research, and the development of an LE training manual. 10 projects were awarded from 111 proposals submitted after they were rigorously evaluated through a multi-stage review process. The initiative also established a first-of-its-kind mental health research metadata repository in Africa, currently containing 112 datasets.



Early Impact

- Strengthened Africa's mental health data and research ecosystem.
- Increased collaboration across disciplines and countries.
- Elevated the role of lived experience from advisory to co-design in research design and evaluation.
- Improved readiness to develop scalable, ethical, data-driven mental health solutions.

Partners

The project is implemented by the African Population and Health Research Center in partnership with Wellcome alongside a diverse network of researchers, reviewers, policymakers, and community stakeholders.

Project Status

Phase 1, which included capacity building, matchmaking, and proposal selection, is complete. The current focus is on implementing and scaling MHDP-A awardees' innovations to strengthen mental health systems across Africa.

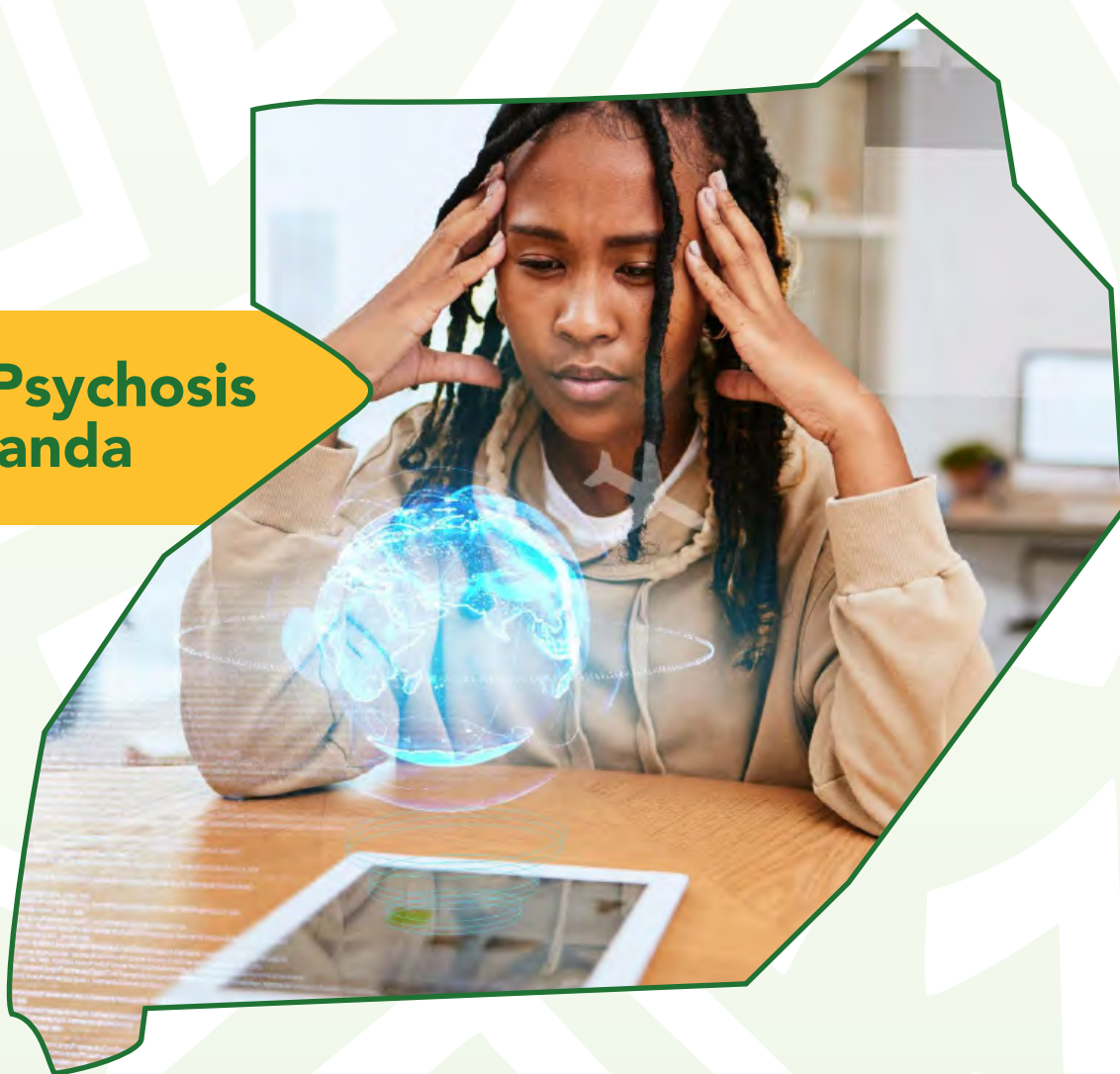


Project Highlights

Key Achievements from MHDP-A Phase 1

In the first phase of the Mental Health Data Prize - Africa (MHDP-A), the focus was on using secondary data to help improve mental health in Africa. Over the past year, 10 projects have moved forward by working together, finding new solutions, and staying committed to fairness.

Digitizing Psychosis Care in Uganda



Most health data science begins when a dataset already exists. In many African mental health systems, that assumption is wrong. Electronic medical records are important, but remain limited in coverage, completeness, and historical depth. A lot of data is already generated through routine care. Data can be found in paper patient charts, handwritten notes, admission records, discharge summaries, follow-up entries, medication records, and clinical observations. These files contain longitudinal histories of people living with severe mental illness. However, the data has not been retrieved. This is why the Mental Health Data Prize mattered. APHRC and Wellcome asked a practical but transformative question.

Could African researchers generate the longitudinal datasets needed to transform mental health research and care?

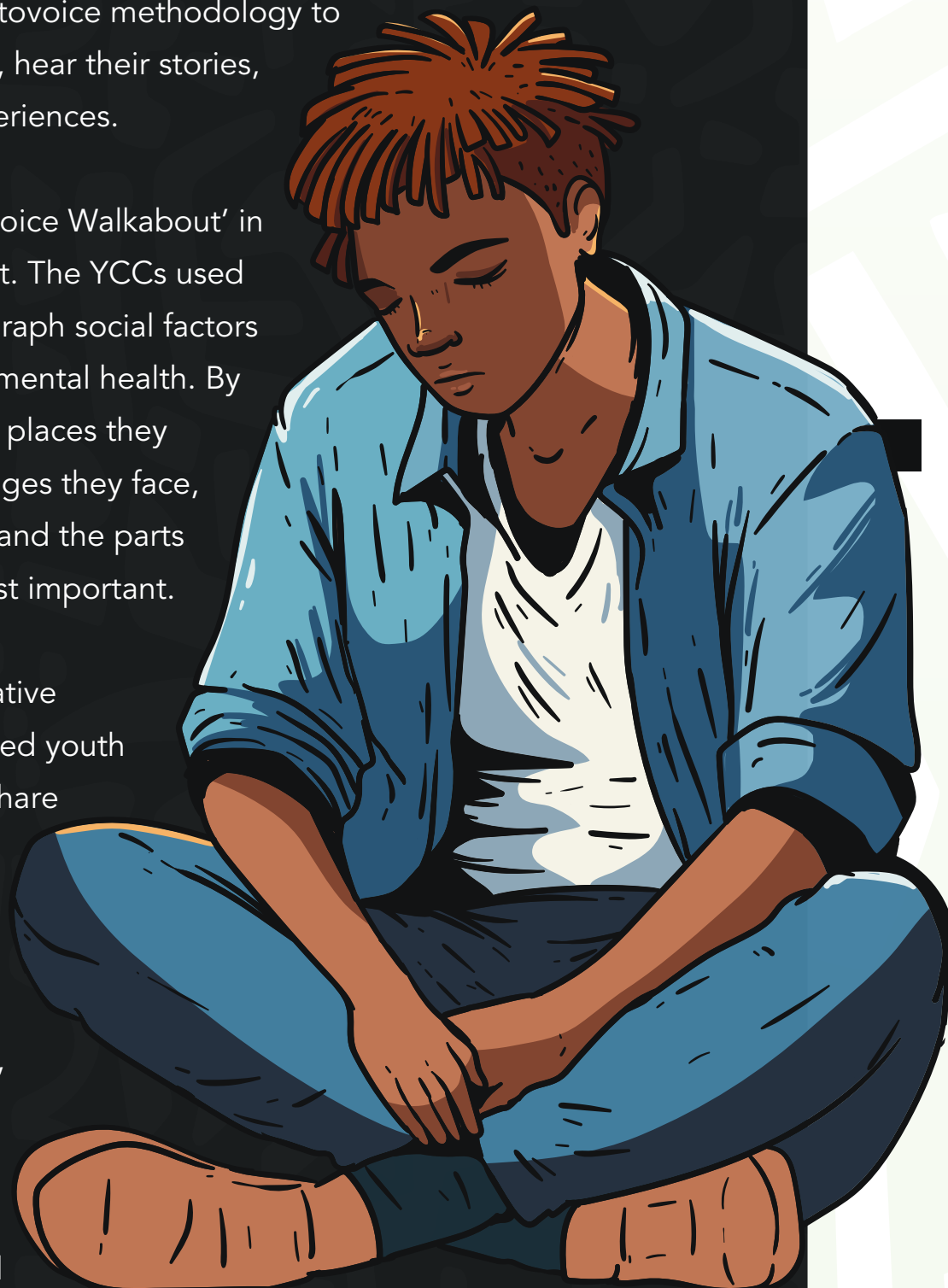
Hekima was our answer. Hekima built an architecture to extract information from paper records, with particular emphasis on 7 main nodes: Policy, Lived experience, Capacity Building, Communication, Scanning, AI Models, and EMR integration. Through these nodes, Hekima has been able to mine data from patient charts to build longitudinal datasets. Hekima shows that AI can be very effective when deployed in scanning systems, governance, lib, capacity building, communication, and integration. Hekima demonstrates that a responsible scale requires evidence from each of the identified nodes.



To generate transformative insights into how key social determinants affect depression symptoms among South African youth, we collaborated directly with young people, whom we refer to as 'Youth Co-Creators (YCCs)'. We used the Photovoice methodology to explore YCCs' livelihoods, hear their stories, and understand their experiences.

We started with a 'Photovoice Walkabout' in the uMkhanyekude district. The YCCs used digital cameras to photograph social factors they believe affect youth mental health. By following the YCCs to the places they chose, we saw the challenges they face, the resources they value, and the parts of their lives they find most important. Combining this real-time documentation with Narrative Building workshops enabled youth with lived experience to share what matters most to them.

While each participant shared an individual story, recurring images and common themes fostered collective dialogue and transformed personal experiences into shared understanding.



Group Therapy and Depression in HIV+ Patients

Our project addressed three key questions:

How does Group Support Psychotherapy (GSP) facilitate recovery from depression?

Can we identify individuals at risk of non-recovery six months after therapy? And how can these data-driven insights be translated into practice? To answer the first question, we developed longitudinal mediation models that demonstrated that recovery unfolds in stages.

During therapy, participants began openly expressing painful emotional experiences, accepting their circumstances, and drawing on spiritual coping. These early emotional shifts were strongly associated with improvements in depressive symptoms both immediately after therapy and six months later. Recovery was subsequently reinforced through reductions in HIV-related stigma

and self-blame, alongside gains in self-esteem, social connectedness, and adaptive coping strategies. To answer the second question, we developed and externally validated an AI-enabled risk-prediction model that identifies individuals at high risk of persistent depression. We seek additional funding to deploy this model as a clinical decision-support tool in a real-world setting, enabling mental health care to move from a one-size-fits-all approach to targeted interventions.

To answer the third question, we upgraded the SEEK-GSP Academy to a blended digital learning platform, incorporating mechanism- and risk-informed training modules to improve accessibility, scalability, and psychotherapy skill development.

Natural Language Processing for Mental Health Service Improvement in Africa

This project developed and implemented Artificial Intelligence (AI) supported call centers at two national referral mental hospitals in Uganda and Tanzania: Butabika National Referral Mental Hospital and Mirembe National Mental Health Hospital.

The project developed locally relevant datasets and AI tools using Automatic Speech Recognition (ASR) and Natural Language Processing (NLP). These tools analyze calls to the hospitals' call centers in Luganda, Kiswahili, English, and various accents and communication styles.

The team created annotation workflows to transcribe and label anonymized call recordings, assess call quality, implement speaker

diarization, and identify mental health-related topics.

The developed AI models perform conversation transcription, language and speaker identification, conversation quality assessment, and detection of mental health topics.

These tools generate insights from mental health interactions, support issue management, and enhance responsiveness and continuity of care. They also provide essential statistics for policymakers and management to inform future digital health services.

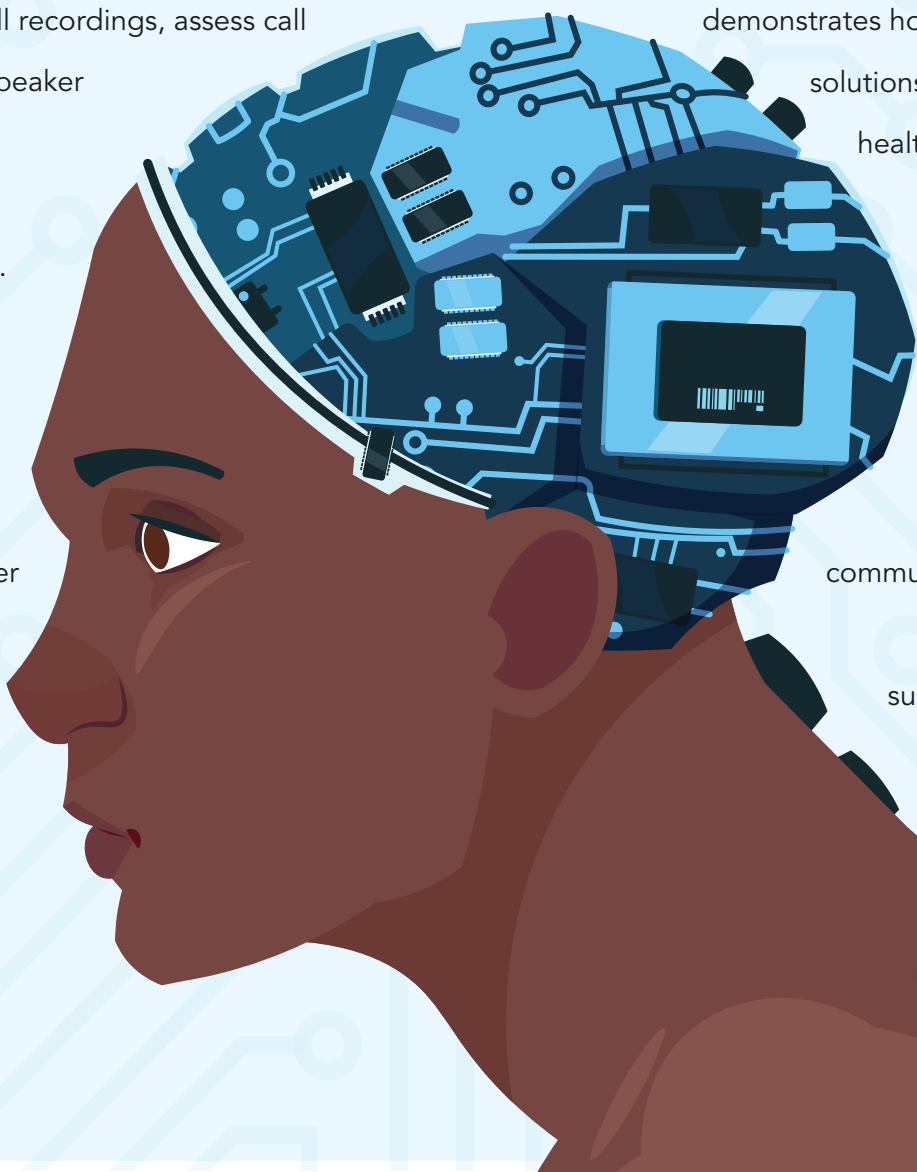
A key strength of the project is its user-centered, participatory approach. Patients, caregivers, peer support workers, and clinical staff contributed to the system design and implementation through interviews and focus groups. This collaboration

ensured the technology met community needs and fostered trust in AI for mental healthcare. The project

demonstrates how locally informed AI solutions can strengthen mental health services and improve patient support in resource-limited settings.

It also underscores the importance of privacy,

communication quality, active listening, and supportive interactions between callers and agents.



AfriCAT-DA: Adaptive Testing for Youth Mental Health

AfriCAT is an innovative digital tool for detecting depression and anxiety in African adolescents. CAT stands for Computerized Adaptive Testing, an advanced approach to digital assessments. Unlike traditional assessments that use a fixed set of questions, AfriCAT employs statistical and machine learning methods to select the most precise and relevant questions based on previous responses. This results in a faster, more accurate, and individualized assessment.

A distinctive strength of AfriCAT is that it is co-designed with adolescents, caregivers, educators, and frontline workers in South Africa and Kenya who have direct experience of living with depression and anxiety, or working closely with people who do. We engaged adolescents in South Africa and Kenya through focus groups and workshops to better understand their experiences with depression and anxiety during formative years. Their insights have shaped the tool's design, ensuring it is approachable, usable, and comfortable for young people to use or recommend.

In addition to adolescents, we consulted policymakers, healthcare workers, educators, and parents. Their input has shaped the tool's implementation to ensure it delivers value in schools, clinics, and community settings.

Understanding Mental Health in Rural and Urban Malawi

We have developed one of Malawi's most comprehensive mental health datasets by integrating population-level and clinical data from both rural and urban areas. This dataset combines information from the Healthy Lives Malawi Long-Term Conditions survey (over 34,000 participants), the Generation Malawi birth cohort (2,500 participants), and MEIRU's mental health clinic records (over 1,200 service users). All data are linked within the Karonga (rural) and Lilongwe (urban) Health and Demographic Surveillance System platforms, operated by the Malawi Epidemiology and Intervention Research Unit (MEIRU).

This unified dataset links community screening data, clinic records, follow-up episodes, and health outcomes for over 30,000 individuals. It offers a unique platform to study mental health across diverse population groups and settings. The data show that depression and anxiety affect individuals aged 15 and above across both sexes and in rural and urban areas. In the general population, the prevalence of depressive symptoms is 2.4% and anxiety symptoms 5.1%. Rates are significantly higher among pregnant women, with 16.6% experiencing depression and 21.0% anxiety. Their spouses are also affected, with depressive symptoms at 19.3% and anxiety symptoms at 20.0%.

In addition to population-level analysis, the project generated operational insights from over 1,000 mental health clinic referrals.



Key barriers to sustained engagement include stigma, travel distance, competing household responsibilities, and socioeconomic challenges. These insights will guide the development of more accessible and responsive community mental health services in Malawi. The MEIRU-Viewer, an open-access digital platform based on the Findable, Accessible, Interoperable, and Reusable (FAIR) data principles, supports this work. It allows researchers, clinicians, and policymakers to explore integrated mental health data, create visualizations, and request datasets for further analysis.

People with lived experience have played a central role throughout the project, shaping research priorities, informing interpretation, and contributing to the design of the digital platform. This participatory approach ensured that both the evidence and solutions were grounded in the realities of the communities served.

This work has strengthened Malawi's mental health evidence base and established a strong foundation for future research, digital innovation, and policy development in Malawi and similar settings.

PAMHoYA: Mental Health Data Platform for Youth

Africa's mental health information landscape is widely recognized as fragmented, limiting planning, budgeting, and service delivery. In South Africa, this fragmentation is reflected in the collection of depression and anxiety data among young people across institutions and studies, using different instruments, constraining comparability, synthesis, and secondary use for surveillance, policy, planning, and care.

To address this challenge, PAMHoYA was developed as a Mental Health Data Discovery Platform and a tool for harmonizing mental health measures for young people in South Africa. The project brought together researchers, policymakers from the South African National Department of Health, civil society organizations, and individuals with lived experience of mental health conditions to co-develop an open-access, user-friendly platform.

This platform enables users to find, compare, and interpret existing mental health data for young people aged 15 to 24. Instead of collecting new data, PAMHoYA focuses on maximizing the value of existing data. The platform uses natural language processing to harmonize mental health measures, including those in different languages, across South African studies. This approach enables secondary analysis and supports both national and sub-national mental health surveillance.

A defining feature of PAMHoYA is its co-development approach. Lived experience experts were engaged not only as contributors but as partners in shaping how data are organized, interpreted, and used. Their involvement helps surface everyday realities of accessing care, navigating services, and living with mental health challenges across different geographic settings, adding context that numbers alone cannot capture.

PAMHoYA is designed for sustainability by collaborating with established, government-funded research infrastructures such as the South African Population Research Infrastructure Network, the South African Medical Research Council, and Harmony. The platform establishes a foundation for a data network that can expand as new datasets become available, supporting research, policy, and planning beyond the project's initial phase.

PAMHoYA supports the broader goal of the Mental Health Data Prize – Africa by demonstrating that harmonized and shared existing data, through co-developed digital tools, can significantly improve mental health surveillance and outcomes across the continent.





Digital Mental Health Solutions in the Western Cape

South Africa's Western Cape Provincial Health Data Centre (PHDC) integrates patient-level data from 5 million public health service users to improve clinical care, support operational reporting, and research. The project integrates two digital tools into the PHDC infrastructure: A Mental Health Dashboard designed to describe service provision and service user characteristics to inform strategic resource allocation, and a Continuity of Care Tool designed to track individuals with severe mental health conditions and facilitate information sharing and communication between care providers across the continuum of care.

The Mental Health Dashboard facilitates spatiotemporal visualization of mental health service utilization to support strategic resource allocation and improve service availability for the management of common mental health conditions at the community level. The Continuity of Care Tool supports collaborative management and enhances the care engagement of people with severe mental health conditions.

Uganda's Digital Mental Health Leap: Harnessing DHIS2 for Data-Driven Insights

Uganda's Digital Mental Health Leap shows that routine mental health records can provide a stronger basis for planning, research, and patient-centred care. Across 18 Regional Referral Hospitals, the project digitised retrospective mental health data from 2022 to 2024 using a customised DHIS2 Event Capture tool. By September 2025, the team had entered approximately 192,436 clinical records into a DHIS2 event list, creating a robust dataset to analyse service use, diagnosis patterns, continuity of care, and gaps in follow-up. The initial analysis focused on interpreting the newly captured data.

The team cleaned and reviewed records, classified diagnoses from clinical notes, and began generating early insights on mental health service patterns across facilities. This analysis has already identified key trends, such as a high caseload for bipolar disorder, consistently low reporting of anxiety disorders, and a significant decline between first and follow-up visits. These findings are prompting deeper questions about access, diagnosis, retention in care, and the patient journey. A key lesson is that digitisation is most effective when it directly enhances service organisation and follow-up.

Building on the development of a DHIS2-based mental health event linelist and tracker register, the team is applying these insights to design and implement national digital registers. These e-registers aim to ensure consistent documentation, better patient follow-up, easier reporting, and improved visibility of service delivery at both facility and national levels. DHIS2 Tracker is particularly relevant for this phase, as it enables longitudinal tracking of registered individuals, while DHIS2 Event programmes are better suited for recording single events without individual registration.

The project aligns with the broader goal of the Mental Health Data Prize - Africa: to use existing data to generate scalable, locally relevant insights and solutions for anxiety, depression, and psychosis in Africa.

By integrating routine data, primary analysis, and DHIS2-based e-registers, the Uganda team is establishing a more responsive digital mental health information system to support clinicians, programme managers, researchers, and policymakers with timely and reliable evidence.

Youth Mental Health Innovation: Leveraging Data and Digital Tools for Scalable Impact

Africa faces a significant but often overlooked youth mental health crisis. In Kenya, 44% of adolescents experience depression or anxiety, yet the mental health system is under-resourced, and stigma remains high. There are few trained professionals, and existing clinical models are costly, difficult to scale, and designed for well-resourced settings rather than local schools. Even when affordable interventions are available, there is limited evidence on their real-world effectiveness and which groups benefit most. Without this insight, scaling interventions are uncertain.

The project took a two-track approach: rigorous data analysis paired with practical digital innovation. Researchers analyzed findings from 6,115 young people across studies conducted between 2018 and 2023, spanning schools in Nairobi, Kiambu, Kisumu, Nakuru, and Makueni. The team applied the “four enoughts” framework, asking whether interventions were good enough, big enough, simple enough, and cheap enough to work when deployed by governments, not just in controlled research settings.

Digitally, the team developed shamiriOS, a modular delivery platform, and shamiriAI, an AI tool that trains and supervises lay providers. Individuals with lived experience of mental health challenges were closely involved in co-designing both tools, reviewing research, and shaping how the AI delivered feedback to providers.

The results are notable. Within four weeks, most participants with elevated symptoms showed significant improvement (effect sizes $d = 0.20$ to 0.39), and 80% no longer met criteria for depression or anxiety by program end. Outcomes were consistent whether sessions were led by the Shamiri team or trained partners. Across trials with over 3,200 students, outcome quality remained high (fidelity agreement $AC2 \geq 0.95$), demonstrating the model’s reliability when implemented by others. With 89–95% of participants finding the intervention helpful and recommending it to peers, and costs as low as \$11 per student, the case for scaling is strong.

Previously, delivery teams used WhatsApp and scattered spreadsheets. ShamiriOS replaced these with unified scheduling, case management, and real-time dashboards, while shamiriAI provides personalized supervisor feedback within minutes. Together, these platforms have supported over 210,000 students across 48 sites, and both tools are open-source and freely available.

ShamiriOS is designed for scalability in diverse, resource-limited settings. Its modular architecture enables integration with schools, county governments, or public health systems with minimal adaptation. The low-cost model reduces reliance on donors, while building local provider capacity ensures sustainability after external teams depart. The long-term goal is for shamiriOS and shamiriAI to serve as core digital infrastructure for government-led youth mental health services across Africa, improving in effectiveness as usage grows.





People with Lived Experience Highlights

A central aspect of the Mental Health Data Prize - Africa (MHDP-A) is the intentional inclusion of People with Lived Experience (PLEs) in mental health research. From the beginning, the project acknowledged that data alone cannot fully represent lived realities. As one contributor stated, "Our stories bring context that numbers cannot explain." Lived experience provides essential context, ensuring research remains both evidence-based and relevant.

Across the ten prize teams, engagement has shifted from basic participation to more meaningful involvement. PLEs informed research questions and tools, supported data collection, validated findings, and contributed to dissemination. While many efforts began as consultative, some evolved into collaborative models, reflecting the view that "being consulted is not the same as being included."

PLE involvement strengthened research quality and relevance by helping to:

- Identify gaps and blind spots.
- Improve cultural sensitivity and accessibility.
- Build community trust
- Highlight priorities beyond clinical outcomes.

In several cases, this expanded the research focus to include dignity, social support, and daily functioning. Key lessons include PLE contributors' emphasis on moving beyond tokenism toward meaningful inclusion. Their priorities were:

- Continuous engagement
- Clear roles and expectations
- Feedback loops to demonstrate how input is used
- Recognition of lived experience as expertise

The project also highlighted the importance of capacity building for both PLEs and researchers. PLE contributors identified needs in research literacy, confidence, and mentorship. Researchers adapted by working more collaboratively and communicating more clearly. Fair compensation, psychosocial support, and flexible participation were consistently identified as essential. As one contributor stated, "Our time and expertise should be valued the same way other experts are."

Looking Ahead

There are further opportunities to strengthen engagement by involving PLEs earlier, expanding their roles into analysis and leadership, broadening participation, and embedding engagement in institutional and funding structures. The MHDP-A experience highlights the value of meaningful PLE engagement in mental health research.

As one contributor observed, "True engagement means shared ownership of the work." Research is most effective when shaped with those it aims to serve.

Nothing About Us, Without Us

By Benta Wambui - Counseling Psychologist, and Onyango Otieno - Mental Health Advocate, with contributions from Christine Ger Ochola - Communications Officer (APHRC) and Ann Waithaka - Senior Communications Officer (APHRC)

Millions of people across Africa experience anxiety, depression, and psychosis, yet much of the data and research addressing these challenges has historically excluded the perspectives of those with lived experience. In 2024, the African Population and Health Research Center (APHRC), in partnership with Wellcome, launched the Mental Health Data Prize Africa (MHDPA), an initiative that harnesses data science to improve understanding and responses to mental health across the continent. Through this program, ten multidisciplinary teams each received up to £200,000 to develop data-driven solutions targeting anxiety, depression, and psychosis. From the inception, MHDPA was guided by the belief that data is most effective when linked to human experience. While numbers reveal patterns, they cannot fully convey the impact of stigma, barriers to care, or the resilience of individuals facing mental health challenges in communities where open discussion remains difficult. To improve mental health outcomes in Africa, data-driven innovation must be developed with the people it serves. Central to MHDPA's approach was involving people with lived experience at every stage, inviting their insights, listening to their reflections, and ensuring their perspectives shaped both priorities and solutions. This approach recognized lived experience as expertise and prioritized meaningful engagement over token consultation.

What We Learned

Early in the process, it became clear that meaningful engagement requires structure, clarity, and time; it cannot rely on invitation alone. Some contributors asked, "What exactly is my role here?" This highlighted the need for clearer role definition, shared between researchers and people with lived experience. Creating space for open dialogue allowed contributors with lived experience to shape and define their roles, while research teams provided guidance, expectations, and practical tools to support engagement. Investing time early in co-developing role descriptions and processes helped reduce uncertainty and made participation more respectful, purposeful, and effective. Participation carried emotional weight.

Through conversations and workshops, we saw that sharing lived experiences, particularly those related to mental health, can be challenging. This led us to be more intentional about safeguarding, supported by creating safe spaces, checking in regularly, and offering flexibility as needed. As engagement increased, its impact on the work became clear. Contributors raised questions that changed the team's approach, including concerns about dataset exclusions, data interpretation, and the consequences of failed safeguards. These changes did more than enhance the work; they fundamentally reshaped it.

What Surprised Us

Initially, engagement was consultative. Contributors shared their perspectives and experiences when prompted, but decision-making remained with the research teams. This reflected a traditional structure where power was not fully shared. As trust grew in a safe, inclusive environment, the dynamic shifted. Contributors began actively shaping discussions and influencing decisions, moving beyond simply providing input. This transition to partnership led to more meaningful involvement, with contributors' insights integrated into the direction of the work. Partnership involved shared ownership of ideas, greater transparency in decision-making, and a more balanced distribution of power. Contributors were encouraged to question, suggest, and co-create, while teams became more intentional about listening and adapting. This shift required ongoing reflection on power dynamics to ensure engagement was genuinely collaborative rather than tokenistic. The diversity of contributors' experiences became clear through conversations that highlighted differences in age, gender, location, language, and access to care. What mattered to one person often differed from what mattered to another. Importantly, learning was mutual: contributors gained insight into data science and research, while teams better understood the real-world context behind the data. This created a shared, respectful space for collective learning.

What We Would Do Differently

Looking back, one thing is clear: we should have started engaging people sooner. Some of the best ideas came up late in the process, highlighting the

value of involving people with lived experience voices from the very beginning. We also noticed that some teams were better prepared for participatory approaches than others. This sometimes led to uncertainty about how to participate meaningfully. If we had spent more time learning together at the start, teams might have been more consistent. It is also important to consider what happens after a project ends. The initiative demonstrated that bonds formed among teams and contributors were sources of insight, trust, motivation, and accountability. If these connections end abruptly, momentum and collaboration may be lost. Planning for ongoing engagement from the outset helps maintain trust, sustain impact, and ensure contributors feel valued.

New Standard for Mental Health Research

This experience reinforced a simple but important truth: data-driven innovation is strongest when grounded in the realities of the people it is meant to serve. While the initiative addressed anxiety, depression, and psychosis, it also highlighted that early partnership with individuals with lived experiences is as important as research outcomes. Meaningful engagement is an ongoing process that requires humility, curiosity, and a commitment to learning. Although tools and approaches may change, the guiding principle remains: nothing about us, without us. We encourage you to apply these lessons to future research, funding, and mental health initiatives across Africa.

Key Insights from the Project

The Mental Health Data Prize – Africa was a multi-country initiative that convened 10 locally led prize teams across Kenya, Uganda, Malawi, and South Africa. The teams used secondary data to develop data-driven solutions addressing anxiety, depression, and psychosis.

Key lessons emerging from implementation include:

1. Limited availability of mental health data

In many African contexts, mental health data, particularly longitudinal datasets, remains scarce, constraining analysis, tracking of trends, and evaluation of interventions.

2. Value of meaningful stakeholder engagement

Active and intentional engagement of communities, stakeholders, and persons with lived experience (PLE) significantly strengthens the relevance, quality, and applicability of data-driven mental health solutions.

3. Leadership role of persons with lived experience

When meaningfully involved, PLE can go beyond participation to actively lead, co-create, and drive innovation in mental health research and programming.



“The MHDP-A initiative demonstrates that better mental health data leads to better decisions. By investing in robust evidence systems, we can develop context-specific and socioculturally responsive interventions that are people-centred, equitable, and informed by the lived realities of communities. This is essential to building inclusive mental health systems and ensuring that no one is left behind in the pursuit of mental wellbeing.”

Frederick Murunga Wekesah
Associate Research Scientist- APHRC

4. Power of cross-country and South–South collaboration

Collaboration across countries facilitated rich peer learning, exchange of methods and tools, and strengthened collective capacity for innovation.

5. Data as a catalyst for advocacy and policy influence

When effectively analyzed and communicated, mental health data can serve as a powerful lever for advocacy, agenda setting, and informing policy and practice reforms.

6. The Role of Targeted Funding in Multidisciplinary Innovation

Targeted funding is essential for maximizing the potential of multidisciplinary teams by fostering collaboration among diverse areas of expertise (such as data science, mental health, implementation research, and lived experience). The MHDP-A investment by Wellcome offered the flexibility, resources, and time necessary for experimentation, iterative learning, and co-creation. Ultimately, it accelerated the development of innovative and context-relevant solutions for mental health challenges.







Acknowledgement

This work was possible thanks to the collective efforts and support of many individuals and organizations. We sincerely thank our partners at the African Population and Health Research Center (APHRC) for their collaboration and leadership throughout the project. We also appreciate our funders, Wellcome, for their generous support and commitment to advancing mental health research in Africa.

We extend our profound gratitude to the ten pioneering teams who won this prize and brought it to life. By turning bold concepts into scalable, ground-level solutions, you have vindicated this investment and set a new benchmark for global mental health research and implementation in LMICs.

We are proud to highlight the following projects:

- Digitizing Psychosis Care in Uganda
- CO-LUMINATE: Youth Mental Health and Social Stress
- Group Therapy and Depression in HIV+ Patients
- Natural Language Processi/ng for Mental Health Service Improvement in Africa
- Digital Mental Health Solutions in the Western Cape
- AfriCAT-DA: Adaptive Testing for Youth Mental Health
- Understanding Mental Health in Rural and Urban Malawi
- PAMHoYA: Mental Health Data Platform for Youth
- Uganda's Digital Leap: DHIS2 for Mental Health Insight
- Youth Mental Health Innovation through Data and Tech



We are deeply grateful to our exceptional team of consultants and Lived Experience partners. By seamlessly blending your technical expertise with the profound insights of real-world experience, you have ensured that our research is not only academically rigorous but ethically grounded and deeply human. We especially want to honor the memory of Ms. Charity Muturi, whose voice and vision remain a foundational pillar of this work. We thank our technical advisory board members for their guidance, expertise, and strategic direction, which enhanced the quality and rigor of the concepts and as a catalyst for impact of these scalable solutions projects. Finally, we are especially grateful to all participants who generously shared their time, experiences, and invaluable perspectives. Your voices are central to this work and continue to inspire progress in mental health research and advocacy in Africa.



African Population and
Health Research Center
Transforming lives in Africa through research



**Mental Health
Data Prize - Africa**



[▶](#) [in](#) [X](#) @mhdp-a