**Reviewer's report**

**Title:** Using the WHO-AIMS to inform development of mental health systems: The case study of Makueni County, Kenya

**Version:** 0  **Date:** 13 Jul 2019

**Reviewer:** David McDaid

**Reviewer's report:**

The authors have worked hard to revise and reshape the paper and it is much improved. That said, one of the challenges of this paper is that is often documenting the lack of availability of services; which of course is appropriate as it reflects reality on the ground. This lack of activity may limit the interest of the paper to some readers, even though it is very important to map the existence of services as well as barriers and facilitators to change.

There are several things that I feel the authors need to do to maximise the value of this paper. Fundamentally they include consideration of whether or not any changes in policy and practice were due to baseline work alone rather than the whole range of engagements that have already been documented.

Some specific comments below:

1. There is the issue of implementation of MHGAP-IG; I think it needs to be clearer that this baseline analysis was one of the first steps in undertaking this implementation. This is not clear when reading this manuscript, although this is clear from Mutiso et al. Int J Ment Health Syst (2018) 12:57.

2. In general I think the authors need to be careful to make sure that they are not going over too much of the same territory as in some of the related papers.

3. How specifically did the baseline analysis shape the later stages of the project including the theory of change work and can the authors say something about the timing - did the baseline work precede the theory of change and wider stakeholder engagement or did it happen concurrently?

4. The paper notes that the process of implementing MHGAP-IG in Makueni was underway; one thing that is not clear is how the objectives/ chronology of this paper fit in with the papers 24-28 that have already been published. This paper is focused on the policy making environment, but policy makers may be to some extent already engaged as part of the wider stakeholder engagement that was undertaken in order for implementation of MHGAP-IG to happen. That is why the chronology is important. Did the WHO_AIMS work influence participation in this wider stakeholder engagement or did the wider stakeholder engagement influence participation in the WHO-AIMS work?
5. The title I would suggest is still far too long.

6. The authors note on line 29-31 that only 7 South East Asia countries have made use of AIMs - it is worth clarifying that there only 11 countries in that constellation - so is 7 of 11 that bad?

7. The section on data analysis states that "recorded interviews were transcribed and summarized using content analysis" but the previous paragraph states "None of the interviews with particular respondents were recorded". This appears to be a contradiction?

8. Is there any danger that because the decision was made in partnership with the County Chief Officer of health that the key informants and facilities to visit may not be as representative as they could be but rather more likely to present a more positive perspective on the baseline than might otherwise have been the case. Is this something to be discussed in limitations?

9. For Figure 2 there needs to be a scale on the Y axis to help the reader understand the magnitude of contacts.

10. Just before the beginning of the discussion section that paper states "This study had immediate outcomes detailed under the results and summarized as follows: (1) decision to fund training of mental health specialists, (2) setting up of a psychosocial section to coordinate psychosocial interventions, and (3) availability of any psychotropics on demand paid for by the county". I could not see any detail for these outcomes earlier in the section, what happened, when and is there any evidence at all to link it to the authors engagement with local policymakers. What evidence is there that these changes occurred prior to the Theory of Change process that is documented in Mutiso et al. Int J Ment Health Syst (2018) 12:57? Or would the changes not have happened if there had not also been a TOC process?

11. The change in "availability of any psychotropics on demand paid for by the county" documented here sounds like the same thing as the Mutiso et al paper which states "An important policy change was expansion of availability of psychotropics by the Makueni County Government beyond the essential list to meet the newly identified needs and demands. These needs and demands arose during the implementation of mhGAP-IG in order to treat the identified DSM-IV/ICD 10 diagnoses. This justified and allowed for stocking of the following additional psychotropics (some of which previously had only been allowed at hospital level): Carbamazepine, sodium valproate, amitriptyline, fluphenazine, fluoxetine, citalopram, haloperidol (both tablets and injectable) and lithium carbonate. These were fully paid for by the Makueni County Government as their contribution to the study." If this is the same thing my question is how can this be attributed solely to the baseline data mapping alone as it seems to also be linked to wider stakeholder engagement set out in the other paper.
12. If this is the same thing it also suggests that this psychotropic access change may be a temporary measure linked to the study rather than a long term change in policy?

**Are the methods appropriate and well described?**
If not, please specify what is required in your comments to the authors.

Yes

**Does the work include the necessary controls?**
If not, please specify which controls are required in your comments to the authors.

Yes

**Are the conclusions drawn adequately supported by the data shown?**
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No

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