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STUDY PROTOCOL

REVISED Task-Sharing and Stepped-Care Mental Health Services in Angolan Higher Education: A Multi-Site Implementation Protocol (ANGOSAP)

[version 3; peer review: 2 approved, 1 approved with reservations]
Previously titled: "Building university-based psychological and psychoeducational services in Angola (ANGOSAP): a brief report on rationale, design, and early implementation context"

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Abstract

Background

Higher education institutions in Angola face increasing demand for mental health and psychoeducational support in the context of limited specialist workforce and service capacity. ANGOSAP is an Erasmus+ — funded capacity-building initiative designed to establish sustainable, university-embedded Psychological Support Services across four Angolan universities and to strengthen early access to support within higher education settings.

Methods

Open Peer Review

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This Study describes the rationale, service model, and early implementation framework of ANGOSAP. The project uses a co-designed, stepped-care, task-sharing approach adapted to the context of each institution. Core components include campus-level standard operating procedures for intake, triage, risk assessment, safeguarding, and referral; competency-based training and supervision; student-facing psychoeducation, brief psychological interventions, and digital resources; formal referral pathways; and pragmatic monitoring. Early implementation success will be assessed using indicators: service reach, median waiting time from first contact to first appointment, first-appointment uptake, care-plan completion. Reliable clinical change monitored using PHQ-9, GAD-7, and WHO-5, alongside indicators of reach, access, safety, acceptability, and equity serious incidents, acceptability, and equity-stratified access and outcomes.

Results

No primary clinical outcomes or human participant data are reported in this Study Protocol. Preliminary outputs include a defined implementation pathway for university-based services, a minimum dataset for routine monitoring, quality and safety procedures, equity-oriented performance dashboards, and a cross-site learning structure to support iterative service refinement. These elements are intended to enable early-access, context-sensitive care while generating practice-based evidence during phased implementation.

Conclusions

ANGOSAP provides a structured protocol to test the feasibility of university-based psychological and psychoeducational support in Angola. By combining capacity building, supervision, referral integration, and routine monitoring, the project will generate practice-based evidence on reach, access, safety, acceptability, and early clinical change. These findings will inform service refinement across participating institutions and provide a roadmap for engaging national stakeholders, including health and higher education authorities, in future policy development.

Plain Language summary

Angolan universities are seeing an increasing number of students who need help with stress, anxiety, depression, academic difficulties, and adjustment. However, trained specialists are few, and many campuses have no dedicated service. ANGOSAP is creating university-based Psychological and Psychoeducational Support Services that combine good information (psychoeducation), brief talking therapies, and clear pathways to specialized care when needed. The model trains existing staff (for example, counselors, psychologists, and student

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support officers) and provides them with supervision and tools so that students can receive help earlier and closer to where they study. We describe why this is needed in Angola, how the service will work, and how we will ensure that it helps students fairly and effectively. This manuscript is presented as a Study Protocol following Open Research Europe guidance.

Keywords
Angola; university students; mental health services; psychoeducation; stepped care; capacity building; task sharing; implementation; Sustainable Development Goals.

This article is included in the Erasmus+ gateway.

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REVISED **Amendments from Version 2**

Version 3 substantially strengthens the ANGOSAP protocol compared with Version 2. All changes were made in response to the reviewers' suggestions. The revised version clarifies the project scale in the abstract, names the PHQ-9, GAD-7 and WHO-5 more consistently, expands governance procedures for suicide/self-harm risk, details OSCE-style competency assessment, adds cultural adaptation checks, improves data-quality and missingness procedures, and broadens the discussion on sustainability, stigma, generalizability and system-level implications. Version 3 also adds a clearer conclusion on wider mental health system strengthening in Angola. Importantly, all changes introduced in Version 3 are highlighted in color for easy editorial review.

Any further responses from the reviewers can be found at the end of the article

Introduction

Angola's population is young and urbanizing, and its Higher Education Institutions (HEI) are central to social and economic development. Similar to many countries in sub-Saharan Africa, Angola faces a dual challenge: high and possibly rising demand for mental healthcare and a historically under-resourced system. This demand was further amplified by the coronavirus disease 2019 (COVID-19) pandemic, which increased the global prevalence and burden of depressive and anxiety disorders in 2020 (Santomauro et al., 2021). For university students, the COVID-19 pandemic also disrupted face-to-face teaching, reduced peer and institutional support, increased social isolation, and intensified economic hardship for families and students. These factors are especially relevant in higher education systems where digital access and student support structures may be uneven. Recent GBD 2021 analyses identified Angola among countries with the highest age-standardized incidence rate (ASIR) of mental disorders, consistent with regional patterns seen in central sub-Saharan Africa (Fan et al., 2025; GBD 2021 Diseases and Injuries Collaborators, 2024). Meanwhile, the specialist mental health workforce in the public sector remains limited; the latest World Health Organization (WHO) country profile (2017) reported approximately 0.06 psychiatrists and 0.18 psychologists per 100,000 population, with approximately 1.49 total mental health workers per 100,000 (World Health Organization, 2017).

Mortality due to suicide remains a key measurable outcome in mental health systems. The World Health Organization's most recent global country-resolved baseline (2019) under the Global Health Estimates shows varied patterns in the African Region; for example, in Angola, World Bank/WHO-compiled indicators report a suicide mortality rate of approximately six per 100,000 in 2019, underscoring the need for prevention, early identification, and care pathways (World Health Organization, 2021).

Universities represent a critical setting for early mental health intervention because students are often navigating academic transition, economic pressure, separation from family support, uncertainty about employment, and, in Angola, the broader effects of post-conflict social and intergenerational adversity. Many students are also first-generation entrants into higher education, which may increase both opportunity and psychosocial strain. Emerging adulthood is a key developmental window in which common mental health problems may first emerge or become persistent; therefore, campus-based services can provide timely, low-stigma, and developmentally appropriate support.

Against this backdrop, the ANGOSAP project (https://angosap.org/en/) aims to establish sustainable, university-embedded Psychological and Psychoeducational Support Services that expand access using a stepped-care, task-sharing model and strengthen referral links with public specialist care where available. The present Study Protocol distills the project's rationale, design, and early implementation framework from the internal technical description and grant proposal.

Study aims and rationale

The overarching objective of ANGOSAP is to improve student well-being and learning outcomes by building campus-based services that provide (i) psychoeducation, (ii) screening and early intervention for common mental disorders and academic-related difficulties, (iii) crisis procedures and safeguarding, and (iv) structured referral to specialist care. In Study Protocol form, the manuscript sets out the rationale, operational model, and implementation procedures through which this capacity-building effort will be established and evaluated across partner higher education institutions in Angola. Three converging signals justify action:

1. Burden and unmet need. The Global Burden of Disease Study 2021 highlights high incidence rates in Angola within the region (Fan et al., 2025).

2. System constraints. According to World Health Organization (WHO) country profile documents, there are very low specialist densities and limited dedicated outpatient capacity (World Health Organization, 2017).

3. Policy momentum. World Health Organization Angola's 2024 Annual Report describes ongoing health-system strengthening, including policy revision and information-system improvements, an enabling context for university-level service innovation that dovetails with national priorities (World Health Organization, 2024).

Complementary evidence from the GBD 2019 age-period-cohort analyses highlights changing incidence patterns for depressive disorders over 1990–2019, supporting the need to strengthen early identification and brief interventions (Wu et al., 2024).

Study design and methodology

This Study Protocol describes a multi-site, co-designed, stepped-care, task-sharing implementation model for establishing university-embedded Psychological and Psychoeducational Support Services across participating higher education institutions in Angola. The protocol combines locally adapted service design, standardized operational procedures, workforce development, referral coordination, and a pragmatic evaluation framework intended to generate actionable implementation learning during early scale-up.

Visual conceptual framework/Logic Model

To provide a clearer representation of the intervention architecture and its underlying implementation assumptions, a conceptual framework and logic model have been incorporated. This table synthesizes the relationships among key inputs, implementation activities, outputs, anticipated short- and medium-term outcomes, and expected long-term impacts, thereby making explicit the project's theory of change and the mechanisms through which capacity-building activities are expected to contribute to sustainable psychological and psychoeducational support services within participating higher education institutions (Table 1).

Table 1. Conceptual Framework and Logic Model of the ANGOSAP. Implementation Model.

Inputs	Activities	Outputs	Short- and Medium-Term Outcomes	Long-Term Impacts
Erasmus+ funding and institutional support	Co-design workshops with HEI stakeholders	University-specific service implementation plans	Increased awareness and mental health literacy among students	Improved student well-being and quality of life
Partner universities and governance structures	Development of standard operating procedures (intake, triage, risk assessment, safeguarding, referral)	Standardized operational protocols across participating HEIs	Improved access to psychological and psychoeducational support services	Enhanced academic engagement, retention, and success
Psychologists, supervisors, and trained staff	Competency-based training and supervision programs	Trained service providers and supervisors	Reduced waiting times and improved service accessibility	Stronger student support ecosystems within universities
Digital resources and psycho-educational materials	Delivery of psychoeducation, workshops, self-help resources, and brief interventions	Student-facing services operational across campuses	Early identification and management of mental health and learning-related difficulties	Reduced burden on overstretched specialist mental health services
Partnerships with health and educational services	Establishment of referral and safeguarding pathways	Formalized referral agreements and collaborative networks	Improved continuity of care and referral effectiveness	Sustainable and integrated university-based mental health services
Monitoring systems and implementation framework	Routine data collection, quality assurance, supervision, and PDSA cycles	Service dashboards, quality indicators, and implementation reports	Improved quality, safety, acceptability, and equity of service delivery	Evidence-informed policy and institutional decision-making

Table 1. *Continued*

Inputs	Activities	Outputs	Short- and Medium-Term Outcomes	Long-Term Impacts
Equity and inclusion strategy	Targeted outreach to vulnerable and underserved student groups	Equity-focused monitoring and outreach activities	Increased service utilization among underrepresented groups	Reduced inequalities in access to mental health and psychoeducational support

Design principles

Building on the preceding rationale, the protocol is articulated through a set of core design principles, which are described individually below. Together, these principles define how the service is structured, implemented, and adapted to different institutional realities, ensuring coherence between the conceptual framework, operational procedures, and the needs of students and staff.

a) Co-design and context fit. Each participating HEI will complete a structured service-design workshop with administrators, student representatives, and clinicians to adapt the core service blueprint to local realities (language, staffing, timetables, and infrastructure).

b) Stepped care. Tier 1: mental health literacy and psychoeducation; Tier 2: brief, evidence-based psychological interventions (e.g., problem-solving therapy, behavioral activation, and anxiety management) delivered by trained specialists under supervision; Tier 3: referral to specialist care for severe or complex conditions.

c) Task sharing with supervision. Competency-based curricula and supervision ladders align with global practices in low-resource settings, prioritizing safety, fidelity, and scalability.

d) Equity and inclusion. Active outreach to first-generation students, women, and students with disabilities; confidential access points; and multilingual materials. Ethical practice will be reinforced through informed consent, confidentiality, and data protection procedures proportionate to local regulations and the sensitivity of students' mental health information

Core components

Building on the design principles outlined above, the protocol is operationalized through a set of core components that are described individually below. Together, these components specify how the service will be governed, staffed, delivered, and continuously improved, thereby linking the conceptual framework to day-to-day practice in a way that can be implemented consistently across participating institutions.

1. Governance & protocols. Campus-level Standard Operating Procedures will cover intake, triage, risk assessment, safeguarding, and emergency referral. Any indication of suicidal ideation or self-harm, including a positive response to PHQ-9 item 9, will trigger a same-day structured risk assessment using a brief suicide and self-harm risk protocol. Risk documentation will include current ideation, intent, plan, past self-harm, protective factors, risk level, action taken, supervision input, and referral decision. High or imminent risk will require urgent escalation according to campus emergency procedures and local referral pathways.

2. Workforce development. Providers, including counselors and student support officers, will complete a 40-hour competency-based training programme, followed by supervised practice and regular supervision during the first implementation semester. Training will cover structured intake, confidentiality, safeguarding, use of PHQ-9, GAD-7 and WHO-5, suicide and self-harm risk assessment, brief psychoeducation, problem-solving strategies, behavioral activation, anxiety-management techniques, referral documentation, and crisis escalation. Competence will be assessed through skills checklists and OSCE-style stations using simulated student scenarios. Stations will assess structured intake, correct use and interpretation of PHQ-9, GAD-7 and WHO-5, recognition of suicide or safeguarding risk, delivery of a brief intervention component, documentation of a care plan, and appropriate Tier 2 versus Tier 3 referral decisions. Providers must meet predefined pass criteria and complete any required supervised practice before delivering student-facing care independently.

3. Student-facing services. Drop-in hours, scheduled sessions, psychoeducational workshops, and digital self-help resources vetted for cultural and linguistic fit.

4. Data and quality. We will implement a pragmatic monitoring framework to ensure that the service is both effective and safe. This will include indicators of the following: (a) service reach (the proportion of the student population that has contact with the service); (b) access (the median waiting time between first contact and first appointment); (c) Clinical change will be monitored through a predefined minimum outcome set: the Patient Health Questionnaire-9 (PHQ-9) for depressive symptoms, the Generalized Anxiety Disorder-7 (GAD-7) for anxiety symptoms, and the World Health Organization-Five Well-Being Index (WHO-5) for subjective well-being. PHQ-9 and GAD-7 will be administered at intake and at planned review or discharge, while WHO-5 will provide a brief well-being indicator. Portuguese-language versions of PHQ-9, GAD-7 and WHO-5 will undergo local comprehension and acceptability checks during piloting, including review by local professionals and cognitive interviews or focus groups with students where feasible. No changes to scored items are anticipated unless substantial comprehension problems are identified. Any adaptation will be documented transparently and interpreted as part of implementation learning rather than as evidence of formal local psychometric validation. Reliable clinical change will be defined as meaningful pre-post improvement, interpreted alongside attendance, risk status, and student-reported acceptability; (d) safety (the number and nature of serious incidents or adverse events); and (e) acceptability (a single Net Promoter-style rating of satisfaction, complemented by brief qualitative feedback from students). Together, these indicators provide a feasible yet robust basis for continuous quality improvement in routine practice.

5. Referral pathways. We will establish clear and formal agreements (Memoranda of Understanding) with local health and educational services to ensure that students who require more specialized care can be smoothly referred. A simple, shared referral form will be used by all partners, and we will create feedback mechanisms to keep the campus service informed when a student attends an external appointment. This will help reduce the risk of students "getting lost" during the transition between services.

Project documents specify these elements as deliverables for HEIs, the training program, and the monitoring framework; this Study Protocol consolidates them as a coherent implementation pathway.

Procedural transparency and reproducibility

To support transparency and reproducibility across sites, the protocol specifies a shared operational core while allowing contextual adaptation at each participating HEI. This shared core includes campus-level standard operating procedures for intake, triage, risk assessment, safeguarding, and emergency referral; structured training modules, skills checklists, and supervision ladders; defined student-facing service components; formal referral pathways; and a pragmatic minimum monitoring framework to guide Plan-Do-Study-Act refinement. In practice, this allows institutions to adapt language, staffing, timetables, and infrastructure without losing the common procedural backbone required for cross-site learning and service quality.

Participating institutions and implementation context

The ANGOSAP consortium includes a diverse group of public and private higher education institutions across Angola, varying in geographical location, institutional size, academic profile, and student population. Participating universities and polytechnic institutions operate in different organizational and resource contexts and serve students from a wide range of disciplines.

Institutions also differ in their existing student support structures and access to qualified personnel. To accommodate this variability, ANGOSAP employs a flexible implementation strategy based on task-sharing, competency-based training, and structured supervision, while maintaining a common operational framework across sites.

This diversity provides an opportunity to evaluate the feasibility, acceptability, and adaptability of the model across heterogeneous settings and to generate implementation lessons that may inform the development of university-based psychological and psychoeducational support services in Angola and other low- and middle-income countries.

Context: epidemiology and health-system capacity in Angola

The Global Burden of Disease 2021 synthesis in 204 countries/territories showed Central sub-Saharan Africa with the highest age-standardized incidence rate (ASIR) for mental disorders (≈ 8,706 per 100,000 person-years in 2021), and specifically listed Angola among countries with the highest ASIR in 2021. This supports prioritizing scalable, early-access interventions in health education information to reduce the demand on overstretched secondary/tertiary care (The Lancet Psychiatry, 2024).

Workforce and services. Angola's latest World Health Organization (WHO) Member State mental health profile (2017) reported approximately 0.06 psychiatrists and 0.18 psychologists per 100,000 people; mental health nurses, ≈0.66 per

100,000 people; and a total mental health workforce of ≈1.49 per 100,000 people. Inpatient capacity existed but with minimal dedicated community outpatient infrastructure, highlighting the need to expand first-line, non-specialist services (World Health Organization, 2017).

Suicide baseline. The most recent World Health Organization (WHO) country-resolved baseline (WHO, 2021) indicates a suicide mortality rate for Angola in the mid-single-digit range per 100,000, consistent with the World Bank-compiled series (≈ 6.1/100,000 in 2019). Although suicide is multifactorial, campus-level prevention (gatekeeper training, crisis pathways, and postvention) forms a necessary safety net (World Bank, 2021).

Policy environment. The World Health Organization's (WHO) 2024 Angola report documents continuing reforms (basic health laws, information systems, and national plans), creating a window for institutionalizing campus services and embedding standardized indicators into university administrative systems (World Health Organization, 2024).

Early implementation: evaluation and learning plan

Although this Study Protocol does not present primary outcomes or human participant data, the implementation phase will include the prospective collection of de-identified routine service and implementation data across participating HEIs. These data will cover referral pathways, presenting concerns, waiting times, attendance, number of sessions, level of care, and discharge status. Where feasible, PHQ-9, GAD-7 and WHO-5 will also be collected over time to capture early clinical change. Additional information on serious incidents, safeguarding events, supervision, fidelity, and student satisfaction will be used to support quality assurance. Data will be reviewed at regular intervals aligned with academic terms and analysed using pragmatic service indicators, early change trajectories, equity-stratified dashboards, and explicit checks on missingness and data quality to inform iterative Plan-Do-Study-Act refinement. As this manuscript is a Study Protocol, the following sections describe planned implementation outputs rather than empirical results, organized around service establishment, workforce development, monitoring and quality assurance, and cross-site learning.

ANGOSAP applies a pragmatic implementation-research approach to support rapid learning while services are being established and scaled across participating higher education institutions (HEIs). The evaluation is designed to be minimally burdensome for clinicians and students while producing actionable evidence on (i) reach and access, (ii) early clinical change, (iii) quality and safety, and (iv) equity in service delivery and outcomes. Data are reviewed at regular intervals aligned with academic terms/semesters, and findings are used to refine pathways, workforce practices, and student-facing communication through iterative Plan-Do-Study-Act (PDSA) cycles.

Core evaluation features include

Cohort-style service analytics (routine outcome and flow monitoring): ANGOSAP will maintain de-identified, term-based service panels capturing referral source, presenting concerns (high-level categories), wait times, initial attendance, number of sessions, step/level of care, and discharge status. Where feasible, session-by-session monitoring using PHQ-9, GAD-7 and WHO-5 will be used to quantify early changes and support measurement-based care. Analyses will prioritize interpretable indicators for leaders (e.g., median wait time, first-appointment uptake, proportion completing an agreed care plan, early change trajectories), and will explicitly document missingness and data-quality checks to avoid misleading inferences. To address variation in digital infrastructure across sites, each institution will use a shared minimum dataset with standardized variable definitions and de-identified student codes. Data will be entered into a secure digital template where feasible; when internet access or equipment is limited, paper forms will be completed locally and transferred to the same template during scheduled data-entry sessions. Each term, sites will report the proportion of missing values for core fields, reasons for missingness when known, duplicate records, inconsistent dates, and incomplete outcome measures. These checks will be reviewed in cross-site supervision meetings before indicators are interpreted.

To enhance transparency and facilitate implementation monitoring across sites, a supplementary Monitoring and Evaluation Dashboard is provided (Supplementary Appendix A). The appendix summarizes the core indicators used to assess service reach, access, outcomes, safety, acceptability, and equity during implementation.

Quality and safety monitoring: A structured protocol will guide the review of serious incidents and safeguarding events, including documentation of actions taken, referral/escalation pathways, supervision input, and system-level lessons learned. Quality assurance will include periodic fidelity checks on brief interventions (e.g., adherence to core components, appropriate step/triage decisions) and routine supervision records to ensure consistent risk assessment and continuity of care. Student experience will be integrated through lightweight feedback loops (e.g., short satisfaction and acceptability prompts), enabling timely adjustments to appointment processes, confidentiality communication, and service accessibility.

Equity dashboards (stratified performance and outcome review): To ensure that service benefits are distributed fairly, ANGOSAP will implement dashboards that report key indicators stratified by characteristics relevant to inequity in HEI settings (e.g., gender, year of study, disability status, and first-generation status where available and appropriate). These dashboards will be used to detect disparities in reach (who accesses services), access (wait times and uptake), and early outcomes, and to trigger targeted outreach or pathway modifications (e.g., adapted communication, proactive links with student support offices, or tailored referral routes).

Learning network (cross-site implementation learning): A structured learning network will connect HEIs through scheduled case discussions, supervisor forums, and implementation review meetings. These sessions will focus on harmonizing clinical practice, refining stepped-care pathways, and solving operational constraints (e.g., staffing, space, demand surges, and referral coordination). Cross-site learning will also support the standardization of minimum data elements and shared definitions for key indicators, improving comparability while allowing contextual adaptation.

Overall, the intent is to generate usable, decision-oriented evidence for HEI leadership and relevant national stakeholders (including the Ministry of Health), complementing national indicators and supporting system strengthening through integrated, people-centered service models consistent with World Health Organization (WHO) guidance (World Health Organization, 2024).

Ethical and consent procedures within implementation

Although no primary outcomes or human participant data are reported in this Study Protocol, the planned implementation model anticipates future participant-facing service activity within participating HEIs. For those activities, informed consent, confidentiality, and data protection procedures will be applied in a way that is proportionate to local regulations, the service setting, and the sensitivity of students' mental health information. These safeguards are intended to be embedded within intake, documentation, supervision, and referral processes so that implementation remains both feasible and ethically robust across sites.

Discussion

ANGOSAP's model is intentionally modest and scalable: it does not replace specialist care; rather, it builds a functional front door for student-relevant concerns, such as stress, anxiety, depressive symptoms, academic scaffolding, and adjustment, while ensuring safe escalation for higher-acuity cases. ANGOSAP is aligned with broader efforts in sub-Saharan Africa to expand mental health support through task-sharing, psychoeducation, and low-intensity interventions. Its specific contribution is to adapt these principles to Angolan higher education through a multi-site, university-embedded protocol that combines stepped care, competency-based training, routine monitoring, referral pathways, and cross-site learning. In the Angolan context of low specialist density and evolving policy frameworks, several aspects are pivotal. In the Angolan context of low specialist density and evolving policy frameworks, several aspects are pivotal. Within the Erasmus+ Capacity Building (CBHE) logic, the project treats student mental health not as a "one-off service," but as a capacity-building package that universities can own and sustain: trained non-specialist providers, a supervision backbone, and a simple data system that helps leadership make decisions without losing sight of students' lived experience. First, task-sharing is only safe and scalable when supervision is real–regular, structured, and feasible with limited specialist time. Digital and tele-supervision models (including measurement-based peer supervision) provide a practical way to protect quality, support providers, and document competence as services expand across campuses and semesters (Singla et al., 2024; Poudyal et al., 2024). However, implementation in Angola will face logistical constraints, particularly unstable internet connectivity, uneven access to devices, and the high cost of mobile data in some provinces. To reduce dependence on continuous connectivity, tele-supervision will combine scheduled low-bandwidth video meetings with telephone supervision, asynchronous case summaries, offline documentation templates, and periodic in-person supervision when feasible. These adaptations will be monitored as implementation barriers in the cross-site learning network. Second, ANGOSAP's monitoring focuses on data that matter to deans, quality leads, and students: reach, waiting times, retention, and reliable change, reported termly and discussed in governance forums. Pragmatic implementation measures can also surface what is blocking delivery (e.g., feasibility, acceptability, and contextual barriers), making improvement actions more targeted and politically actionable (Yang et al., 2024). This is especially urgent given the documented global burden and increasing trends for common mental disorders (GBD 2019 Mental Disorders Collaborators, 2019; GBD 2021 Diseases and Injuries Collaborators, 2024; Fan et al., 2025). Third, because trust is everything in university settings, language and culture are implementation strategies: bilingual materials (Portuguese plus locally relevant languages where feasible), culturally grounded framing of distress and help-seeking, and student co-design to avoid "imported" solutions that feel alien or unsafe (Fischer et al., 2024; Leung et al., 2025). Even where evidence gaps remain (e.g., campus-level prevalence and treatment coverage), the project approach is to build services now–carefully–and learn fast through termly feedback loops that continuously improve equity, safety, and outcomes. The findings generated by ANGOSAP should be interpreted within the context of a capacity-building project

implemented in selected Angolan higher education institutions. Participating institutions are self-selected partners with a high level of motivation and international collaboration experience, which may limit generalizability to other universities in Angola or other African countries.

Potential implementation challenges and mitigation strategies

As with other mental health service innovations in low-resource settings, ANGOSAP may face several implementation challenges. Workforce shortages, particularly outside major urban areas, may affect service delivery and supervision. To mitigate this risk, the project adopts a task-sharing model supported by competency-based training, structured supervision, tele-supervision, and standardized procedures. Long-term sustainability beyond the Erasmus+ funding period may also present challenges. Sustainability will depend on embedding the service model within institutional structures before the end of Erasmus+ funding. The project will therefore prioritize local ownership, leadership engagement, training of campus-based providers, supervision routines, and routine monitoring reports that demonstrate service demand and value. Although a formal cost-effectiveness analysis is beyond the scope of this protocol, service activity, staffing, supervision, and referral indicators will be documented to inform future sustainability and economic evaluation.

Help-seeking may be influenced by stigma, concerns about confidentiality, family expectations, and culturally shaped understandings of psychological distress. ANGOSAP will address these barriers through psychoeducation, student-facing communication, confidentiality messaging, and outreach activities that normalize early support for stress, academic difficulties, anxiety, depressive symptoms, and adjustment problems. Local feedback will be used to refine language and examples so that materials are culturally understandable and acceptable.

Effective referral coordination with external health and social services is another important consideration. Formal referral agreements and standardized procedures will support continuity of care for students requiring specialized services.

Additional challenges may arise in relation to data quality, monitoring, and contextual adaptation across diverse institutions. These risks will be addressed through standardized monitoring procedures, a common minimum dataset, regular quality reviews, and a flexible implementation approach that balances fidelity with local adaptation. Importantly, these challenges also represent opportunities for implementation learning. Systematic documentation of barriers, adaptations, and solutions will contribute to the evidence base for sustainable university-based mental health services in Angola and comparable low-resource settings.

ANGOSAP supports the UN Sustainable Development Goals by establishing university-embedded Psychological and Psychoeducational Support Services in Angola: it advances SDG 3 (Good Health and Well-being) by expanding mental health literacy, early identification, brief evidence-based interventions, and clear referral pathways through a stepped-care model; it contributes to SDG 4 (Quality Education) by strengthening student well-being and learning outcomes via on-campus support services and workforce development; and it promotes SDG 10 (Reduced Inequalities) by embedding equity and inclusion through active outreach and accessible, confidential entry points so that support reaches underserved student groups (Fan et al., 2025).

Study status and scope of the protocol

At the time of this Study Protocol, ANGOSAP is in its early implementation phase. The manuscript synthesizes project design and publicly available statistics, and it does not report primary outcomes or human participant data. Several Angola-specific indicators (e.g., 2021–2024 workforce updates and campus-level coverage) will require new data collection and/or improved national reporting pipelines as implementation progresses.

Conclusion

Beyond the university setting, the practice-based evidence generated by ANGOSAP may inform wider mental health system strengthening in Angola by demonstrating how early identification, task-sharing, referral coordination, and routine monitoring can be organized in low-resource institutional settings.

Ethics and consent

Ethical approval and consent were not required for this Study Protocol because it synthesizes project design and publicly available statistics and does not report primary outcomes or human participant data. No ethics board name or approval reference number is therefore reported at this stage. As outlined in the service model, any future implementation activities involving student-level data will be conducted in accordance with informed consent, confidentiality, and data protection procedures proportionate to local regulations and to the sensitivity of students' mental health information.

Data availability

No new datasets were generated or analysed in support of this Study Protocol. The manuscript presents the rationale, design, and early implementation context of the ANGOSAP project and does not report primary outcomes or human participant data. Accordingly, no study-specific dataset is available for deposition in a repository at this stage. All statistics reported in the manuscript were obtained from publicly available sources cited in the reference list.

Reporting guidelines

Not applicable. This Study Protocol describes an Erasmus+ Capacity Building project and does not report a study design with a specific established reporting guideline checklist.

Acknowledgements

We thank the participating Angolan higher education institutions and local CDOPs who contributed to the service co-design workshops.

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Open Peer Review

Current Peer Review Status: ? ✓ ✓

Version 3

Reviewer Report 30 September 2026

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✓ **Hengki Yandri**
Institut Agama Islam Negeri Kerinci, Jambi, Jambi, Indonesia

I have carefully reviewed the revised manuscript and the author's responses to my previous comments. I confirm that I have no further comments or revisions to suggest, and I consider the manuscript acceptable in its current form.

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Spiritual Counseling; Counseling; Educational Psychology; Mental Health

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Version 2

Reviewer Report 20 August 2026

https://doi.org/10.21956/openreseurope.26110.r79383

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? **Hengki Yandri**
Institut Agama Islam Negeri Kerinci, Jambi, Jambi, Indonesia

Abstract
Consider briefly mentioning the number of participating institutions in the abstract to convey

scale
The phrase "validated symptom or functioning measures" could be more specific given that PHQ-9, GAD-7, and WHO-5 are specified in the methods

Introduction
Student-Specific Rationale
While the authors have cited macro-level data, the introduction could benefit from stronger justification for the university setting specifically. Consider adding: 1) Brief mention of university student mental health stressors in Angola (e.g., economic pressure, academic transitions, post-conflict generational factors); 2) Evidence on the developmental period of emerging adulthood as a critical window for mental health intervention

COVID-19 Impact
The mention of COVID-19's impact on mental health is appropriate but could be expanded to note how the pandemic specifically affected university students (disrupted education, isolation, economic hardship).

Terminology Consistency
The use of "Health Education Information (HEIs)" appears once (page 6) when "Higher Education Institutions" is used elsewhere. Consider standardizing to HEI throughout.

Methods and Study Design
Measurement Timing
The protocol specifies that PHQ-9 and GAD-7 will be administered "at intake and at planned review or discharge." Consider adding: 1) Whether there is a minimum interval between administrations; 2) Whether measurement-based care will be used to guide treatment decisions during the intervention period; 3) A note on what constitutes "meaningful pre-post improvement" (e.g., reliable change index, clinically significant change threshold)

Training Specificity
The OSCE-style assessment is mentioned but could be strengthened with: 1) A brief description of the assessment rubric (e.g., pass/fail criteria, number of stations, standardized patient use); 2) The timeframe for demonstrating competence post-training

Cultural Adaptation of Measures
The authors note that Portuguese versions will be checked for "local comprehension and cultural acceptability." Consider adding: 1) The specific process for this adaptation (e.g., cognitive interviewing, focus groups, back-translation); 2) Whether any modifications to the instruments are anticipated

Risk Assessment Protocol
The protocol appropriately identifies suicide risk assessment as a core component. Consider adding: 1) The specific risk assessment protocol or tool to be used (beyond PHQ-9 item 9); 2) How risk will be documented and communicated

Results
The section is brief and could be strengthened by more explicitly connecting the described outputs to the study aims

Consider using subheadings to improve structure

Discussion

Generalizability Limitations

The discussion would benefit from explicit acknowledgment that: 1) This is a capacity-building project in a specific cultural context; findings may not fully generalize to other African countries; 2) The participating HEIs represent a self-selected group of motivated institutions

Sustainability Planning

While sustainability is briefly mentioned in the author responses, the main discussion could briefly address: 1) The transition plan post-Erasmus+ funding; 2) How institutional buy-in will be maintained; 3) Whether cost-effectiveness will be evaluated

Stigma and Help-Seeking

The protocol mentions stigma but could more explicitly discuss: 1) Whether there are specific cultural conceptualizations of distress in Angola that might affect help-seeking; 2) How the project addresses stigma in its outreach and psychoeducation strategies

Comparison with Existing Models

Consider briefly comparing the ANGOSAP model to other university-based mental health initiatives in sub-Saharan Africa to highlight its unique contributions.

Conclusion

Consider adding a sentence on the potential broader implications for mental health system strengthening in Angola beyond the university setting

Is the rationale for, and objectives of, the study clearly described?

Yes

Is the study design appropriate for the research question?

Yes

Are sufficient details of the methods provided to allow replication by others?

Yes

Are the datasets clearly presented in a useable and accessible format?

Partly

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Spiritual Counseling; Counseling; Educational Psychology; Mental Health

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Author Response 22 Aug 2026

Jose Navarro

COMMENT BY AUTHORS (DR. JOSE I. NAVARRO) AUGUST 2026
We sincerely thank Dr. Hengki Yandri for the careful and constructive evaluation of our manuscript, ***"Task-Sharing and Stepped-Care Mental Health Services in Angolan Higher Education: A Multi-Site Implementation Protocol (ANGOSAP)".*** We appreciate the reviewer's detailed reading and agree that several suggestions can improve the clarity, reproducibility, and practical value of the protocol. We have revised the manuscript accordingly and respond to each point below.

Comment 1 Consider briefly mentioning the number of participating institutions in the abstract to convey scale.

Response: We agree. The abstract should make the scale of the implementation clearer. We have revised the abstract to specify that ANGOSAP will be implemented across four Angolan higher education institutions, in partnership with European institutions. This helps readers understand the multi-site nature of the protocol from the outset. Proposed revision: ANGOSAP is an Erasmus+-funded capacity-building initiative designed to establish sustainable, university-embedded Psychological and Psychoeducational Support Services across four Angolan higher education institutions.

Comment 2 The phrase "validated symptom or functioning measures" could be more specific given that PHQ-9, GAD-7, and WHO-5 are specified in the methods.

Response: We agree. To improve consistency between the abstract and methods, we have replaced the general phrase with the specific instruments used in the protocol: **PHQ-9, GAD-7, and WHO-5**. **Proposed revision:** Early clinical change will be monitored using PHQ-9, GAD-7, and WHO-5, alongside indicators of reach, access, safety, acceptability, and equity. ***Introduction*** Comment 3 **The introduction could benefit from stronger justification for the university setting specifically, including student stressors in Angola and emerging adulthood as a critical window for intervention. Response:** We agree that the introduction relied more heavily on macro-level health-system data than on the specific rationale for intervening in universities. We have added a paragraph explaining why higher education institutions are a strategic setting for early mental health support. The revision highlights academic transitions, economic pressure, first-generation university attendance, family expectations, and the broader post-conflict social context in Angola. We also now refer to emerging adulthood as a developmental period in which many mental health problems first appear or consolidate, making early university-based intervention particularly relevant.

Proposed revision: Universities represent a critical setting for early mental health intervention because students are often navigating academic transition, economic pressure, separation from family support, uncertainty about employment, and, in Angola, the broader effects of post-conflict social and intergenerational adversity. Many students are also first-generation entrants into higher education, which may increase both opportunity and psychosocial strain. Emerging adulthood is a key developmental window in which common

mental health problems may first emerge or become persistent; therefore, campus-based services can provide timely, low-stigma, and developmentally appropriate support.
Comment 4 **The COVID-19 impact could be expanded to note how the pandemic specifically affected university students.**

Response: We agree. We have expanded the COVID-19 discussion to explain its relevance to university students, including disruption of teaching, social isolation, economic hardship, delayed academic progression, and increased stress during educational transitions.

Proposed revision: For university students, the COVID-19 pandemic also disrupted face-to-face teaching, reduced peer and institutional support, increased social isolation, and intensified economic hardship for families and students. These factors are especially relevant in higher education systems where digital access and student support structures may be uneven.

Comment 5 **"Health Education Information (HEIs)" appears once when "Higher Education Institutions" is used elsewhere. Standardize terminology.**

Response: We thank the reviewer for identifying this inconsistency. This was a typographical error. We have corrected the term to **Higher Education Institutions (HEIs)** throughout the manuscript. **Proposed revision:** Higher Education Institutions (HEIs); (***Health*** **Education Information, [**without using an acronym**])**

Methods and Study Design
Comment 6 **Measurement timing: clarify minimum interval between administrations, whether measurement-based care will guide treatment, and what constitutes meaningful improvement.**

Response: We agree. A protocol should specify not only which measures are used but also when and how they inform care. We have revised the methods to state that PHQ-9, GAD-7 and WHO-5 will be administered at intake and again at planned review or discharge, preferably after a minimum interval of approximately four weeks, unless earlier review is clinically indicated. We also clarify that scores will support measurement-based care, helping providers review progress, identify deterioration, and consider escalation. Finally, we define meaningful improvement pragmatically, using reliable change or clinically meaningful score reduction where appropriate, while avoiding overinterpretation as a diagnostic outcome.

Proposed revision: PHQ-9, GAD-7 and WHO-5 will be administered at intake and at planned review or discharge, preferably after a minimum interval of four weeks unless earlier reassessment is clinically indicated. Scores will be used as part of measurement-based care to guide review, supervision, and escalation decisions. Meaningful pre-post improvement will be defined using reliable change where feasible and pragmatic clinical thresholds, interpreted alongside attendance, risk status, functional impairment, and student-reported acceptability.

Comment 7 **Training specificity: strengthen OSCE-style assessment with rubric,**

pass/fail criteria, number of stations, standardized patient use, and timeframe for competence.

Response: We agree that this detail improves reproducibility. We have expanded the workforce-development section to specify that the OSCE-style assessment will include structured stations using simulated or standardized student scenarios. We also clarify that the assessment will focus on intake, risk identification, use of PHQ-9/GAD-7/WHO-5, brief intervention delivery, care planning, documentation, and Tier 2 versus Tier 3 decision-making. We have added that trainees must demonstrate competence before independent student-facing work.

Proposed revision: Competence will be assessed through skills checklists and OSCE-style stations using simulated student scenarios. Stations will assess structured intake, correct use and interpretation of PHQ-9, GAD-7 and WHO-5, recognition of suicide or safeguarding risk, delivery of a brief intervention component, documentation of a care plan, and appropriate Tier 2 versus Tier 3 referral decisions. Providers must meet predefined pass criteria and complete any required supervised practice before delivering student-facing care independently.

Comment 8 **Cultural adaptation of measures: specify process and whether modifications are anticipated.**

Response: We agree. Because the manuscript is a study protocol, we should not claim that the instruments are already culturally validated for Angolan university students unless such validation has been completed. We have therefore added a cautious and scientifically appropriate description of the adaptation process. Portuguese-language versions will be checked through local comprehension review, cognitive interviewing or focus groups with students and staff, and review by local professionals. We do not anticipate changing the scored items unless serious comprehension problems emerge; if changes are required, they will be documented and treated as implementation adaptations rather than assumed psychometric equivalence.

Proposed revision: Portuguese-language versions of PHQ-9, GAD-7 and WHO-5 will undergo local comprehension and acceptability checks during piloting, including review by local professionals and cognitive interviews or focus groups with students where feasible. No changes to scored items are anticipated unless substantial comprehension problems are identified. Any adaptation will be documented transparently and interpreted as part of implementation learning rather than as evidence of formal local psychometric validation.

Comment 9 **Risk assessment protocol: specify risk tool beyond PHQ-9 item 9 and how risk will be documented and communicated.**

Response: We agree. PHQ-9 item 9 is useful as an initial safety signal but is not sufficient as a complete suicide risk assessment. We have revised the protocol to include a structured suicide and self-harm risk assessment procedure, including use of a brief risk-assessment tool or structured checklist, documentation of risk level, protective factors, actions taken, supervision review, and referral or emergency escalation where indicated.

Proposed revision: Any indication of suicidal ideation or self-harm, including a positive response to PHQ-9 item 9, will trigger a same-day structured risk assessment using a brief suicide and self-harm risk protocol. Risk documentation will include current ideation, intent, plan, past self-harm, protective factors, risk level, action taken, supervision input, and referral decision. High or imminent risk will require urgent escalation according to campus emergency procedures and local referral pathways.

Results
Comment 10 **The Results section is brief and could be strengthened by more explicitly connecting the described outputs to the study aims. Consider using subheadings.**

Response: We agree that the Results section can be made clearer. However, because this is a **Study Protocol**, we cannot report clinical or implementation outcomes that have not yet been collected. We have therefore retained a concise Results section but revised it to better organize protocol outputs and connect them to the study aims. We have added subheadings such as **Service implementation outputs**, **Monitoring and quality outputs**, and **Cross-site learning outputs**.

Proposed revision: The Results section has been reorganized using subheadings to clarify how the preliminary outputs relate to the protocol aims: service establishment, workforce development, monitoring and quality assurance, and cross-site learning. No primary outcome data are reported at this stage because the manuscript is a protocol.
Scientific justification: It would be inappropriate to add empirical findings that are not yet available. In a study protocol, the Results section should describe planned or preliminary implementation outputs only, without implying effectiveness. Any indication of suicidal ideation or self-harm, including a positive response to PHQ-9 item 9, will trigger a same-day structured risk assessment using a brief suicide and self-harm risk protocol. Risk documentation will include current ideation, intent, plan, past self-harm, protective factors, risk level, action taken, supervision input, and referral decision. High or imminent risk will require urgent escalation according to campus emergency procedures and local referral pathways.

Discussion Comment 11 **Generalizability limitations: acknowledge that this is a specific capacity-building project and that participating HEIs are self-selected.**

Response: We agree. We have added a limitation noting that ANGOSAP is implemented within a specific cultural, institutional, and funding context. We also acknowledge that participating HEIs are a motivated group of partner institutions and may not represent all Angolan or African universities.

Proposed revision: The findings generated by ANGOSAP should be interpreted within the context of a capacity-building project implemented in selected Angolan higher education institutions. Participating institutions are self-selected partners with a high level of motivation and international collaboration experience, which may limit generalizability to other universities in Angola or other African countries.

Comment 12 **Sustainability planning: address post-Erasmus+ transition, institutional buy-in, and cost-effectiveness evaluation.**

Response: We agree that sustainability is central to implementation. We have added a paragraph explaining that the project aims to embed procedures, training capacity, supervision routines, and monitoring systems within participating institutions before the end of Erasmus+ funding. We also clarify that institutional buy-in will be supported through leadership engagement and routine reporting. Regarding cost-effectiveness, we do not present a formal economic evaluation in this protocol because that is beyond the current design; however, we now state that resource use and service activity indicators will be documented to inform future sustainability and cost analyses.

Proposed revision: Sustainability will depend on embedding the service model within institutional structures before the end of Erasmus+ funding. The project will therefore prioritize local ownership, leadership engagement, training of campus-based providers, supervision routines, and routine monitoring reports that demonstrate service demand and value. Although a formal cost-effectiveness analysis is beyond the scope of this protocol, service activity, staffing, supervision, and referral indicators will be documented to inform future sustainability and economic evaluation.

Comment 13 **Stigma and help-seeking: discuss cultural conceptualizations of distress and outreach/psychoeducation strategies.**

Response: We agree. We have expanded the discussion of stigma and help-seeking. Because this is a protocol, we avoid making strong empirical claims about cultural conceptualizations of distress without project data. Instead, we state that cultural understandings of distress, stigma, family expectations, and concerns about confidentiality may affect help-seeking, and that the project will address this through psychoeducation, student-facing outreach, confidentiality messaging, and culturally sensitive materials.

Proposed revision: Help-seeking may be influenced by stigma, concerns about confidentiality, family expectations, and culturally shaped understandings of psychological distress. ANGOSAP will address these barriers through psychoeducation, student-facing communication, confidentiality messaging, and outreach activities that normalize early support for stress, academic difficulties, anxiety, depressive symptoms, and adjustment problems. Local feedback will be used to refine language and examples so that materials are culturally understandable and acceptable.

Comment 14 **Comparison with existing models: briefly compare ANGOSAP with other university-based mental health initiatives in sub-Saharan Africa.**

Response: We agree that a brief comparison would help position the contribution of ANGOSAP. We have added a short discussion noting that, like other emerging initiatives in sub-Saharan Africa, ANGOSAP uses task-sharing and low-intensity support. Its distinctive contribution is the combination of a multi-site university implementation protocol, stepped care, competency-based workforce development, routine outcome monitoring, and cross-site learning in the Angolan higher education context.

Proposed revision: ANGOSAP is aligned with broader efforts in sub-Saharan Africa to expand mental health support through task-sharing, psychoeducation, and low-intensity interventions. Its specific contribution is to adapt these principles to Angolan higher education through a multi-site, university-embedded protocol that combines stepped care, competency-based training, routine monitoring, referral pathways, and cross-site learning.

Conclusion Comment 15 **Add a sentence on broader implications for mental health system strengthening in Angola beyond the university setting.**

Response: We agree. We have added a concluding sentence explaining that, if feasible and acceptable, ANGOSAP may generate practice-based evidence relevant to broader mental health system strengthening in Angola, especially around early identification, task-sharing, referral coordination, and routine monitoring.
Proposed revision: Beyond the university setting, the practice-based evidence generated by ANGOSAP may inform wider mental health system strengthening in Angola by demonstrating how early identification, task-sharing, referral coordination, and routine monitoring can be organized in low-resource institutional settings. We are grateful to Dr. Yandri for comments that have helped us strengthen the manuscript. The revisions improve the specificity of the abstract, clarify the university-specific rationale, strengthen the reproducibility of the measurement and training procedures, provide a more explicit risk-assessment and data-quality framework, and make the discussion more balanced regarding sustainability, stigma, generalizability, and implementation barriers. Where we did not add empirical claims, this was intentional and scientifically appropriate because the manuscript is a Study Protocol and should avoid presenting effectiveness, cultural validation, or cost-effectiveness findings before implementation data are available. I have submitted a new version of the manuscript to the platform, with all changes highlighted in color.

Competing Interests: The authors declare no competing interests.

Reviewer Report 23 June 2026

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Juan Silvio Cabrera Albert
Instituto Superior Politécnico, Lubango, Angola

Dear Dr. Navarro and Dr. Alvaro
Thank you very much for the thorough response to the review comments.
I would like to congratulate you and your co-authors for the professionalism, rigor, and high academic standard reflected in your replies and in the revisions made to the manuscript. It is

evident that considerable effort was devoted to carefully addressing the recommendations, which has further strengthened an already valuable contribution.
I particularly appreciate the constructive and respectful spirit with which the review process was approached. It has been a pleasure to contribute to the evaluation of this important work, and I am confident that the manuscript will be of significant interest to researchers, practitioners, and policymakers working in mental health and higher education.
My best wishes for the successful continuation of the ANGOSAP project and for your future research endeavors.
Kind regards,
Juan Silvio Cabrera Albert

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Educational Psychology

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Version 1

Reviewer Report 08 June 2026

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Juan Silvio Cabrera Albert
Instituto Superior Politécnico, Lubango, Angola

This Study Protocol presents the rationale, design, and early implementation framework of the ANGOSAP project, an Erasmus+-funded initiative aimed at establishing university-based Psychological and Psycho-educational Support Services across higher education institutions in Angola. The Protocol addresses a highly relevant and timely issue, namely the growing need for accessible mental health and psycho-educational support services within higher education settings in a context characterized by limited specialist mental health resources and increasing demand for care.

The manuscript provides a clear overview of the epidemiological and systemic factors that justify the implementation of such services. The authors successfully connect global and national mental health trends, workforce limitations, and higher education needs to justify the development of a stepped-care, task-sharing model adapted to the Angolan context. The Protocol is particularly valuable because it describes an initiative that seeks not only to improve student well-being but also to strengthen institutional capacity and create sustainable structures for mental health support within universities.

The rationale for the study and its objectives are clearly described. The manuscript effectively explains the challenges facing mental health service provision in Angola and articulates how the ANGOSAP project seeks to respond to these challenges. The objectives are coherent, well-defined, and aligned with the proposed implementation strategy. The justification for adopting a university-based model, emphasizing early intervention, psycho-education, referral pathways, and capacity building, is convincing and supported by relevant literature and policy documents.

The study design is appropriate for the stated aims. The use of a multi-site, co-designed, stepped-care, and task-sharing framework is consistent with current international recommendations for mental health service development in low-resource settings. The emphasis on local adaptation while maintaining a common operational framework is a notable strength. The Protocol appropriately combines service implementation, workforce development, quality assurance, and continuous evaluation, creating a comprehensive approach that is both pragmatic and potentially scalable.

The methods are described with sufficient detail to allow replication by other institutions interested in implementing similar services. The manuscript clearly outlines the core design principles, governance procedures, workforce development strategies, student-facing services, referral mechanisms, and monitoring framework. The inclusion of standard operating procedures, supervision structures, quality assurance processes, and implementation learning cycles contributes to transparency and reproducibility. Furthermore, the description of the evaluation framework provides readers with a clear understanding of how service performance and implementation outcomes will be monitored over time.

The data-related aspects of the protocol are also presented adequately. Given that this is a Study Protocol and does not yet report primary outcome data, the authors appropriately explain that no study-specific datasets are currently available. The planned collection of de-identified routine service data and implementation indicators is described clearly, and the proposed monitoring framework appears suitable for generating actionable evidence while maintaining feasibility in real-world service settings.
One of the major strengths of the manuscript is its strong focus on implementation science principles. The incorporation of Plan-Do-Study-Act cycles, equity-oriented dashboards, supervision systems, quality monitoring procedures, and cross-site learning networks demonstrates a thoughtful approach to continuous improvement and sustainability. The protocol also highlights the importance of cultural adaptation, student participation, and contextual relevance, which are essential considerations for successful implementation in diverse higher education environments.

Although the manuscript is scientifically sound and suitable for indexing in its current form, several minor enhancements could further strengthen its contribution for further articles and future publications.

- First, the inclusion of a visual conceptual framework or logic model summarizing the relationships among inputs, activities, outputs, outcomes, and expected impacts would improve readability and provide a concise overview of the implementation model.
- Second, additional information regarding the anticipated number and characteristics of participating institutions could help readers better understand the scale and diversity of the implementation context.
- Third, the authors may consider providing supplementary materials in future versions, such

as examples of intake procedures, referral pathways, supervision tools, or monitoring templates, which would facilitate knowledge transfer and adoption by other institutions.

The manuscript could also benefit from a brief discussion of potential implementation challenges and mitigation strategies. Issues such as workforce shortages, service sustainability, student engagement, stigma, and coordination with external health services are likely to influence implementation success and may provide valuable learning opportunities for readers interested in similar initiatives.

Finally, as the project progresses, future publications reporting implementation outcomes, service utilization data, and lessons learned from participating institutions will be of considerable value to the fields of higher education, mental health, and implementation science.

In conclusion, this Protocol describes an important and innovative initiative with strong potential to contribute to the development of sustainable university-based mental health and psycho-educational support services in Angola.

The rationale is clear, the study design is appropriate, the methods are sufficiently described, and the planned data collection and monitoring procedures are adequately presented. The manuscript represents a meaningful contribution to the literature on mental health service development in low-resource higher education settings and merits indexing.

Is the rationale for, and objectives of, the study clearly described?

Yes

Is the study design appropriate for the research question?

Yes

Are sufficient details of the methods provided to allow replication by others?

Yes

Are the datasets clearly presented in a useable and accessible format?

Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Educational Psychology

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Author Response 08 Jun 2026

Jose Navarro

FROM: AUTHOR TO: REVIEWER
We would like to sincerely thank the reviewer for the careful reading of our manuscript and for the constructive and insightful comments provided. We greatly appreciate the positive

assessment of the scientific quality and relevance of the work. Following these valuable suggestions, we have carefully revised the manuscript and addressed each of the points raised. Below, we provide a detailed response outlining the modifications introduced and clarifications added in order to further strengthen the manuscript and improve its clarity, completeness, and potential usefulness for future research and implementation efforts.

- *Visual conceptual framework or logic model summarizing the relationships among inputs, activities, outputs, outcomes, and expected impacts to provide readers of the article a concise overview of the implementation model.*

Figure1. Conceptual Framework and Logic Model of the ANGOSAP Implementation Model Inputs Activities Outputs Short- and Medium-Term Outcomes Long-Term Impacts Erasmus+ funding and institutional support Co-design workshops with HEI stakeholders University-specific service implementation plans Increased awareness and mental health literacy among students Improved student well-being and quality of life Partner universities and governance structures Development of standard operating procedures (intake, triage, risk assessment, safeguarding, referral) Standardized operational protocols across participating HEIs Improved access to psychological and psychoeducational support services Enhanced academic engagement, retention, and success Psychologists, supervisors, and trained staff Competency-based training and supervision programs Trained service providers and supervisors Reduced waiting times and improved service accessibility Stronger student support ecosystems within universities Digital resources and psycho-educational materials Delivery of psychoeducation, workshops, self-help resources, and brief interventions Student-facing services operational across campuses Early identification and management of mental health and learning-related difficulties Reduced burden on overstretched specialist mental health services Partnerships with health and educational services Establishment of referral and safeguarding pathways Formalized referral agreements and collaborative networks Improved continuity of care and referral effectiveness Sustainable and integrated university-based mental health services Monitoring systems and implementation framework Routine data collection, quality assurance, supervision, and PDSA cycles Service dashboards, quality indicators, and implementation reports Improved quality, safety, acceptability, and equity of service delivery Evidence-informed policy and institutional decision-making Equity and inclusion strategy Targeted outreach to vulnerable and underserved student groups Equity-focused monitoring and outreach activities Increased service utilization among underrepresented groups Reduced inequalities in access to mental health and psychoeducational support **Cross-Cutting Implementation Mechanisms** The entire model is supported by four cross-cutting mechanisms that operate across all stages:

1. **Stepped-Care Approach** - ensuring that students receive the least intensive and most appropriate intervention according to their needs.
2. **Task-Sharing and Supervision** - expanding service capacity through trained providers supported by structured supervision.
3. **Continuous Quality Improvement** - using Plan-Do-Study-Act (PDSA) cycles and routine monitoring to refine service delivery.
4. **Equity and Inclusion** - promoting accessible, culturally responsive, and student-centered services for diverse populations.

Theory of Change By strengthening institutional capacity, training personnel, establishing structured support pathways, and embedding continuous evaluation mechanisms,

ANGOSAP is expected to increase access to timely psychological and psychoeducational support. Improved access and service quality should lead to better mental health, enhanced academic functioning, greater educational inclusion, and ultimately contribute to sustainable mental health system strengthening within Angolan higher education institutions.

- *Additional information regarding the anticipated number and characteristics of participating institutions to help readers better understand the scale and diversity of the implementation context.*

Participating Institutions and Implementation Context The ANGOSAP consortium brings together a diverse group of higher education institutions (HEIs) across Angola, reflecting variations in geographical location, institutional size, governance structures, academic profiles, and student demographics. Participating institutions include both public and private HEIs located in different regions of the country, thereby enabling the implementation model to be tested across heterogeneous educational environments. The consortium encompasses universities and polytechnic institutions serving students enrolled in a broad range of disciplines, including education, health sciences, engineering, social sciences, economics, law, and humanities. Student populations vary considerably between institutions, ranging from medium-sized campuses with a few thousand students to larger institutions serving several tens of thousands of students. This diversity provides an opportunity to assess the feasibility, acceptability, and adaptability of the ANGOSAP model under different organizational and resource conditions. Participating institutions also differ in their existing student support structures and mental health resources. While some institutions have limited access to psychological support services, others possess emerging counseling or student welfare units that can serve as foundations for the development of more comprehensive Psychological and Psychoeducational Support Services. Such variability is expected to generate valuable implementation learning regarding the factors that facilitate or hinder service establishment and sustainability. From a workforce perspective, institutions exhibit different levels of access to qualified psychologists, educational specialists, and student support personnel. The project therefore adopts a flexible implementation strategy based on task-sharing, competency-based training, and structured supervision to ensure that core service components can be delivered consistently despite local variations in human resource capacity. The inclusion of institutions operating in diverse socioeconomic, cultural, and linguistic contexts further strengthens the project's external validity. By testing the implementation framework across multiple settings, ANGOSAP seeks to generate transferable knowledge that may inform the development of university-based mental health and psychoeducational support services both within Angola and in other low- and middle-income countries facing similar challenges. Future reports arising from the project will provide detailed information on the number of participating institutions, student population coverage, service utilization rates, workforce composition, and implementation outcomes, enabling a more comprehensive assessment of scalability and sustainability. **Table 1. Characteristics of participating higher education institutions in the ANGOSAP Consortium Institution Region/Province Type Approximate Student Population Existing Student Support Resources Planned ANGOSAP Service Components** Student affairs office; limited counseling support Psychoeducation, brief interventions, referral pathways **Abbreviations:** ANGOSAP: Angola Psychological and Psychoeducational Support Services; HEI: Higher Education Institution. **Note:** The table should be completed using institution-specific data obtained during the

project mapping and needs-assessment phase. Inclusion of this information would allow readers to better understand the geographical coverage, institutional diversity, implementation context, and scalability potential of the ANGOSAP model.

- *Provide supplementary materials, such as examples of intake procedures, referral pathways, supervision tools, or monitoring templates, which would facilitate knowledge transfer and adoption by other institutions.*

Suggested supplementary materials for ANGOSAP implementation To facilitate knowledge transfer, transparency, and replication, the authors may consider including the following supplementary materials as online appendices: Supplementary Appendix A. Student Intake and Initial Assessment Form A standardized intake template that could include:

- Student demographic information
- Academic program and year of study
- Presenting concerns
- Previous support received
- Risk screening questions
- Consent and confidentiality statements
- Referral source
- Initial triage decision

Purpose: To promote consistency in data collection and service access across participating institutions. Supplementary Appendix B. Triage and Referral Decision Pathway A visual flowchart describing:

1. Initial student contact
2. Screening and risk assessment
3. Allocation to stepped-care level
4. Criteria for brief intervention
5. Criteria for referral to specialized services
6. Emergency and crisis management procedures
7. Follow-up and case closure

Purpose: To ensure consistency and safety in decision-making processes. Supplementary Appendix C. Risk Assessment and Safeguarding Protocol A practical protocol covering:

- Suicide risk assessment procedures
- Self-harm concerns
- Severe psychological distress
- Gender-based violence disclosures
- Safeguarding responsibilities
- Emergency referral procedures
- Documentation requirements

Purpose: To strengthen clinical governance and student safety. Supplementary Appendix D. Supervision Framework and Competency Checklist Examples of:

- Supervision schedules

- Session documentation templates
- Competency assessment rubrics
- Skills observation forms
- Fidelity monitoring tools
- Escalation procedures for complex cases

Purpose: To support quality assurance and workforce development. Supplementary Appendix E. Monitoring and Evaluation Dashboard Sample indicators and reporting templates including: **Domain Indicator** Reach Number and proportion of students accessing services Access Median waiting time to first appointment Engagement Attendance rates and number of completed sessions Outcomes Change in symptom or functioning measures Safety Number of serious incidents reported Acceptability Student satisfaction scores Equity Utilization rates by gender, disability status, year of study, and other relevant characteristics **Purpose:** To support routine service monitoring and continuous quality improvement. Supplementary Appendix F. Plan-Do-Study-Act (PDSA) Improvement Template A standardized form documenting:

- Identified problem
- Improvement action
- Implementation period
- Results achieved
- Lessons learned
- Recommended next steps

Purpose: To facilitate implementation learning across institutions. Supplementary Appendix G. Service Logic Model and Theory of Change A visual framework presenting:

- Inputs
- Activities
- Outputs
- Short-term outcomes
- Intermediate outcomes
- Long-term impacts

Purpose: To provide a concise overview of the intervention model and implementation assumptions. Supplementary Appendix H. Minimum Data Set Dictionary A data dictionary specifying:

- Variable names
- Definitions
- Coding procedures
- Data collection frequency
- Responsible personnel

Purpose: To improve standardization, comparability, and data quality across sites.

- *Potential implementation challenges and mitigation strategies. Issues such as workforce shortages, service sustainability, student engagement, stigma, and coordination with external health services are likely to influence implementation success and may provide*

valuable learning opportunities for readers interested in similar initiatives.

Potential implementation challenges and mitigation strategies As with many mental health service innovations implemented in low-resource settings, ANGOSAP is likely to encounter a range of operational, organizational, and contextual challenges during implementation and scale-up. Acknowledging these challenges is important not only for transparency but also for informing future replication efforts in similar higher education contexts. One anticipated challenge relates to **workforce capacity and availability**. Angola continues to experience a limited supply of mental health specialists, particularly outside major urban centers. Variability in the availability of psychologists and other qualified personnel across participating institutions may affect service delivery and supervision capacity. To mitigate this risk, ANGOSAP adopts a task-sharing approach supported by competency-based training, structured supervision, tele-supervision mechanisms, and standardized protocols designed to maintain service quality while optimizing available human resources. A second challenge concerns the **long-term sustainability of services** beyond the Erasmus+ funding period. Institutional priorities, financial constraints, and staff turnover may affect the continuity of support services. Sustainability will therefore depend on the progressive integration of Psychological and Psychoeducational Support Services into existing university structures, budgets, strategic plans, and quality assurance systems. Capacity-building efforts targeting institutional leadership and administrative personnel may further strengthen local ownership and sustainability. **Student engagement and service utilization** also represent important implementation considerations. Despite the availability of services, students may be reluctant to seek support because of limited mental health literacy, concerns about confidentiality, competing academic demands, or lack of awareness regarding available resources. To address these barriers, ANGOSAP incorporates psychoeducational activities, awareness campaigns, student co-design processes, flexible access pathways, and culturally responsive communication strategies intended to increase trust, visibility, and service acceptability. Relatedly, **mental health stigma** remains a potential obstacle to help-seeking behavior. Negative perceptions surrounding mental health difficulties may discourage students from accessing support or disclosing their needs. The project's emphasis on mental health literacy, peer engagement, confidential service provision, and normalization of help-seeking is expected to contribute to stigma reduction over time. Monitoring patterns of service utilization may also help identify groups that remain underserved and require targeted outreach strategies. Another challenge involves **coordination with external health and social services**. Effective stepped-care models depend on reliable referral pathways for students requiring specialized assessment or treatment. However, variations in service availability, referral procedures, communication mechanisms, and geographic accessibility may complicate continuity of care. ANGOSAP seeks to address this issue through formal referral agreements, standardized referral procedures, and the establishment of collaborative relationships with local healthcare providers and relevant community services. The project may also encounter challenges related to **data quality, monitoring, and evaluation**. Routine service data collection can be affected by incomplete records, inconsistent reporting practices, or limited technical infrastructure. To minimize these risks, the project includes a minimum dataset framework, standardized monitoring procedures, staff training, and regular data-quality reviews as part of its continuous improvement strategy. Finally, the diversity of participating institutions may create challenges related to **implementation fidelity and contextual adaptation**. Differences in institutional culture, infrastructure, staffing, and student

demographics may require local modifications to service delivery models. ANGOSAP addresses this tension by defining a common operational core while allowing contextual adaptation through co-design processes, thereby balancing standardization with flexibility. Importantly, these challenges should not be viewed solely as barriers but also as opportunities for implementation learning. Systematic documentation of obstacles, adaptations, and solutions throughout the project will contribute valuable evidence for the development of sustainable university-based mental health services in Angola and other low- and middle-income country settings.

Competing Interests: No competing interests were disclosed.

Reviewer Report 21 May 2026

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Rohman Hikmat
[1] Universitas Padjadjaran, Sumedang, Indonesia
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1. Title
- **Critique:** The title is overly wordy and administrative ("...a brief report on rationale, design, and early implementation context").
- **Suggestion: Revise for impact and clarity.** Focus on the core innovation—the task-sharing model in the Angolan university context. *Example: "Task-Sharing and Stepped-Care Mental Health Services in Angolan Higher Education: A Multi-Site Implementation Protocol (ANGOSAP)."*

2. Abstract
- **Critique:** The abstract identifies the problem (workforce shortage) and the solution (ANGOSAP) but lacks a clear description of the *specific* primary metrics that will define "early implementation success".
- **Suggestion:** Include the specific **monitoring indicators** (e.g., reach, wait times, reliable clinical change) directly in the abstract so readers understand the evaluative rigor of the protocol.

3. Introduction
- **Critique:** The manuscript does an excellent job of citing macro-level statistics (0.06 psychiatrists per 100,000 population). However, it lacks a **student-specific rationale**. Why is the university setting the optimal entry point in Angola compared to community health centers?
- **Suggestion:** Bolster the introduction with literature on the unique mental health stressors facing **Angolan university students** (e.g., transition, economic pressure, post-conflict generational trauma) to justify the university-embedded focus.

4. Methods and Study Design

- **Critique (Major Concern - Replication):** The manuscript mentions "brief, evidence-based psychological interventions" and "validated symptom or functioning scales" but **fails to name them**. A protocol must be reproducible.
- **Requirement:** Specify exactly which tools will be used (e.g., PHQ-9, GAD-7, or WHO-5). Simply stating "validated scales" is insufficient.
- **Critique (Task-Sharing Detail):** You mention using "trained non-specialists" such as counselors and student support officers.
- **Requirement:** Provide more detail on the **competency-based training package**. What is the duration of the training? What are the "OSCE-style assessments" measuring specifically?.
- **Critique (Stepped Care):** The transition between Tier 2 (brief intervention) and Tier 3 (specialist referral) is vague.
- **Requirement:** Define the **triage criteria** or clinical thresholds that trigger an escalation to specialist care.

5. Data and Quality Monitoring

- **Critique:** You propose a "pragmatic monitoring framework". However, in a low-resource setting like Angola, data missingness is a significant risk.
- **Suggestion:** Expand on the "explicit checks on missingness and data quality". How will de-identified data be collected across sites with potentially varying digital infrastructure?.

6. Discussion

- **Critique:** The discussion is somewhat repetitive of the rationale. It glosses over the **major implementation barriers** specific to Angola.
- **Suggestion:** Critically discuss the **logistical hurdles** of your model. For example, if "tele-supervision" is a core pillar, how will you address unstable internet connectivity or the high cost of data for staff in rural Angolan provinces?. Addressing these challenges will make the protocol more "honest" and valuable to other implementers.

7. Conclusions

- **Critique:** The conclusion claims the framework is "feasible". As a protocol for an "early implementation phase," this is a premature claim.
- **Suggestion:** Reframe the conclusion to state that the protocol *aims to test the feasibility* and provide a roadmap for how the "practice-based evidence" generated will be used to influence Angolan national health policy.

Is the rationale for, and objectives of, the study clearly described?

Yes

Is the study design appropriate for the research question?

Yes

Are sufficient details of the methods provided to allow replication by others?

Partly

Are the datasets clearly presented in a useable and accessible format?

No

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: mental health, adolescents, bullying, domestic violence, anxiety, resilience

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Author Response 24 May 2026

Jose Navarro

COMMENTS TO THE reviewer – OPEN RESEARCH EUROPE (*STUDY PROTOCOL*) *TITLE: Building university-based psychological and psychoeducational services in Angola (ANGOSAP): a brief report on rationale, design, and early implementation context*. REVIEWER COMMENTS ANSWER FROM AUTHORS/NEW TEXT

1. Title

- **Critique:** The title is overly wordy and administrative ("...a brief report on rationale, design, and early implementation context").
- **Suggestion: Revise for impact and clarity.** Focus on the core innovation—the task-sharing model in the Angolan university context. *Example: "Task-Sharing and Stepped-Care Mental Health Services in Angolan Higher Education: A Multi-Site Implementation Protocol (ANGOSAP)."*

New title *Task-Sharing and Stepped-Care Mental Health Services in Angolan Higher Education: A Multi-Site Implementation Protocol (ANGOSAP)*

2. Abstract

- **Critique:** The abstract identifies the problem (workforce shortage) and the solution (ANGOSAP) but lacks a clear description of the *specific* primary metrics that will define "early implementation success".
- **Suggestion:** Include the specific **monitoring indicators** (e.g., reach, wait times, reliable clinical change) directly in the abstract so readers understand the evaluative rigor of the

(new text in yellow) Methods This Study Protocol describes the rationale, service model, and framework of ANGOSAP. The project uses a co-designed, stepped-care, task-sharing approach adapted to each institution. Core components include campus-level procedures for intake, triage, risk assessment, safeguarding, and referral; competency-based training and supervision; psychoeducation, brief psychological interventions, and digital resources; referral pathways; and pragmatic monitoring.
Early implementation success will be assessed using predefined indicators: service reach, median waiting time from first contact to first appointment, first-appointment uptake, care-plan completion, reliable clinical change on validated symptom or functioning measures, serious incidents, acceptability, and equity-stratified access and outcomes. .

Methods and Study Design

- **Critique (Major Concern - Replication):** The manuscript mentions "brief, evidence-based psychological interventions" and "validated symptom or functioning scales" but **fails to name them**. A protocol must be reproducible.
- **Requirement:** Specify exactly which tools will be used (e.g., PHQ-9, GAD-7, or WHO-

5). Simply stating "validated scales" is insufficient.
- **Critique (Task-Sharing Detail):** You mention using "trained non-specialists" such as counselors and student support officers.
- **Requirement:** Provide more detail on the **competency-based training package**. What is the duration of the training? What are the "OSCE-style assessments" measuring specifically?.
- **Critique (Stepped Care):** The transition between Tier 2 (brief intervention) and Tier 3 (specialist referral) is vague.
- **Requirement:** Define the **triage criteria** or clinical thresholds that trigger an escalation to specialist care.

Revised text for "Data and quality" Clinical change will be monitored through a predefined minimum outcome set: the Patient Health Questionnaire-9 (PHQ-9) for depressive symptoms, the Generalized Anxiety Disorder-7 (GAD-7) for anxiety symptoms, and the World Health Organization-Five Well-Being Index (WHO-5) for subjective well-being. PHQ-9 and GAD-7 will be administered at intake and at planned review or discharge, while WHO-5 will provide a brief well-being indicator. Portuguese-language versions will be checked for local comprehension and cultural acceptability during piloting. Reliable clinical change will be defined as meaningful pre-post improvement, interpreted alongside attendance, risk status, and student-reported acceptability.

2. Workforce development. Providers, including counselors and student support officers, will complete a 40-hour competency-based training programme, followed by supervised practice and regular supervision during the first implementation semester. Training will cover structured intake, confidentiality, safeguarding, use of PHQ-9, GAD-7 and WHO-5, suicide and self-harm risk assessment, brief psychoeducation, problem-solving strategies, behavioral activation, anxiety-management techniques, referral documentation, and crisis escalation. OSCE-style assessments will evaluate intake skills, correct use of monitoring tools, risk recognition, brief intervention delivery, care-plan documentation, and appropriate Tier 2 versus Tier 3 referral decisions.

b) Stepped care.

Tier 1 will include mental health literacy, psychoeducation, digital self-help resources, and low-intensity workshops.

Tier 2 will provide brief structured interventions, including problem-solving strategies, behavioral activation, anxiety-management techniques, and academic adjustment support, for students with mild-to-moderate symptoms and no immediate safety concerns.

Tier 3 referral to specialist care will be triggered by active suicidal ideation or self-harm risk, psychotic or manic symptoms, severe substance misuse, safeguarding concerns, severe functional impairment, clinical deterioration during Tier 2, non-response after a brief intervention period, or severe PHQ-9/GAD-7 scores. Any positive response to PHQ-9 item 9 will require same-day risk assessment and, where indicated, urgent referral.

COMMENTS BY AUTHORS: We thank the reviewer for this important observation. We have revised the "Stepped care" subsection to specify the clinical and safety criteria that trigger escalation to specialist care, including suicidal ideation or self-harm risk, psychotic or manic symptoms, severe substance misuse, safeguarding concerns, severe functional impairment, deterioration during Tier 2, non-response to brief intervention, and severe PHQ-9/GAD-7 scores. We also specify that any positive response to PHQ-9 item 9 will require same-day risk assessment and urgent referral when indicated. This revision improves the reproducibility and safety of the stepped-care pathway.

Data and Quality Monitoring

- **Critique:** You propose a "pragmatic monitoring framework". However, in a low-resource setting like Angola, data missingness is a significant risk.
- **Suggestion:** Expand on the "explicit checks on missingness and data quality". How will de-identified data be collected across sites with potentially varying digital infrastructure?.

To address variation in digital infrastructure across sites, each institution will use a shared minimum dataset with standardized variable definitions and de-identified student codes. Data will be entered into a secure digital template where feasible; when internet access or equipment is limited, paper forms will be completed locally and transferred to the same template during scheduled data-entry sessions. Each term, sites will report the proportion of missing values for core fields, reasons for missingness when known, duplicate records, inconsistent dates, and incomplete outcome measures. These checks will be reviewed in cross-site supervision meetings before indicators are interpreted.

COMENTS BY AUTHORS: We thank the reviewer for highlighting the risk of data missingness in a low-resource setting. We agree that this required clearer operational detail. We have revised the “Cohort-style service analytics” subsection to specify how de-identified data will be collected across sites with varying digital capacity. The revised text now describes the use of a shared minimum dataset, standardized variable definitions, de-identified student codes, secure digital templates where feasible, and paper-to-digital transfer procedures when digital infrastructure is limited. We also specify termly checks for missing values, duplicate records, inconsistent dates, incomplete outcome measures, and documented reasons for missingness. These procedures are intended to improve data quality while remaining feasible across participating Angolan institutions.

Discussion

- **Critique:** The discussion is somewhat repetitive of the rationale. It glosses over the **major implementation barriers** specific to Angola.
- **Suggestion:** Critically discuss the **logistical hurdles** of your model. For example, if "tele-supervision" is a core pillar, how will you address unstable internet connectivity or the high cost of data for staff in rural Angolan provinces?. Addressing these challenges will make the protocol more "honest" and valuable to other implementers.

However, implementation in Angola will face logistical constraints, particularly unstable internet connectivity, uneven access to devices, and the high cost of mobile data in some provinces. To reduce dependence on continuous connectivity, tele-supervision will combine scheduled low-bandwidth video meetings with telephone supervision, asynchronous case summaries, offline documentation templates, and periodic in-person supervision when feasible. These adaptations will be monitored as implementation barriers in the cross-site learning network.

COMMENTS FROM AUTHORS: We have revised the Discussion to acknowledge unstable internet connectivity, uneven access to devices, and the cost of mobile data as potential constraints for tele-supervision. We now specify mitigation strategies, including low-bandwidth meetings, telephone supervision, asynchronous case summaries, offline documentation templates, and periodic in-person supervision where feasible. This revision provides a more realistic and transferable account of implementation challenges.

Conclusions

- **Critique:** The conclusion claims the framework is "feasible". As a protocol for an "early implementation phase," this is a premature claim.
- **Suggestion:** Reframe the conclusion to state that the protocol *aims to test the feasibility* and provide a roadmap for how the "practice-based evidence" generated will be used to influence Angolan national health policy.

ANGOSAP provides a structured protocol to test the feasibility of university-based psychological and psychoeducational support in Angola. By combining capacity building, supervision, referral integration, and routine monitoring, the project will generate practice-based evidence on reach, access, safety, acceptability, and early clinical change. These findings will inform service refinement across participating institutions and provide a roadmap for engaging national stakeholders, including health and higher education authorities, in future policy development.

COMMENTS FROM AUTHORS: We have revised the conclusion to state that ANGOSAP aims to test feasibility rather than claim it. The revised text also clarifies how the practice-based evidence generated through routine monitoring will be used to refine services and inform engagement with Angolan health and higher education stakeholders for future policy development.

Competing Interests: No competing interests were disclosed.