

# Researchers As Leaders: Is The African Mental Health Research Initiative (AMARI) An Effective Apparatus For Resolving Mental Health Problems In Africa?

## **Abstract**

The mental health of Africa's populations ought to be central to considerations of security. This study frames psychology as social thus transforming it from a private individual problem to a public and collective one needing a socio-political response. Therefore, this work approaches mental health from a leadership viewpoint to assess whether the African Mental Health Research Initiative (AMARI), in generating *research leaders*, is effective in resolving mental health problems.

## Methods

Contemporary leadership scholarship informed a framework through which AMARI's was assessed. AMARI's effectiveness was explored by using findings from qualitative interviews and case studies of the research conducted by AMARI fellows.

## Results

Although various definitions of leadership were given, participants' leadership concept is underdeveloped. Despite this, the case studies demonstrated that good leadership takes place in AMARI, with research being produced that is relevant to each country. However, participants spoke of difficulties specific to researchers in Africa and for a need to have African responses to these problems.

## Conclusion

AMARI sits as a juncture where it can transform the mental health paradigm in Africa. By using leadership as an entry point, there is the potential to generate structurally competent research leaders who will develop sustainable solutions to mental health problems.

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## INTRODUCTION

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Peace is the absence of violence.<sup>1</sup> Violence 'is present when human beings are being influenced so that their actual somatic and mental realizations are below their potential realizations.'<sup>2</sup> The working definition to be used in this study will thus define violence as 'the cause of the difference between the potential and the actual'.<sup>3</sup> Typical conceptions of violence involve a subject-action-object relation where a person (subject) commits the violent act. This personal violence is easily visible and can be pointed to in acts such as a person beating their partner. Another, more insidious, form of violence, devoid of the subject-action-object relation, is structural violence. It is woven into the scaffolding of society and shows up as unequal power resulting in unequal life chances.<sup>4</sup> Educational opportunities favouring boys over girls, which results in limited career options for girls is a structural violence.

Mental illness therefore, with its reduction in one's potential, can be seen a violence. The process of finding *peace* of mind has to encompass and factor in the structural forces at play in the aetiology, pathophysiology and management of mental illness. This requires a departure from Western post-Enlightenment psychiatric conceptions in which the mind (constructed as "psychology") is located inside the body and what is "social" located outside of the body. Instead, this pursuit of peace must 'see our psychology as having a root outside the body, in the way that we live'.<sup>5</sup> Placing psychology outside necessarily relocates this violence from the mental space to the socio-political space thus transforming it from a private individual problem to a public and collective one requiring a *socio-political* response. The Movement for Global Mental Health in its call for action on improving access to care and promoting the human rights of people with mental disorders globally, seeks to do this.<sup>6</sup> Global mental health discourse has emphatically voiced the dire mental health situation in Africa stressing the increasing contribution of mental illness to the global burden of disease.

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<sup>1</sup> Galtung, Johan (1969), 'Violence, Peace, and Peace Research', *Journal Of Peace Research*, Vol. 6, No. 3, p.167

<sup>2</sup> Galtung (1969), p.168

<sup>3</sup> Galtung (1969), p.168

<sup>4</sup> Galtung (1969), p.171

<sup>5</sup> Summerfield, Derek (2012), 'Afterword: Against "Global Mental Health"', *Transcultural Psychiatry*, Vol. 49, No. 3-4, p. 527

<sup>6</sup> Patel, Vikram (2014), 'Why Mental Health Matters To Global Health', *Transcultural Psychiatry*, Vol. 51, No.6, pp. 784

The scale of the burden of disease is typically understood using two metrics: years lived with disability (YLD) and disability-adjusted life year (DALY). The global burden of mental illness accounts for 32.4% of YLDs and 13.0% of DALYs surpassing both cardiovascular disease burden in terms of YLD and circulatory diseases for DALY's. By 2020, it is estimated that 1.5 million people will die each year by suicide, and between 15 and 30 million will make the attempt.<sup>7</sup> The violence of the reduced quality of life of millions of people and premature death is particularly acute in Africa where despite the considerable burden of disease, mental illness receives disproportionately little attention from researchers, global and national policy makers, funders and governments.<sup>8</sup>

This disproportional attention is seen in the shortage of research into mental health problems on the continent.<sup>9</sup> In its 5 years of existence, the Lancet Global Health committed to focusing on 'disadvantaged populations, be they whole economic regions or marginalised groups within otherwise prosperous nations'.<sup>10</sup> 637 papers that referenced Africa were published by May 2018.<sup>11</sup> A search for "mental health disorders" in Africa produces just 16 items.<sup>12</sup> The dearth of research is echoed in the limited mental health services in the region. Levels of public spending on mental health is scant in low-income and middle-income countries (LMIC): mental health receives less than 1% of health-care funding and of this more than 80% is allocated to mental hospitals.<sup>13 14</sup> In already resource deplete areas, this low spend on mental health becomes a double disadvantage: the poorest countries spend the smallest proportion of their already limited health-care resources on mental health.<sup>15</sup> The case for human resources is dire: the median number of mental health

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<sup>7</sup> Bertolote, José & Fleischmann, Alexandra (2015), 'A Global Perspective In The Epidemiology Of Suicide' *Suicidologi* Vol. 7, No. 2, pp. 6

<sup>8</sup> Lopez, Alan & Murray, Christopher (1998), 'The Global Burden Of Disease, 1990–2020', *Nature Medicine*, Vol. 4, No.11, pp. 1241-1243

<sup>9</sup> Sankoh, Osman, Sevalie, Stephen & Weston, Mark (2018), 'Mental Health In Africa', *The Lancet Global Health*, Vol.6, No. 9, p. 954

<sup>10</sup> Sankoh (2007), p. 954

<sup>11</sup> Sankoh (2007), p. 954

<sup>12</sup> Sankoh (2007), p. 954

<sup>13</sup> 'WHO Mental Health Atlas', World Health Organization, (2017)

<sup>14</sup> A balance between hospital-based and community-based mental health services has been shown to be the most effective form of comprehensive mental health care. However, this balance has only been achieved in a few high income settings with – most formal mental health service provision tends to lean heavily towards hospital-based services despite community-based care being more efficacious.

<sup>15</sup> Saxena (2007), p. 883

workers globally, whilst having extreme variation, is 9 per 100, 000.<sup>16</sup> Between 2014-2016, there were 0.1 psychiatrists and 0.3 psychiatric nurses per 100 000 population in low-income countries. In comparison, the rate of psychiatrists in high income countries is 120 times greater and is more than 75 times greater for nurses.<sup>17</sup>

The problem of the scarcity of mental health resources is compounded by inequitable distribution of these resources between countries, between regions and within local communities. Need and access tend to be inversely linked to one another: those with highest need have the least access to care. Mental, neurological and substance use (MNS) disorders and the need for care are highest in poor people, women and young people, those with the lowest education and rural communities: yet these groups have the lowest access to appropriate services. For example, between 76% and 85% of people with mental disorders in LMICs receive no treatment for their disorder; in Sierra Leon, up to 98% of patients with mental illness can go untreated<sup>18 19 20</sup>

## OVERVIEW OF AMARI

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The African Mental Health Research Initiative (AMARI) seeks to contribute to the resolution of the violence of mental health in Africa. The Wellcome Trust fund the Alliance for Accelerating Excellence in Science in Africa (AESA) through the African Academy of Sciences (AAS). AESA then select and fund 11 Developing Excellence in Leadership, Training and Science (DELTA) programs of which AMARI was one in May 2015.<sup>21</sup> This program seeks to alleviate the mental health problems in the region by building an Africa-led network of 47 research leaders in MNS disorders in Zimbabwe, Ethiopia, Malawi and South Africa. AMARI set out to recruit 21 research fellows at MPhil level, 20 PhD researchers and 6 Post-Doctoral

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<sup>16</sup> World Health Organization (2017)

<sup>17</sup> 'Psychiatrists and nurses (per 100 000 population)', Global Health Observatory (GHO) data, World Health Organisation, 2016

<sup>18</sup> 'Mental Disorders', World Health Organisation, (2017)

<sup>19</sup> Lund, Crick, De Silva, Mary, Plagerson, Sophie, Cooper, Sara, Chisholm, Dan, Das, Jishnu, Knapp, Martin & Patel, Vikram (2011), 'Poverty and mental disorders: breaking the cycle in low-income and middle-income countries', *Lancet*, Vol, 378, No.9801, pp.1502-1514

<sup>20</sup> Yoder, Helene, Tol, Weitse, Reis, Ria, & Jong, Joop (2016), 'Child Mental Health in Sierra Leone: A Survey and Exploratory Qualitative Study', *International Journal of Mental Health Systems*, Vol.10, No. 48, pp.1-13

<sup>21</sup> 'AMARI: An Africa-Led Network Of Research Excellence', AMARI (2019)

(post doc) researchers equipping them to lead high quality mental health research programs that meet the needs of their respective countries.

The 47 AMARI fellows receive a number of training courses to prepare them for their fellowships and future careers. Included in this training package is an introductory course to the PhD and Post-Doctoral research programs, introduction to epidemiology, a statistics course, and an Academic Career Enhancement Series (ACES). The ACES course covers non-academic skills needed to build a career in research. This includes training in mentoring, presentation skills, the use of digital media, work-life balance, teamwork skills, teaching techniques, grant writing, and strategic career planning.<sup>22</sup>

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<sup>22</sup> AMARI (2019)

## STRUCTURE OF AMARI

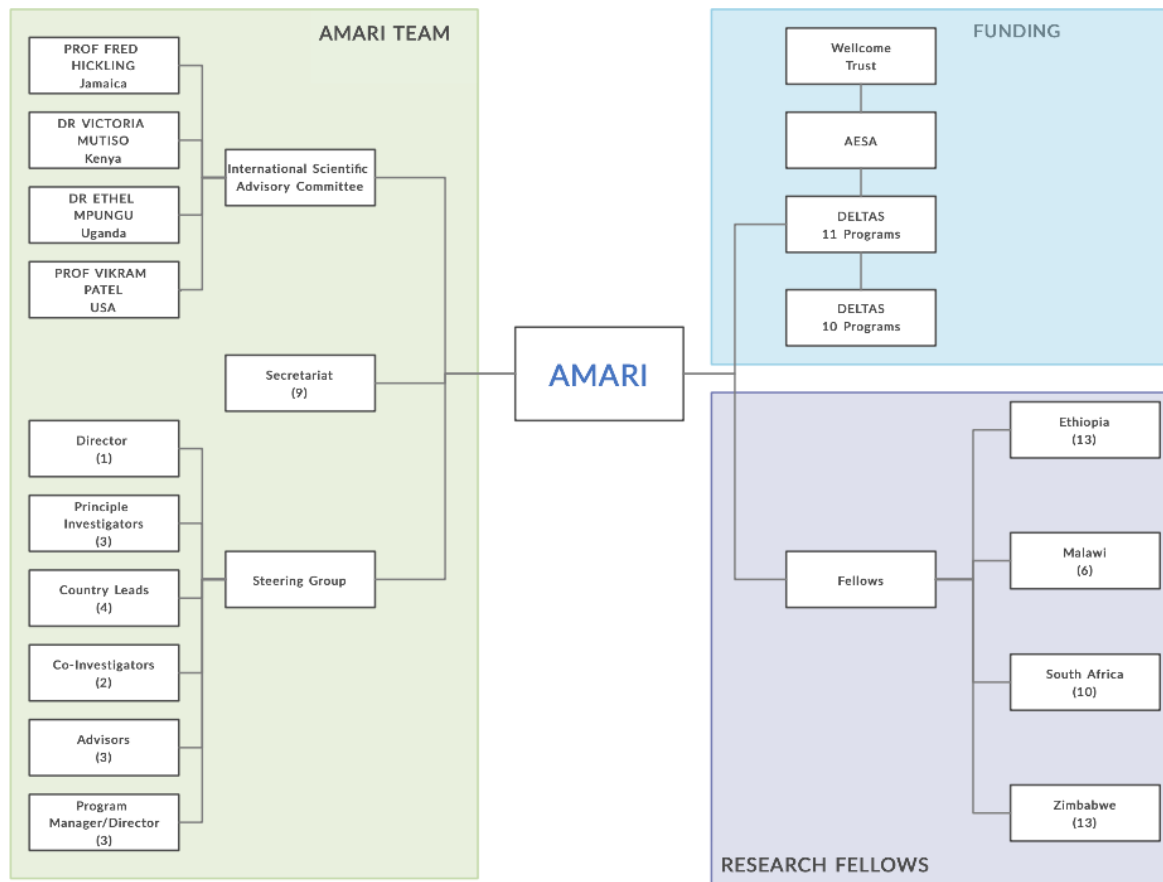


FIGURE 1: STRUCTURE OF AMARI

As mental illness can be seen as an inherent violence preventing those with mental health disorders from reaching their fullest potential, it follows that a resolution of this problem must be the pursuit of peace. Olonisakin in her exploratory research proposes that ‘peacemaking is... about "leadership building"’.<sup>23</sup> Therefore, AMARI, whose overall goal is to build an Africa-led network of future leaders in MNS disorder research, makes a fascinating case for leadership analysis.

Since these fellows look specifically at the mental health needs of their respective countries, AMARI places emphasis on responding to the situation of a particular context which avoids providing a homogenous solution for the problem of mental illness in Africa. This demonstrates a much needed appreciation of the psychology as social. This study seeks to

<sup>23</sup> Olonisakin, Funmi (2015), ‘Re-conceptualising Leadership for Effective Peacemaking and Human Security in Africa’, *Strategic Review for Southern Africa*, Vol.37, No.1, p. 149



understand whether AMARI, in training researchers as leaders, is an effective apparatus for resolving mental health problems in Africa with a particular focus on Zimbabwe.

## OVERVIEW

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### ZIMBABWE

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## CONTEXT

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Zimbabwe has experienced its worst economic crisis in the last decade with an inflation rate currently sitting at 200%.<sup>24</sup> This economic instability is compounded by a turbulent socio-political climate and vulnerability to adverse weather which culminate in high living costs, commodity and power shortages, stagnant salaries and 90 percent unemployment rates, and increasing discontent of Mnangagwa's government. The devastation caused by Cyclone Idai has further exacerbated these issues. The effects on health care are acute. Zimbabwe is proposing the designation of health services as “essential” in an attempt to limit strikes by medical personnel: public sector doctors struck for the second time in less than a year demanding a increases in salaries.<sup>25</sup> Mental health service provision is threatened by a decimated infrastructure, gross supply chain challenges and deteriorating access to services which. The exodus of many mental health care professional into the private sector or to other countries further perpetuated this.<sup>26</sup> Economic uncertainty increases stress and contributes to the increasing burden of mental illness; of note alcohol and substance misuse has increased in Zimbabwe.<sup>27 28</sup>

## INFRASTRUCTURE

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<sup>24</sup>Muronzi, Chris (2019), 'Discontent Swells In Zimbabwe Amid Crackdown, Economic Woes', *Aljazeera*

<sup>25</sup>'Zimbabwe Proposes Designating Health Services As Essential Amid Doctor's Strike', Reuters, 2019

<sup>26</sup>Khameer, Kidia, Machando, Debra, Mangezi, Walter, Hendler, Reuben, Crooks, Megan, Abas, Melanie, Chibanda, Dixon, Thornicroft, Graham Semrau, Maya & Jack, Helen (2017), 'Mental Health In Zimbabwe: A Health Systems Analysis', *The Lancet Psychiatry*, Vol.4, No.11, pp. 876-886

<sup>27</sup>Khameer (2017),

<sup>28</sup>'National Strategic Plan for Mental Health Services 2019 – 2023: Towards Quality of Care in Mental Health Services', Ministry of Health and Child Care Zimbabwe, (2019)

Zimbabwe's mental illness burden is estimated to be 15-30%. Issues around limited financing and resources, policy and law, criminal justice and forensic services, shortages of a workforce, training and research as well as stigma against mental illness contribute to the problem of mental health.<sup>29</sup> Like many other LMICs, less than 1% of health-care funding is allocated to the provision of mental health care services. Available funds are typically directed towards central psychiatric centres rather than community based facilities. Currently, there are 4 tertiary psychiatric units which are located in Harare (2 facilities), Bulawayo and Masvingo as well as 4 provincial psychiatric units and 2 forensic psychiatric facilities.<sup>30</sup> Some psychiatric units have closed down or are non-functioning as a result of inadequate resources: only the Harare Hospital Psychiatric Unit has been refurbished recently (with funding from Medicines Sans Frontier) leaving the other facilities in dire need of refurbishment. Zimbabwe also faces an issue of its workforce being concentrated around the central facilities. Of the 17 registered psychiatrists in Zimbabwe, only 14 work in the country and of these 12 are based in Harare. Consequently, despite the majority of the population residing in rural areas, most of the country is left without access to specialist care.<sup>31</sup>

#### FUTURE PROSPECTS

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Despite this bleak context, much is taking place in Zimbabwe to tackle mental illness. There is political will to address and scale up mental health services across the country. The Ministry of Health and Child Care (MoHCC) launched the National Strategic Plan for Mental Health Services 2019 – 2023 with a commitment from the government of Zimbabwe to raise the standards of care and bring mental health services closer to communities. There is also a vibrant and thriving research community which has made substantial progress and attracted more mental health funding for the country. Of note, 2 of the 5 research and training programs sighted in the National Strategic Plan for Mental Health Services 2019 – 2023 include the “Friendship Bench Project” and “AMARI” of which Dixon Chibanda and Walter Mangezi (AMARI director and Steering Group member) are leads.<sup>32</sup>

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<sup>29</sup> Khameer (2017), p.877

<sup>30</sup> Ministry of Health and Child Care Zimbabwe (2019), p. 8

<sup>31</sup> Khameer (2017), p.881

<sup>32</sup> Ministry of Health and Child Care Zimbabwe (2019), p. 11

### EVIDENCE FOR LEADERSHIP BEING A GOOD SOLUTION

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Zimbabwe's context is replete with insecurity with evidence of violence that is both personal and structural. If the most intractable challenge to human security in Africa is violent conflict (personal violence) that is not abating but continually mutating or relapsing, destabilising and decimating societal infrastructure (structural violence), and leaving a legacy of trauma, then the inheritance of hundreds of millions of people across the continent is structural poverty and injustice, unstable economies rife with crippling debt repayments, environmental degradation and exceptionally inadequate health, education and social service provision.<sup>33 34</sup> Human security in Africa is a luxury. Challenging the idea that the wellbeing of the individuals ought to be central to considerations of security, given Africa's precarious context, then becomes superfluous.<sup>35</sup> If then, we accept the warnings of the increasing burden of mental health disorders in which 'depression' is predicted to be the most debilitating disease, 'what is "mental health" in a broken social world?'<sup>36</sup> As such, any approach attempting to resolve the mental health problems in Africa that divorces the social contexts in which these individuals are situated is erroneously short sighted at best. That millions of people might cite poverty and a lack of rights as a basis of their misery as opposed to depression, for example, ought not to be disregarded. It is imperative to avoid a distorted view of the 'burden of mental illness' in which the contributions of human insecurity are ignored. Addressing inequality in the healthcare settings requires that practitioners attend to the social structures that shape and enable the perpetuation of these realities. However, these structures are frequently rendered invisible in the biomedical healthcare ecosystem.<sup>37</sup> Structural competency offers an entry point for expanding the myopic lens of health care. Metzl defines structural competency as

'the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication "non-compliance," trauma, psychosis) also represent the downstream implications of

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<sup>33</sup> Olonisakin (2015), p. 124

<sup>34</sup> Summerfield, Derek (2004), *Cross-Cultural Perspectives on the Medicalization of Human Suffering*, in Rosen, G.M (Ed.), *Posttraumatic stress disorder: Issues and controversies*, (New York: John Wiley & Sons Ltd)

<sup>35</sup> Olonisakin (2015), p.124

<sup>36</sup> Summerfield (2004), p.526

<sup>37</sup> Metzl, Jonathan & Hansen, Helena (2014), 'Structural Competency: Theorizing A New Medical Engagement With Stigma And Inequality', *Social Science & Medicine*, Vol. 103, p.131

a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health'.<sup>38</sup>

If the problem of mental illness is to be meaningfully addressed, it is essential that practitioners depart from the narrow biomedical model and instead recalibrate and expand their concept of mental health by utilising a framework that adequately captures the structural forces at play. An approach that is less than will be enacting and perpetuating violence. Leadership, with its concern with establishing human security through meeting the needs of people can provide an entry point to alleviating the problem of mental health in Africa.

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### LEADERSHIP THEORY OPTIONS

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The idea that leadership is a useful framework for approaching the complex healthcare landscape is uncommon. As is often the case in other fields, when leadership does appear, it is often in the form of a surrogate for management. To assess whether AMARI is an effective apparatus for resolving the mental health problems in Africa, it is necessary to conceptualise its leadership. Conventional approaches are unfitting because their entry point to leadership are at the individual level. Popular views of leadership are often person-centric: they are limited to the position or person based leadership typologies.<sup>39</sup> A position-based approach to leadership relies on hierarchical structures in which power and responsibility are aggregated to a particular position which a **person** assumes; by virtue of assuming such a position one becomes a leader.<sup>40</sup> A person based approach is concerned with a property or set of properties endowed in varying degrees to different people. Therefore, this standpoint implies that leadership resides *in select people* and confines leadership to those who are believed to have special, usually innate, leadership traits.<sup>41</sup> Murphy convincingly asserts that leadership '...is unstable, that the qualities necessary at one time are unnecessary at

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<sup>38</sup> Metzl (2014), p.128

<sup>39</sup> Grint, Keith (2010), *Leadership: A Very Short Introduction*, (Oxford: Oxford University Press), p.4

<sup>40</sup> Olonisakin, p.129

<sup>41</sup> Northouse, Peter Guy (2010), *Leadership: Theory And Practice*, 5th edn, (Los Angeles, London, New Delhi, Singapore, Washington DC: Sage)

other times...'.<sup>42</sup> Thus, leadership study requires a departure from the static person-centric frameworks and calls for a flexible situational approach instead.

Northouse's conceptualisation of leadership defined as '*a process whereby an individual influences a group of individuals to achieve a common goal*' is a more useful entry point. This leadership as process implies a relationality between leader and follower whereby the leader affects and is affected by followers. Therefore leadership exists **between** the interactions of the 'leader' and the 'follower'. As a result, leadership as a non-linear multidirectional event is emphasised. Thus leadership becomes available to everyone and is not restricted to the formally designated leader in a group.<sup>43</sup> With this viewpoint, the leader-follower binary as leadership must be dissolved. Instead, the interactions between the two must be further analysed. It is the essence of this interaction between the leader and the follower that can provide an entry point for analysing AMARI. If there are different interactions taking place between different leader-follower relationships, and, there are different situations with distinctive needs calling for a particular response, then leadership cannot be distilled to a particular 'thing'. Since it is based on ever changing interactions between individuals who are responding to changing situational needs, it cannot be boxed to a property or set of properties, unlike a list of traits. Therefore, a mechanism for capturing and measuring these various interactions is needed.

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#### DEFINING AMARI AS A LEADER

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A results based approach is useful for understanding the various dynamics taking place in AMARI. This typology utilises the products of leadership as an 'indicator of the degree to which the purpose of the exercise of leadership is realised'.<sup>44</sup> To answer the research question, this research will combine the process and results based approaches to leadership. This study adopts Bentley's declaration that '[l]eadership is not an affair of the individual leader. It is fundamentally an affair of the group'.<sup>45</sup> It is crucial to resist the temptation of reducing the entity to the sum of its components. Since the component parts

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<sup>42</sup> Murphy, Albert (1941), 'A Study of the Leadership Process', *American Sociology Review*, Vol.6, No.5, pp. 674-687

<sup>43</sup> Northouse (2010), p. 3

<sup>44</sup> Grint (2010), p.8

<sup>45</sup> Burns, James (1978), *Leadership*, (New York:Harper and Row), p.302

of an entity may change over time (e.g. an AMARI steering group member leaves), without altering its *leadershipness*, it is necessary to maintain that the entity is greater than the sum of all its parts and therefore is a leader in its own right.<sup>46</sup>

For the purposes of this study, Murphy's definition stating that '*leadership process is a response to a situational need*' will be utilised.<sup>47</sup> AMARI is the entity responding to the mental health situation in Africa – it is the leader. The leadership process will be taken to be the method(s) of response to aforementioned need(s). This thesis seeks to assess whether AMARI, as a leader is effective in its response to the mental health problems in Africa, with a particular focus on Zimbabwe. To do this, effectiveness will be assessed across three planes by exploring the following questions:

1. Has AMARI achieved its internally set goals?
2. Can the AMARI fellows solve the articulated problem?
3. Are the needs of those with mental illness being met (focus on Zimbabwe)?

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<sup>46</sup> Jackson, Brad & Parry, Ken (2011), 'Very Short Fairly Interesting and Reasonably Cheap Book About Leadership', (London: Sage Publication)

<sup>47</sup> Murphy (1941)

## METHODS

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### COUNTRY PROFILE

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#### Contextual information about mental health in Zimbabwe

WHO Mental Health Atlas country profiles were used to compile an overview of Zimbabwe capturing the salient MNS problems.<sup>48</sup> Global burden of disease data were collected from the Institute for Health Metrics and Evaluation.<sup>49</sup>

#### QUALITATIVE INTERVIEWS

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AMARI fellows and key informants (AMARI Steering group members and AAS staff) were approached to take part in individual, semi-structured interviews. Purposive sampling and snowballing were used to achieve representation across the spectrum of level of study (MPhil, PhD and post doc), country and gender.<sup>50</sup> 13 participants took part in the semi structured interviews. The final sample included 10 AMARI fellows, and 3 key informants (2 AMARI steering group and 1AAS staff).

In the final sample, of the 3 key informants, 2 were men and 1 a woman representing Ethiopia, Kenya and Zimbabwe. The final fellow sample is shown in Figure 2.

Country		Level of Study		Gender	
Ethiopia	2	Post doctoral	2	Female	3
Malawi	3				
South Africa	2	PhD	6	Male	6
Zimbabwe	3	MPhil	2		

FIGURE 2: AMARI COUNTRY PROFILES

Before the study ethical approval and Research Data Protection Registration (KDPR) approval were obtained from the King's College London (KCL) College Research Ethics Committee (CREC) and the KCL Research Governance Office respectively. Before interview,

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<sup>48</sup> The most recent published WHO Mental Health Atlas available were used for Ethiopia, South Africa and Zimbabwe. Malawi did not have a profile from 2017. The available profile from 2011 still has a lot of missing information. World Bank data was used for the income classification.

<sup>49</sup> Country profiles - Appendix A

<sup>50</sup> Palinkas, Lawrence, Horwitz, Sarah, Green, Carla, Wisdom, Jennifer, Duan, Naihua & Hoagwood, Kimberly (2013), 'Purposeful Sampling For Qualitative Data Collection And Analysis In Mixed Method Implementation Research', *Administration And Policy In Mental Health And Mental Health Services Research* Vol. 42, No. 5, p.536

the interviewer described the study to the participant in English and obtained written consent.

## DATA COLLECTION

*Face-to-face* interviews, lasting between 21.39 and 38.06 minutes, were held via Zoom. An interview guide including both closed and open ended questions was generated to cover the following four areas: the AMARI structure, stakeholders and vision, the participant's understanding of leadership, leadership in the participants working environment and the personal leadership of the participant.<sup>51</sup>

## DATA ANALYSIS

All interviews were audio-recorded and transcribed verbatim before being entered into NVivo 12. All data were anonymised and then coded. Thematic analysis, with an inductive approach, was utilised to analyse the data; categories and the relationships that emerged between were grouped into overarching themes.

## ASSESSING RELEVANCE OF THE RESEARCH

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Contextual information on the mental health landscape for Zimbabwe, as well as the qualitative interviews, informed the creation of a marking criteria – the Relevance of Research Rubric ( Figure 3 - below) was used to measure whether AMARI is an effective apparatus for resolving mental health problems.

The following four indices were used to assess for effectiveness

- Global priorities: this list was compiled using the 25 grand challenges identified by the National Institute of Mental Health
- National priorities: national strategic plan, mental health policies, policy briefs and national reports on the status of mental health were used to identify national priorities for Zimbabwe
- AMARI priorities: this list was informed by the responses from the qualitative interviews

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<sup>51</sup> Interview guide – Appendix B



- Impact Criteria – critical global mental health literature informed this domain

One research project from Zimbabwe was randomly selected to form the basis of a case study. The four studies were marked using this Relevance of Research Rubric marking guide and given a rating.<sup>52</sup>

<b>Domain</b>	<b>Criteria</b>	<b>Points</b>
Global Priorities	Meets 1 global challenge	
	Meets 2 global challenges	
	Meets >3 global challenges	
National Priorities	Meets 1 national priority	
	Meets 2 national priorities	
	Meets >3 national priorities	
AMARI Priorities	Meets 1 AMARI priority	
	Meets 2 AMARI priorities	
	Meets >3 AMARI priorities	
Impact Criteria	Meets 1 Impact criteria	
	Meets 2 Impact criteria	
	Meets >3 Impact criteria	
Total score		

FIGURE 3: RELEVANCE OF RESEARCH RUBRIC

<sup>52</sup> Relevance of Research Rubric marking guide - Appendix C

## THEMATIC ANALYSIS

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Whether or not AMARI is an effective leadership apparatus for resolving the mental health problems in Africa requires an analysis along multiple planes as mentioned above. The following questions are relevant:

- i. Has AMARI achieved its internally set goals?
- ii. Can the AMARI fellows solve the articulated problem – *are they leaders?*
- iii. Are the needs of those with mental illness being met?

A point of departure is to first assess whether or not AMARI has achieved its own internally set goals. This, in turn, encapsulates and speaks to the two remaining questions. The confines of this study only allows for an analysis of AMARI's broad leadership goals therefore the desired outcomes of AMARI will be taken to be:<sup>53</sup>

1. Building an African-led network of 47 research leaders in MNS disorder research
2. Leading high-quality mental health research programs and developing sustainable career pathways for its fellows
3. Meeting the needs of the fellows' countries: the research has to be locally relevant

The following sections will explore each goal in turn, utilising data from the semi-structured interview.

### AMARI GOAL 1: BUILDING AN AFRICAN-LED NETWORK OF 47 RESEARCH LEADERS

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To ascertain whether AMARI has effectively achieved its goal to build a cohort of fellows, the perception of leadership of the participants were explored first, followed by their leadership concept and lastly the opinions of leadership effectiveness. This is important for evaluating whether AMARI has in fact produced and will produce research leaders. The following themes arose for each of these domains.

#### PERCEPTIONS OF LEADERSHIP

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##### **Theme 1: Lack of researchers/leaders in Africa**

In keeping with scholarship, many of the participants noted the dearth of leaders and research surrounding mental health in Africa:

“...very little human resource you quickly become a leader by default” - *Key informant*

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<sup>53</sup> AMARI (2019)

“So one of the big problems with research in mental, neurological and substance use disorders in our context is that there’s very few people who are trained” - *PhD fellow*

To mitigate for this situation AMARI set out to train 47 researchers: 21 MPhils, 20 PhDs and 6 post-doctoral fellowships.

## **Theme 2: A different type of fellow**

It was highlighted both in AMARI literature and the interviews that this program seeks to generate a different kind of fellow.

“I think AMARI has ***seen the gap*** in terms of research skills in terms of the need for developing future leaders, so I see AMARI as a platform where you are taught both the research skills and also leadership skills in the hope that maybe in the future, we’ll be able to also meet our own research lines or research programs or projects etc.” - *PhD fellow*

There is something peculiar about the what type of fellow is desired which rests in the relationship between “researchers” and “leaders”. Both AMARI literature and the participant responses oscillate between different combinations of “researcher” and “leader” whilst seemingly alluding to the same phenomenon. The different variations of this researcher/leader dynamic that arose were:

1. Researchers

“...critical mass of young researchers, who will be able to do research in mental, neurological and substance use disorders.” – *PhD fellow*

2. Researchers who lead

“...build a cohort of African researchers who are able to take research in this space to the next level, you know, as leaders.” – *Key informant*

3. Leaders who research

“So it is now training, it is just encouraging the African leaders in research” – *Post doc fellow*

4. Research leaders

“In short AMARI wants to achieve future African research leaders” – *PhD fellow*

One can approach assessing whether or not AMARI has been successful in achieving its first two internally set goals by adopting a black and white or grey lens. The first AMARI fellows were recruited in 2016 and the project will run until 2021.<sup>54</sup>A black and white lens merely requires counting of the number of fellows on the program to assess for success. To date there are 42 fellows. The straight forward answer, therefore, would be yes, AMARI is well on its way to succeeding in equipping 47 fellows. However, a grey lens necessitates that we interrogate and understand what *type* of fellow AMARI seeks to generate before a declaration of success or lack of. There are differences in the typology of the fellow (researcher/leader dynamic) which would dictate a more nuanced review of these results. It seems sensible then that different weighting be placed on the key performance indicators to ensure that they are congruent with the fellow typology being assessed. The key performance indicators specific to leadership articulated in the AMARI Theory of Change which simply state: “Fellows as leaders:....[number] of fellows in leadership roles in research teams....[number] of post doc[s] in teaching.... [and number] of post doc[s] in supervising” are too simplistic in assessing for leadership success, especially when it is unclear what is meant by leader or leadership

Despite there being different typologies of fellow described, the common thread in the articulations is that leadership is involved. The character of this leadership however, is ill-defined.

## THE LEADERSHIP CONCEPT

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The participants provided several definitions for leadership (Figure 4 -below).

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<sup>54</sup> AMARI (2019)

Coverage	Definition	Example
69%	Achieving outcomes	...I think leadership is when one is leading a certain group of individuals, probably maybe in order to achieve certain goals
54%	An individual providing a vision	I should have a vision you know, to be able to see the future of whatever we want to achieve...
54%	Helping people realise their potential	I also think leadership is developing the people around you and lifting them up - so really developing capacity around you...
46%	There are different types of leaders	...there are different kinds of leadership
38%	Being a role model	So as generally leadership is becoming the model for there for juniors or for colleagues.
31%	Having a shared vision	...so its about being able to kind of bring people that you work with that I guess along into some kind of shared vision and shared sort of set of activities
15%	Being a good communicator	...are you able to take your work to your village and explain it to your people in your language? Now that is what I call leadership.
8%	Influencing others	Leading is influencing people to...
8%	Having interpersonal skills	...in fact I think the most important aspect of leadership is not your academic skills, your intellectual skills, it's your people skills.
8%	Managing conflict	...leadership to me also involves dealing with the uncomfortable things that happen.
8%	Servant leadership	And I'm like fan of servant leadership, so leading from behind...

FIGURE 4: PARTICIPANTS' DEFINITIONS OF LEADERSHIP<sup>55</sup>

## LEADERSHIP EFFECTIVENESS

Much like the defining leadership, determining effectiveness is imprecise – approaches vary across organisational settings, leadership concepts and contexts. Thus, this thesis used different methods to ascertain effectiveness. The participants themselves also provided their own versions of what is it to exercise effective leadership (Figure 5 – below). The themes achieving outcomes, visioning and helping others achieve their potential came up both for leadership effectiveness and the leadership concept and so will be discussed in turn.

<sup>55</sup> "Coverage" given as a percentage depicts the proportion of participants who gave this response for each category. This will be the case for the remainder of the data given as coverage.

Coverage	Effective leadership involves	Example
54%	Setting and achieving goals	all the things and the decisions and the considerations that I have to put in place to enable that program to succeed in an excellent way, the skills that are required to manage all that and produce excellent results will embody what I would consider as leadership
54%	Helping others achieve their potential	What she has done effectively, that a lot of people haven't done, is she sits down and she'll give you time, despite having a hectically busy schedule but she will sit down and give you time
46%	Being a good role model	...there are so many leaders there, so many influential and well recognised leaders there that I want to model them for example. They are so many professors, just for example I want to be like them that is they are models for me and I hope I would be a model for my juniors and for some of my colleagues
38%	Analysing and responding to a situation	So I think he probably did some risk assessment of the situation and was able to identify the strengths and weaknesses and the things that you could focus on and build on.
38%	Providing a vision and pathway	I think a leader has to provide a vision, say, for instance, for us to tackle mental health, we need to do activities, ABC and D.
31%	Good communication	Yes, I think she is a good communicator, which I think is vital. Not only communicate within a team but go out and disseminate results. She has communicated with policy makers and the stakeholders also within the community organisation in the NGO world so yeah that kind of communication and communicating across different settings.
23%	Being caring and considerate	So with that already, to me, I find it very effective because there are times I'm feeling vulnerable as a person, they would come in and take me through whatever I'm experiencing. Whether I'm stressed with personal life issues, they would help on that. If it is an issue of being stressed professionally, they are also available.
23%	Good networking skills	...he was very good at networking and building partnerships that were productive
23%	Being transparent about limitations	But it wouldn't be so dogmatic that they cant aso sort of say but I don't have all of the answers to this and I need bring you on to help me with this. It needs to have that kind of understanding their limits and how they can effectively use other people.
23%	Being influential	One when he speaks people should be listening. And when he gives instructions people should be able to follow and there should be some sort of trust. Both the leader as well as those followers. So that's good leadership
15%	Resolving conflicts	I think also resolving conflict and being willing to stand up and confront something. I think one of the difficult parts of leadership
8%	Having a good succession plan	So I think if you really want to have leadership, and if you want to hand over to the next generation it's important that they are involved in the process so that they don't have to reinvent the wheel when they takeover.

FIGURE 5: PARTICIPANT'S EXPLANATIONS OF EFFECTIVE LEADERSHIP

### THEME 1: ACHIEVING OUTCOMES

The fact that the participants provide different conceptualisations of leadership is in keeping with scholarship.<sup>56</sup> Achieving set outcomes ranked number one for both the definition of

<sup>56</sup> Northouse (2010)

leadership and what constitutes effective leadership (Figures 4 and 7). These phenomena will be analysed in conjunction the chosen Murphyian definition which states that the '*leadership process is a response to a situational need*'.<sup>57</sup> AMARI is the entity responding to the mental health situation in Ethiopia, Malawi, South African and Zimbabwe . One of AMARI's responses to the situation is to produce 47 fellows. As alluded to before, because of the different possible typologies of fellow, measuring AMARI's success in doing this is complicated. The level of analysis plays a part in seeing whether the leadership process is successful. Assessing for effectiveness requires looking at AMARI's outcomes at least at two different levels. The first is the macro level – this looks at AMARI as a leadership apparatus churning out fellows. The other the level of analysis is at the micro level at which the individual fellow sits. Incidentally, the individual fellows and AMARI are the top two most named examples of leaders given by the participants. Effectiveness at the macro level calls for AMARI to produce fellows who are each responding to a situational need. The 42 AMARI fellows suggest that AMARI is having success with this particular goal. That each fellow is responding the situational need of their respective country further supports this. Measuring effectiveness at the micro level is more complicated since it is goes beyond merely counting the number of fellows. AMARI seeks to produce a fellow that exercises leadership which necessitates the demonstration of leadership as a marking criteria. Since outcomes are important both in the definition of leadership and its effectiveness, it begs the question 'what outcomes does AMARI desire of its fellows? AMARI's third goal emphatically states the answer to be meeting the needs of the fellows' countries. AMARI places emphasis on responding to the situational needs of the particular contexts (Ethiopia, Malawi, South Africa and Zimbabwe) in order to avoid providing a homogenous solution for the problem of mental illness in Africa. '*Meeting the needs*' is an ambiguous statement which makes evaluation of success potentially troublesome. One must not assume that by virtue of having fellows from different countries AMARI fellows meet the mental health needs of their respective communities. Given the complexities of the mental health landscapes across the continent, is it vital that country specific needs are defined in order to evaluate whether leadership outcomes are being met. It is clear that AMARI seeks to produce multiple leadership dynamics in having various fellows dealing with different country

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<sup>57</sup> Murphy (1941) p. 674-687

contexts in different ways. To go beyond accepting this as a surrogate for needs being met, thus the ‘Relevance of Research Rubric will be used to evaluate the effectiveness of the research that the fellows are conducting. This will be discussed later.

### THEME 2: VISIONING

Having or providing a vision was the most frequent definition of leadership provided by the participants. 5 Participants mentioned it with regards to effectiveness.

“Ok firstly I think it’s having a vision of what you set out to do and you know clearly setting out steps to achieve that vision.” – *PhD fellow*

Differences appeared in who provided the vision. Most participants insinuated that the vision is provided or held by an individual. Four participants mentioned that this vision was a collective phenomenon.

“But it is truly a partnership with a common vision or goal and, and acknowledgement that is sometimes different routes to take to get there.” – *PhD fellow*

When asked about who generated the vision for AMARI 7 participants stated that AMARI Director Dixon Chibanda (alone or with is team) provided it and 4 cited the Wellcome Trust for generating the vision.

#### **Motivations for taking part in AMARI**

Coverage	Motivation for joining AMARI	Example
54%	Funding opportunity	And the challenge that I had was now trying to look for sources of funding in terms of data collection... and I applied for AMARI when they advertised the post because I thought it would be something that would facilitate my PhD studies.
38%	Develop research career or add to body of research in home country	So I enjoy research and I think this is what I want to do for my career. So in order to advance my research career and you know to be an independent researcher you need a PhD, that’s like a pre-requisite. So when the AMARI opportunity came, I thought it would be good to apply and be involved so that I have the qualifications I need to advance my research career.
8%	Develop leadership skills	And I thought about this, and then I thought, well, actually, if I want to have any kind of leadership and activist role, which I see myself as being an activist in mental health. being the only way to get taken seriously is to have a PhD. And so this why, I applied and prayed and thankfully was successful, I got accepted on the program

FIGURE 6: PARTICIPANTS' MOTIVATIONS FOR BEING PART OF AMARI



It is clear from the participant responses that visioning is an important aspect of defining leadership and what constitutes effectiveness. What is interesting about the part that vision plays in leadership rests in interrogating what the vision is and who dictates it. The participants stated that Dixon Chibanda (AMARI's Director) and the Wellcome Trust were responsible for generating AMARI's vision. This is in keeping with their notions of a single entity, be it an individual or an organisation, setting the vision.

We know that the vision of AMARI is to produce research leaders. The working definition of leadership requires that these leaders respond to the situational needs of their respective contexts. It follows then, that the visions of the fellows have to be congruent with the needs of Ethiopia, Malawi, South Africa and Zimbabwe. Thus the research that is being conducted must speak to these needs. That emphasis is placed on a single entity providing a vision may be of possible concern. Also, the reasons for joining AMARI are potentially controversial. The funding opportunity and a platform for furthering ones research capacity where the predominant reasons cited for joining AMARI, which could mean that AMARI is being misused. It is important to ensure that AMARI is not used as a vehicle for merely meeting the needs of the fellows rather than the needs of the communities. How power and influence are co-opted by these visionaries is very important. This is particularly pertinent in mental health because of the inherent vulnerability of the service users. There is a danger of a paternalism whereby by virtue of their scientific calibre as a researcher - having expert power - the fellows feel as though they have the authority to dictate the needs of this group. Similarly, the reward power of the Wellcome Trust and referent power of Dixon Chibanda could produce and inflict a vision that meets their own personal needs rather than those of the service users. What this could result in is the fellows doing research for research's sake (fellows' vision) or emphasising outputs that serve personal agendas without meaningfully impact community (Wellcome Trust vision).

“... [the] Wellcome Trust focuses on science... they want to see cutting edge science, they want to see that our fellows publish in high impact journals to carry out research, and the leadership thing is a small component, it's almost like a token.” – *Key informant*

Having shared vision provides a preventative measure for these outcomes. Four participants mentioned a shared vision in defining leadership and five explicitly stated that service users are the most important stakeholders of AMARI. It is important to draw attention to who the

followers are in this given definition of leadership in order to understand what a shared vision is i.e. *who* contributes to this shared vision. There are many configurations of the leader-follower dynamic. An inexhaustive list of the possible leader-follower relationships could be Wellcome Trust-AMARI, AMARI-Fellow, AMARI-Service user, Fellow-Service user or Service User-AMARI. The scope of this study does not allow for an in-depth interrogation of these relationships and what they mean for shared vision. Thus, the predominant configuration to be considered will be the AMARI-Fellow dynamic. Given that power is (potentially) concentrated between the funder, Chibanda and the fellows it is important to ensure that the inclusion of the service users is not merely performative. AMARI's desire to incorporate the voices of the service users is vital for avoiding the concentration and misuse of power because it allows for multiple inputs into its vision thus distributing power amongst several stakeholders.

### THEME 3: HELPING OTHERS ACHIEVE THEIR POTENTIAL

Over half of the participants defined leadership as helping others realise their potential. This also ranked number one, alongside achieving outcomes for leadership effectiveness (Figure 7).

#### ***As a definition of leadership***

“...as well you have to impart that information to other people who are less knowledgeable...we have to push the next generations and make it even much better...” – *PhD fellow*

#### ***In leadership effectiveness***

“...a mark of a good leader would really be well how can I do that and get the best out of people and keep them onside.” – *Key informant*

It is clear that helping people achieve their potential is an important aspect of how the participants conceptualise leadership. This is even more pressing for AMARI and the contexts that they work in due to the scarcity of human resources. Many participants commented on the profound shortage of those doing MNS disorder research and leaders in their countries.

“So this idea about kind of being able to get the best out of the people you can be working with is so crucial here when we have a limited pool of people.” – *Key informant*

The participants mentioned several different ways in which they enact leadership defined as helping others reach their potential. Most fellows spoke of going on to help junior AMARI fellows or other students after they had acquired skills from being part of AMARI.

Mentoring and inspiring the next generation also featured significantly in the interviews.

“And critically the role I see myself playing is being a mentor and also showing people that it’s possible” – *Key informant*

Interestingly, despite this support, the participants felt they received or gave out with respect to achieving potential, it seems that the maximal capacity of the fellows or those they support is not being reached because of insufficient leadership training. The participants unanimously stated that more leadership training should be included in AMARI.

“...in fact that’s what I need because there are situations where things change every day so I need to be updated on whatever new development that comes in terms of leadership. I need more training.” – *MPhil fellow*

If AMARI’s vision is to generate fellows who are research leaders, one has to question whether they are succeeding in this if the fellows don’t feel as though they are sufficiently equipped to be leaders. Whilst they do the best they can with the few resources that are available to them, AMARI has the potential to maximise their potential by focusing more on specific leadership training in its curriculum.

## AMARI GOAL 2: LEADING HIGH-QUALITY MENTAL HEALTH RESEARCH PROGRAMS AND DEVELOPING SUSTAINABLE CAREER PATHWAYS FOR ITS FELLOWS

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In considering AMARI’s success in achieving its second broad goal – to produce fellows that lead high-quality mental health research – that this must be deeply cognisant of the particularities of the African context was repeated by many of the fellows. Two themes arose: firstly, participants spoke of the difficulties that are specific to research leaders on the continent; second was discussion around having African responses to these Africa-specific problems. Both of these are underpinned by a matter of ownership.

### THEME 1: CHALLENGES SPECIFIC TO THE AFRICAN CONTEXT

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Many participants spoke about the importance of understanding and responding to the African context.

“But I believe there is scope for a uniquely African leadership program. The type of program that responds to the needs of African scientists. In mind that they always work in environments are very, very challenging.” – *Key informant*

That participants voiced contextual differences goes some way to acknowledging and responding to the heterogenous landscape of the continent. Typically, approaches to global mental health tend to lump Africa as one homogenous entity. It is very important to recognise and appreciate the differences not only between but also within the countries if leadership responses will meet the needs of the community.

“...we have different countries in almost different social economic status levels. For example, South Africa, you can't compare South Africa to Malawi and Zimbabwe. You can't even compare UK and us African countries.” – *PhD fellow*

Being aware of the different structural forces at play is important for recognising the web of interpersonal networks, environmental factors and political/socioeconomic forces that dictate ones mental health. An analysis that does not consider these structural forces will be shallow and thus will not meet the needs of the communities it seeks to serve.

The African context, with its colonial history, ongoing conflicts, political instability, poverty and environmental insecurity presents complex structural forces that require careful interrogation and management. This means that the approach to dealing with the mental health problems in Africa must be intersectional and multidisciplinary in order to avoid detrimental consequences.

“...how do we keep communities well...what do we need to do to keep people well, mentally well, because of the violence and the trauma and the experiences of apartheid and whatever that has caused so many divisions? So I think for me, the intersectionality isn't there or not enough. I think people are conscious about it, but maybe just overwhelmed about what that could mean.” – *PhD fellow*

Due to the ‘infancy’ of mental health research in Africa, AMARI and its fellows are well positioned to deconstruct and reconstruct mental health practices and ensure that structural competency is incorporated. This would go some way to achieving AMARI's goal of producing high impact research.

Participants commented on the need to refuse the dictates of the West with its biomedical model of mental health.

“Since...being part of AMARI, what I’m seeing is that they are trying to build a network of leadership [in] mental health research so that as Africans we should also generate enough information to make informed decisions” – *PhD fellow*

The exportation of “*advanced*” Western epistemologies to the “*developing*” world is widespread in mental health. The assumption is that Western Psychiatric constructions of mental illness and interventions for its treatment can be transplanted onto an African context, albeit “*adapted*” to fit “*LMIC settings*”. It is important to question the universality and relativity of psychopathology, psychotherapeutics, cross-cultural psychopharmacology and psychosocial interventions. Participants spoke of the need to challenge such assumptions and instead construct epistemologies surrounding mental illness that centre and are fashioned by Africans.

“Well...you want Africans to tell their own story. No one, no one can tell our story better than us” – *Key informant*

This endeavour is not without difficulty. One has to raise the question about whether or not there are enough resources to produce and distribute this African knowledge. Finances are needed in order to overcome some of these resource needs. This is a particular problem in contexts, such as the AMARI countries, in which mental health is not prioritised by governments and thus receives a small proportion of the already meagre health expenditure.

“I think the first thing is to really, you know, to make a case for the provision of these services maybe from policy level. Even with a few financial resources that are available to make sure that mental health services are also prioritised as much as other programmes such as HIV or TB or Malaria would be” – *PhD fellow*

The financial constraints of these contexts present a potential problem with regards to producing African epistemologies and interventions for mental illness. AMARI through DELTAS receives £4.2 million from the Wellcome Trust. Questions of the balance of power in dictating what knowledge is produced must be asked when the program seeks to distance itself from accepting western models through producing African-led research that is funded by the West. There were suggestions of the Wellcome Trust flexing its power and thus dictating what knowledge is produced:

“...it’s very simple. If a funder has an agenda we have to stick to that agenda if we want to be funded” – *Key informant*

This reliance on donor funding may create a dependency that stunts the desired emancipation of African research from the West. Financial liberation would allow for a greater freedom to produce research that is free of influence of geo-political ties and donor self-interest. Is it really the case that funding for MNS disorder research cannot be found in Africa? Ultimately, this is a matter of ownership.

“So we want to generate research that contributes towards the growth, the development of Africa, through empowering the cohort of fellows to carry out vigorous, cutting edge research which would normally have to be carried out by people coming from the UK, or America. We want people in Africa to be able to do that research on their own, you know, we want people in Africa to be able to compete for grants on their own and be funded.” – *Key informant*

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### AMARI GOAL 3: MEETING THE NEEDS OF THE FELLOWS’ COUNTRIES

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AMARI’s third goal seeks to produce research that is locally relevant. To explore whether it is successful in this case studies of research from each country were completed. Assessment was guided by the Relevance of Research Rubric (Appendix B).

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#### ZIMBABWE

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**Title:** A case study exploring occupational injustice among young adults dually afflicted with substance use disorder and HIV/AIDs in Zimbabwe

**Relevance Score:** Great (10 points – G3N2A2I3)

This study seeks to build insight into the way in which occupational injustices are experienced and negotiated by young adults dually affected by HIV/AIDs and substance use

disorders SUD in Zimbabwe. The aim of to use the knowledge garnered in this study could inform the development of integrated rehabilitation interventions for those dually affected young adults in Zimbabwe through conducting narrative interviews with dually afflicted young adults, in-depth interviews with key informants and document analysis of policy and legislation documents, strategic plans, reports on progress in addressing SUD and HIV/AIDS. This study acquired the highest global priority and impact scores with three points in each of those domains. With respect to global priorities, the study scored points based on its aim for the elimination of stigma, discrimination and social exclusion of patients and emphasis on community rehabilitation. The national priority scores were based on the emphasis on substance use disorders. The impact score was also highest in this study of all the case studies. In showing that it is vital to be mindful of key structures perpetuating occupational injustice and social exclusion which feed from conditions and systems perpetuating stigma and discrimination, this study demonstrates much structural competency. Given the political/socioeconomic context in Zimbabwe, this study demonstrates a leadership by paying particular attention to the injustice of individuals, groups or communities who are denied resources and opportunities in physical, socioeconomic, cultural and even political sense. By paying attention to the non-biomedical outcomes of SUD and HIV/AIDS this study present the potential to meet the needs of dually affected young adults and provide them with an opportunity to engage and participate in freely chosen, healthy, meaningful and empowering occupations and thus live fully productive, inclusive and satisfying lives.

## LIMITATIONS

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The Relevance of Research Rubric seeks to ascertain whether the research being conducted by the AMARI fellows is in line with their third broad goal – to meet the needs of those with MNS disorders. Initially there were three domains for the Impact category: cultural competency, dissemination of research and translation of research (Figure 9 - below).

Domain	Criteria
Cultural competency	1 Qualitative data from service users
	2 Service users involved in study design
	3 Intervention tool that used is validated for context
	4 Intervention delivered/available in native languages
	5 Multidisciplinary (non-health care people consulted e.g. traditional healers)
Dissemination of research	6 Research findings published
	7 Policy brief generated
	8 Presenting research findings at conference
	9 Discussion of research on other media platforms (radio, TV, newspapers etc)
Translation of research	10 Intervention has the support factors to be implemented practically in the given setting (feasibility)
	11 Plans for further research
	12 Policy makers consulted
	12 Plans to scale up
	13 Change of practice in local community as a result of research
	14 Change of practice nationally as a result of research
	15 Change of practice internationally as a result of research

FIGURE 7: IMPACT CRITERIA (RELEVANCE OF RESEARCH RUBRIC)

To assess whether the fellows' research goes beyond merely being research for research's sake and is a response to the situational needs it is important to make an assessment against all of these domains. However, some of the impact criteria were difficult to assess. For example marking the translation of their work given the timeframe of this study would be difficult to meaningfully assess thus producing invalid results. Furthermore, given the staggered nature of the AMARI cohort intakes the fellows are at different stages of their research thus the results would have been unreliable especially for the dissemination and translation of research domains. In order to avoid creating the impression that certain countries are doing irrelevant research these two domains were omitted. However, the importance and desirability of these two domains remain in assessing whether AMARI meets situational needs still merits further exploration.

Secondly, some of the national priority criteria were ill-defined. Therefore assessing if a study deserves the point is difficult and this presents opportunity for marker bias.

## CONCLUSION

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The problem of mental health in Africa is particularly bad. The continent suffers with some of the lowest levels of resource availability and public spending on mental health equates to less than 1% of health-care funding, resulting in the dire shortage of therapeutics and mental health care workers. Much is taking place to mitigate for these problems, mostly in the form of task-sharing and shifting within the processes of intervention scale up. AMARI seeks to contribute to bettering the landscape of mental health in Africa through generating an Africa-led network of research leaders in MNS disorders in Zimbabwe, Ethiopia, Malawi and South Africa. This program has three goals: building an African-led network of 47 research leaders in MNS disorder research, leading high-quality mental health research programs whilst developing sustainable career pathways for its fellows and meeting the needs of mental health service users. The means to assess whether AMARI can be successful in achieving this first requires an interrogation of what type of fellow it seeks to produce, as otherwise its assessment is meaningless. It is vital, therefore, that before an evaluation of its effectiveness AMARI and its onlookers articulate what constitutes a fellow, for each fellow typology will have different key performance indicators. Despite this, the fact that 42 researchers are enrolled into the program should be celebrated.

A full analysis of whether it is effective in being a leader that produces fellows, who themselves are leaders, required AMARI to have a more nuanced articulation of what typology of fellow it desires to produce. For this to occur, a grounding in leadership scholarship is necessary as otherwise the concept of a fellow who is a “research leader” is without weight. It is evident from the interview responses and AMARI literature that the conceptualisations of leadership require maturation. There is room for the definitions of leadership, perceptions of leadership effectiveness and involvement in leadership to be more congruent. Thus, as desired by all of the participants, specific leadership training will go some way to developing the concept and practice of leadership of those involved in AMARI.

It remains though, that the leadership that is taking place speaks to the AMARI’s goal of meeting the needs of the communities of Ethiopia, Malawi, South Africa and Zimbabwe. The participants stressed the importance of the inclusion of service users so as to ensure that the research being conducted is in response to the contextual situation. The Zimbabwe case study, alongside the Relevance of Research Rubric, demonstrated that the research does indeed respond to the priorities of their respective contexts.

Overall AMARI sits as a juncture where it can profoundly transform the mental health paradigm in Africa. By using leadership as an entry point, there is the potential to generate research leaders whose perceptions of high-impact research is structurally competent and so provides peace of mind to millions of people suffering with mental illness.

“You know, one of the challenges I always find with mental health is sometimes we do so much research without thinking of the ordinary person in the street. You know, we run our clinical trials, finish your clinical trial, you publish in a high impact journal you start writing your next book hoping for your next grant. The impact of our work is often not felt. It’s because scaling up, scaling up is dirty, it’s not easy and I understand that’s why a lot of people will naturally avoid it because a lot can go wrong. So that’s what I would love to see, you know, programmes that are really rooted in empirical observation being taken to scale. That’s my wish.” - *Key informant*

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## Country Profiles

APPENDIX 1: COUNTRY PROFILES

	Population	Income classification	DALYs per 100,000	% of total YLD	Standalone mental health policy	Workforce (per 100,000 population)	
Ethiopia	100 million	Lower middle income	2599.58	25.50%	Yes (2012/13 - 15/16)	Psychiatrists	0.08
						Mental health nurses	1.00
						Psychologists	0.04
						Other	0.62
Malawi	15.7 million	Low income	2684.23	23.95%	NA	Psychiatrists	0.01
						Mental health nurses	0.22
						Psychologists	0.02
						Other	0.11
South Africa	55.3 million	Upper middle income	3415.26	32.84%	Yes (2013)	Psychiatrists	1.52
						Mental health nurses	NA
						Psychologists	NA
						Other	NA
Zimbabwe	15.8 million	lower middle income	2748.67	24.49%	Yes (2014)	Psychiatrists	0.10
						Mental health nurses	3.49
						Psychologists	0.06
						Other	0.90



## **Interview Guide**

### APPENDIX 2: INTERVIEW GUIDE

#### **AMARI**

1. What do you believe is the vision of AMARI?
2. Who was involved in generating this vision?
3. What led you to taking part in AMARI?
4. What goal(s) do you want to achieve with AMARI?
5. Who are the other stakeholders of AMARI?
6. What role do you have in AMARI?
7. Does your vision/ideas/goal align with AMARI's vision?

#### **General leadership perceptions**

1. What does leadership mean to you?
2. Provide one example of leadership?
3. Why is this leadership?
4. Was this leadership effective?
5. What makes the leadership effective or not effective?
6. Why did you choose this particular example/leader?

#### **Leadership within their environment**

1. Who do you see as a leader within your working environment?
2. What makes them a leader within your working environment?
3. Are they effective as a leader?
4. What makes them effective or not effective as a leader?
5. What interferes with effective leadership?
6. What makes this leadership effective?
7. Who makes decisions within your working environment?
8. Who is involved in the decision making process?
9. What one change has this person tried to make and have they been successful?

#### **Personal leadership**

1. Do you feel involved in the leadership process?
2. In what position of the leadership are you?
3. How are you involved in the leadership processes here?
4. Do you feel supported in your leadership?
5. Would you want more leadership training?
6. What do you think should be included in that training?

APPENDIX 3: RELEVANCE OF RESEARCH RUBRIC (RRR)

Domain	Criteria	Points
Global Priorities	Meets 1 global challenge	
	Meets 2 global challenges	
	Meets >3 global challenges	
National Priorities	Meets 1 national priority	
	Meets 2 national priorities	
	Meets >3 national priorities	
AMARI Priorities	Meets 1 AMARI priority	
	Meets 2 AMARI priorities	
	Meets >3 AMARI priorities	
Impact Criteria	Meets 1 Impact criteria	
	Meets 2 Impact criteria	
	Meets >3 Impact criteria	
<b>Total score</b>		

APPENDIX 4: RRR GLOBAL PRIORITIES

APPENDIX 5: NATIONAL PRIORITIES (ZIMBABWE)

Domain	Number	Goal
Objective 1: Improve Quality of Patient Care and Service delivery	1	Ensure Standard Operating Procedures (for managing admission /discharge/violent patients/suicidal patients) are adopted by all currently functional psychiatric units,
	2	Develop and adopt of SOP for key conditions
	3	Establish and implement guidelines for rehabilitative ward programs to ensure therapeutic ward environments
	4	Develop and implement quality of care standards document for use in mental health units
	5	Improve Quality of Care through in service training of staff in Quality of Care, SOPs, 5S model and Kaizen
	6	Ensure consistent psychotropic drug procurement and supply to all psychiatric units, provincial, district hospitals and local clinics
	7	Develop and implement Self Appraisal Protocol for individual staff members and
	8	Improve mental health assessments

	9	Ensure regular meetings of the Mental Health Review Tribunal (MHRT), Special Boards and Hospital Mental Health Boards
	10	Renovation of tertiary, forensic and provincial psychiatric units
	11	Establish dedicated child/adolescent outpatient and admission facilities
	12	Establish alcohol and substance rehabilitation units at each provincial hospital and at tertiary units based on guidelines from the Alcohol and substance rehabilitation taskforce
	13	Strengthen community mental health services through supervisory visits
Objective 2: Improving mental health awareness and community empowerment	14	Improve media presence of the mental health dept and mental health activities
	15	Commemorate international days to promote awareness of mental health issues
	16	Develop local Information, Education and Communication (IEC) material on pertinent mental health issues
	17	Adoption of the Friendship Bench as a Ministry of Health program
	18	Develop and implement a School and Higher Learning Centre Mental Health Awareness Programme
	19	Develop and disseminate guidelines for workplace mental health care
Objective 3: Research and Data Management	20	Form a research and development task force to direct research agenda and to identify existing local data useful to clinical practice in mental health
	21	Develop and implement a research agenda based on current situation and data available
	22	Coordinate national surveys
	23	Review and update data collection systems for mental health information to ensure accurate records
	24	Review the Mental Health Act of 1996

Objective 4: Review of legislation	25	Develop a national alcohol and substance use treatment and rehabilitation regulations and guidelines for treatment and rehabilitation of patients with alcohol and substance use disorders
	26	Coordinate reviewing and finalising the National Drug Control Master plan
	27	Propose introduction of a mental health levy derived from alcohol and tobacco taxes to fund mental health and rehabilitation activities
Objective 5: Mental Health Training, Human resource development, administration of mental health services	28	Substantively fill posts for provincial mental health coordinators
	29	Strengthen the Provincial Mental Health Coordinator and District Mental Health Focal person network through training, supervisory visits and quarterly meetings
	30	Public Mental Health module for clinical psychologists, clinical social workers, psychiatric nurse practitioners and psychiatrists with attachments to provinces and to head office
	31	mhGap training of non specialist health workers
	32	Establish a 3rd mental health nurse training program at Ngomahuru Hospital
	33	Training in alcohol and substance use disorder management to facilitate opening of government rehabs in each province
	34	Improve training of and number of clinical psychologists

#### APPENDIX 6: AMARI PRIORITIES

	AMARI Priorities
1	Carry out participatory research - include service users throughout research process
2	Provide early access to mental health services
3	Integrate mental health services into the community, primary health, district hospitals.
4	Provide mental health education (to the public)
5	Scale up existing evidence based interventions
6	Deliver task-shared interventions into the community
7	Train traditional healers and spiritual leaders in mental health

APPENDIX 7: IMPACT CRITERIA

Domain		Criteria
Cultural competency	1	Qualitative data from service users
	2	Service users involved in study design
	3	Intervention tool that used is validated for context
	4	Intervention delivered/available in native languages
	5	Multidisciplinary (non-health care people consulted e.g. traditional healers)