Sturgeon S

EMPOWERMENT: OBSERVATIONS ON MENTAL HEALTH IN SUB-SAHARAN AFRICA

Ms S Sturgeon is a lecturer in the School of Social Work at the University of Cape Town

INTRODUCTION

Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has (Margaret Mead, World Federation of Mental Health President 1956-57). This statement can only become a reality when people have confidence and believe in themselves.

This paper suggests that the social and economic history of the African continent has contributed to the disempowerment of its people. This has impacted on the field of mental health. It is essential that this process be reversed, and suggestions for a way forward are presented for consideration of the mental health workers of the region.

SOCIO-ECOMOMIC FACTORS AND MENTAL HEALTH

Mental health is a question first and foremost of economic and political welfare (Desjarlais *et al.* 1995:15). Nowhere is this statement more valid than in Africa. Unless this is appreciated, it is unlikely that mental health issues are going to be addressed in any meaningful and sustainable way.

As we know, mental health is not just the absence of mental disorder or illness, but represents a positive state of mental well-being. It is the total balance of the individual personality, considered from the biological and psychosocial points of view. The political and socio-economic context of individuals impacts directly on their mental health. Social workers, grounded in systemic and ecological understanding and social development principles, are in a unique position to appreciate this and assist mental health professionals to address mental health issues in a holistic way.

The economic and social implications of mental ill-health go largely unrecognised by policy makers. The statistics are frightening, but are only known largely to those in the mental health field. A report by Harvard and the World Bank in 1996 states that over 10,5% of the Global Burden of Disease as measured in disability-adjusted life-years are caused by psychiatric and neurological disorders. Future projections suggest this figure could rise to 15% in 2020, a greater increase than that for cardiovascular disease. Globally, depression accounts for over 10% of years of life lived with a disability, and in sub-Saharan Africa psychiatric and neurological conditions account for 16% of total disability; 34% of all disability is due to behaviour-related problems (Report of WHO Collaborating Centre 1999, Desjarlais 1995).

Five of the 10 leading causes of disability world-wide in 1990 were psychiatric disorders (unipolar depression, alcohol misuse, bipolar affective disorder, schizophrenia and obsessive compulsive disorder). It is suggested that in developing regions, non-communicable diseases such as depression and heart disease are replacing infectious diseases and malnutrition as the leading causes of disability and premature death (Jenkins *et al.* 1997).

MENTAL HEALTH IN SUB-SAHARAN AFRICA

Mental health issues facing sub-Saharan Africa are formidable. The prevalence of neurological and psychiatric disorders in Africa are probably the same, if not higher, in developed countries,

particularly for conditions such as epilepsy. Current economic, physical and social conditions in sub-Saharan Africa make the prevention and treatment of these disorders very difficult, which in turn leads to further mental health problems.

These debilitating social conditions include poverty, political, economic and social instability, civil unrest, displaced populations, and political and criminal violence. While there is not a direct link between these conditions and mental health, they put communities at risk, exacerbate existing problems and limit the resources needed for addressing these issues. The average African is 22% poorer today than in 1975. Unemployment is over 100 million (Oxfam America 1995). There are more than 5 million refugees in Africa, not including those displaced within their own country (Desjarlais *et al.* 1995). Twenty-one million adults and children are infected with HIV/AIDS and 4 million have died. Health services in Africa only reach about half the population, with 70-80% of the population living in rural areas (Oxfam America 1995). On the Index of Social Progress, which measures 46 social indicators, the African continent is the least developed region of the world (Estes 1995).

IMPACT OF THE SOCIO-ECONOMIC HISTORY OF THE REGION ON MENTAL HEALTH

The cycle of economic and social factors negatively affecting the mental health of the population and *vice versa* must be broken. Depressed parents are unable to provide adequate emotional support for their children; abused children become abusers and violence breeds violence. As noted by the UN Secretary-General, Boutrous Boutrous Ghali *Psychosocial disorders affect the development - and the peace and security - of many societies* (Remarks at the launch of the Harvard Report at the UN, May 1995).

To understand the present situation it is necessary to examine the region's long history of external intervention coupled with the current impact of globalisation. It could be argued that globalisation has impacted on Africa since the 15th century, starting with the pre-colonial period of the slave, gold and spice trades. The colonial period from the 1800s saw Africa controlled by many European powers, with increasing exports of raw materials and imports of manufactured goods from the industrial North. Multi-national corporations now fulfil the role previously occupied by colonial states (Primo & Taylor 1999), a condition of *corporate colonisation*.

The current economic order can be traced back to the Bretton Woods, New Hampshire meeting of economic policy makers and political leaders towards the end of Word War II in July 1944. The World Bank and the International Monetary Fund (IMF) were set up, the former primarily to finance European reconstruction and the latter to address balance of trade and currency exchange. The World Bank, aiming at the elimination of global poverty, encouraged developing countries, including the newly independent African countries, to borrow in order to industrialise and attract foreign investment (Prigoff 1999).

It is generally accepted that these developmental projects have not been successful and have rather thrown developing countries into ever-increasing debt, fuelled by the ongoing devaluation of their currencies (Max-Neef 1989; World Bank 1995).

In the 1980s the IMF, through its Structural Adjustment Programmes, and the World Trade Organisation (established in 1995) dictated policies to over 100 African countries seeking loans or in debt. These have largely been destructive of their economies and natural environments. The policies have demanded trade liberalisation, currency devaluation, privatisation, incentives for export production and cutbacks on government expenditure on health, welfare and poverty alleviation (Primo & Taylor 1999). The policies, however, did not preclude investment in

armaments and the proliferation of armed conflict in developing countries, some feel, can be traced to these policies and the efforts of governments, faced with increasing discontent among their citizens, to deflect the blame elsewhere (Prigoff 1999).

The *economic development* advocated by international funders has not led to an improvement in the *well-being* or mental health of the majority of people and marginalises the poor even further (Max-Neef 1989; Korten 1990). Mental health services have suffered the most, as they have been considered *discretionary* as opposed to *essential* by the World Bank. Tertiary health care and advanced medical technology also are under threat (Desjarlais 1995), although without this support, I suggest, primary health care is weakened.

The IMF policy also intended that international donor aid be directed towards non-governmental organisations who, rather than the state, were expected to provide basic social programmes and services (Primo & Taylor 1999). Inevitably, these factors prevented countries from addressing mental health issues in a planned and co-ordinated way. Funding priorities of international funders move in and out of fashion, resulting often in fragmented and short-term projects. Impressive programmes can be suddenly dropped and any advances made soon lost, bringing into question the wisdom of financing the programme in the first place. This has frequently resulted in fragmented, unsustainable, uncoordinated services. Projects are often not directed at local priorities and local mental health workers are relegated to, and eventually believe themselves to be, junior partners in these relationships.

Further, international trade arrangements were controlled by agreements such as the General Agreement on Tariffs and Trade (GATT) and the North American Free Trade Agreement, (NAFTA), and later by the World Trade Organisation, which tend to favour the major nations and international corporations. The current state of openness, *free trade* and interdependence of national economies within a global economy have increased the vulnerability of developing countries and favoured strong, industrialised countries and multi-national corporations (McGrew 1992). The global economy is concentrating more power in fewer hands, while developing countries compete with each other to provide cheap materials and labour. Ten trans-national companies control most of the world's food market. Of the world's 100 largest economies, 50 are corporations. Only 27 countries have a GNP greater than the sales of Shell and Exxon combined (*Cape Times* 1999).

THE PRESENT SITUATION

The World Bank is now aware that the Structural Adjustment Programmes do not address the needs of developing countries and that governments must provide basic services such as primary education and primary health (Primo & Taylor 1999). In relation to mental health, the appointment early in 1999 of a Mental Health Specialist to the Health, Population and Nutrition team of the World Bank is a significant development. The aim of this move is to encourage fuller consideration of issues concerning mental health and care for the mentally ill in world development activities (WFMH, Report of the Secretary General 1998). However, developing countries still remain very vulnerable to globalisation issues, for example, the recent Asian crisis and the current British government's sales of gold reserves.

Unfortunately, it will take time for changes to come about in the field of mental health in Africa. Many countries in the region still have no mental health legislation or, if they do, it is largely unfunded. Mental health programmes are generally limited to curative health care provided in ill-equipped hospitals where staffing and supply of psychotropic medication are grossly inadequate. Some of these institutions, built by colonial powers, reflect the worst of the old *mental asylums* of Europe. Conditions lead to gross violations of human rights. There are moves

challenging international pharmaceutical companies regarding their commitment to the needs of developing countries.

In some countries mental health services have been decentralised and integrated into a primary health care system with varying levels of success, largely dependent on the training of the staff and the funding available. As there are very few psychiatrists, psychologists or social workers, the system is largely dependent on primary health care workers or *medical officers*, as they are sometimes called. The links between the levels of mental health care are often poor, with the *medical officers* feeling they are coping alone under very difficult circumstances.

In addition to these services, mental health projects are undertaken by non-governmental organisations, funded and often evaluated by international funders. These projects may or may not link constructively with state services or be sustainable. Past and current political and economic realities have led to individual African countries looking to Europe and America rather than working together. Indeed, communication links with the West are often better than those with neighbouring countries, or even within a country. Mental health professionals hear with surprise from someone in Europe about programmes taking place in their own region. These practical issues are compounded by the belief of many that *international experts know best.*

The combined impact of these polices and practices, I suggest, has often been negative, both directly and indirectly. They have created a climate of economic insecurity and dependence and have been disempowering to governments, NGOs and individuals in the developing countries of Africa as well as being unhelpful in addressing mental health issues.

SOCIAL DEVELOPMENT – THE WAY FORWARD

It is important for mental health professionals and consumers to recognise the effects of globalisation and the impact of political and socio-economic factors on mental health. The concept of *social development* recognises the significance of these factors and provides a useful framework within which a multi-sectorial and multi-disciplinary partnership of mental health workers and consumers can combine their special talents and perspectives.

Social development is defined as *a process of planned social change designed to promote the well-being of the population as a whole in conjunction with a dynamic process of economic development* (Midgley 1995:25). The positive and empowerment philosophy of social development fits well with the inclusive concept of *mental health* as opposed to *absence of mental illness*. The approach allows for multi-disciplinary intervention on many levels, including *individual therapy so that immediate and short-term considerations are not ignored: economic restructuring - focusing on urban and rural poverty; preventative educational campaigns and empowerment* (Elliott 1993:31).

EMPOWERMENT OF MENTAL HEALTH WORKERS IN THE REGION

The concept of empowerment is fundamental to the whole process of development. The word *empowered* summarises the essence of mental health. It includes an inner sense of security and worth, and, derived from this, confidence in interacting with the world in a realistic, yet positive, manner (Hepworth & Larsen 1993). *Empowerment* is the core task of all mental health professionals and is concerned with assisting others to *believe in their own capacity to effect change* (Potgieter 1998:9). Yet mental health professionals in Africa often do not feel empowered or able to effect change themselves.

Desjarlais *et al.* in 1995 put forward an excellent agenda for action in mental health in developing countries. This agenda encompassed a full range of activities, including national

commitment to mental health, recognition of human rights, establishment of community mental health services and psycho-social rehabilitation and the recognition of the pivotal role of families and women. To undertake these activities within the difficult context outlined earlier, mental health workers will themselves need to be empowered and *believe in their own capacity to effect change*.

In the spirit of the *African Renaissance* punted by South Africa's new President, Thabo Mbeki, the pervading feeling of inevitability, of dependency and of *learned helplessness* of developing countries needs to be challenged on every level. His challenge could be interpreted as attempting to empower the continent by exhorting Africans to take back their sense of identity and capacity to *make a difference* in their own countries.

Addressing mental health issues will require a concerted effort by the international community and also creative and committed local initiatives in constructive partnerships. A new understanding of the nature of these partnerships is required, where African governments, non-governmental organisations and individuals are empowered to take the initiative in relationships with international donors.

International support

To assist in this process, on an international level, mental health professionals in *developed* countries continually need to be reminded of the impact of globalisation on the mental health of citizens of developing countries. They should add their voice to those calling for renegotiated international trade agreements and structural adjustment policies, and evaluation of the consequences of past agreements on the well-being and development of people (Prigoff 1999).

Empowerment of governments

Governments need to be encouraged take the initiative in changing their relationships with international institutions. Although governments of developing countries have lost some of their economic power through globalisation, politically they can take decisions regarding their relationships with multi-national organisations and international funders (Primo & Taylor 1999). In this sense African governments need to become empowered to put the well-being of their people above the drive for economic growth alone. Enlightened communities need to put pressure on governments to do this. The mental health of people as a positive state of well-being can only be achieved through a process of human development which gives priority to developing the capacities of people in every area of political, social and economic functioning.

Regional and local empowerment

With little hope of significant changes in global economic conditions in the short term, empowerment of those working on regional and local levels in the mental health field is the key to development of mental health services (Desjarlais *et al.* 1995). Building on and growing indigenous and local structures is advocated strongly by many (for example, Max-Neef 1989; Korten 1990), and particularly in relation to women (Sen & Grown 1987). Max-Neef's Human Scale Development model, with its focus on quality of life and fundamental human needs, is very helpful for the mental health field (Max-Neef 1989). There are examples of such projects in the region, where local communities have owned and developed successful projects. The powerful kinship system in Africa, although weakened by urbanisation, is an important aspect of community strength.

One of the unfortunate effects of the influence of Western medicine has been to alienate local mental health workers from their own, and their patients', cultural beliefs and practices

regarding mental health issues (Swart 1998). While some of these are detrimental and violate human rights, it is essential that any approach to mental health issues is acceptable to the community concerned. On a practical level, given the lack of funding, it is necessary to mobilise local expertise. It seems many creative partnerships could be forged between Western and traditional systems of healing. Local workers will need to be empowered to be assertive in this relationship and confident enough to advocate for selective traditional interventions. It is sad that this happens so seldom or, if it does, it happens without open sanction. The Western mind-body split is generally not present in many African cultures, a factor which can facilitate psycho-social rehabilitation.

Mental health professionals will need the skills to assist communities to identify local needs and appropriate ways of addressing these that are acceptable to the people concerned, for example, training in rapid rural appraisal or other appropriate research methodologies. There are many examples of these courses, such as the course recently organised by the European Union Concerted Action Initiative in Zambia in March 1999. Many more are needed, and should be given, preferably by local or regional experts familiar with local issues. Capacity building is essential in order for local workers and communities to gain the confidence and authority to take the initiative in identifying needs and planning, managing and evaluating programmes. Funding may need to be solicited from international donors, but ownership of these initiatives must remain within the region concerned. The importance of this process is beginning to be recognised (for example, Mikkelsen 1995).

Mental health workers also need to be trained to understand the process of engaging with and empowering communities, skills that are not necessarily part of medical training (Hope & Timmel 1996). Social workers could play an important role here.

EMPOWERMENT BY REGIONAL COOPERATION

To realise the intention of empowering the region, documentation on projects that are properly evaluated and demonstrated to be cost-effective should be disseminated throughout the region. The Nations for Mental Heath demonstration project of WHO is such an initiative (Nations for Mental Health 1997), but material is not disseminated widely enough within the region. Organisations such as the World Federation for Mental Health could assist with this process of identifying examples of good practice. There are a number of such innovative mental health projects needing dissemination currently. An exchange of mental health workers between countries in Africa would assist in sharing successful programmes, rather than the current experience of visits by international experts from outside Africa.

Similarly, there are an increasing number of mental health training institutions and programmes within the region offering training relevant to the African situation. These are beginning to be used by persons from other African countries, but all too often funding agendas require that workers be trained overseas. A concerted effort should be made to compile an inventory of regionally available and appropriate courses, and to develop funding sources to make this accessible, such as WHO fellowships. This would encourage the development, not only of relevant training, but also of local expertise. It may even reduce the current brain drain of leaders in the field.

Individual African countries need to identify what they can contribute to one another regarding mental health policies and programmes, and to form partnerships that strengthen the negotiating power of the region in relation to international funders. Countries within the African region should learn from one another which mental health policies and structures work best, consult with one another and pool resources. International funders should be encouraged to support this

process. The Regional Strategy for Mental Health for the Period 2000-2210 proposed by the World Health Organisation Regional Office for Africa in September 1999 is an example of such regional co-operation. The strategy identifies the importance of regional collaboration and partnerships.

SOUTH AFRICA'S CONTRIBUTION

I cannot comment on the contribution that other countries could make, but I could make some suggestions regarding South Africa's possible contribution. South Africa has a unique position in Africa in that its history has been very different from that if the rest of the continent. Apartheid brought about isolation, which meant that international funding was not available to the government. Ironically, this means that the country has not incurred the debt to international funders that other African countries suffer from and is therefore less dependent. However, this *independence* has largely disappeared with the advent of globalisation, and cut-backs in public spending are evident. Mental health services have been curtailed, at a time when it was hoped they could be extended to the full population.

However, during the apartheid years in South Africa a rich NGO sector emerged to meet locally identified needs, often neglected by government, which was directly funded by international donors (Parekh *et al.* 1997; Mamphiswana 1999). Although there are many definitions of NGOs (Korten 1990), a variety of these organisations were, and are, involved in mental health issues. NGOs were largely responsible for completing need assessments, identifying projects, looking for funding and managing the projects themselves, with very little contact from the funders. While this led to poor service at times, at best it also developed a strong, assertive style of work, with the empowerment of local people. Projects were firmly grounded and owned by the community. It is this style of partnership that South Africa could model for other countries.

Currently, funding patterns in South Africa have changed. International funders have redirected their funding to government and many NGOs are in financial trouble as a result. Alternately, funding is directed to NGOs through government channels and international funders are starting to become more directly involved with projects. These developments are eroding the power of NGOs. At the same time the government has not yet clarified its relationship with NGOs, particularly in relation to funding. NGOs believe they are able to respond more flexibly to issues, represent community concerns more directly, and that they have an important place in the delivery of mental health services.

Of further concern for NGOs concentrating specifically on mental health is the way the new government policy on subsidies will be implemented. The policy states that specialist NGOs will no longer be subsidised. How this will be addressed in a way that maintains the expertise necessary for effective advocacy and leadership in appropriate service delivery, yet provides a holistic, unfragmented service to families and communities must still be thought through. This tension mirrors the dilemma of a focus on mental illness or on mental health. Whatever the decision, it is important that the NGOs of South Africa remain empowered to reflect the needs of local communities and challenge the state when necessary.

Training is another area that South Africa could possibly offer to the region. Cognisant of not becoming yet another *colonial* power impacting on the continent, training institutions in South Africa may offer training that is both cheaper and more relevant to the region that that offered in Europe or America.

Conversely, South Africa can learn much from other African countries regarding the delivery of mental health services within the primary health care model, which some countries adopted

several years ago (Freeman & Pillay 1998). There are success stories and failures, and South Africa can benefit from both.

CONCLUSION

In conclusion, it is imperative that all mental health professionals understand the impact of economic and political forces on the well-being and mental health of countries. Such understanding equips them to address mental health issues within a social development framework. There is a wealth of talent and knowledge that can be mobilised in the region if both professionals and consumers feel empowered. Supported by the region and working on local issues, they can *make a difference*.

REFERENCES

DESJARLAIS, R; EISENBERG, L; GOOD, B & KLEINMAN, A 1995. **World mental health: Problems and priorities in low-income countries.** New York: Oxford University Press.

ESTES, RJ 1995. Social development trends in Africa 1970-1994: The need for a new paradigm. **Social Development Issues,** 17(1):18-47.

ELLIOTT, D 1993. Social work and social development: Towards an integrative model for social work practice. **International Social Work,** 36:21-36.

FREEMAN, M & PILLAY, Y 1997. Mental health policy - Plans and funding. **In:** FOSTER, D; Freeman, M & Pillay, Y (eds) **Mental health policy issues for South Africa.** Pinelands, South Africa: Multimedia Publications.

HEPWORTH, DH & LARSEN, J 1993. **Direct social work practice. Theory and skills.** (4th ed) Chicago: Dorsey Press.

HOPE, A & TIMMEL, A 1996. **Training for transformation. A handbook for community workers** (Revised edition). Book 111. Gweru, Zimbabwe: Mambo Press.

JENKINS, R; McCULLOCH, A & PARKER C 1997. **Supporting governments and policy-makers.** Nations for Mental Health. Division of Mental Health and Prevention of Substance Abuse. World Health Organization: Geneva.

KORTON, D 1990. **Getting to the 21st century: Voluntary action and the global agenda.** New York: Kumerian Press.

MAMPHISWANA, O 1999. The South African non-governmental organization: Broadening options for transition to a new socio-economic and political dispensation. Paper read at the Intra-University Consortium for International Social Development. University of Cape Town (4-8 July 1999).

MAX-NEEF, M; ELIZALDE, A & HOPENHAYN, M 1998. Human Scale Development: An option for the future. **Development Dialogue,** (1):6-80.

McGREW, A 1992. The Third World in the new global order. **In:** ALLEN, I & THOMAS, A (eds.) **Poverty and development in the 1990s.** Oxford: Oxford University Press.

MIKKELSEN, B 1995. **Methods for development work and research: A guide for practitioners.** London: Sage Publications.

NATIONS FOR MENTAL HEALTH 1997. **An overview of a strategy to improve the mental health of underserved populations.** Division of Mental Health and Prevention of Substance Abuse. World Health Organisation. Geneva.

OXFAM AMERICA 1995. **The impact of structural adjustment on community life: Undoing development.** Washington, D.C.: Oxfam America.

POTGIETER, MC 1998. **The social work process.** South Africa: Prentice Hall.

PRIGOFF, A 1999. The impact of market globalization on social systems worldwide: Community economic development and networking for social transformation. Paper read at 11th International Symposium of the Intra-University Consortium for International Social Development (IUCISD), Cape Town.

PARAKH, A; McKAY, A & PETERSEN, I 1997. Non governmental organisations. **In:** FOSTER, D; FREEMAN, M & PILLAY, Y (eds) **Mental health policy issues for South Africa.** Pinelands, South Africa: Multimedia Publications.

PRIMO, N & TAYLOR, V 1999. **Globalisation: In search of alternatives.** Cape Town: SADEP.

SEN, G & GROWN, C 1987. **Development, crises and alternative visions. Third World women's perspectives.** New York: Monthly Review Press.

SWART, L 1998. **Culture and Mental Health. A Southern African view.** Oxford: Oxford University Press.

WORLD BANK. International Bank for Environmental Progress 1995. **A report of work in progress.** Washington D.C.: Environmental Development.

WORLD FEDERATION FOR MENTAL HEALTH 1998. **Report of the Secretary General.**

WORLD HEALTH ORGANISATION (WHO) COLLABORATING CENTRE REPORT 1999. Institute of Psychiatry. London.

Cracks start to show in global free market: wealth gap keeps growing. **Cape Times,** Cape Town 25 June 1999:17.

Paper presented by Shona Sturgeon at the 1999 World Congress of the World Federation for Mental Health 5-10 September 1999 Santiago, Chile.

Ms Sturgeon is Vice-President of the World Federation for Mental Health, Africa Region.