Mental Health in Zimbabwe: Are there Lessons for South Africa?

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The notions of an appropriate or relevant psychology and mental health service for South Africa has recently become a major issue of concern and debate. (e.g. oasssa conference on Apartheid and Mental Health 1986; Dawes 1986; Foster 1986). A potentially informative contribution to the debate is to look at and analyse Mental Health in other African Countries. This is not to say that any other country is exactly the same as South Africa and would therefore have answers directly applicable, but nor is South Africa so unique that it cannot learn from the experience of others. Zimbabwe could be regarded as a good starting point as it is a country which suffered many years of apartheid rule, where care was given inequitably and where, at least theoretically, this should have changed. Secondly, again at least in theory, consideration would be given to issues of individual and group democracy. And importantly, Zimbabwe is on South Africa's borders and accessible to South African passport holders.

Since independence in 1980 there have been various 'adjustments' in mental health services in Zimbabwe which, although important, are not particularly significant to the so-called 'relevance debate'. For example, services which were racially segregated have become non-racial; the incarceration of psychiatric patients in concrete courtyards without prospect of review, rehabilitation and discharge has been stopped; the compulsory shaving of heads for patients is a thing of the past; windows were put into the punishment cells at psychiatric hospitals and more staff

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have been employed. This more humane treatment of psychiatric patients is so widely accepted, though, that it does not enlighten the concern with relevance for South Africa. Zimbabwe's plan for mental health, however, needs serious consideration. It is also important to consider the process of implementation of those aspects of the plan of action which have been set in motion. Lessons for South Africa from Zimbabwe will thus be considered from two points of view, first, from Zimbabwe's plan of action for mental health itself, and second from the way principles of this plan are being put into practice.

Zimbabwe's plan for mental health was devised at an "intersectorial, interministerial" workshop held in 1984. The workshop was attended, significantly, by high ranking officials of almost every ministry of Zimbabwe - thus including representatives of ministries seemingly unrelated to health, such as agriculture, transport and defence. Representatives from organizations such as the Zimbabwean National Traditional Healers Association and the Zimbabwean National Mental Health Association (a non-government body) attended. Other African countries also sent delegates. The workshop was run under the auspices of the World Health Organization, who were represented by delegates expert in Third World health.

Before outlining the plan of action itself there are two points of ideology which need mention. Both fall under the broad category 'primary mental health'. In the background policy to the mental health plan it is noted firstly that

> "Prior to the attainment of independence, Zimbabwe was characterized by imperialist exploitation and racism which led to

> under-development and a biased care system... In view of this it is significant that the government of Zimbabwe has chosen scientific socialism as a superior socio-economic system that places the interest of the previously exploited and oppressed majority in the forefront, thereby creating conditions conducive to their mental health". (Zimbabwe Mental Health Plan of Action (ZMHP) Pg 4).

In tune with this thinking, various changes ostensibly unrelated to mental health are noted as changes which have already, and will continue to have, positive effects on the mental health of the population. Among these changes are:-

1. The introduction of a policy of reconciliation.

2. The abolition of racial segregation.

3. National primary school education and non-racially biased opportunities for further education and training.

4. Development of health facilities including free health services for those earning less than $150 per month.

5. Establishment of Worker committees, and the formation of the Zimbabwean Congress of Trade Unions.

The second (related) point of ideology is that in order to achieve the Zimbabwean, (and indeed WHO,) goal of "Health for all by the year 2000" emphasis should be placed on achieving a system which would be

"scientifically sound, socially acceptable to all the people of Zimbabwe, affordable and (which should ultimately) provide full participation by communities themselves" (ZMHP, p4)

Thus it is seen that social, economic and political conditions are perceived as central to mental health, that all government departments are recognized as having an important part to play, and that community participation is regarded as fundamental.

A summary of Zimbabwe's plan for mental health follows. The plan involves both principles which are seen to embody the ideology and some proposals as to how these should be realized.

1. Community participation and mental health education - individuals and families, armed with appropriate information should assume conscious responsibility for their own health, welfare and development and those of others in the community.

2. Education through mass media - the target population and the nature of the medium should be carefully selected and then transmitted.

3. Consideration should be given to techniques such as films, psychodrama, role-plays to communicate and deal with mental health issues.

4. Programmes for the prevention or amelioration of alcohol and drug abuse, and other forms of potentially self-destructive and anti-social behaviour should be undertaken as part of a general programme around "Education for Responsible Living".

5. Mental health education could be advanced by programmes for pre-school groups, youth organizations, women's clubs, adult literacy classes, and primary schools.

6. Campaigns should be undertaken to promote child spacing so as to facilitate healthy psycho-social development.

7. Individual and community well-being and good mental health should be facilitated by suitable housing, employment and recreational facilities, strengthening of social support systems and, where necessary, social skills training.

8. Workers' committees could promote mental health and positive attitudes towards it. The possibility that one member from each workers' committee undergo a brief training in basic mental health skills should be considered. Such a person could also identify problems and know when and where to refer.

9. The positive attitude of the government to issues of mental health should be communicated to the general public.

At the workshop, it was recognized that mental health problems could be identified and recognized even before birth. Programmes should thus begin here and continue through the different developmental stages.

It was suggested therefore that the following programmes be set up:

(a) Peri-natal mental health care - Mothers should be assessed as to whether they are able to care for a child. Child abandonment for

example could be avoided by dealing with the mother's depression beforehand. Mothers at risk for bearing children with mental retardation, brain damage etc. because of, for example, malnutrition in the mother, need to be recognized and helped. If recognition occurs too late to intervene with the mother an early stimulation programme with the child should be implemented. Traditional birth attendants should be trained as this could improve peri-natal care and reduce the likelihood of mortality and brain damage.

(b) Child mental health - Teachers should be trained for the early identification of specific disabilities in schoolchildren. Aspects of mental health should be introduced into educational material for use in schools generally. Greater liaison should be set up between physical and mental health personnel so that the 'whole' child is dealt with.

(c) Adolescent mental health - 'Walk-in' centres tied to general youth centres should be opened to deal with adolescent crises related to family, career, drugs, alcohol, etc.

(d) Treatment and after-care facilities - Psychiatric units need to be upgraded and new ones built at provincial and district level. Halfway houses and sheltered employment facilities need to be set up.

(e) Decentralization - Accessibility to mental health resources would be ensured through district hospitals and village health workers trained in mental health. Aspects of mental health care should be given in village development committees and schemes for urban, commercial farming and mining areas.

(f) Rehabilitation - Provision should be made for devising resettlement schemes for discharged psychiatric patients.

(g) Traditional healers - Traditional healers should be encouraged to refer "severe and treatable" mental disorders to the formal sector, and "equally health workers in the formal sector may gain from greater understanding of the effectiveness of traditional healers in dealing with psycho-social problems" (ZMHP, p9)

(h) Occupational mental health - Trade unions and workers' committees should be involved in the prevention and management of accidents which result in mental and physical disability. Heavy-duty truck drivers should undergo psycho-physiological examination.

(i) Mental health in prisons - Offenders serving prison sentences should be regularly assessed and should be exposed to programmes aimed at psychological rehabilitation.

It is recognized that in order to realize these principles, personnel would need to be trained. Whereas before independence there was no clinical psychology or psychiatry specialization offered in Zimbabwe, courses have now been established in these disciplines. A course in psychiatric social work and a one-year psychiatric training course for medical assistants have been introduced. Student intake for psychiatric nursing has been increased. Psychiatric nursing was introduced into general nursing and medical assistant training. A diploma in psychiatric health for doctors going to work in district hospitals was also set up.

In terms of the outlined principles though, it is obvious that more than

mental health professionals would need to be trained or given skills - this too was recognized. Two such groups were identified. Firstly non-psychiatric workers who are in professional contact with the community, and secondly individuals who through their normal social interaction have effects on others' mental health. In the first category three subgroups are mentioned:

i) non-psychiatric health staff (referred to in the previous paragraph)

ii) workers such as teachers, rehabilitation officers, personnel in children's homes etc.,

iii) workers whose duties are directed towards the community, such as police, judicial personnel, leaders of youth groups, trade unionists, rural development officers etc.

The training of these people would in general incorporate such skills as counselling, communication and motivation, early identification and referral of persons with mental-health problems, management and support of the mentally ill and handicapped, basic administration skills, and logistics and data gathering. The training of such personnel would be done by people skilled in the area. As part of the process of decentralization, those already working nearer the periphery would be delegated as trainers. The emphasis of the training would be towards "doing" rather than "knowing" - in other words it would be "task-oriented and competency based".

In the second category (individuals in contact with others through their normal social interaction) the mother is identified as the prototype

primary mental health worker. Mental health education should also include increasing individual's ability to cope with personal problems as well as helping people to deal effectively with crises in the community.

A further suggestion for dealing with mental health problems would be to place a "nurse counsellor" at general medical outpatients. The need for such a service is supported by the fact that throughout the world approximately twenty percent of all patients arriving at out-patient clinics with identified medical problems are in fact suffering solely from psychological ones. (WHO quoted in ZMHP) In summary, Zimbabwe aims to improve mental health on the one hand by changing general socio-political and economic structures, and on the other by embarking on a back-up primary mental-health-care system. This would involve not only those working in health per se but the population and government as a whole.

LESSONS FOR SOUTH AFRICA

Lessons for South Africa from Zimbabwe will be evaluated in terms of three criteria which may be considered fundamental to a relevant mental health. These criteria are also either directly or implicitly contained in the Zimbabwean ideology around mental health. Firstly the mental health of the population should be improved. Secondly there should (ultimately) be community participation and control of mental health, and thirdly the therapeutic model should be appropriate to the situation. As mentioned, lessons can be taken on two levels; from the plan of action itself and from the process of carrying out this plan. As it is not possible to comment on each and every principle of the plan and to evaluate each step that has taken place, this discussion will be limited to general points.

The Link to the Political Economy

The first significant lesson for South Africa is in the fact that Zimbabwe recognizes that mental health cannot be divorced from socio-economic and political conditions. Zimbabwe has taken the Southern African lead in acknowledging that blaming the individual, or seeing the problem as lying solely within the individual, does not offer an adequate explanation of mental ill-health. The call for this to be recognized in South Africa made by De Beer (1984) around general health and echoed by Vogelman (1986) for mental health, has been made reality in mental health policy in Zimbabwe.

The second important lesson concerns inter-ministerial co-operation around mental health. That Zimbabwe is taking this seriously is reflected by the fact that almost every ministry attended a workshop on mental health and that these delegates delivered papers on how their departments may contribute to mental health. Through this conference the various ministries and the government as a whole have shown themselves dedicated to working together and improving mental health in Zimbabwe. Such co-operation is crucial to better mental health for the population.

Mental Health Care

The policy of prevention rather than cure is fundamental to Zimbabwe's mental health plans and indeed to any primary mental health programme. The plan of action makes provision for this through its various mental-health-education plans as well as through, for example, its perinatal, child and adolescent programs. It is important to recognize that prevention goes much further than mass education, if fact goes further than education itself. A shift of emphasis to prevention rather than cure is necessary if South Africa is to have an impact on the mental

health of the majority of its people. Certain of Zimbabwe's specific intended programmes could certainly form the basis for such programmes in South Africa.

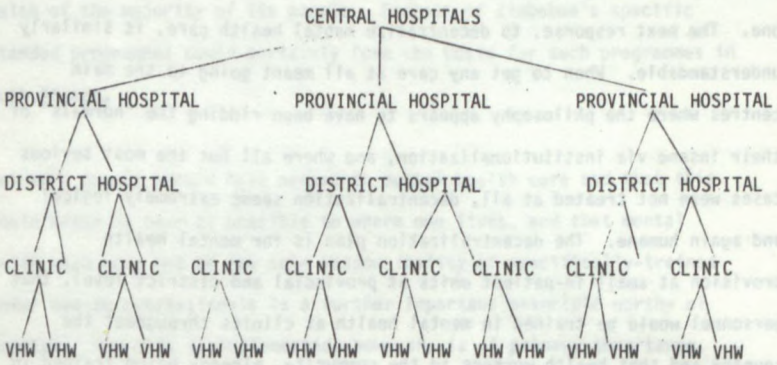
That more people should have access to mental health care and that this should occur as near as possible to where one lives, and that mental health care need not be the sole responsibility of specifically-trained mental health professionals is a further important principle worthy of adoption. How this is implemented, however, is of primary importance. Zimbabwe is in the process of implementing this plan from a particular viewpoint and the next section of this article will outline this approach and consider some of its advantages and disadvantages, taking into consideration that models relevant to South Africa are being sought.

The model adopted in Zimbabwe did not occur in a vacuum and it is necessary to briefly look at the mental health system that was inherited at independence and examine how aspects of the model presently being implemented have come about. At the time of independence, psychiatric problems were dealt with at a centralized level. Besides the odd private practitioner who served the white elite, there were three mental hospitals in Rhodesia. Two in Salisbury and one in Bulawayo with a section for blacks and a section for whites. The black hospital in Salisbury had no psychiatrist, no psychologist, and no occupational therapy or physiotherapy. The hospital was run by psychiatric nurses and aides. Ingutsheni, the main chronic hospital situated in Bulawayo was little better.

In view of this situation, that the initial response after independence in the area of mental health, was to "humanize" the hospitals by increasing

staff, by involving relatives in rehabilitation, etc. is not a surprising one. The next response, to decentralize mental health care, is similarly understandable. When to get any care at all meant going to the main centres where the philosophy appears to have been ridding the "normals" of their insane via institutionalization, and where all but the most serious cases were not treated at all, decentralization seems extremely logical and again humane. The decentralization plan is for mental health provision at small in-patient units at provincial and district level, that personnel would be trained in mental health at clinics throughout the country and that health workers in the community, already being trained in general health, i.e. Village Health Workers (VHW) would eventually be trained in mental health as well. This policy dovetails very nicely with the principles contained in the mental-health plan to involve psychiatric professionals as well as non-psychiatric personnel in mental health care. It also makes less of the fact that so few professions exist and that it takes so long and is so expensive to train professionals.

The model as conveyed then, appears to mean that the most disturbed people would be referred to the more central hospitals while the less disturbed would be treated closer to their homes and by less qualified personnel. The structure for mental health care would thus diagramatically look as such:



It is envisaged that those further from the centre would be trained by those nearer to it. Seeing that so few professionals exist in the first place though, initially at least, the focus would be on the training of professionals. It is envisaged that, once enough personnel have been trained, there would be at least one psychiatrist at each provincial hospital, or if this were not possible one General Medical Officer (doctor) with a one year course in psychiatry. At this level too, there would be two community psychiatric nurses. These nurses would train non-specialist workers at district and village-health-worker level, visit each district hospital in the province once a month or, at least once every two months, to diagnose problem cases and prescribe medication, and work at the provincial hospital. Whilst this is the goal which is being striven towards, at present there are neither trained medical orderlies nor the required trained psychiatric nurses at all the provincial hospitals, though they have begun to operate at certain centres.

Given this explanation of the structure of the service or intended service, two crucial issues need to be addressed : community control and therapeutic model. The point that will first be explored is whether the

decentralization notion and the way it is being set up is at least moving in the direction of the ideological goal of full participation and involvement by individuals and communities in mental health.

Community Control

The model being set up is a filter one. As stated above, depending on severity, one would be treated closer or further away from one's home after having been seen and referred by those less centralized. It seems that this may act against community involvement and indeed may act against the intended education programme which would be set up against the notion of the insane being in need of institutionalized treatment - or at least treatment outside the community. Secondly it would seem that rehabilitation back into the community is made much more difficult if the patient (such a person no doubt is a patient) has been taken away for treatment of his/her madness. Community acceptance of the mentally ill is certainly not likely to be enhanced by this system.

One could also quite easily land up with a psychotic/neurotic distinction, whereby a neurotic (less severe) is treated in the community while the psychotic (more severe) is treated at a central hospital. This idea is reinforced by the notion which is widely speculated in Zimbabwe, that neurotic problems can be treated by a nyanga (traditional healer) while psychotic problems should be left for advanced western medicine.

It is not the task of this paper to offer suggestions as to how mental or emotional problems should be treated in the community either in Zimbabwe or in South Africa, but it certainly hasn't always been true that mentally ill people have had to be treated outside their community, and more cognizance should be taken of past solutions as well as looking forward to

new ones.

Perhaps more important though is the fact that communities who should participate in decision-making - a major principle of primary mental health - are not involved. Primary mental health should mean that the people themselves must build up organizations and decision making systems at local level and be involved in strategies for the prevention and cure of health problems. The Zimbabwean model does not begin with this principle even though this is the intention once the level of VHW is reached. This is problematic in that by the time the community's involvement is called upon the system already exists, the structure already exists, much money has already been spent, people's interests would invariably have become involved, and lastly a system which has been set up to improve and extend mental health to all is extremely difficult to reject.

Furthermore, even at the level of the village health worker, community participation is not guaranteed. Two of the hallmarks of VHW are meant to be slelection by, and accountability to, the people whom they are to serve. But there is not always full and direct participation in either of these. Even within communities hierarchies exist, with those people who have slightly more privilege (be that in terms of education, wealth or tribal status) becoming the representatives of the people and hence the power - this often means bureaucratic rather than community control over the VHW. This reflects differences between direct and representative democracy.

One may at this point be tempted to reject the notions of participation, selection and accountability by communities as an unworkable pipedream.

However, there is evidence that direct democracy in such issues is possible. Before national liberation in Zimbabwe, certain semi-liberated zones had been set up where everyone had a direct say in decision-making through mass meetings and direct democratic structures. Since independence, the democracy has moved to be a representative one rather than a direct one. The initiative and participation of the people was undermined by an increased bureaucratisation with decisions mainly being filtered down to the people rather than up from them.

This is not meant as an attack on the Zimbabwe government, they are in a very difficult position of attempting to accommodate class interests. While wanting to encourage the people's control, the government needs at the same time to encourage industrial and agricultural entrepreneurs. The resultant effect has been largely a continuation of a class (though not race) divided society with little direct people's democracy. It would seem then that, for the present at least, the objective of more mental health for more people has taken priority over the goal of community participation.

Therapeutic Model

The second point of caution concerns the therapeutic models themselves. The history of therapy is one of specific models having been developed for specific societies. Therapy as it is presently known and practised in Western society is "infused by bourgeois ideology" Hayes (1986). While some people think that all the theory underlying therapy, as well as the therapy itself, should be done away with, it seems more common nowadays to consider the possibility of "transformations" of models (Hayes 1986), or a "radical overhaul" of psychology (Dawes 1986), rather than dismissing psychology as a whole.

That a primary health care system is a radically different way of looking at mental health is undeniable, but this does not in itself offer a model for direct treatment of psychological problems. Treatment, as it is being set up in Zimbabwe, is predominantly "medical model". The least time-consuming, and considered by many the most effective treatment of psychological problems, is medication. Further, if one accepts that Nyangas can treat neurotic but not psychotic problems and that a large majority who seek psychiatric/psychological help have previously been, or are simultaneously being, treated by an nyanga (information received through various interviews with psychiatrists and psychologists in Zimbabwe) then the medication argument is enhanced.

The medical model, however, reinforces the 'individual blaming' syndrome. In many cases, treatment with medication confirms the belief that the problem lies within the individual rather than being societal. This does not mean that drugs are not useful or important, only that the patient is made to identify the problem within him/herself through having to take medication for the 'illness'.

Problems of the medical model extend beyond this though into issues of control, power and dehumanization. This is carried through beyond psychiatary into other mental health disciplines. In the clinical psychology course for example, while emphasizing in the course outline the "cultural bases" of clinical populations and that "there's a decided orientation towards community psychology", the models used are those developed in western psychology where to a large extent the power and control reside with the therapist. The course puts a fairly large emphasis on problem-management. Behaviour therapy techniques to deal with, for example, anxiety, depression, alcohol and drug addictions,

sexual disorders, etc. are taught. Bahaviour therapy has often stood accused regarding the extent of the therapist's power and control. Kovel (1983) sums up these arguments rather well. Comparing behaviour therapy to other kinds of therapy, he says :

"...only behaviour therapy fetishizes the process of reinforcement itself. And by making behaviour into an idol, it turns the human subject into an object of manipulation while correspondingly inflating the behavioural standards of the given social order." (p 282)

This approach is difficult to reconcile with the ideological one which states that "individuals and families, armed with appropriate information should assume conscious responsibility for their own health, welfare and development of themselves and those of others in the community." Behaviour therapy is certainly not all that is offered in the clinical psychology course, but nowhere is there a component in the course which has, or is attempting to, radically transform either the theoretical models or the practise of traditional psychology in terms of the ideological goals. Although a large block of the internship placement is spent in a community setting, this does not in itself mean a different way of working. In this case, it seems to mean rather, the same way working, just a different setting. The theory and practice, it would seem, lack "a social theory of personal life". (Hayes, 1986). At the same time, though, the emphasis on practical methods of treatment rather than methods which require extended time and a helpee with a certain degree of sophistication is laudable. For "relevant" psychology, however, the practical approach would need modification towards a practice based on an understanding of a "socially constructed person" and where more control lies with the individual.

I have noted two areas in which Zimbabwean directions in mental health do not fully serve to endorse their ideological mental health goals directly. The question that now arises is whether the achievement of more services to more people (which Zimbabwe's direction has already achieved and will continue to achieve more of) is a model appropriate for South Africa to adopt, given that this is seen as a process towards reaching the ideological goals.

Structuring Mental Health Care

The drastically impoverished mental health care system inherited at independence in Zimbabwe has been shown, and hopefully the logic of choosing to reach more people as the priority over issues of community control and transformation of therapeutic models, has been conveyed. While there is no doubt some sense in the argument that such moves are "worse than useless" in that professional control and bureaucratic structures are being entrenched, to simply negate the people who are helped is being smug in the extreme. Taken together with the intended preventative changes there can be no doubt that Zimbabwe's achievements in mental health are important. On the other hand, this does not mean that the direction which Zimbabwean mental health has taken should be replicated in South Africa.

In mental health it is an exacting task to achieve both direct community participation and a service which is going to be available quickly and efficiently to the majority of the population. These two things are not mutually exclusive, or at least should not be. What is more important, though, is the emphasis. Does one embark on a type of decentralized structure such as Zimbabwe has chosen, with the ultimate goal as in the stated ideology, or does one attempt from the time that one is conscious

of the ideology to build structures which reinforce that ideology from the first instance, at the possible risk of a slower process?

Such questions, though, cannot be asked in isolation as it seems that mental health achievements run parallel with achievements in other spheres - notably the political and economic. Unless there is direct democracy as it relates to political and economic control, mental health is unlikely to be different. Zimbabwe, for example, sees itself of the road to scientific socialism, and perhaps when there is change in political and economic relations, then mental health too will have greater direct participation and a model more in line with a changed historical situation will be developed. At present though it seems that mental health in Zimbabwe, in spite of the achievements made, is not able to implement certain of its ideological goals because of the historical position that it is in and the particular historical process which it is going through. South Africa's mental health structure is, and will be, similarly linked to broader processes of change.

Nevertheless a truly democratic country must have concommitant changes in its social institutions - mental health being one such institution - and ways of implementing this structure within mental health need to be investigated. I believe that there are pointers in this article which suggest that if a choice has to be made between more services for more people in the immediate future (Zimbabwe's choice) or a slower process of community involvement and devising new therapeutic models through working with those who are to receive the service through a dialectical process, then the latter is preferable.

Conclusion

For South Africa, then, there are a number of lessons to be learned from Zimbabwe; many from its achievements and intended plans, but also from analysis of the direction which is being followed. That mental health is inextricably linked to socio-economic structures, that inter-disciplinary co-operation is fundamental, that preventative programmes should be prioritized and that mental health care need not be the sole domain of mental health professionals are just some of the important lessons to be learned from Zimbabwe. A crucial point to be learned also is that the task of putting an ideology into practice is extremely complex as it does not just depend on decisions within a discipline such as mental health. Nontheless, those working in the mental health field cannot sit back and wait to see what political and economic changes occur before planning mental health structures. It has to be ensured by those in the mental health field that participatory mental health does not lag behind economic and political participation. Furthermore the momentum towards true democracy is enhanced by those working towards this goal in every direction - mental health included.

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