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MENTAL HEALTH AND DEVELOPMENT IN A SHACK SETTLEMENT: THE CASE OF BHAMBAYI

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In South African shack settlements, poverty, overcrowding, unemployment and a sense of hopelessness characterise the conditions under which people live. A growing body of knowledge reveals that mental health suffers under these conditions (Lewis and Lewis, 1979; Chambers, 1983; Levenstein, 1989) and is exacerbated by the oppressive political situation and resultant violence which characterises South Africa (Vogelman, 1986; Foster et al, 1987; Butchart and Seedat, 1990).

The purpose of this paper is to evaluate the work of the Community Mental Health Project (CMHP) in a South African shack settlement and to draw out lessons that can inform future mental health programmes in similar contexts. In order to understand the context in which the project has been operating, we begin with a brief description of Bhambayi, the shack settlement in which the project has been located. We then go on to examining the goals and conceptual framework of the CMHP, as well as its structure and its activities. Lessons are then drawn which inform the relationship between mental health and development and increase our understanding of the position of mental health services in deprived communities, particularly shack settlements.

A DESCRIPTION OF BHAMBAYI.

Bhambayi is a shack settlement situated some 30 km north of Durban where 20 000 to 30 000 people live in overcrowded conditions. Most dwellings in Bhambayi are mud, wood and corrugated iron shacks although a few are constructed of bricks and concrete blocks. With the exception of the clinic, there is no piped water to the area and the residents have to queue to buy water from the five communal taps serving the entire community. There is no formal sewage system in the area and the inadequate self-constructed pit latrines often result in sewage flowing in open drains. In addition, until a year ago, there was no waste removal service to Bhambayi which resulted in large amounts of accumulated garbage. A consequence of these living conditions is that diseases and psychosocial problems associated with overcrowding and poverty are prevalent.

Bhambayi incorporates a 40-hectare area, known as the Phoenix Settlement, which was established as a model community by Mahatma Gandhi in 1904. The irony is that this area now epitomises some of the worst living standards in South Africa. The rest of Bhambayi consists of privately owned land and land which falls under the jurisdiction of the Durban City Council. With so many individuals and agencies involved in the area, lines of responsibility for the community are often unclear. This has made administration of the area confusing and inefficient, and hindered development initiatives. For example, the obtaining of security of land tenure for residents, an important requirement for development of the area, becomes highly complicated when so many landowners are involved, as are attempts to get piped water into the area.

Although Bhambayi may be regarded as a geographic community, it is not a homogeneous one. The community is divided along a range of dimensions, four of which are mentioned here. Firstly, although the present population is African, ethnic and political differences amongst and between Zulus and Mpondos who reside in the area are evident.

Secondly, there are many individuals in the area who thrive on the chaotic nature of Bhambayi. Members of the community have varying degrees of commitment to development initiatives. Drug and illegal arms dealing, for example, forms an important source of income for many of the residents and dealers have a vested interest in ensuring that the community remains disorganised as this facilitates trafficking.

Thirdly, a common characteristic of shack settlements is the existence of "lords" who thrive in these areas at the expense of the residents. In Bhambayi, for example, shack "lords" build shacks on privately owned land

and rent them out to tenants, often at exhorbitant rates. In addition, there are other "lords" who have gained control of essential resources in the community such as the water kiosks. There are also the shebeen and spaza shop owners who thrive in the area at the expense of the residents. According to Zingle (1990) these "lords" are likely to resist development initiatives which interfere with their source of influence.

Fourthly, although there is a civic structure which ostensibly represents the whole community, Bhambayi is divided into twelve recognised areas, each with its own name, its unique character and demography, and its own leadership. The civic leadership tends to be male-dominated and appears to be infiltrated by individuals such as drug dealers and "lords", who have a vested interest in maintaining the status quo of the area and who appear to be more concerned with taking care of their own interests than with co-operating for the collective interests of the community as a whole. These individuals often compete with one another for power and control so that the civic leadership structure has proven to be ever-changing and unstable as well as unrepresentative of community interests.

Obviously any intervention in Bhambayi is made difficult by the number of landowners and agencies involved in the administration of the area, the unrepresentative and unstable leadership structures and the presence of individuals and groups who are concerned primarily with taking care of their own interests and not co-operating for the collective interests of the community as a whole.

THE COMMUNITY MENTAL HEALTH PROJECT.

Goals of the CMHP.

The CMHP, launched in 1987, is a project of the Department of Paediatrics and Child Health of the University of Natal Medical School. Located in Bhambayi, it has had the overall aim of developing an understanding of the role of mental health services in deprived communities through research and service work. In contrast to the formal mental health structures which focus on curative treatment, which are primarily located in urban centres and allow no community representation (Vogelman, 1986), the CMHP, with its emphasis on prevention and empowerment, set out to develop a model for community-controlled mental health services.

Conceptual framework of the CMHP.

The activities of the CMHP were based on the concepts of prevention and empowerment. Whilst preventative approaches in mental health are primarily

concerned with the product or end result of intervention (Swift, 1984), empowerment approaches are process oriented and guided by the needs of the community. The CMHP aimed at developing a model of mental health service delivery whereby the goals of prevention, namely, a decrease in the incidence, prevalence and duration of mental disability could be achieved through an empowering process.

Prevention.

Prevention is the concept underlying the mental health model in community psychology. The most widely accepted conceptualisation of prevention in mental health is provided by Caplan (1964) who distinguishes between primary, secondary and tertiary prevention. Primary prevention is concerned with preventing disorders from occurring and efforts are geared towards addressing environmental causes and increasing people's resistance to stress. Secondary prevention focuses on reducing the length and severity of disorders through early detection and treatment, whilst tertiary prevention is concerned with reducing the handicap or impairment that results from a disorder - this being achieved through interventions such as half-way houses and rehabilitation.

Empowerment.

The notion of empowerment underlies a number of community psychology and development approaches (Rappaport, 1977 & 1984; Lazarus, 1988). In contrast to oppression which results in a lack of control over situations and outcomes amongst those who are oppressed, empowerment, as defined by Rappaport (1984), is " .. the mechanism by which people, organisations and communities gain mastery over their lives" (p3). Serrano-Garcia (in Lazarus, 1988) has identified three major dimensions to empowerment, namely, the development of personal power, the development of an awareness of alternative realities, and the development of strategies for gaining access to particular resources in society. Empowerment thus encompasses both personal and political power.

Personal power refers to the feeling or perception that one has control over one's life. Such feelings can occur in the absence of political power or real control over situations and resources. Community participation, and in this particular context, community control of service provision, is seen as one way of achieving empowerment at both the personal and socio-political levels as well as facilitating the development of institutions which meet the needs of those being serviced.

Community control should, however, be distinguished from community involvement and community participation. Nassi (1978) defines community

involvement as reflecting programmes "for the poor" in which professional dominance is maintained and the involvement of the community exists largely for the purposes of fund raising and public relations. She defines community participation as programmes "by the poor" in which there may be shared responsibility for the running of the services. Finally, community control reflects programmes "of the poor" and implies control and power of the community over the health service programmes.

Studies on community participation suggest that projects which focus mainly on the delivery of health services have difficulty in achieving broad and long term community participation, whereas high participation is more commonly associated with an integrated development approach to community priorities not strictly related to health care (Rifkin, 1986). This supports de Beer's (1992) view that all sectors of society should be involved in development. He conceptualises development as being the mobilisation of human, natural and economic resources to meet the needs of the population through community empowerment and economic growth. Health and more specifically mental health, is seen as an important aspect of development.

One would therefore expect that in an area like Bhambayi, which is underdeveloped and where there is no multisectoral development, community participation in a project focusing only on one aspect of development, that is, mental health, would be limited and that the development of community controlled mental health services would become a difficult, if not impossible, task.

Structure of the CMHP.

A multi-disciplinary working committee has been responsible for the administration and progress of the project and has met on a bi-monthly basis. The composition of this working committee varied over time with paediatricians, medical doctors, and psychologists from the University of Durban-Westville and the University of Natal, as well as development professionals from non-governmental organisations being represented. In addition to these professionals, Bhambayi civic representatives were invited to attend the working committee meetings. This they did from time to time, but owing to the changes in leadership, durable representation from the community was difficult. Their poor attendance was exacerbated by the fact that working committee meetings were always held at the University of Natal Medical School during the day, making these meetings largely inaccessible to community members.

The staff of the CMHP comprised one co-ordinator (a mental health professional) and fieldworkers. During the research phase of the project, four

fieldworkers were employed to conduct interviews. The number of fieldworkers was reduced to two and then one following the termination of the research phase and as the CMHP undertook specific intervention projects.

The day-to-day activities of the CMHP were supervised by a supervision committee drawn from the working committee. This committee was effectively given executive responsibility for the project, an arrangement which did not prove to be very successful. Firstly, the members of the supervisory committee were volunteers, employed full-time by other organisations, who did not have the time nor energy to manage the CMHP efficiently. Secondly, neither the supervisory committee nor the working committee had much direct contact with the community and therefore were not familiar with the nature of the problems in Bhambayi. This resulted in tension between the working committee and the staff employed by the CMHP who often felt the working committee did not understand the context in which they were working.

Activities of the CMHP.

The initial target of the CMHP was youth and children in deprived areas, a group seen to be largely neglected by existing mental health services. Consequently, the CMHP began its work in Bhambayi with research into the type, extent and seriousness of mental health problems amongst youth and children. Formal and informal mental health resources operating in the area were also investigated. It was hoped that this research would guide the planning and implementation of mental health programmes in the community. Although many mental health problems such as mental retardation, undisciplined and violent behaviour and sleeping problems, were identified within these groups, the results of this research confirmed that no institutions or organisations were paying special attention to the mental health needs of the youth and children (Motsemme, 1989).

Primary prevention activities.

As community control was one of the goals of the CMHP, the project attempted to start this process by acquiring community support and participation with regard to its administration. The most obvious route to acquire this appeared to be through the civic structure in Bhambayi. While the survey on the mental health status of the community revealed a high level of mental health problems, the needs of the community, as communicated to the CMHP through members of the civic structure, were for multisectoral development that would have an impact on water supply, housing, unemployment and educational problems.

The CMHP soon realised that attaining community support, let alone community participation and control, required the project to respond to the

priorities set by the community. The only other development agency operating in Bhambayi was the Phoenix Settlement Trust which did not have much credibility with the community at the time, having been seen to have failed the residents with regard to development initiatives. The CMHP was therefore obliged to focus its efforts on addressing the need for multisectoral development. The CMHP responded to this task by playing the role of broker, which meant facilitating contact between the civic structure and relevant outside development agencies. One of the major problems experienced by deprived communities, particularly in peri-urban and rural areas is the lack of access to resources which results from a lack of knowledge and expertise required to access these resources. Examples of brokerage activities of the CMHP include negotiating with the relevant authorities with regard to refuse removal services, piped water for the area, and for the reconstruction of the library-museum complex of the Ghandi Settlement as a community centre.

These brokerage activities of the CMHP may be regarded as primary prevention activities as they address environmental factors contributing to mental ill-health. Other primary prevention activities of the CMHP have included organising a creche and a women's sewing co-operative. The creche was established in 1988, and following the empowerment approach, was managed by a parents' committee. Although this creche is still in operation, the parents' committee has disintegrated and the control of the creche is vested in the hands of the creche mother - who has resisted any attempts to revitalise the parents' committee as it interferes with her sphere of influence and control. The women's group was established in 1989 and unemployed women from the community were taught skills like sewing, cookery, crochet and candle-making. Talks by professionals on various health related topics such as AIDS, and child and maternal care were also arranged for the group. This group is still being run successfully despite various attempts to hijack it, and several leadership crises.

Finally there was the establishment of support groups for the care-givers of mentally retarded children. The emphasis was on teaching the care-givers how to cope with the pressures of dealing with a mentally retarded child, how to develop the abilities of the child, as well as encouraging the formation of child-care groups. These groups were run concurrently with special classes for mentally retarded children in the area which are elaborated on in the section on tertiary prevention activities.

Secondary prevention activities.
Secondary prevention activities included providing a crisis counselling and referral service. Attached to the day clinic, this service was established in

1988 in response to mental health problems presenting at the clinic. Clinic staff were trained to identify and refer patients having problems of a psycho-social nature to this service. Due to the nature of the problems which related mainly to housing, unemployment, pension, child abuse and mental retardation, the service operated mainly as an information and advice service. Where possible clients were referred on to the relevant agencies while others were accommodated by activities within the project, for example, the women's group, the care-givers' group, and special classes for mentally retarded children.

This service ran successfully for two years. During 1990, a state run polyclinic was, however, opened very near to Bhambayi which led to the closure of the local day clinic. A consequence for the CMHP was that community support of the crisis counselling and advice service dwindled to the degree that it was not feasible to continue with this activity.

Tertiary prevention activities.

A major activity of the CMHP which falls within the sphere of tertiary prevention was the establishment of a special class for mentally retarded children in 1988. The principal of the local primary school approached the CMHP to assist with mentally retarded children who attended her school in the absence of alternative facilities in the area. The CMHP responded by selecting and training a woman from the community to conduct special classes to teach mentally retarded children basic skills. As already mentioned under primary prevention activities, a support group was also established for the care-givers of these children. These classes and the care-giver support group functioned relatively well during the first year. This indicated that mental retardation was an issue for the care-givers to the extent that they were prepared to attend weekly support group sessions for several months. When the local school was closed towards the end of 1990, attendance of these special classes dropped off dramatically. It was established that the reason for the decline in attendance was because previously the mentally retarded children had been brought to the classes by siblings or neighbour's children attending the local school. As most of the care-givers of these children were working, they were unable to bring the children to the school themselves when the school closed down.

In addition to the above activities the CMHP has played an important role in providing community-based experience for Masters' students studying clinical/counselling psychology at the University of Durban-Westville. The students (in their first year of the Masters degree) have been required to undertake a project through the CMHP for the last three years. Examples of projects undertaken by the students include the development of the training

programme which was used by the "teacher" who ran the classes for the mentally retarded children as well as a method for evaluating the progress of the mentally retarded classes both by the "teacher" and their care-givers.

LESSONS FROM THE EXPERIENCE OF THE CMHP.

This evaluation provides an overview of the difficulties the CMHP encountered in attempting to develop a model for community controlled mental health services that emphasise prevention and empowerment in Bhambayi. Lessons are drawn from the experiences of the CMHP which may inform future community mental health initiatives in deprived communities and increase our understanding of the relationship between mental health and development.

Lesson One: Mental health services are more likely to be utilised in deprived communities when integrated into and linked with a primary health care system.

Even though there was a high rate of psychological and social problems in Bhambayi, the residents did not voluntarily present with these problems at the crisis counselling and advice service provided by the CMHP. Most of the clients were referred to this service by the local clinic whose staff were trained to detect mental health problems. When the clinic closed down, the number of clients dwindled to the extent that the need did not warrant continuing with this service.

The experience of the CMHP indicates that in deprived communities people do not voluntarily seek help for psycho-social problems. This supports Broughton's (1986) findings that people living under conditions that exist in shack settlements tend to accept symptoms of stress and mental ill-health as "normal". People living under these conditions do, however, seek help for physical health problems and the primary health care system presents as an attractive option for identifying and referring mental health problems.

Lesson Two: A certain level of development is required for the implementation of community controlled mental health services.

In response to community priorities, much of the work of the CMHP has focussed on broad multisectoral development in Bhambayi which undoubtedly falls within the sphere of primary prevention and therefore would impact positively on mental health. Nevertheless we would argue that the mental health professionals employed by the project, given their mental health skills base, could have been more efficiently utilised in other communities where

development initiatives and agencies are already involved in addressing basic material needs. Mental health services are more likely to be prioritised once these needs have been addressed. The experience of the CMHP therefore suggests that community participation in mental health service delivery is only likely to be achieved if such initiatives are attached to broad development programmes which allow for community priorities not related to mental health care to be addressed. This experience confirms Rifkin's (1986) research which indicates that community participation in health service delivery is more feasible when associated with an integrated development approach.

This view also seems to be shared by the World Health Organisation (WHO): "Much of the preventative work should be done by the general health services and through the intervention of other agencies such as community development, agricultural extension and education services." (WHO, 1990, p17).

"It is important to help communities develop their own responses to mental health needs, using existing resources and community strengths ..... In encouraging this form of self-help, (mental) health workers must not see themselves as striving alone to mobilise community action; partnerships should be formed between health workers, between health and development workers, and between health workers and local voluntary and non-governmental groups. These partnerships are a vital ingredient in dealing with mental health problems at the primary health care level." (WHO, 1990, pp29-30).

Lesson Three: Community controlled development is hindered by the lack of a sense of community and by individuals and groups acting in their individual or group interests as opposed to the collective interests of the community as a whole.

The experience of the CMHP in Bhambayi indicates that although poverty can sometimes create a sense of community amongst people, it can also be a very divisive force. The residents of Bhambayi, in their struggle for survival, would often act in their own individual interests rather than for the common good of the community. This is well illustrated by the dissolution of the parent management structure of the creche and concentration of control of the creche in the hands of the creche mother.

In addition, shack "lords" and other "lords", that is, individuals who have gained control of essential resources, had infiltrated the civic structure and were found to resist development initiatives in the area as these initiatives

were seen to interfere with their source of influence. The CMHP's efforts to create multisectoral development in the area were in fact hampered by certain leaders spreading rumours about the lack of credibility of the project staff who were criticized for having been affiliated with an earlier leadership structure. Consequently, the CMHP had great difficulty in gaining support for and participation in development initiatives from the civic structure which was ever-changing and dominated by individuals who had a vested interest in the community remaining unstable and violence ridden.

Added to the problem of "lords" in Bhambayi was the existence of a thriving drug economy which provided the means of subsistence for a large proportion of the area's population. To the extent that development threatens the drug economy and therefore the subsistence of a large number of families, development initiatives are unlikely to be supported by this constituency.

The experience of the CMHP is supported by Rifkin (1986) who suggests " .. that particularly in areas of poverty, individual concerns often over-ride community goals" (p244). As Brown (1978) comments: "Ultimately there can be little community control in a society where social class is so strongly defended and where true communities hardly exist" (p391).

Lesson Four: Community control of mental health services, requires the development of organisations which can represent the interests of those sectors of society who have a vested interest in this aspect of development.

Civil society is made up of all those organisations and institutions outside of state structures which represent the interests of their members (de Beer, 1992). They are regarded as highly important for community controlled development in that they provide the vehicle for empowerment of communities or particular constituencies to express their interests, as well as to participate in decision-making with regard to the allocation of resources.

Following from lesson three, geographic communities are rarely homogeneous and therefore community organisations very rarely represent the interests of an entire geographic area. The civic structure in Bhambayi was, for example, male-dominated and infiltrated by "lords" who did not support development initiatives. One cannot therefore place control of resources for development in the hands of such a body. Due to the multisectoral nature of development and the existence of competing interests in geographic communities, community controlled development initiatives require the development of organisations which represent particular constituencies who have a vested interest in particular aspects of development. It is through institutions which represent a particular sphere of

interest, in this instance mental health, that community participation and community control of development will flow.

Lesson Five: Non-governmental organisations in the mental health sector should facilitate the development and empowerment of community organisations which are best suited to advocating the needs of those requiring mental health services.

Following from lesson four no single community organisation, such as a civic organisation, will represent the interests of all groups in a community (de Beer, 1992). And the experience of the CMHP in Bhambayi was that the civic structure did not represent the interests of those for whom mental health services were an issue. While the CMHP persisted in attempting to gain community support and involvement through the civic structure as this was thought to be politically appropriate, it would have, perhaps, been more appropriate to facilitate the development of organisations which represented the constituency for whom mental health was an issue. In attempting to establish community control of mental health services, we would argue that non-governmental organisations in the mental health sector are well placed, in view of their relative neutrality, to facilitate the development of such organisations. A key function of these community organisations would then be to enter into partnerships with state structures with regard to the allocation of resources for mental health services.

Lesson Six: Women form a particular constituency for whom mental health services are a priority and thus should be specifically targeted for organisation and empowerment.

Due to women's traditional care-giving role, health, and more specifically mental health, is far more likely to be an issue of concern for women. As civic structures are generally male-dominated it seems unlikely that the need for mental health services would receive much consideration when it comes to the allocation of resources.

Following from lesson four, it is therefore appropriate that in the quest for the development of community-controlled mental health services, women and other users or potential users of mental health services should be specifically targeted for organisation and empowerment by non-governmental organisations in the mental health sector.

Lesson Seven: Management of community service organisations needs to be aware of the social conditions of the communities which are being serviced.

The CMHP was, in effect, managed by the working and supervisory committees who, due to their lack of contact with the community, did not have an adequate understanding of the social conditions in Bhambayi. In addition, working committee and supervisory meetings were held at academic institutions and were thus largely inaccessible to community members. This served to further alienate the management of the CMHP from the community. For example, understanding of the social conditions of Bhambayi, such as the control of the shack "lords", would have facilitated more strategic planning around the role of the CMHP in the development of Bhambayi and perhaps obviated some of the problems that the project experienced.

CONCLUSION.

The experience of the CMHP provides us with a number of valuable lessons which inform our understanding of the relationship between mental health and development in deprived communities. These lessons suggest that firstly, given that mental health is not a priority in most deprived communities, mental health services should be integrated and linked to the primary health care system. Furthermore the implementation of community-controlled mental health services requires a minimum level of development and location within a broad multisectorial development approach which allows for the community's material priorities to be met.

Secondly, certain features of shack settlements inhibit development, and hence the possibility of community controlled mental health services. These features include the problem of security of land tenure which is an important requirement for community-controlled development and which is linked to the problem of individuals/groups opposing development initiatives which interfere with their sphere of interest. This leads to community divisions and a lack of a sense of community which is essential if development is to be community controlled.

Thirdly, civic structures are often unrepresentative of all the interests of a community, especially the interests of women as they are generally male-dominated. Mental health is unlikely to be a concern for everyone in the community. Consequently, the development of organisations which represent the interests of those for whom mental health services are a priority may need to be facilitated by non-governmental organisations. Such organisations could be responsible for advocating the needs of this constituency, and it is through

them that community control of mental health services might best be achieved.

Fourthly, and most importantly, those responsible for the management of community service organisations need to be aware of the social conditions that characterise the communities in which their organisations are working, in order to plan stategically for their intervention.

We conclude our paper by echoing Maforah's (1989) claim that full community participation is important for the success of community mental health programmes.

"In order for preventive and promotive programmes to be successful, the communities' participation is vital. Communities should be involved right from the planning stage of programmes. They should be encouraged to identify their own mental health needs and priorities, and be advised on how they themselves can solve their own mental health problems" (Maforah, in Levenstein 1989, p69).

The lessons of the CMHP in Bhambayi do, however, indicate that although it is easy to pay lip-service to the notion of community participation, involvement and control, in reality these are difficult goals to achieve.

REFERENCES.

Broughton, M H (1986) Psychosocial and mental health problems in black children in and around Durban. Unpublished masters thesis, University of Natal, Durban.

Brown, P (1978) Political-economic and professionalistic barriers to community control of mental health services: A commentary on Nassi. **Journal of Community Psychology**, 6, 384-392.

Butchart, A & Seedat, M (1990) Within and without: The social construction of in-betweenity, in Nicholas, L J & Cooper, S (Eds) (1990) **Psychology and Apartheid.** Cape Town: Vision Publications.

Caplan,G (1964) **The principles of preventative psychiatry.** New York: Basic Books.

Chambers, R (1983) **Rural development: Putting the last first.** London: Longman Scientific & Technical.

de Beer, C (1992) **Towards a framework for national development.** A Development Research Group document.

Foster, D, Sandler, D & Davis, D (1987) **Detention and torture in South Africa: Psychological, legal and historical studies.** Cape Town: David Philip.

Lazarus, S (1988) The role of the psychologist in South Africa: In search of an appropriate psychology. Unpublished PhD thesis, UCT, Cape Town.

Levenstein, S (1989) Mental health in South Africa, in Owen, C P (Ed) (1989) **The case for a National Health Service.** Cape Town: NAMDA and Department of Adult Education and Extra-Mural Studies, UCT.

Lewis, M D and Lewis, J A (1979) Community-based mental health training. **Journal of Community Psychology**, 7, 95-103.

Motsemme, L (1988) Analysis of mental health needs in Bhambayi. Unpublished paper, Community Mental Health Project, Durban.

Nassi, A (1978) Community control or control of the community?: The case of the community mental health centre. **Journal of Community Psychology, 6**, 3-15.

Rappaport, J (1977) **Community psychology: Values, research and action.** New York: Holt, Rinehart and Winston.

Rappaport, J (1984) Studies in empowerment: Introduction to the issue, in Rappaport, J et al (Eds) (1984) **Studies in empowerment: Steps towards understanding and action.** New York: The Haworth Press.

Rifkin, S (1986) Lessons from community participation in health programmes. **Health Policy and Planning, 1(3)**, 240-249.

Swift, C (1984) Empowerment: An antidote for folly, in Rappaport, J et al (Eds (1984) **Studies in empowerment: Steps towards understanding and action.** New York: The Haworth Press.

Vogelman, L (1986) **Apartheid and Mental Health.** Conference Proceedings of OASSSA First National Conference. Johannesburg: OASSSA.

World Health Organisation (1990) **The introduction of a mental health component into primary health care.**. Geneva: World Health Organisation.

Zingle, J (1990) All dressed up to kill and nowhere to go: Violence in Natal. Unpublished paper, Institute for Social and Economic research, University of Durban-Westville, Durban.