

## **Beneath the rhetoric: Policy to reduce the mental health treatment gap in Africa**

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In this paper I problematize knowledge on reducing the ‘gap’ in treatment produced by 14 national mental health policies in Africa. To contextualize this analysis, I begin with a historic-political account of the emergence of the notion of primary health care and its entanglement within decolonization forces of the 1960s. I unpack how and why this concept was subsequently atrophied, being stripped of its more revolutionary sentiments from the 1980s. Against this backdrop, I show how, although the 14 national mental health policies are saturated with the rhetoric of primary health care and associated concepts of community participation and ownership, in practice they tend to marginalize local meaning-systems and endorse a top-down framework heavily informed by colonial medicine. The policies thus end up reproducing many of the very Eurocentric assumptions that the original primary health care notion sought to transcend. More specifically, the paradigms of evidence-based research/practice and individualised human rights become the gatekeepers of knowledge. These two paradigms, which are deeply embedded within contemporary global mental health discourse, are legislating what are legitimate forms of knowing, and by extension, valid forms of care. I argue that a greater appreciation of the primary health care concept, in its earliest formulation, offers a potentially fruitful terrain of engagement for developing more contextually-embedded and epistemologically appropriate mental health policies in Africa. This in turn might help reduce the current ‘gap’ in mental health care treatment so many countries on the continent face.

**Keywords:** Africa; Treatment gap; Global mental health; Policies; Epistemological assumptions

### **Introduction**

*Psychiatry in underdeveloped countries could profit...from avoiding the mistakes already committed in very advanced countries of the world. When we, however, try to abstract a lesson from European and American experience we must make sure that it will apply in the contemporary African situation...This is no easy matter, but we are*

*getting more and more convinced that an independent diagnosis of our position may prove more profitable in the end than a borrowed remedy (Lambo, 1960:1703)*

Over the last decade, the mental health situation in the ‘global south’ has gained renewed attention as an important public health matter within the international arena (Global Mental Health Group, 2007; Patel, 2014). One issue of particular concern is what is understood as a considerable number of people with mental health problems in the developing world not receiving care, defined as the mental health ‘treatment gap’ (Petersen et al., 2011; WHO, 2001). This issue has in turn given rise to a ‘broad new social movement’ led by the international psychiatric community but incorporating a broad coalition of actors and agencies (Horton, 2007: 806). Commonly referred to as ‘global mental health’, this movement is implementing all sorts of research projects and interventions, backed by significant amounts of global funding, geared towards reducing this ‘gap’ in treatment.

Under the banner of this movement, strong appeals have been made to African countries to develop national mental health policies to guide their health care systems in addressing the ‘gap’ in treatment (Faydi et al., 2011; Omar et al., 2010; WHO, 2001). These calls appear to have been widely responded to, with the continent witnessing a major acceleration in national mental health policy development. According to the World Health Organization (WHO, 2011) nineteen African countries had a mental health policy in 2010, the vast majority of which had been approved or revised since 2005. In light of this growth in policies, a burgeoning body of research has emerged which is focused on evaluating the content of such policies and/or the processes followed in their development (Faydi et al., 2011; Omar et al., 2010; Ssebunnya et al., 2012). Notwithstanding the importance of these issues, what have received far less attention, if any at all, are the epistemologies and associated politics, underpinning these policies.

In light of this gap, this paper looks critically at thinking around reducing the ‘gap’ in mental health treatment within 14 national mental health policies on the continent. Rather than focusing primarily on the content of these policies, my analysis is more interested in epistemological questions regarding the conventions of meaning-making that lie *behind* the knowledge that is produced by the policies, disentangling the power dynamics at play. In order to contextualise this analysis, I begin this paper with an historic-political account of the origins of the notion of primary health care (PHC), and associated ideas of community participation and ownership. I unpack how this concept was deeply intertwined with the forces of decolonization during the 1960s, and drew heavily on the grass-roots health initiatives being pioneered in various developing countries. At the heart of these initiatives was an attempt to destabilise the epistemologies underpinning colonial public health by developing contextually-embedded health interventions which draw on local resources and forms of meaning-making. Since the 1980s, although primary health care has increasingly formed part of official public health jargon, it has tended to be stripped of its more complex

and revolutionary policy implications. I explore how and why it was so quickly atrophied, ultimately representing only a brief, and primarily rhetorical disruption to the colonial public health paradigm.

This analysis provides a historic-political platform from which to understand the nature of contemporary policy thinking on the ‘gap’ in mental health care, and in particular its embeddedness within more general global health trends. Turning to the 14 national mental health policies, I demonstrate how they are saturated with the rhetoric of primary health care. And yet in reality, beneath the bold rhetorical statements, the policies do not seem to involve any real public participation and ownership. Rather, ideas of community participation and ownership tend to play out as essentially matters of education and training in the supposedly proper nature of mental illness and apparently appropriate forms of treatment. And constructions of what is ‘proper’ and ‘appropriate’ across the 14 policies are guided by two main paradigms: those of scientific evidence and human rights. These paradigms of thought are two of the main conceptual frameworks shaping contemporary global mental health discourse (Global Mental Health Group, 2007; Mari and Thornicroft, 2010; Patel, 2014). I demonstrate how such paradigms are both underpinned by several contentious and Eurocentric assumptions, an argument which has indeed been made by a number of critical cultural psychiatrists (Bemme & D’souza, 2014; Ingleby, 2014; White & Sashidharan, 2014) and social science scholars (De Sousa Santos, 2007; Sardar, 1998).

To be sure, this is not an argument against the potential importance of scientific evidence and human rights. Rather, this paper is critiquing the *hegemonic* way in which these ideas are mediating policy thinking around legitimate forms of care, and the consequent marginalization of others ways of thinking, based on alternative epistemologies and knowledge politics. It is expressing discomfort with the policies’ espousal of a top-down model of care, guided by centrally-defined, Eurocentric criteria, somewhat masked by grassroots rhetoric. Ultimately, it is problematizing the way in which the policies end up reproducing many of the very Eurocentric assumptions that the notion of primary health care, in its earliest formulation, sought to transcend. I conclude this paper by proposing that a return to the original notion of primary health care might offer a potentially productive terrain of engagement for thinking about the development of more contextually-embedded and epistemologically appropriate mental health care policies on the continent.

### **Collection and analysis of the national policies**

My analysis focuses on the knowledge produced on the ‘gap’ in treatment of 14 national mental health policies: Ethiopia (2012); Gambia (2007); Ghana (1996) Lesotho (2005); Liberia (2009); Namibia (2005); Nigeria (2011); Rwanda (2012) Sierra Leone (2012); South Africa (2013); Tanzania (2006); Uganda (2011); Zambia (2005); and Zimbabwe (2004).

These policies are those which I was able to access between December 2011 and January 2013. To my surprise, national mental health policies in Africa are not readily available in the public domain, and thus locating them was not a simple matter. This was confirmed by the director of the WHO's African Regional Office, who indicated that obtaining the mental health policies requires negotiating directly with the Ministries of Health (MoH) (Personal communication, 4<sup>th</sup> October 2011). Accessing the policies thus involved over a year-long process of communication with the MoHs in these different countries, who frequently themselves were unaware how to retrieve a copy of their own policy. In certain instances, when the policy was located, it did not exist in electronic form, and thus needed to be photocopied and posted to me as a hard copy. These difficulties around attaining the policies raise all sorts of questions around whose voices and interests might be embodied in these policies, and the degree of ownership local governments genuinely have. I will return to these questions in the conclusion of this paper.

My analysis of these policies is situated within the theoretical corpus of Science and Technology Studies, a broad field concerned with how health, bodies and disease are politically and discursively produced in medical science policy and practice (Law, 2008; Latour, 1999). In particular, I draw upon the Kuhnian concept of a paradigm (Kuhn, 1962) and Bruno Latour's notion of 'the black box' (1987, 1999). According to philosopher of science Thomas Kuhn (1962), a paradigm serves as a conceptual prism through which people make sense of the world. It constitutes a world view or what he also calls a 'disciplinary matrix', a kind of constellation of communal commitments and presuppositions. Conjointly, these elements provide 'abstracted rules' (ibid: 47) or accepted norms around what count as significant questions, what modes of analysis are appropriate and what kinds of solutions are acceptable. What this suggests is that paradigms are not inevitable mappings of the world, but are constructed by particular people within particular socio-economic and political milieu.

What makes paradigms such elusive entities for analysis, however, is that they are as invisible as they are powerful. As Kuhn emphasises (1962:37), 'One of the things a scientific community acquires with a paradigm is a criterion for choosing problems that, while the paradigm is taken for granted, can be assumed to have solutions'. Thus, what are concealed within paradigms are the shared properties, which appear so natural, but which are in fact constructed ways of seeing and acting in the world. These are deeply buried in what Bruno Latour calls 'the black box'.

According to Latour (1987) the black box holds all the common sense assumptions that a culture shares which turns questions, priorities and interests into facts. As Latour (1987: 206) puts it, the box is 'well sealed' and people generally do not 'live in a world of fiction, representation, symbol, approximation and convention: they are simply *right*' (emphasis in original). Thus, our paradigms of knowledge become so taken-for-granted, so intrinsically accepted as 'given', that almost by definition their underlying scaffolding disappears. Latour

(1999: 304) goes on to note in later work, how what this concealment enables is a focus on ‘inputs and outputs’ and not on the complex processes that produce these effects. Those processes are all of the interests, values and politics that shape how we see and think in the world. Through such ‘black-boxing’, these processes are normalised and archived in such a way as to be inherited and accepted as common-sense reality.

Thus, drawing on these ideas, my analysis sought to open up the ‘black box’ of knowledge on reducing the ‘gap’ in mental health care treatment produced by the 14 national mental health policies. It attempted to make visible the dominant paradigm(s) of thought mediating the knowledge produced by these policies, unearthing the hidden assumptions and capillaries of power. It sought to explore how these dominant structures of knowledge may be marginalising other ways of thinking about and addressing the ‘gap’ in mental health care treatment.

### **Primary health care: Its emergence and how it was subsequently atrophied**

Before turning to these policies, I first briefly touch upon the more general trends in global public health discourse since the 1960s, and in particular the emergence of the notion of primary health care (PHC). This will provide a historic-political platform from which from which my analysis of the 14 contemporary mental health policies can be understood.

#### *Origins of primary health care: Decolonization and nationalist movements of the 1960s*

The development of the notion of primary health care, and associated ideas of community participation and ownership, was deeply intertwined with the forces of decolonization and spread of nationalist, anti-imperialist and leftist movements during the 1960s. Within this political context, the knowledge politics underpinning the epistemological order of European modernity and colonialism were increasingly being questioned (Cueto, 2004; Walt & Vaughan, 1981; Werner and Sanders, 1997). This order had produced particular paradigms of thought, merging around a shared set of abstractions, inter alia rationalism, science, liberalism universalism, human rights, and progress.

So for example, it was a knowledge tradition in which scientific modes of thinking became crystalized as the ultimate form of rationality, the guarantor of universal truths and progress (Cooper, in press; Sardar, 1998; Turnbull, 2009); it was one in which questions of justice and morality were increasingly subsumed within the notion of human rights, with its universal and individualistic epistemological assumptions (Cooper, 2015; De Sousa Santos, 2007; Pannikar, 1984). And what was central to this epistemological order was the way in which it tended to negate its ‘others’, assuming that alternative ways of thinking and acting, which

may lie outside of its own consciousness, are ultimately illegitimate (De Sousa Santos, 2007; Sardar, 1998). The paradigm of colonial medicine was intimately entangled with this kind of thinking, characterized at least in part by the struggle between supposed 'rational' Western biomedicine and 'primitive' 'traditional' therapeutics (Vaughan, 1991; Comaroff, 1993). In its imaginary, 'Western' medicine, with its scientific rationalism and universal ethical codes, embodied the highest form of rationality and modernity, in contrast to the supposed backward and superstitious nature of 'indigenous' medical beliefs and practices.

Within the context of the liberation ferment of the 1960s and early 1970s, it was these particular paradigms that came under increased attack by international and African academics alike. Scholars of the time began to denounce the notion that in order for developing countries to act effectively upon contemporary conditions, they needed to 'catch up' with the geopolitical North, following the same trajectory of development (Walt & Vaughan, 1981). Key international health agencies and policy-thinkers began to interrogate colonial public health's preoccupation with the transmission of medico-scientific practices, and its denigration of 'other' healing epistemologies (Werner and Sanders, 1997). More and more scholars stressed the indignity of health care being 'owned' by particular groups, and the form and objectives of these systems being imposed upon populations on quasi-rational grounds (Cueto, 2004). There was thus increased talk about the 'wide and deep-seated error in the way health services are provided in developing countries', with a growing interest in new kinds of health care models, based on alternative kinds of epistemologies (Newell, 1988:904).

It was within this context that various countries within Asia and Africa starting pioneering what could be understood as 'alternative' kinds of health care initiatives, initiatives which were based upon different sorts of paradigms (Baum, 2007; Cueto, 2004; Werner and Sanders, 1997). Known as Community-Based Health Programs, these programmes were not just health initiatives, but were part of the larger anti-imperialist struggles by marginalized people for greater voice and independence. Led by groups of community health workers, these grassroots initiatives sought to address key health issues by drawing on local resources and socio-moral frames of illness and recovery. The focus was on using these understandings in ways which encouraged community ownership and participation in the development and delivery of services (Werner and Sanders, 1997). In the realm of mental health care specifically, a number of innovative initiatives began to emerge, including the 'Aro village psychiatry' programme developed by Nigerian psychiatrist and activist Thomas Lambo. Employing what he called a kind of 'methodological syncretism', Lambo's village sought to integrate different treatment modalities in innovative ways, or what he describes as an attempt to fuse the 'secrets of the spirit world' with the 'best of science' (Bass, 1994:77). Similar kinds of mental health care initiatives started emerging elsewhere in Africa during this time, including for example in Senegal, Ghana and Sudan (Alem et al., 2008).

*Alma Ata Declaration: The crystallization of primary health care*

The successes of these programmes were increasingly contrasted with the major health initiatives being instigated by US agencies and the WHO since the 1950s, initiatives which were seen to be failing to achieve their anticipated effects in the developing world (Cueto, 2004; Newell, 1988; Walt & Vaughan, 1981). The late 1960s and early 1970s was thus characterised by a rising tide of critique of, and experimentation with alternatives to, the Eurocentric paradigms of health and development which had dominated since the colonial era.

Such sentiments culminated in the now landmark international conference that took place at Alma-Ata, Kazakhstan in 1978 (WHO & UN Children's Fund, 1978). At this event, a Declaration was passed which articulated the notion of Primary Health Care (PHC), a broad philosophy for thinking about the development and delivery of health care services. This philosophy drew heavily on the ideas underpinning the Community-Based Health Programs, with their emphasis on accessibility, medical pluralism and community ownership (Baum, 2007). As defined at Alma Ata, PHC involved the provision of health care as close as possible to where people live, to be delivered by a range of epistemologically diverse practitioners. Highly critical of medical and professional elitism, the Declaration highlighted how health professionals should be responsible for describing possible interventions and their implications, but should not choose (Newell, 1988; Werner & Sanders, 1997). Rather, such interventions, should evolve from local socio-economic and political conditions, and respond to the expressed needs of the community (Schaay & Sanders, 2008). The complexities of what the Declaration was attempting to capture are exemplified by Newell (1988:905), one of the architects of primary health care:

A PHC system can still be classed as successful even if the illnesses and deaths targeted continue to occur *if* that society truly has a choice but decides to take up other priorities knowing the implications...This is completely different from the view that the targeted health priorities are an abomination because they are so easily dealt with, and it is intolerable that they should continue when effective technologies and sufficient resources exist to deal with them...The advocate of PHC will reply that even if these actions and interventions are applied and achieved, the health system may still be classed as a failure...If what results is still an oppression, does not deal with that society's priorities, and is inconsistent with the way of life and the dignity of that population, then it is not successful.

It is thus clear that the PHC paradigm had strong socio-political underpinnings, intimately linked to issues of power and voice. Questions about the form and goals of health care were primarily about the authority and ownership in knowledge-production and decision-making (Baum, 2007; Werner & Sanders, 1997). The Declaration thus represented a remarkable

moment when the dominant paradigm of colonial public health was being interrogated and new ideas, based on alternative kinds of epistemological politics and moral landscapes, were being formulated. It was also a particularly unusual moment in that its conceptual roots lay with the ideas emerging from the grassroots health care programmes of the developing world, rather than based on concepts originating from the geopolitical north. It thus represented a challenge to the global politics of knowledge making, in which social theory tends to be built on a 'one-way flow of information from the metropolises to the geopolitical peripheries' (Connell, 2007:12) or as Comaroff and Comaroff (2012:113) put it, where the 'global South' is seen as 'that half of the world about which the 'global North' spins theories'.

*The rise of neoliberalism and the corruption of primary health care*

As the 1980s unfolded, all sorts of global health initiatives were launched under the primary health care banner, with the concepts of 'community care', 'participation' and 'empowerment' now forming part of the official jargon (Werner and Sanders, 1997). In practice however, these notions tended to be stripped of their more complex and potentially revolutionary policy implications (Cueto, 2004). Considerations of power and voice that were at the heart of the original primary health care notion were increasingly placed on the periphery, with the privileging of technical service packages which could achieve measurable outcomes in the short-term (Schaay & Sanders, 2008). While community-involvement and health worker diversity was encouraged, the focus was increasingly on training and education in order to make the delivery of services possible (Baum, 2007; Werner & Sanders, 1997). Contemporary global mental health initiatives appear to be no exception. Although global mental health discourse and practice consistently refers to the need for greater community involvement, in reality, their role tends to be that of assisting in the implementation of an externally imposed medico-scientific and human rights agenda (Campbell and Burgess, 2012; Mills and Fernando, 2014).

It is pertinent to ask why the concept of PHC was so quickly undermined, particularly in light of the fervent tide of radical thinking of the 1960s in which it arose. According to Werner and Sanders (1997:19) the revolutionary nature of the Alma Ata was unlikely to sit comfortably with global power structures, including the public health establishment, 'who for so long had maintained a powerful monopoly on the knowledge and power of healing'. Furthermore, almost immediately after Alma Ata, the global economic boom of the 1960s started receding, with the 1980s bringing about a combination of global recession, suffocating foreign debt and worsening poverty. This situation saw the emergence of a new political context dominated by more conservative, neoliberal ideas, heavily informed by European modernist thinkers (Castells, 2001; Pillay, 2003). Led by the examples of Thatcher and Reagan, the focus became on rationalizing public systems and developing clearly definable targets which would minimize costs and maximize outputs in the short-term (Castells, 2001; Sanders et al., 2008).

Such thinking very quickly spread to the developing world by the US-dominated IMF and World Bank as conditions for loans, loans which by now many developing countries were dependent upon (Castells, 2001; Pillay, 2003). And as the 1990s unfolded, and continuing into the present, these international financial agencies have played an increasingly powerful role in directing health care systems in developing nations (Baum, 2007; Cueto, 2004). Within this climate, the anti-imperialist and leftist sentiments of the 1960s have increasingly waned. And Alma Ata has ultimately proved incompatible with this ascendance of neoliberal ideas.

### **The national mental health policies**

In light of these trends in global public health discourse, I now turn to the national mental health policies emerging from 14 African countries. Looking at these policies as a whole, they appear to all follow a very similar format, beginning with a socio-demographic description of the country, followed by an account of the national health care system. Thereafter, an epidemiological profile of mental illness in the country is commonly provided, where after a detailed summary of the national mental health system is given. This summary, somewhat mechanistic and technocratic, includes inter alia, information on current national mental health legislation; details around financial and human resources dedicated to mental health; descriptions of national mental health administration arrangements, service organizations and management structures; and information on mental health training programmes and research activities in the country.

Having provided this background, all of the policies then go on to unpack their vision, outlining the specific values, goals and action strategies being endorsed. Here, all 14 policies state that a primary health care approach will be adopted. Thereafter, the focus is on elucidating how such a model of care will be developed on a national scale. In such accounts, the rhetoric of community participation and empowerment appears most explicitly. And yet when one looks more closely at the descriptions of these notions, they emerge as essentially matters of education and training in ‘appropriate’ kinds of knowledge and ‘proper’ sorts of treatment. And conceptualisations of ‘appropriate’ materialise as based on two main criteria: those of evidence-based knowledge/practices and human rights. How do these ideas play out within the policies?

#### *Explicit endorsement of primary health care, community ownership and local empowerment*

All 14 policies state explicitly that the overarching policy framework is the primary health care approach. For example, South Africa’s (9) policy states: ‘In line with the values of the Alma Ata Declaration...this document sets out the provisions of a mental health

system...based on primary health care principles'. Similarly, Uganda's policy (2) highlights how 'The Alma Ata Declaration and subsequent WHO recommendations have provided the guiding philosophy for the development of this policy'. Echoes are present across the 14 policies, where it is emphasized that 'the guiding principle of this policy' (Tanzania: 4) or 'the underpinning philosophy for the development of this policy' (Liberia: 2) is 'the primary health care strategy' (Tanzania:4; Zimbabwe: 5), 'a primary health model of care' (Lesotho: 27; Liberia: 32), 'primary health care system' (Ethiopia: 2; Namibia: 9; Sierra Leone: 6) and one which 'promotes community mental health at the grassroots-level' (Rwanda :4). Across the policies, it is emphasized that this approach is 'the most viable way of closing the huge treatment gap' (Lesotho: 27; Sierra Leone: 6), 'the best way to address the large mental health treatment gap' (Liberia:32;Namibia:12) and 'will address the mental health access gap that currently exists in the country'(Nigeria: 2).

Many of the policies provide a formal definition of a PHC approach, where the ideas of community involvement and ownership feature most prominently. It is ascertained that such a framework of care is 'an approach to the delivery of services which emphasizes decentralization and community participation' (Zambia: 14) or prioritises 'community involvement and participation' (Liberia: 7; Namibia: 2; Uganda: 13). It is emphasized that PHC 'refers to care which is based on the needs of the population...and requires the active participation of the community and family' (Ethiopia: 17) and necessitates the 'decentralization of mental health care, allowing for more participatory decision making...including the engagement of consumers and family members' (Gambia: 8).

Much attention is placed on further unpacking these particular ideas, with all 14 policies containing a relatively large section, variously entitled 'Community Involvement and Participation'. Here a wide range of different groups residing within the community are outlined, and descriptions are provided on how these various groups should be empowered to participate in the development and delivery of mental health services. For example, comments such as these are ubiquitous across the policies: 'Encourage active collaboration between all sectors involved in mental health, including strong community participation in mental health'(Namibia: 10), 'People with mental disorders and their families must be empowered and actively involved in the design, implementation and evaluation of mental health services'(Sierra Leone: 10); 'Mental health care users should be involved in the planning, delivery and evaluation of mental health services (South Africa: 21); and 'Community involvement and participation are paramount in the success of mental health care delivery (Zimbabwe: 7).

*Beneath the primary health care rhetoric: A focus on education and training*

When looking more closely at descriptions of empowerment and participation, however, there seems to be very little real influence and genuine authority on the part of the

community. For example, Gambia's(20) policy states [my emphasis]: 'Many people have very little *knowledge* about mental disorders and are *unaware* of the availability of simple and effective preventive, treatment and rehabilitative measures'. The policy then provides the following bulleted set of 'action strategies' (my emphases):

- Families of people with mental disorders should be considered as partners in mental health care and therefore actively participate in it, being *educated* and *trained*;
- Individuals with mental disorders, families and communities should be participants in mental health education programs;
- Media will be engaged to *promote awareness* and the active participation of the community

In a similar way, within in Uganda's (16) policy, under the policy goal 'To promote and strengthen the involvement and participation of all stakeholders in mental, neurological and substance abuse control services', the following bulleted points are listed [my emphases]:

- Develop initiatives aimed at *raising public awareness* about mental and neurological health, and substance abuse problems;
- Carry out *community sensitization* about mental, neurological and substance abuse
- Develop Information, Education and Communication materials...to *create awareness* of neurological and substance abuse

Analogous sentiments are contained in Liberia's (31) policy, where the under the heading 'Community involvement and participation' the following are stated:

- The mentally ill and their families will be engaged and consulted when designing programs
- There will be *education* for families and mentally ill patients about the nature, care and suitable treatment options for mental diseases
- Teachers will be *educated*, so they can provide social skills training and rudimentary counselling in their schools;
- There will be public *awareness programs* to *sensitize* the community

In a similar manner, having spoken about the necessity of facilitating 'active community participation', Zambia's (9) policy goes on to describe in detail how 'The Government shall therefore encourage use of *mass media and advertising strategies* to place mental health on the community health agenda', while Zimbabwe's (7) policy asserts that 'It is hoped that as the public becomes *more informed*, this will result in an *empowerment process* whereby members of the community will appreciate their role in the promotion of mental health and the prevention of mental illness'. Relatedly, Rwanda's (15) policy talks about the need to

‘involve the community more’ and ‘ensure that the community becomes responsible for mental health care’ and that ‘*information* dissemination and community *sensitization* will be promoted in this regard’.

Numerous similar examples could be provided in this regard. The point is that within the section on ‘community participation and ownership’, the focus for all 14 policies is on unpacking the development and implementation of ‘education programmes’, ‘awareness-raising strategies’ and ‘mass media campaigns’. As such, ‘ownership’ and ‘empowerment’ seems to be envisioned as essentially that of informing people about the supposed ‘true’ nature of mental illness and ‘appropriate’ forms of treatment.

Within discussion on community participation and ownership, ‘traditional’ healers, as a particular group within the community, seem to receive a significant amount of attention. According to all 14 policies, ‘traditional’ healers are widely consulted by people with mental disorders and their families, with ubiquitous statements that ‘traditional healers are commonly the first points of contact for many people with mental disorders’ (Gambia: 35; Uganda: 15), ‘are currently the first point of contact for most people who develop a mental health problem’ (Lesotho: 11; Nigeria: 14) and ‘are usually consulted by people with mental health problems before they seek help from conventional health practitioners’ (Zambia: 5).

Having highlighted the widespread use of traditional healers, it is thereafter commonly asserted that collaboration with such healers is essential. Bold statements such as these are common across the policies: ‘Traditional healers...will be involved in prevention, detection, rehabilitation and social inclusion of persons with mental illness’ (Ethiopia: 19); ‘Traditional healers should be involved in the care of people with mental disorders, in collaboration with formal mental health care system’ (Gambia: 7; Lesotho: 17) or as Sierra Leone’s (11) policies unambiguously asserts, ‘Collaboration with traditional healers will be a priority’.

And yet once again, these notions of collaboration and involvement emerge as essentially matters of education and training. For example, according to Nigeria’s (7) policy (my emphasis):

Dialogue and exchange of ideas may be helpful, (within the context of the overall Governmental approach to *regulate* traditional health practitioners and encourage professional standards and accountability) with a view to exploring the possibility of collaborative ways of working which may eventually include the use of *diagnostic algorithms* by traditional healers to assist them in making *appropriate referrals*.

Such sentiments aptly capture dominant conceptualisations of what ‘involvement’ and ‘collaboration’ with traditional healers might entail. For example Liberia’s (71) policy emphasizes how ‘Along with Community health workers...traditional healers will be

encouraged to participate in seminars and workshops about *the recognition* of psychiatric disorders', while Ethiopia's (24) policy highlights how 'traditional healers, who account for a significant extent of mental health care, will be *sensitized* and *trained* to improve their skills and services'. Relatedly, when talking about the 'need to involve the community more' in the provision of mental health care, Rwanda's policy (14) asserts that it is necessary to 'define dialogue mechanisms with traditional-practitioners to establish contact with the aim of ensuring *complementarity* and to *mitigate charlatanism*'. In a similar manner, Gambia's (35/36) policy describes an initiative introduced by the MoH that sought to 'collaborate' with traditional healers. The policy explains, 'Essentially traditional healers, through the program are introduced to *modern* medications and treatment methods'. The policy concludes by emphasizing that the programme has been 'extremely successful', with 'improved *awareness* and *knowledge* about mental disorders...and their *appropriate* treatment amongst traditional healers.

It is therefore clear that beneath the bold rhetoric, the ideas of community 'involvement', 'ownership' and 'empowerment' seem to lack any real and meaningful substance, with very little genuine attempt to understand and respond to the experiences and understandings of local peoples, on their own terms. Rather, these notions emerge primarily as matters of education and training across the 14 policies. As such, the policies seem unable to know patients and their families as anything but ignorant, and in need of psychoeducation in 'proper' knowledge. They seem unable to conceive of 'traditional' healers as anything other than in need of training in 'appropriate' forms of diagnosis and treatment. And as the policies unfold further, it becomes clear that what are conceived of as 'appropriate' forms of care, are those which are based solely and unequivocally on two kinds of paradigms: those of evidence-based knowledge/practice and international human rights standards.

### *Evidence-based knowledge/practice*

The idea of evidence-based knowledge/practice permeates the policies, centrally embedded within a variety of topics addressed by the policies. For example, the following kinds of statements are ubiquitous across the policies: 'It is vital that service delivery is evidenced-based'(Zambia: 12), 'practice must be based on scientific evidence ...and adapted to scientific evolution in the field of mental health' (Rwanda: 17), 'The MoH is committed to the provision of evidence-based care'(Nigeria: 2), 'Mental health services should offer a range of interventions in keeping with evidence-based care'(Namibia: 9), 'the highest quality services will be provided in accordance with the best evidence-based medicine'(Liberia: 29) and that 'services shall reflect the highest standard possible according to current scientific knowledge'(Gambia: 6; Uganda: 13). Indeed, the following verbatim statement appears in Lesotho's (22), Sierra Leone's (19) and Gambia's (12) policy: 'High quality care means that the latest evidence-based interventions are provided for mental health at all service levels'.

Ensuring that ‘the latest evidence-based interventions’ are provided, requires according to the policies, that services are developed primarily through ‘a decision-making process for which there is consistent scientific evidence showing that a particular approach will improve outcomes’ (Liberia: 11; Namibia: 2), or as Ethiopia’s (19), Liberia’s (31) and Zimbabwe’s (6) policies state verbatim: ‘Scientific evidence will inform decisions for services and interventions’. Similarly, Gambia’s (7) policy emphasises how ‘Scientifically validated evidence is the primary source of information used to inform decision-making for services’.

For the policies, not only should services be *developed* through evidence-based procedures, they should also be *delivered* through ‘evidence-based’ protocols. Indeed, many of the policies place considerable attention on the development and subsequent training of health care workers in ‘evidence based guidelines’ (Ethiopia: 12; Nigeria: 11; South Africa: 20; Uganda: 5) or ‘evidenced-based protocols’ (Gambia: 10) or ‘evidenced-based tools’ (Rwanda: 13) or ‘evidenced-based treatment guidelines, protocols and standard operating’ (Sierra Leone: 9). For example, Nigeria’s (5) policy explains:

Good practice guidelines are an invaluable adjunct to improving care and establishment of good practice at all times...Evidence based guidelines for both primary care and specialist sectors shall be prepared

In a similar manner, having spoken about the concept of ‘local autonomy’, whereby ‘the planning, delivery and management of mental health services should be decentralised to local, community levels’, Lesotho’s policy(22/23) explains:

Clinical protocols will be developed and extended to all sectors to enable staff to deliver appropriate evidence-based interventions...These protocols will apply to all levels of care...Once the clinical protocols have been established, all health service staff will be trained and oriented in the use of these protocols for routine service delivery.

In addition to services needing to be developed and delivered through ‘evidence-based’ practices, ensuring the provision of ‘evidence-based interventions’ also appears to require consistent monitoring and evaluating through evidence-based procedures. As Sierra Leone’s (19) policy states:

High quality care means that the latest evidenced-based interventions are provided for mental health services at all service levels. It also refers to a quality improvement monitoring mechanism...Care protocols and basic quality standards for services will therefore be developed at all levels of care.

This statement reflects the common view across the 14 policies, where it is highlighted that evidence-based monitoring and evaluation procedures are the ‘lifeblood of an effective mental health service’ (Lesotho: 19), and are ‘essential for the ongoing delivery of evidence-based services’ (Ethiopia: 4). In fact, all of the policies contain a relatively large section, variously entitled ‘Monitoring and Evaluation’. Here, meticulous details are provided on what such monitoring and evaluation should entail, essentially that of defining and collecting standardized mental health indicators and using these ‘for a continuous process of service measurement and improvement’ (Liberia: 66). For example, Lesotho’s (22) policy states:

It is essential that the quality of mental health services is improved and maintained...Towards this end, national standards for mental health will be developed...facilities will be regularly reviewed, assessed and accredited, using these quality standards...The mental health competencies of all health care staff need to be assessed, using the standards.

In a similar fashion, Gambia’s (13) policy explains how:

Ongoing validation of services and interventions should be implemented and used to refine services and interventions...and inform evidence-based decisions....

It is thus clear that the notion of ‘evidenced-based’ knowledge/practice emerges across the policies as central to what it means for services to be ‘appropriate’ and of a ‘high quality’. According to the policies, services should be *developed* through evidence-based decision-making processes, should be *delivered* by health care workers trained in evidence-based clinical protocols and should be consistently *monitored* through evidence-based procedures of standardization and measurement. Ultimately, ‘appropriate’ care is essentially ‘evidence-based’ care.

Although this notion of evidence-based knowledge/practice takes on a kind of self-evident quality within the policies, it is in fact underpinned by several, somewhat contentious epistemologies. Elsewhere, I (Cooper, 2015) and others (Bemme & D’souza, 2014; De Sousa Santos, 2007; Ingleby, 2014; Sardar, 1998; White & Sashidharan, 2014) have problematized the paradigm of evidence-based knowledge/practice in considerable detail. In summary, this paradigm is underpinned by a set of now well-known positivist assumptions, with an emphasis on empiricism, rationalism and value-free enquiry. That is, it assumes that the world can be objectively and incontrovertibly known through the principles and methods of science, and in particular, a well-designed randomized clinical trial. Put differently, it is assumed that knowledge which is valid and meaningful includes *only* those aspects of ‘reality’ which are directly observable and measurable as tangible indicators and outcomes.

These kinds of assumptions are deeply rooted within the epistemological order of Western modernity, and associated colonial public health discourse. As I have been emphasizing, the thinking space of Western modernity was characterized by a strong commitment to science, with conceptions of ‘truth’ and ‘validity’ increasingly governed by the principles of science. Deeply entangled with this order, colonial public health discourse tended to promote *only* those forms of care based on scientific theories and practices, with the denigration of other kinds of treatment modalities, based on alternative kinds of epistemologies (Vaughan 1991; Comaroff, 1993).

Thus, through their ubiquitous endorsement of evidence-based care, the policies reproduce the assumption that the *only* appropriate kinds of services are those which are based on scientific evidence. In other words, service development decisions, treatment delivery practices and care evaluation procedures are understood as valid *only* insofar as they are informed by a scientific rationalism. As a consequence, other potentially meaningful ways of knowing and being, which may lie outside of scientific metaphysical realities, are automatically delegitimized and disavowed within the national policies.

All of this is not to suggest that scientific knowledge and practices are unimportant or not potentially meaningful. Indeed, the tremendous advantages coming out of industry, medicine, and technology in many African countries could not have occurred without scientific procedures (Latour, 1999). In addition, this is not an argument against the importance of evaluation and accountability in service provision. Indeed, the ways in which mental health services globally have often led to abuse and neglect, as much as to care, is a very frightening reality (Demyttenaere, 2004).

What is being problematized here, however, is the way the current evidence-based edifice, in which the policies are inserted, assumes that only *certain* kinds of knowledges, and only *particular* sorts of evaluative practices are legitimate. Ultimately, the policies are implying that very little of value can be known outside of the metacodes of science, indeed one of the great enchantments of the modernist/colonial epistemological order (De Sousa Santos, 2007; Sardar, 1998). The question is then, what alternative sorts of knowledges and practices, which may not be based on scientific rationalism, but which may be important to service users and their families, are being silenced? How might these ‘other’ understandings and ways of being, change the way in which ‘appropriate’ kinds of services are conceptualised, developed and assessed?

### *Human rights*

Constructions of appropriate services within the policies appear to be based on another, interrelated paradigm, that of human rights. Across all of the policies, it is explicitly stated

that the development and delivery of services should be consistent with human rights standards. More specifically, seven of 14 policies indicate that the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) should be used as the guiding framework in this regard. Indeed, statements such as these are scattered across the 14 policies: ‘services will uphold and protect the human rights of people with mental disorders’ (Lesotho: 16), people should be ‘cared for...with due regard to their rights as human beings’ (Nigeria: 5); ‘treatment will be consistent with international conventions on human rights’ (Ethiopia: 20, Liberia: 29); or ‘as laid out in international human rights conventions’ (Lesotho:16).

After indicating that services should be in line with international human rights standards, the policies tend to provide a long list specifying which particular rights should be promoted and upheld by mental health services. These lists appear almost as blueprints of the rights outlined by the UNCRPD, including exhaustively, but variously phrased: the right to be treated in the least restrictive environment, rights related to involuntary admission, rights related to seclusion and restraint, and rights to confidentiality, informed-consent, non-discrimination, privacy, and autonomy. For example, the follow excerpt comes from Sierra Leone’s (15) policy, which aptly reflects the common way in which human rights features in the policies:

Treatment should promote and respect the human rights of people with mental disorders...People with mental health problems and their families must be informed about their treatment and rehabilitation and must have liberty to give consent to their care...Clinical guidelines including confidentiality issues and informed consent...will therefore be developed.

Another example comes from Gambia’s (6) policy, again pertinently capturing dominant policy sentiments:

People with mental disorders should enjoy full human rights...Mental health treatment and care should promote and protect the autonomy and liberty of people with mental disorders...People with mental disorders have the right to be treated in the most effective least restrictive and least intrusive manner...Care delivered to people with mental disorders should be strictly confidential.

And a further illustration from Liberia’s (30) policy:

Treatment will be consistent with international conventions on human rights...This will include the right to essential and appropriate mental health care; treatment will promote autonomy and not be custodial; the seriously mentally ill will be treated in a

safe and the least restrictive environment; the use of physical restraints will be discouraged; confidentiality will always be upheld and adhered to.

Numerous similar examples could be provided. The point is, for the policies, 'appropriate' forms of care are essentially those which are based on human rights codes and in particular, the principles of 'autonomy', 'liberty', and 'privacy'. In discussions around human rights, many of the policies acknowledge that there are diverse understandings of, and healing modalities for, mental illness. However, it is stressed that these should be tolerated only if they are in line with human rights standards, or as South Africa's (20/21) policies puts it, 'There are varying cultural expressions and interpretations of mental illness, which should be respected, insofar as they protect the human rights of the mentally ill'.

Through its emancipatory rhetoric, promoting the ideals of freedom, privacy and choice, human rights discourse is generally accepted as a good thing. If we move beneath face-value understandings, however, like the paradigm of 'evidence-based knowledge/practice', human rights discourse is also underpinned by several polemical knowledge assumptions. And these epistemologies are deeply inserted within a modernist/colonial thinking space. In its theoretical origins and embodiment within contemporary international conventions, the paradigm of human rights tends to assume a universality of human nature (De Sousa Santos et al., 2007; Pannikar, 1984). That is, one which is endowed with universal dignity and knowable by an equally universal organ of knowledge, that of rationality. Human rights discourse also has a strong individualistic undertone, with the assumption that human beings are essentially individual, autonomous entities (Sardar, 1998). This set of assumptions is succinctly captured by postcolonial scholars De Sousa Santos et al. (2007:13):

The concept of human rights is based on a well-known set of presuppositions, all of which are distinctly Western and liberal in origin, namely: there is a universal human nature that can be known by rational means; human nature is essentially different from and higher than the rest of reality; the individual has an absolute and irreducible dignity... the autonomy of the individual requires that society be organized in a non-hierarchical way, as a sum of free individuals.

A human rights paradigm is thus underpinned by very particular assumptions about personhood and dignity, and how they can be known. However, these understandings may not be universally shared. In fact a large body of critical social research in Africa, including in relation to mental health, has demonstrated that understandings of human dignity and morality, and by extension a 'human', are considerably varied and diverse (e.g. Engelke, 1999; Englund, 2000; Mamdani, 2000; Sardar, 1998). Such research has revealed, for example, that for many people in Africa, selfhood and dignity are understood as conditions which are acquired, rather than 'given', and thus place great value on the gradual social maturation of people as constantly evolving. Relatedly, in such circumstances, personhood is

frequently recognised as deeply intertwined with the spiritual, the corporeal, and the social community, rather than about an autonomous individual. Ultimately, this research has revealed that attempts to bring about social justice through the utilization of human rights rhetoric have frequently been unsuccessful as they are incompatible with locally relevant meanings and value hierarchies.

To be sure, my argument is not one of relativism, a kind of ‘anything goes’. Forms of care that respect and dignify people with mental disability are worthy ideals. But what is ‘respectful’ and what enhances ‘dignity’ are not as self-evident as the notion of human rights would have us believe. Ultimately, human rights discourse does not belong to the realm of morality per se, but rather reflects a particular *political* morality that may not be shared by everyone, everywhere. Through its underpinning assumptions however, the notion of human rights is able to gain a universal force that is unconditional. Consequently, ‘other’ ways of making commensurate demands for dignity and justice, which may be formulated in different languages of entitlement, are ultimately marginalized by the paradigm of human rights. Indeed, as Englund (2000: 579) so pertinently concludes from his analysis of human rights discourse in Malawi, ‘Human rights talk ... threatens to overshadow other ways of conceiving human dignity ... by attributing legitimacy to specific moral notions, thereby defining the contours of what is not only acceptable but also conceivable’.

As exemplified in the national mental health policies, *only* those kinds of services which are based on international human rights standards, and in particular the inherently individualistic and liberal codes of ‘autonomy’, ‘liberty’ and ‘privacy’ are deemed ‘appropriate’. The slippery issues of dignity and justice are therefore decontextualized, and engaged with in a ‘one-size-fits-all’ manner by the policies. As a consequence, alternative kinds of values and moral systems, which may not be in accordance with international human rights standards, but which may be important to service users and their families, are ultimately silenced by the policies. And these ‘other’ understandings of justice and dignity might fundamentally change the way in which ‘appropriate’ kinds of services are conceived of and evaluated.

## **Conclusions**

In this paper I have argued that the 1960s represented an extraordinary moment in history when the hegemonic paradigms of the health care professions were being interrogated, and alternatives were being sought. It was out of this context that the concept of primary health care (PHC) arose, one which was based on other kinds of epistemologies and moral landscapes to those that had dominated since the colonial era. Sadly however, the emergence of PHC can be understood as representing only a brief, and primarily, rhetorical disruption to the colonial public health paradigm. Since the 1980s, it has been taken up and promoted in ways which scarcely resemble its original formulations. In this paper I have demonstrated

how national policy thinking around reducing the ‘gap’ in mental health care in Africa appears to be strongly in line within this trend.

I have shown how although formally espousing a grassroots, primary health care approach to service development and delivery, in reality, the policies achieve the opposite: the marginalization of local values and meanings and the endorsement of a top-down framework of care heavily informed by the knowledge politics of colonial medicine. In particular, the paradigms of evidence-based research and individualised human rights become the gatekeepers of knowledge within the policies. These legislate as to what are legitimate forms of knowing, and by extension, valid forms of care. Such thinking appears to share much with contemporary global mental health discourse where, as Vikram Patel (2014:10), one of the key architects of the movement for global mental health unequivocally states, ‘While there must always be space for discourse and conflicting ideas, these must be based firmly on an equal commitment to science and to the right of people who are demonstrably unwell to receive care’ (see also Global Mental Health Group, 2007; Mari and Thornicroft, 2010). Ultimately, intimately entangled with these global mental health sentiments, the policies end up reproducing many of the very Eurocentric epistemologies that the PHC concept, in its original formulation, sought to transcend.

This has very real consequences in relation to the ‘gap’ in treatment which the policies are seeking to address. The policies might find that when the services being promoted are implemented, they still remain underutilized. Indeed, a growing body of epidemiological research is showing that despite government-funded mental health services becoming more available in Africa, they are still considerably underutilised on the continent (Kohn et al., 2004; Demyttenaere, 2004). As I have suggested elsewhere (Cooper, in press), might such low levels of service uptake point to a potential disconnect between dominant constructions of ‘appropriate’ services, and the common ways of life and forms of meaning-making that prevail within the community? Might the high usage of ‘traditional’ healers, which all of the policies emphasise, be not because people are ‘ignorant’, but because the care provided by such healers are valuable to those who access them? Ultimately, might, as suggested by Ecks (2009), the whole ‘gap’ in treatment be conceptualised differently if ‘other’ social resources and ‘alternative’ forms of healing were better seen and appreciated by the policies?

All of this suggests that rather than ‘educating’ and ‘sensitising’ people in biomedical science and international human rights discourse, mental health policies might benefit from encouraging a better appreciation of, and more appropriate service response to, the values and priorities of those they are attempting to help. Similarly, rather than ‘training’ traditional healers in the supposedly ‘correct’ approaches to treatment, the policies might profit from fostering a greater understanding and recognition of ‘other’ healing epistemologies. Importantly, this does not translate into testing the practices of ‘alternative’ healers with scientific methods associated with objectivity and scientific protocols, including clinical

trials. This approach is becoming a growing trend within the developing world in an attempt to establish collaboration between ‘biomedical’ practitioners and ‘traditional’ healers (Lang, 2014; Levine, 2012; Turnbull, 2009). Such initiatives have indeed been described as a kind of ‘Randomized Controlled Crime’, as ‘alternative’ healing systems are tolerated only so long as they can be shown to have a scientific basis (Adams, 2002:679).

As such, what might be required is that policies rethink how diverse forms of meaning-making and the ways of treating mental illness might be potentially legitimised on their own terms, and within their own metaphysical worlds. This is not an easy task, one which raises all sorts of slippery epistemological questions around how medical evidence is produced and legitimised (Levine, 2012). These kinds of questions need to be opened up for further consideration and debate within the policy arena.

These sorts of questions were indeed exactly what Nigerian psychiatrist and activist Adeoye Lambo was grappling with when he pioneered his innovative ‘Aro village psychiatry’ programme. Warning African psychiatrists about the dangers of implementing a ‘borrowed remedy’, Lambo (cited in Bass, 1994:69) emphasised that ‘Just as there is no one single religion, so too is there no one single way to practice medicine. There are many medicines’. And according to Lambo, the best ‘practices of medicines’ are those which are intimately entangled with local realities, lexicons and matrixes and properly respond to such contexts, whatever the setting. This vision of Lambo’s was precisely what the original PHC concept was trying to capture. As such, it might offer a potentially productive terrain of engagement for thinking about the development of more contextually-embedded and epistemologically appropriate mental health care policies in Africa. Ultimately, this might go some way towards reducing the current ‘gap’ in mental health care treatment so many countries on the continent face.

This paper is most certainly aware of the dangers of representing Africa as dependent borrowers and dupes of western systems. However, the key argument still holds: that mental health policy-thinking on the continent is deeply intertwined with strong epistemic power relations and economic forces operating on a global scale. Indeed, I had not intended, initially, to present my examination of the 14 policies together as a single analysis. And yet delving into these policies, I was again and again surprised by the large degree of homogeneity between them, with so many statements frequently appearing verbatim across the policies. I was also constantly struck by how similar the policies were to global mental health discourse, in many ways embodying a kind of blue-print of the policy recommendations that are being advocated within the international arena (see for example Mari & Thornicroft, 2010; Patel & Eaton, 2010; WHO, 2003).

This uniformity raises all sorts of questions around exactly whose voices are being reflected and whose interests are embodied in these policies. My difficulties in obtaining the policies,

and related unawareness of the existence of their own national mental health policy by so many Ministries of Health, raise further questions around how these policies were developed and whose opinions they might reflect. I can only speculate on these kinds of questions here. The point is that local Governments on the continent may have somewhat limited power in directing the nature of their own national mental health policies, and might ultimately be constrained in their ability to promote alternative models of mental health care. However, to end on a more positive note with the words of Adeoye Lambo (1960:1703), who in the emancipatory spirit of the 1960s stressed, ‘It is no easy matter, but we are getting more and more convinced that an independent diagnosis of our position may prove more profitable in the end than a borrowed remedy’.

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