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ARTICLE

Negotiating South–South cooperation for mental health: the World Health Organization and the African Mental Health Action Group, 1970s–90s

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Abstract

This article explores the African Mental Health Action Group (AMHAG), one of the earliest examples of the World Health Organization's (WHO) attempts to promote 'ownership' over development through the South–South cooperation envisaged in Technical Cooperation in Developing Countries. Formed in 1978, the AMHAG was intended to guide national and regional policy on mental health, while also fostering national and collective self-reliance. For a short period, between the late 1970s and the early 1990s, it was central to the WHO's strategy for promoting policies of mental health in primary healthcare in Africa. It was a largely ineffective tool, with national governments having different opinions on the value of mental health, and poor coordination between AMHAG countries. Approaching the AMHAG as a regional project and transnational network, however, the article provides explores the importance of regions and regionalism in international health cooperation, as well as the inequities of participation in health development. Drawing on WHO archival material spanning over twenty countries and two national liberation movements, it argues that participating countries were differently positioned not only to navigate relationships between countries, but also to contend with the shifting landscape of international assistance, as well as – for some – contexts of war, violence and political and economic instability. The article not only serves as a case study of power imbalances in a failed development initiative, but also sheds light on the WHO's engagement with mental health during a period that historians of psychiatry in Africa have tended to overlook.

Keywords: World Health Organization; South–South cooperation; Mental health; Psychiatry; Development; Africa

In May 1978, government representatives from seven African countries met at the World Health Organization (WHO) headquarters, Geneva, for the first meeting of the African Mental Health Action Group (AMHAG). As the cornerstone of a new Special Programme of Technical Cooperation on Mental Health, the AMHAG was to serve as a forum to facilitate knowledge sharing, to agree priorities for inter-country action and strategy, and to advise the WHO on additional development needs.[1] The AMHAG represented one of the WHO's earliest attempts to promote technical cooperation among developing countries (TCDC). This model of United Nations (UN) managed South–South cooperation reflected the ideological and economic solidarity that underpinned the creation of the Group of 77 (G-77) developing countries and demands for a New International Economic Order (NIEO), as well as a conviction that developing countries shared histories and challenges that would be better addressed by regional approaches and solutions.[2] In the case of the AMHAG, TCDC was additionally tied to regional and

[1]World Health Organization Archives, Geneva (hereafter WHO), M4/370/15 Jkt 1, f. 26c, 'Special Programme of Technical Cooperation in Mental Health in Southern African Countries: Plan of Action by the WHO Secretariat for the African Mental Health Action Group, Geneva, 12 May 1978'.

[2]The Buenos Aires Plan of Action for Promoting and Implementing Technical Cooperation among Developing Countries (BAPA), adopted by the UN in 1978, enshrined these principles of national and collective self-reliance in TCDC, and set out a

international responses to the situation in southern Africa, in which the 'burden of general economic underdevelopment was aggravated by the sufferings endured by the population in their struggle to eliminate the last vestiges of racial discrimination on the continent'.[3] Founding member countries had made a moral and a medical case for action, describing the strain refugees fleeing minority-white rule and apartheid placed on already stretched and underdeveloped mental healthcare services. As C.M. Mwananshiku, Zambia's Minister of Health, stressed in May 1977, 'The apartheid policy with its numerous evil connotations…creates unnecessary man-made health problems, the very opposite of what we in the World Health Organization seek to achieve'.[4]

This article traces the history of the AMHAG and the wider circumstances that shaped the possibilities and limits of WHO-managed South–South cooperation on mental health in Africa between the late 1970s and the early 1990s. South–South cooperation has been underhistoricised in the literature, with regionalism and regional protagonists often overshadowed by internationalism and nationalism as ways of conceptualising international health cooperation.[5] Yet the exchange of expertise, technology, personnel and financing between countries in what is currently referred to as the global South further highlights the multifaceted nature of the cooperation label and what it serves to justify, as well as the ways cooperation initiatives could occlude the importance of power imbalances. One of the historical precursors to TCDC, the Commission for Technical Co-operation in Africa (CCTA) was set up following the Second World War as an institution for inter-imperial cooperation, geared at reducing UN 'interference' in colonial affairs and maintaining control over regional development.[6] The AMHAG, like other TCDC initiatives, was by contrast framed as a way of breaking away from neo-colonialism, instead fully harnessing the 'capacities and potentialities' of 'local' personnel in the development process.[7] However, AMHAG countries had to negotiate multiple layers of cooperation: they were not only regarded as repositories of direct experience that could be mobilised as expertise in the development of regional and ultimately international communities of practice on mental health, but also considered to be participant-recipients of global North WHO and donor-managed bilateral cooperation. As this article shows, participating countries were differently positioned not only to navigate relationship between countries, but also to contend with the WHO's own organisational priorities and budgetary constraints, shifting donor priorities and the political and economic impact of structural adjustment policies (SAPs).

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blueprint for change in approaches to development assistance. UNDP, *The Buenos Aires Plan of Action* (Special Unit for TCDC; New York: United Nations Development Programme, 1994). On the NIEO see especially: Nils Gilman, 'The New International Economic Order: A Reintroduction', *Humanity*, 6, 1 (2015), 1–16; Priya Lal, 'African Socialism and the Limits of Global Familyhood: Tanzania and the New International Economic Order in Sub-Saharan Africa', *Humanity*, 6, 1 (2015), 17–31; Daniel J. Whelan, '"Under the Aegis of Man": The Right to Development and the Origins of the New International Economic Order', *Humanity*, 6, 1 (2015), 93–108. On the ways this reflected wider contexts of decolonisation and self-determination, see especially: N'Dri Therese Assie-Lumumba, 'Behind and beyond Bandung: Historical and Forward-Looking Reflections on South–South Cooperation', *Bandung: Journal of the Global South*, 2, 1 (2015), 1–10.

[3]World Health Assembly (hereafter WHA) 30, Verbatim Records of Plenary Meetings: Summary Records and Reports of Committees, Thirtieth World Health Assembly, 2–19 May 1977, Official Records of the World Health Organization, No. 241, Part II, 481.

[4]*Ibid.*, 64.

[5]Exceptions here include: Sunil S. Amrith, *Decolonizing International Health: India and Southeast Asia, 1930–65* (Basingstoke: Palgrave Macmillan, 2006); Anne-Emanuelle Birn, Carles Muntaner and Zabia Afzal, 'South–South Cooperation in Health: Bringing in Theory, Politics, History, and Social Justice', *Cadernos de Saúde Pública*, 33, Suppl. 2 (2017), S37–52; Monica Saavedra, 'Politics and Health at the WHO Regional Office for South East Asia: The Case of Portuguese India, 1949–61', *Medical History*, 61, 3 (2017), 380–400; John M. Kirk, *Healthcare Without Borders: Understanding Cuban Medical Internationalism* (Gainesville: University Press of Florida, 2015); Francisco Sagasti, *Rethinking Technical Cooperation among Developing Countries (TCDC) and South–South Cooperation (SSC): An Issues Paper* (New York: South–South Cooperation Office, UNDP, 2006).

[6]Philip J. Havik, 'Regional Cooperation and Health Diplomacy in Africa: From Intra-Colonial Exchanges to Multilateral Health Institutions', *História, Ciências, Saúde-Manguinhos*, 27, Suppl. 1 (2020), 123–44; Jessica Pearson-Patel, 'Promoting Health, Protecting Empire: Inter-Colonial Medical Cooperation in Postwar Africa', *Monde(s)*, 7 (2015), 213–30.

[7]WHO Executive Board (hereafter EB), Sixtieth Session, Provisional agenda item 16, *Technical Cooperation Among Developing Countries: Report by the Director-General*, EB60/7, 16 May 1977 (Geneva: World Health Organization, 1977).

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As a result, participation at times not only intensified feelings of resentment and mistrust, but also saw the AMHAG, as a project that emerged within a distinct social and political context, side-step more difficult questions about the mental health and psychosocial implications of apartheid, migration and war.

The importance of understanding TCDC as an inherently political process, encompassing different notions of expertise, unequal power relations and shaped by wider contexts, will be a familiar argument to scholars of development, as well as historians of the UN. As a large body of literature demonstrates, 'technical' assistance is far from a neutral undertaking, and while development, initiatives rarely achieve their ostensible aims, they often have other consequences, not least depoliticisation.[8] The AMHAG typified the WHO's increasingly development-centred approach to mental health from the 1970s,[9] and as a case study, it is revealing of wider challenges of development – the WHO would find that the areas deemed suitable for intervention, as well as the forms of expertise and patterns of cooperation regarded as acceptable, were all subject to negotiation between national, regional and international actors.[10] The AMHAG stands out from many other health development programmes, however, mental health was so rarely considered a priority either by national governments in Africa or in the wider fields of international health and development. Indeed, the history of the AMHAG highlights how different actors worked to secure funding and action on mental health by tying it to other political priorities: in the international sphere, and at the World Health Assembly in particular, southern African delegates mobilised international concern about apartheid to make a case for additional resources for mental health; requests for AMHAG activities similarly professed commitment to the WHO's own mental health priorities, which from the 1970s centred on mental health in primary healthcare; at national and regional levels, meanwhile, it soon became clear that mental health needed to be tied to related 'problems' such as alcoholism and migration, if they were going to secure government support.

Despite the WHO's intentions, the AMHAG ultimately proved a weak vehicle for promoting the integration of mental health into primary healthcare. Yet, it served other purposes, not least in facilitating networking and knowledge exchange on mental health. It confirms the African Region on how the role of the WHO in setting policy on mental health has often been one of creating opportunities for the emergence of new 'epistemic communities'.[11] While membership remained small for much of the 1980s, by 1992, the AMHAG had grown to encompass 28 African countries, as well as one national liberation movement.[12] In this way, the AMHAG highlights ongoing transnational engagement on mental health

[8]The influential text here is: James Ferguson, *The Anti-Politics Machine: 'Development,' Depoliticization, and Bureaucratic Power in Lesotho* (Minneapolis: University of Minnesota Press, 1994). On development, see also: Stephen J. Macekura and Erez Manela (eds), *The Development Century: A Global History* (Cambridge: Cambridge University Press, 2018); Thandika Mkandawire and Charles Soludo, *Our Continent, Our Future: African Perspectives on Structural Adjustment* (Dakar: CODESRIA, 1999); Lindsay Whitfield, *The Politics of Aid: African Strategies for Dealing with Donors* (Oxford: Oxford University Press, 2009). On the UN and specialised agencies, see especially: John Manton and Martin Gorsky, 'Health Planning in 1960s Africa: International Health Organisations and the Post-Colonial State', *Medical History* 62, 4 (2018), 425–48; Eva-Maria Muschik, 'Managing the World: The United Nations, Decolonization, and the Strange Triumph of State Sovereignty in the 1950s and 1960s', *Journal of Global History*, 13, 1 (2018), 121–44; David Webster, 'Development Advisors in a Time of Cold War and Decolonization: The United Nations Technical Assistance Administration, 1950–59', *Journal of Global History*, 6, 2 (2011), 249–72.

[9]Despite this, it has received only a little attention: Melissa Diane Armstrong, *An Ambulance on Safari: The ANC and the Making of a Health Department in Exile* (Montreal: McGill-Queen's University Press, 2020); Narendra N. Wig, 'Development of regional and national mental health programmes', in Giovanni de Girolamo *et al.* (eds), *Promoting Mental Health Internationally* (London: Gaskell Academic Series, 1999).

[10]Similar points have been made in: Kaisa Harju, 'Between Donor Interest, Global Models and Local Conditions: Treatment and Decision-Making in the Somalia-Finland Tuberculosis Control Project, 1981–3', *Medical History*, 64, 1 (2020), 94–115; Reiko Kanazawa, 'Disease in a Debt Crisis: Financing Global Health, Development and AIDS between WHO and World Bank, 1978–87', *Medical History*, 64, 3 (2020), 303–24.

[11]S. Sturdy, R. Freeman and J. Smith-Merry, 'Making Knowledge for International Policy: WHO Europe and Mental Health Policy, 1970–2008', *Social History of Medicine*, 26, 3 (2013), 532–54.

[12]WHO Press Release, *African Mental Health Action Group*, WHO/MNH/92.15, 31 December 1992.

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in Africa during a period that historians of psychiatry have tended to characterise as one of stagnation and neglect.[13] The years following independence had seen psychiatrists from countries such as Senegal, Nigeria and Uganda come together at regional meetings to discuss transcultural psychiatric research and share their experiences in attempting to reform the mental healthcare systems inherited from colonial rule. Many of these activities did stall from the late 1970s, as political and economic instability limited attempts to innovate and restricted psychiatrists' mobility. Yet the AMHAG offered a new space for the discussion – one dominated by government administrators, instead of psychiatrists, but still, one imbued with a sense of shared challenges stemming from decades of underdevelopment. For AFRO, in particular, this forum would additionally represent an opportunity to exert autonomy within WHO structures. Although the WHO set up and coordinated the AMHAG, the WHO's decentralised structure meant that most of the funding and administration was channelled through AFRO's budget for inter-country activities.[14] The tensions that resulted were not unique to the AMHAG. AFRO served as a dynamic political space, working, particularly from the 1970s, to lobby on such issues as apartheid and colonialism, as well as to challenge assumptions that the regional offices existed to fulfil directives from headquarters.[15] In the case of the AMHAG, AFRO would find useful opportunities to critique the hegemony of WHO's mental health staff and the ongoing reliance on foreign 'expert' consultants.

The article starts by situating the AMHAG in a longer history of WHO engagement with mental health in Africa. Doing so allows us to understand TCDC not just as a UN-led attempt to allow 'ownership' over development, but as part of long-negotiated relationships involving multiple actors and 'experts'. The article then turns to the early years of the AMHAG, from the late 1970s to the mid-1980s, when the group was most active. It asks why, at a time when TCDC and primary healthcare initiatives were relatively well-supported internationally, cooperation between AMHAG countries was uneven. This necessitates consideration of the wider contexts in which psychiatry and mental healthcare operated – structural adjustment, economic crises and in some instances war – themes that are explored in the final section, and which all shaped the limits of cooperation on mental health. To do so, the article draws on WHO archival material, including country files, AFRO memos and correspondence from psychiatrists, psychiatric nurses and government officials in Africa – material that is prone to some flattening of debate, but which nevertheless allows for those competing and even conflicting orientations to come to the fore. Certainly, a different history of the AMHAG would be told through a national case study, or through donor archives and oral histories, fully centring those voices who ran mental health services on a day-to-day basis, and who rarely feature in the correspondence of the (predominantly white male) psychiatrists and administrators who were afforded the most mobility in international cooperation.[16] Reading across the files to explore the AMHAG as a transnational network nevertheless allows for analysis of how cooperation was negotiated both between and across countries, as well as at regional

[13]On psychiatry in Africa since independence, see: Emmanuel Akyeampong, 'A historical overview of psychiatry in Africa', in Emmanuel Akyeampong, Allan G. Hill and Arthur Kleinman (eds), *The Culture of Mental Illness and Psychiatric Practice in Africa* (Bloomington: Indiana University Press, 2015); Matthew M. Heaton, *Black Skin, White Coats: Nigerian Psychiatrists, Decolonization, and the Globalization of Psychiatry* (Ohio: Ohio University Press, 2013); Katie Kilroy-Marac, *An Impossible Inheritance: Postcolonial Psychiatry and the Work of Memory in a West African Clinic* (Oakland: University of California Press, 2019); Yolana Pringle, *Psychiatry and Decolonisation in Uganda* (Basingstoke: Palgrave Macmillan, 2019).

[14]On the WHO, see: Nitsan Chorev, *The World Health Organization between North and South* (Ithaca: Cornell University Press, 2012); Marcos Cueto, Theodore M. Brown and Elizabeth Fee, *The World Health Organization: A History* (Cambridge: Cambridge University Press, 2019); Javed Siddiqi, *World Health and World Politics: The World Health Organization and the UN System* (London: Hurst, 1995).

[15]See eg. Philip J. Havik and José Pedro Monteiro, 'Portugal, the World Health Organisation and the Regional Office for Africa: From Founding Member to Outcast (1948–1966)', *The Journal of Imperial and Commonwealth History* (2021), 1–30, doi:10.1080/03086534.2021.1892374.

[16]See eg. the perspective offered in: Julia Vorhölter, 'A Pioneer of Psy: The First Ugandan Psychiatric Nurse and Her (Different) Tale of Psychiatry in Uganda', *Transcultural Psychiatry* (2020), 1–11. doi:10.1177/1363461520901642.

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and international levels. In doing so, the article not only highlights the inequities of participation in international cooperation on mental health, but also multiple understandings of cooperation and the ways it could be utilised.

The WHO and mental health in Africa

Africa sits uneasily within the vision of international collaboration on psychiatric epidemiology that inspired much of the mental health work at the WHO from the 1950s.[17] Without any mental health projects on the continent until the 1960s, the WHO received only fragmentary information about mental disorders in African countries, and how they might fit into an emerging worldwide clinical picture of mental illness. J.C. Carothers' WHO-commissioned monograph, *The African Mind in Health and Disease*, published in 1953, represented what the WHO considered to be a unique opportunity to bring together material on the subject for the first time, with hopes it would have 'implications for all who are concerned with Technical Assistance to under-developed areas'.[18] That Carothers' racial determinism and tendency towards sweeping and unfounded generalisations became the subject of fierce critique, including by Nigerian psychiatrist Thomas Adeoye Lambo, Gambian psychiatrist E.F.B. Forster, and anthropologists Margaret Mead and Melville J. Herskovits, failed to convince the WHO to publicly dismiss the monograph. Writing to a colleague in 1956, Ronald Hargreaves, former Chief of the Mental Health Section, noted that it was not the WHO's responsibility, 'as publishers, to step in at all', and that it would be preferable to 'leave the anthropologists to argue it out among themselves'.[19]

As plans for a long-term programme in psychiatric epidemiology started to take shape from 1957, with the aim of developing standardised classifications and diagnostic criteria, attention started to focus on how Africa might collaborate internationally. In early 1958, a CCTA conference, co-sponsored by the WHO and the World Federation for Mental Health, met in Bukavu, Belgian Congo (now Democratic Republic of Congo), bringing together psychiatrists and other specialists interested in mental health in Africa for the first time. A WHO seminar on the same subject in Brazzaville later in the year further highlighted to the WHO some of the broad contours of trends in treatment and prevention within psychiatric institutions, difficulties recruiting and training specialists, and concerns about the relationship between social change and mental health.[20] Practical challenges for the WHO's plans for a large-scale international study remained, however. The infrastructure and personnel required to participate in these surveys – which were wedded to epidemiological and statistical, rather than ethnographic methodologies – limited African participation in the eyes of the WHO, with only Mauritius and Nigeria deemed viable study sites.[21] With Mauritius deemed unrepresentative of the continent, and with Lambo at Aro Hospital, Nigeria, already committed to a cross-cultural study on mental disorders with Cornell University, the WHO would need to wait until the mid-1960s before a research project could be developed.[22]

[17]On this history, see especially: T. Adeoye Lambo, 'A World View of Mental Health: Recent Developments and Future Trends', *American Journal of Orthopsychiatry*, 43, 5 (1973), 706–16; Harry Yi-Jui Wu, *Mad by the Millions: Mental Disorders and the Early Years of the World Health Organization* (Cambridge: The MIT Press, 2021).

[18]World Health Organization and Marcolino Gomes, *The Work of WHO, 1953: Annual Report of the Director-General to the World Health Assembly and to the United Nations*, Official Records of the World Health Organization, no. 51 (Geneva: World Health Organization, 1954), 26.

[19]WHO M4/445/13, f. 3, letter from Ronald Hargreaves to Jerome S. Peterson, 17 February 1956.

[20]*Mental Disorders and Mental Health in Africa South of the Sahara: CCTA/CSA-WFMH-WHO Meeting of Specialists on Mental Health* (Bukavu: CCTA, 1958); *Seminar on Mental Health in Africa South of the Sahara* (Brazzaville: World Health Organization, 1958).

[21]See correspondence in WHO M4/445/2 AFR (Mental Health Study on the Epidemiology of Mental Diseases in the African Region). On wider methodology, see: Wu, *Mad by the Millions*, ch. 3.

[22]See: World Health Organization, *Report of the International Pilot Study of Schizophrenia*, vol. 1 (Geneva: World Health Organization, 1973); Heaton, *Black Skin*, ch. 4. On the Cornell study, see: Alexander H. Leighton *et al.* (eds), *Psychiatric*

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WHO engagement with mental health planning on the continent was similarly tentative, with technical assistance predominantly comprising WHO training fellowships and grants-in-aid to support university-level teaching rather than specialist advice.[23] Even AFRO, which had yet to establish a mental health advisor position, but which asked for guidance on how best to support the development of mental health services, was advised to focus on basic public health principles and ways to stimulate government interest.[24] Instead, WHO mental health officers followed the lead of an increasingly large group of indigenous-born, western-trained psychiatrists in Africa, facilitating the creation of an 'epistemic community' on mental health. Psychiatrists such as Lambo, Tolani Asuni (Nigeria), Taha A. Baasher (Sudan), C.C. Adomakoh (Ghana) and A.C. Raman (Mauritius) were in regular correspondence with WHO mental health officers, and participated in pan-African conferences, a (largely unsuccessful) correspondence network, and formed the Association of Psychiatrists in Africa, which met formally for the first time in 1969.[25] While psychiatrists were divided over questions of universalism, culture and traditional medicine, pan-African meetings were spaces in which the role of psychiatrists in the context of post-colonial development planning was debated, and where issues of social change and economic productivity were at the fore.[26] Attendees shared experiences in dealing with government administrators, and of trialling new initiatives, including decentralisation, village settlements, collaboration with traditional healers and the use of medical auxiliaries. Outlooks were not limited to the national frame, moreover, with shared recognition of the legacies of colonial rule and the underdevelopment of psychiatry; however varied opinions were on the value of large psychiatric institutions, few accepted that solutions could be easily transplanted from 'the West'.

The role of psychiatrists in shaping approaches to mental healthcare delivery strengthened as the WHO sought to formulate coherent policies on mental health in developing countries in the run-up to Alma-Ata in 1978. Direct experiences represented a form of expertise that proved particularly pervasive, with examples of initiatives in Zambia, Tanzania, Nigeria, Sudan and Uganda, among others, discussed at WHO regional seminars, professional association meetings, and the 1974 Expert Committee on the Organization of Mental Health Services in Developing Countries.[27] The final report of the Expert Committee marked the culmination of these discussions and set out the main strands of the WHO's emergent policies on what became known as mental health in primary healthcare: decentralisation, community-based mental healthcare and task-sharing between psychiatrists and a wide range of health workers and community agencies.[28] The contexts in which psychiatry operated were ever present in the report. In addition to general constraints stemming from 'the limited resources devoted to mental health', the historical reliance on 'costly, centralised, custodial mental hospitals', and the broader underdevelopment of basic health services, the highlighted 'very serious threats to their citizens' wellbeing associated with rapid population growth, crises of food production, internal migration and accelerated

Disorders among the Yoruba: A Report from the Cornell-Aro Mental Health Research Project in the Western Region, Nigeria *(Ithaca: Cornell University Press, 1963).*

[23]See eg. WHO M M-Projects, Liberia-31 (Mental Health); WHO M M-Projects, Uganda-38 (Assistance to the Department of Psychiatry).

[24]Maria Pfister, *Report on Duty Mission in Africa, 23 May–13 July 1962*, MHO/PA/28.63 (Geneva: World Health Organization, 1963), 20–2.

[25]The association rebranded itself as the Association of African Psychiatrists in 1975, a shift that reflected both the increased number of indigenous-born psychiatrists and a more politically oriented outlook that included affiliation with the Organization of African Unity (OAU). G.A. German and A.C. Raman, 'From Birth to Maturity – Historical Aspects of the Association of Psychiatrists in Africa', *African Journal of Psychiatry*, 2, 2 (1976), 255–65.

[26]*Mental Health Services in the Developing World: Reports on Workshops on Mental Health, Edinburgh (1968) and Kampala (1969)*, Commonwealth Foundation Occasional Paper, IV (Hove: Hove Shirley Press, 1969); T.A. Lambo (ed.), *First Pan-African Psychiatric Conference Report* (Ibadan: Government Printer, Nigeria, 1961).

[27]See eg. T.A. Baasher *et al.* (eds), *Mental Health Services in Developing Countries: Papers Presented at a WHO Seminar on the Organization of Mental Health Services, Addis Ababa, 27 November to 4 December 1973* (Geneva: World Health Organization, 1975); Joy Moser, *Development of Mental Health Services in Africa*, OMH/74.3 (Geneva: World Health Organization, 1974).

[28]WHO, *Organization of Mental Health Services in Developing Countries: Sixteenth Report of the WHO Expert Committee on Mental Health*, Technical Report Series no. 564 (Geneva: World Health Organization, 1975).

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social change'. While such factors provided an imperative for reorganising services to 'help more than a minute fraction of these sufferers', the social, political and economic causes were addressed only obliquely.[29]

The WHO's attempt to provide an evidence-base for the feasibility and effectiveness of these new approaches through the WHO Collaborative Study on Strategies for Extending Mental Health Care saw the selection of seven pilot study areas around the world, including in Senegal and Sudan. The 'interventions' focused on the production of 'problem outlines', the development of tools for identifying mental disorders and the development and provision of training.[30] All reinforced the technical, rather than the political, in mental healthcare. Indeed, the centrality of the technical remained even as the focus of the WHO's mental health work shifted away from its previous reliance on psychiatrists and psychiatry 'as a specialised branch of medicine' towards consideration of the effects of psychosocial environments on the mental health of whole populations.[31] It also sat uneasily with growing concerns among medical professionals and others both within South Africa and in exile about the health implications of apartheid.[32] These voices, reflected in the WHO's literature review-based *Apartheid and Mental Health*, published in early 1977, highlighted how mental health was inextricably connected to forced mass uprooting, splitting up of families, economic deprivation and poverty, racial reclassification and enforced inferior status, police harassment, denial of political and social activity and a cultural 'double-bind' situation, whereby cultural heritage was both dismissed as ignorance and superstition, and reinforced through the creation of tribal Homelands.[33] The political dimensions of health were inescapable. As H. Hellberg, delegate for Finland, noted at the World Health Assembly (WHA) in May 1977, 'While WHO should do its utmost to help those suffering from the effects of psychosocial pressures, it should not forget that the essential need was for the removal of the racial and political oppression which to a large extent was the cause of the problem'.[34]

It was against this backdrop that delegates of southern African countries called for international assistance to support the development of mental healthcare. Instead of outlining the historic structures and ongoing needs of psychiatry, which decades after independence was in most countries still organised around a single mental hospital, inherited from colonial rule, delegates chose to tie mental health to wider concerns about colonialism, apartheid and refugees. This was a salient issue at the 1977 WHA, as delegates reported on large influxes of refugees from Namibia, Southern Rhodesia and South Africa into frontline states – a loose grouping of countries that bordered or were in close proximity. M.P.K. Nwako, Minister of Health, Botswana, described how 'his country was experiencing an increase in mental health problems, and found itself unprepared to deal with them': many new arrivals were 'suffering from stress' not only due to separation from their families, but also because of difficulties in securing employment.[35] P.S.P. Dlamini, Minister for Health and Education, Swaziland, similarly noted the high prevalence of psychosocial problems among displaced persons, placing strain on healthcare services. Particular support was needed for those countries who had only 'recently attained independence' and so had 'only

[29]*Ibid.*, 7–8.

[30]*Mental Health Care in Developing Countries: A Critical Appraisal of Research Findings: Report of a WHO Study Group*, Technical Report Series (Geneva: World Health Organization, 1984); N. Sartorius and Timothy W. Harding, 'The WHO Collaborative Study on Strategies for Extending Mental Health Care, I: The Genesis of the Study', *American Journal of Psychiatry*, 140 (1984), 1470–3.

[31]*The WHO Medium-Term Mental Health Programme 1975–1982: Interim Report* (Geneva: World Health Organization Division of Mental Health, 1978), 1.

[32]These would become more vocal following the death of Steve Biko in police custody in September 1977. See especially: WHO, *Apartheid and Health* (Geneva: World Health Organization, 1983); John Dommisse, 'Apartheid as a Public Mental Health Issue', *International Journal of Health Services*, 15, 3 (1985), 501–10.

[33]WHO, *Apartheid and Mental Health Care* (Geneva: World Health Organization, 1977), 6–7. On the wider context of this report, see especially: Tiffany Fawn Jones, *Psychiatry, Mental Institutions, and the Mad in Apartheid South Africa* (Abingdon: Routledge, 2012), ch. 6.

[34]WHA 30, *Verbatim Records of Plenary Meetings*, Part II, 5.

[35]*Ibid.*, 342–3.

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inadequate mental healthcare services'.[36] A TCDC initiative – the Special Programme of Technical Cooperation in Mental Health – was not only necessary because of the emerging political and health emergency, but also because it would address inequities in the distribution of health resources.[37] Cooperation between countries promised to make the provision of additional assistance more equitable insofar as it would contribute to national self-reliance, economic independence, 'mutual endeavour' and 'equal partnership'.[38] As Dlamini stressed, countries in southern Africa did not just want 'help from WHO', but 'technical cooperation between the countries themselves in finding common solutions to their healthcare needs'.[39]

The late 1970s marked a turning point in the WHO's engagement with mental health in Africa. From a position of minimal input on policy, with activities limited primarily to research, the provision of WHO fellowships, and facilitating transnational networks, the late 1970s saw the start of active promotion of mental health development in national policy formation. While this reflected the rise of health planning more generally in the contexts of primary healthcare and 'Health for All by the Year 2000', it represented an attempt to take on a greater role in directing discussions already long underway on the continent.[40] Yet it positioned high-level government officials, rather than psychiatrists, at the centre of inter-country cooperation, and as gatekeepers of policy. Government officials formed the core of the AMHAG, which as an acronym was used first to identify the group that met annually in Geneva to guide the special programme, and only later became shorthand for participating countries. The involvement of high-level officials in TCDC was intended to 'guarantee effective attention to health', and was regarded as key to attracting donor funding, particularly in light of primary healthcare policies.[41] In the case of the AMHAG, it placed psychiatrists in an ambiguous position. They still played key roles in the special programme – they participated in inter-country workshops, wrote the reports that senior health administrators presented at AMHAG meetings, and were often in charge of implementing new strategies. Yet it meant that the AMHAG did not replace existing professional connections on the continent, instead entering into competition with them. Just as the WHO had negotiated its role in Africa though psychiatrists and transnational networks, so it would find that the meaning and scope of cooperation on mental health would be contested, now among a more diverse group of actors. Government officials and psychiatrists within participating countries, as well as AFRO, had their own ideas about the benefits of cooperation, and how experience mapped onto expertise.

The AMHAG, experience and expertise

The AMHAG created a new regional space within psychiatry in Africa, organised around the solidarity of frontline states. The group comprised initially of Tanzania, Zambia, Botswana, Swaziland and Rwanda, with Lesotho joining in time for the first group meeting in Geneva in May 1978. Kenya followed in 1980, along with Burundi and Zimbabwe in 1982. The South-West Africa People's Organisation (SWAPO) and the African National Congress (ANC) additionally became associate members in 1981 and 1982, respectively, allowing them to participate in TCDC activities. Not all of these countries were frontline states – Rwanda, Kenya and Burundi were exceptions – but the boundaries of the AMHAG were determined initially more by these political considerations than that of geographical proximity, language or economic relationships. While membership of the AMHAG was open to any member country in the WHO's African Region, most AMHAG members until the mid-1980s were either host to refugee

[36]*Ibid.*, 480.

[37]WHA Resolution 30.45, *Special programme of technical cooperation in mental health*, Eighteenth plenary meeting, Committee A, 18 May 1977 A30/A/SR/18 (Geneva: World Health Organization, 1977).

[38]*Technical Cooperation Among Developing Countries. Report*, 1.

[39]WHA 30, *Verbatim Records of Plenary Meetings*, Part II, 480.

[40]*The WHO Medium-Term Mental Health Programme*, 4–5.

[41]*Technical Cooperation Among Developing Countries. Report*, 10. See also: WHO M4/370/15AF Jkt 6, memo from Chief CPD to Director MNH, 3 March 1983.

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populations from South Africa and other minority-white rule countries or, in the case of Rwanda, had historically produced refugees. This framing of cooperation mapped uneasily onto existing expertise on mental health on the African continent. While psychiatrists from Senegal, Nigeria and Uganda had played key roles in transnational networks of psychiatry in the 1950s and 1960s,[42] they did not become members of the AMHAG until the late 1980s.

The role of cooperation in the fight against colonialism and apartheid had long been embedded into African geopolitics.[43] While the Organization of African Unity (OAU) was criticised by some African leaders for its conservative approach, it had since its founding in 1963 aimed to mobilise resources for the liberation of the continent and to persuade rival liberation movements to work together.[44] From the mid-1970s, this also extended to working with the WHO to increase levels of health assistance for liberation movements, as well as a joint OAU-WHO plan to assist victims of apartheid.[45] While concern about the relationship between colonialism, apartheid and health had allowed delegates from southern Africa to secure the funds for the Special Programme of Technical Cooperation on Mental Health, in their subsequent formal requests to join the AMHAG, government officials offered a wider range of reasons for cooperation. S.H. Siwale, Zambia's Minister of Health, advocated for Zambia's inclusion as both 'beneficiary and collaborator'. In addition to being a frontline country with a large number of refugees, Zambia had a long history of training medical assistants of the kind advocated by mental health in primary healthcare policies, meaning they could 'offer something to the programme'.[46] The representative for Lesotho stressed that they were committed to the decentralisation of healthcare, and similarly invited participants of the first AMHAG meeting to send their health workers 'to benefit from the experience gained'.[47] For others, funding acted as a key motivating factor.[48] Indeed, the perceived benefits of cooperation reflected broader political goals that went beyond solidarity. This was particularly clear in the case of the liberation movements, SWAPO and the ANC, for whom participation in the group not only represented access to additional funding and training but helped legitimise them as governments-in-waiting.[49]

The meaning of regional cooperation varied, both between the WHO and national governments, and among government officials. Practically, cooperation at the regional AMHAG level largely comprised training agreements and exchanges, as well as inter-country workshops which, requiring WHO and donor funding, needed to prioritise mental health in primary healthcare approaches.[50] The WHO's mental health officers also embarked on visits and sponsored consultants to assist governments in developing national mental health action plans. Yet, while all AMHAG countries developed such plans, they often languished, with little, and in some cases no WHO country budget funding redirected to support mental health. That membership of the AMHAG did not require governments to overturn decades of under-funding for mental health was perhaps part of what made membership acceptable – the AMHAG offered opportunities to network, gain access to consultants and additional programme funding without any obligation to alter national health budgets. This was problematic for those at the WHO's headquarters, who intended AMHAG activities to promote the integration of mental health into primary healthcare, but saw only a few countries deciding to commit to it. The unevenness that resulted

[42]Heaton, *Black Skin, White Masks*; Kilroy-Marac, *An Impossible Inheritance.*

[43]Steven L.B. Jensen, 'Embedded or Exceptional? Apartheid and the International Politics of Racial Discrimination', *Studies in Contemporary History*, 13, 2 (2016), 314–23; Gilbert M. Khadiagala, *Allies in Adversity: The Frontline States in Southern African Security, 1975–1993* (Athens: Ohio University Press, 1994).

[44]Samuel M. Makinda, F. Wafula Okumu and David Mickler, *The African Union: Addressing the Challenges of Peace, Security, and Governance* (London: Routledge, 2016), ch. 1.

[45]Marcolino Gomes Candau, Director-General of the WHO, *Collaboration with the United Nations: Health Assistance to Refugees in Africa*, Provisional agenda item 22.4, Seventy-first Session of the Executive Board, EB71/30, 3 January 1983.

[46]WHO M4/370/15 Jkt 1, f. 2, letter from S.H. Siwale to C.A.A. Quenum, 30 June 1977.

[47]WHO M4/370/15 Jkt 1, f. 26B, 'African Mental Health Action Group. First meeting, Geneva, Friday 12 May 1978', 5.

[48]WHO M4/370/15 Jkt 1, W.J. Muya, 'Programme/Proposals on the Setting up of Mental Health Service', 27 August 1979, 4.

[49]Armstrong, *An Ambulance on Safari*, ch. 5.

[50]WHO M4/370/15AF Jkt 6, memo from Chief CPD to Director MNH, 3 March 1983.

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would later by attributed to historically shaped government disinterest or ignorance. Yet, it also reflected a lack of evidence for the feasibility and effectiveness of community-based mental healthcare, and with mental health omitted from the Alma-Ata Declaration, there was little to convince government officials of the need for change.[51]

While psychiatrists working in Africa since the 1960s had long stressed the importance of knowledge sharing, many government officials remained wary of what regional cooperation on mental health would entail. Tanzania, often held up as one of the AMHAG 'success' stories, with an active WHO-DANIDA funded programme to develop a national plan for community-based mental healthcare, was particularly concerned about the potential for interference. Under President Julius Nyerere, Tanzania had well-established political priorities for health development, and Tanzanian officials made it clear to the WHO's Assen Jablensky that 'in spite of the major material and manpower constraints there is a fairly clear idea of the general direction in which this development should go'.[52] One way of addressing this was to limit the extent of cooperation, allowing greater negotiation of activities in line with national priorities. Rwanda and Burundi, two countries linked historically through colonialism, as well as geographically and linguistically, entered into their own TCDC relationship.[53] The two liberation movements also preferred to work directly with either Botswana, Zambia or Tanzania, whose governments had already demonstrated their support by hosting SWAPO and ANC exiles. Tanzanian psychiatrist Johnson Hauli, for example, had pre-existing ties with the ANC's government-in-exile, and in a project that went beyond the formal remit of the AMHAG, would work with the ANC Health Department to survey the mental health problems of ANC members in Tanzania and Zambia.[54] Indeed, concern for privacy, trust and shared experiences framed repeated calls for joint SWAPO and ANC workshops, seminars and exchange visits, if this glossed over security concerns that made such activities problematic.[55]

That political priorities and concerns shaped cooperation did not come as a surprise to those participating in the AMHAG, but it nevertheless had implications for 'success' of TCDC. Most countries had limited specialist personnel, meaning they zealously guarded training places for national students, and were unable or unwilling to release specialists for inter-country cooperation activities.[56] Even though his position was funded by the WHO, Ugandan-born psychiatric nurse tutor Vincent Wankiiri, then based in Lesotho, was forced to turn down requests for AMHAG-supported training assistance to Rwanda and Zimbabwe due to resistance from the Lesotho Government.[57] Yet, more than national politics, it was the organisational structure of the AMHAG that most sharply limited the possibilities of cooperation. Despite member countries calling for countries to nominate a focal point for cooperation

[51]Timothy W. Harding *et al.*, 'The WHO Collaborative Study on Strategies for Extending Mental Health Care, III: Evaluative Design and Illustrative Results', *American Journal of Psychiatry*, 140 (1983), 1481–5; Sartorius, 'Mental Health and Primary Health Care', 75.

[52]WHO M4/370/15 Jkt 1, 'Note for the Record: Visit to Tanzania, 21–24 November 1977', 4. On development in Tanzania, see: Bonny Ibhawoh and J.I. Dibua, 'Deconstructing Ujamaa: The Legacy of Julius Nyerere in the Quest for Social and Economic Development in Africa', *African Journal of Political Science*, 8, 1 (2003), 59–83; Michael Jennings, '"Almost an Oxfam in Itself": Oxfam, *Ujamaa* and Development in Tanzania', *African Affairs*, 101 (2002), 509–30; Urban Jonsson, 'Ideological Framework and Health Development in Tanzania 1961–2000', *Social Science and Medicine*, 22, 7 (1986), 745–53; Leander Schneider, 'Freedom and Unfreedom in Rural Development: Julius Nyerere, Ujamaa Vijijini, and Villagization', *Canadian Journal of African Studies*, 38, 2 (2004), 344–92.

[53]WHO M4/370/15AF Jkt 6, AFRO memo from MOH to RD, 25 June 1982, 1.

[54]Armstrong, *An Ambulance on Safari*, ch. 5.

[55]See eg. WHO M4/370/15AF Jkt 7, f. 134, 'Training in Mental Health for SWAPO Health Workers. Report on Workshop, Luanda 13–25 August 1984, by Fikre Workneh'. On the ANC and SWAPO in exile, see: Chris Saunders, '"Forged in the trenches"? The ANC and SWAPO: Aspects of a relationship', in Arrigo Pallotti and Ulf Engel (eds), *South Africa after Apartheid: Policies and Challenges of the Democratic Transition* (Leiden: Brill, 2016); Paul Trewhela, *Inside Quatro: Uncovering the Exile History of the ANC and SWAPO* (Sunnyside: Jacana, 2009); Christian A. Williams, *National Liberation in Postcolonial Southern Africa: A Historical Ethnography of SWAPO's Exile Camps* (Cambridge: Cambridge University Press, 2015).

[56]See opportunities in: *Directory of Training Courses in Mental Health in Africa for the Countries of the African Mental Health Action Group*, MNH/POL/88.1 (Geneva: World Health Organization, 1988).

[57]WHO M4/370/15LES, letter from V. Wankiiri to J. Orley, n.d.

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from as early as November 1977, few did, and it was not recommended as a requirement until 1987.[58] This meant there were issues with continuity between meetings and only reinforced dependency on the WHO for guidance and coordination.

Ongoing WHO efforts to use the AMHAG to promote community-based mental healthcare indicated a level of WHO-direction that was problematic within the TCDC context. AFRO was most outspoken about what it saw as unnecessary interference, questioning why it was necessary for six WHO-supported experts to attend a workshop in Swaziland in 1984 when there were only fourteen national representatives from the seven AMHAG countries, and then among them 'a good number…will be psychiatric specialists or persons in that field'. 'With such level of participation', they wondered, would the workshop not 'be turned into a meeting of experts in mental health, etc.?'[59] Such concern reflected a wider tendency within the WHO to overlook expertise on the continent, as well as the increasingly vocal position of AFRO in relation to WHO headquarters. While the pool of consultants available to AMHAG countries in 1980 included nine from the African Region, those selected were much more likely to come from beyond the continent, including the UK, Belgium, Australia and India.[60] National governments had the final say on consultancies, but many of the WHO consultants appointed were Europeans who had worked in newly independent African countries during the 1960s and had decades old personal and professional relationships with those at the WHO.[61] It was a pattern that was not only reminiscent of an older tendency for international health and development 'experts' to have ties to former colonies,[62] but was also at odds with arguments made by psychiatrists at regional meetings in the 1970s on the unsuitability of 'transplanting' ideas and practices from 'the West'.

The reliance on 'foreign', 'expert' psychiatrists was a key weakness in the context of a TCDC initiative aimed at allowing 'ownership' over development. Consultants not only represented significant budget lines, often equalling or even exceeding funds earmarked for training, but also failed to build capacity effectively. This was particularly evident in the case of Tanzania where, with WHO-DANIDA funding, the WHO assigned consultants from France, India and Bulgaria on rolling 11-month contracts.[63] The WHO was aware of the tensions involved in bringing in consultants from outside the continent, but justified their use, stressing that there was no official AMHAG inter-country team to provide specialist advice on planning, and pointing out their expertise stemming from direct experience.[64] This position was difficult to defend in practice. Representatives from AFRO critiqued the WHO for undermining the purpose of the AMHAG and for presuming that there was no existing 'recognised expertise' elsewhere in the African Region.[65] Writing in October 1983, the Director for Development of Health Systems lamented the use of yet another external consultant for a meeting in Swaziland. The meeting, they stressed, was to be a '*national* meeting', and once the national authorities had decided on the content, form, and related needs, then assistance would be requested, but 'from one of the countries which have successfully carried out such an experience: Zambia or Botswana'. It was 'therefore desirable' that the external consultant 'should not interfere on the matter'.[66] Making a similar point with reference to Botswana, AFRO stressed that there was a need to 'identify that expertise resources at national level', and to use this to build capacity, 'enriching their professional experience for the national and regional

[58]WHO M4/370/15 Jkt 1, 'Note for the Record: Visit to Zambia, 17–19 November 1977', 4; WHO Special Programme of Technical Cooperation in Mental Health, *African Mental Health Action Group. Eleventh meeting, Geneva, 5 May 1988: Report*, MNH/POL/88.3 (Geneva: World Health Organization, 1988), 21.

[59]WHO M4/370/15SWA Jkt 2, AFRO WHOGRAM from D. Tembo to E.M. Samba, 4 October 1984.

[60]WHO M4/370/15AF Jkt 5, f. 87, 'African Mental Health Action Group. Third meeting, Geneva, 10 May 1980: Report', MNH/80.11, 18.

[61]See eg. WHO M4/370/15AF Jkt 6, memo from Director, MNH/HQ to Regional Director, AFRO, 19 October 1983.

[62]Joseph M. Hodge, 'British Colonial Expertise, Post-Colonial Careering and the Early History of International Development', *Journal of Modern European History*, 8, 1 (2010), 24–46.

[63]WHO M4/370/15TAN Jkt 5, memo from Assen Jablensky to Director-General, WHO, 16 August 1984.

[64]WHO M4/370/15KEN Jkt 1, memo from Director MNH/HQ to Regional Director, AFRO, 22 November 1983.

[65]WHO M4/370/15BOT Jkt 2, AFRO memo from A. Franklin to N. Sartorius, 6 October 1983.

[66]WHO M4/370/15SWA Jkt 1, AFRO memo from A. Franklin to N. Sartorius, 13 October 1983.

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benefit'.[67] The use of Hussein Dia, a psychiatrist in Mauritania, as an AFRO consultant to advise the Niger Government on the development of a national mental health service, was an excellent example of the 'kind of approach' that should be 'further followed and extended in the Region'.[68] It was necessary not only to strengthen regional capacity, but also to confirm the value of AFRO and African expertise in international health.

The lack of a formal place for African psychiatrists in the AMHAG would, in turn, prove a point of frustration for them, too. Annual high-level AMHAG meetings in Geneva to determine the scope and direction of regional cooperation were intended for government officials rather than psychiatrists. In practice, this limited discussion of the 'crucial planning issues' to be implemented and prompted some psychiatrists to be wary of how they framed 'progress' in mental health in their own countries. On at least one occasion, one of the psychiatrists sent two separate reports to WHO headquarters: while the 'official report' noted briefly that activities were constrained for 'various reasons', the 'unexpurgated' version complained about their government's 'obsessional preoccupation with financial considerations, lack of unawareness [sic.] of the magnitude and implications of mental health problems and inter-personal conflicts both unwittingly and otherwise'.[69] Far from representing a straightforward continuation of older transnational networks of psychiatry, the AMHAG required caution. Recognising the need to reassert the expertise of African psychiatrists in developing coherent policies on mental health, the Association of African Psychiatrists renewed their network in the mid-1980s. With financial support from the Association of Black Psychiatrists of America, the association held a major international conference in Nairobi, Kenya, in 1986.[70] Attendees called on the association to formulate 'position statements' on mental healthcare, as well as debate on the extent to which they should support WHO policies, such as 'Health for All by 2000'.[71] Recognising the importance of defining the role of African psychiatrists in WHO structures, attendees additionally entered into negotiations with WHO representatives, agreeing that the association would become 'arbiter of standards in postgraduate training throughout the African region'.[72] Although this downplayed disagreement over support for WHO collaboration, as well as internal politics that saw some Kenyan psychiatrists boycott the meeting altogether, such calls nevertheless reflected a sense of a continued need for a united voice on mental health across the region.

Effective regional cooperation would be increasingly necessary from the mid-1980s, as many African countries were burdened with debt and stringent conditionality, and had to navigate contexts of political and economic instability, HIV/AIDS, and in some cases war. The possibilities offered by the AMHAG to challenge norms and policies in international health remained throughout its lifespan, yet were ultimately limited. The unevenness of commitment to mental health, different understandings of the meaning of cooperation, and the unequal power dynamics inherent in decisions about 'expertise', would only be exacerbated as international and donor funding for cooperation shifted away from TCDC and mental healthcare. Indeed, this indicated that the technical in technical cooperation was never free from the political. While cooperation activities often sidestepped difficult discussions about the wider contexts of psychiatry and mental healthcare, it would become increasingly difficult to ignore from the mid-1980s.

[67]WHO M4/370/15BOT Jkt 2, AFRO memo from A. Franklin to N. Sartorius, 6 October 1983, 1.
[68]*Ibid.*, 2.
[69]WHO M4/370/15LES, f. 4., letter to N. Sartorius, 25 April 1984.
[70]WHO M4/370/15KEN Jkt 2, AFRO memo from G.L. Monekosso to N. Sartorius, 26 November 1986.
[71]WHO M4/370/15KEN Jkt 2, G. Allen German, 'Consultant Report on a Visit to Kenya – August 1986', MNH/POL/86.9, August 1986, 2.
[72]*Ibid.*, Appendix 1.

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Cooperation and the politics of mental health

The work of the AMHAG had never been isolated from the wider social, political and economic contexts in which psychiatry and mental healthcare operated. Annual reports submitted by Zimbabwe highlighted racial disparities and inequities of care resulting from decades of minority-white rule.[73] Participants at an AMHAG training workshop for SWAPO health workers similarly raised the importance of recognising how refugee and exile communities lived in states of 'constant stress and tension', living in 'unfamiliar surroundings', and 'always anticipating possible attacks'.[74] Yet, if individuals within AMHAG countries were concerned about the mental health and psychosocial wellbeing of 'high risk' population groups, such as refugees, it rarely became central to regional cooperation on mental health. This was in part a communication issue. Participants at a high-level AMHAG meeting in Geneva in 1980 drew attention to weaknesses in coordination, noting that 'despite the obvious needs…those responsible for refugee health and welfare activities have not been sensitised to the possibilities offered by the Special Programme for active involvement and cooperation'.[75] Yet, it was just as indicative of the varying priorities of national governments, as well as donors, with those traditionally giving to health development prioritising primary healthcare and physical health issues, rather than mental health or specialist services for refugees.[76]

In setting priorities for AMHAG cooperation, government officials repeatedly requested research and intra-regional meetings on alcoholism and migration. To a certain extent this was strategic – it was easier to build up a case for inter-sectorial action within their national governments on issues with much more obvious importance for social and economic development. The centrality of migration in entrenching economic dependency relationships with South Africa, for example, was a problem that also saw regional economic cooperation under the framework of what became known as the Southern African Development Coordination Conference (SADCC) from 1980.[77] But in prioritising issues such as alcoholism and migration, the AMHAG sidestepped more difficult questions not only about the mental health effects of violence, but also the historic and ongoing neglect of psychiatry and mental health within national contexts. Added to this was a reluctance to consider the political dimensions of health even within the AMHAG's priority areas. A 1980 WHO-funded research study into the psychosocial consequences of uprooting, for example, raised concerns about alcohol consumption among Botswana miners working in South Africa, finding that psychosocial symptoms such as palpitations were a common experience. It attracted no significant discussion within the AMHAG, however, with the findings not being made public due to 'political considerations'.[78] Even activities relating to alcohol required caution. As one health worker commented with regard to Swaziland: 'The uncertainty of the political climate, the succession, etc., means that nobody in high office can make unpopular changes. Many either have an alcohol problem themselves or own bottle stores'.[79] The result was that many of the AMHAG's activities appear to have been more useful in providing the WHO with a large quantity of standardised data on mental health services in African countries, than for decision-making.[80]

[73]See eg. WHO M4/370/15ZIM Jkt 1, 'Department of Psychiatric Services: Annual Report, January to December 1981'.

[74]WHO M4/370/15AF Jkt 7, f. 134, 'Training in Mental Health for SWAPO Health Workers', 3.

[75]WHO M4/370/15AF Jkt 5, f. 87, 'African Mental Health Action Group. Third meeting, Geneva, 10 May 1980: Report', MNH/80.11, 20.

[76]WHO M4/370/15AF Jkt 6, memo from Chief CPD to Director MNH, 3 March 1983.

[77]Gilbert M. Khadiagala, 'The SADCC and its approaches to African regionalism', in Chris Saunders, Gwinyayi Albert Dzinesa and Dawn Nagar (eds), *Region-Building in Southern Africa: Progress, Problems and Prospects* (New York: Zed Books, 2012).

[78]E.T. Maganu, 'The health of mine workers in Botswana. A study of the effects of mining and migration', in *International Migration for Employment Working Paper* (Geneva: International Labour Office, 1988). See also: WHO M4/370/15BOT Jkt 1, David I. Ben-Tovim, 'Health Survey of Mineworkers: Psychosocial Aspects of Impact upon the Family', unpublished report, n.d.; WHO M4-370-15BOT Jkt 2, letter from David Ben-Tovim to Norman Sartorius, 15 June 1984.

[79]WHOA M4/370/15SWA Jkt 2, letter to J. Orley, 20 November 1984.

[80]WHO M4/370/15ZAM Jkt 2, letter from P.C. Msoni to W.S. Boayue, 13 April 1993; WHO M4/370/15UGA, letter from J. Orley to G. Rwegellera, 12 December 1984.

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The inability of the AMHAG to address the wider political contexts of mental health was made clear in 1986, when Uganda became a member. The country offered a particularly bleak view of what prolonged war, conflict, and financial mismanagement could do to a country whose mental health services had in the 1960s been 'the best in the region'.[81] G.G.C. Rwegellera, a Ugandan psychiatrist and WHO country representative, noted that the national mental hospital, Butabika, was 'now nothing but a shadow of what it used to be': 'The sewage system is all blocked, the water taps are nearly always dry, and patients have little or nothing to wear, and hardly any beddings to sleep in'.[82] He sent a long list of 'urgent requirements' for consideration at the AMHAG meeting in Geneva in 1987, seeing the group as an avenue for emergency relief as much as for programme development.[83] The provision of emergency aid was not something that the AMHAG was equipped to handle, however.[84] Instead, the advice from the WHO was to use this crisis as an opportunity to implement decentralisation policies.[85] That this appeared to ignore the fact that psychiatric and nursing staff were 'thin on the ground', and that regional units would have nowhere to send 'difficult or complicated patients' only added to the annoyance of Uganda's psychiatrists, who saw little need for WHO interference at a policy level.[86] As another Ugandan psychiatrist later stressed, 'external help' was not required: 'What mental health in Uganda really needs are *funds* for the rehabilitation of institutions, transport and personnel'.[87]

Calls from Uganda for assistance from the AMHAG prompted a rare discussion on political instability and the need for regional action. Mozambique was experiencing a brutal civil war, while the effects of civil unrest and political instability could be observed in all the frontline states, requiring 'special help…from the international community for rehabilitative mental health programmes'. This included additional training for health workers, the rehabilitation of vandalised or destroyed infrastructure, the need to care for orphans, widows, the disabled and other victims of violence, and attention to broad social issues, notably juvenile delinquency, alcoholism and drug abuse.[88] In making these demands for increased levels of assistance, the AMHAG was directing attention to an issue that was still largely neglected by international humanitarian organisations. Yet even if AMHAG members had followed the meeting with proposals for action, it is unlikely they would have received significant funding. Initial WHO funding for the special programme had almost completely run out by 1982, leaving the AMHAG reliant on AFRO for small amounts of money to support inter-country activities, and on WHO country budgets – allocations which national governments remained reluctant to direct towards mental health.[89]

Financial problems within the WHO and AFRO would in time limit all aspects of cooperation on mental health, constraining activities relating to the mental health and psychosocial effects of war, migration and uprooting even as they became areas of international concern.[90] Moreover, the impact of wider economic instability in the 1980s was wide-reaching. AMHAG countries had to contend with the shifting priorities of international donors, such as that which saw the Swedish government phase out development assistance to Swaziland from 1982 on ideological grounds, as well as the realignment of

[81]WHO Special Programme of Technical Cooperation on Mental Health, *African Mental Health Action Group, Tenth Meeting: Report, Geneva, 8 May 1987*, MNH/POL/87.3 (Geneva: World Health Organization, 1987), 8.

[82]WHOA M4/370/15UGA, letter from G.G.C. Rwegellera to J. Orley, 25 March 1986.

[83]*African Mental Health Action Group, Tenth Meeting*, 9.

[84]WHO M4/370/15UGA, letter from J. Orley to E. Morgan, 7 May 1986.

[85]WHO M4/370/15UGA, letter from J. Orley to G.G.C. Rwegellera, 18 April 1986.

[86]WHO M4/370/15UGA, AFRO memo from G.G.C. Rwegellera to J. Orley, 16 June 1986.

[87]WHO M4/370/15UGA, 'Report of Activities for the Period 1988–1989', 4. On the approaches to rehabilitation taken in Uganda, see especially: J. Boardman and E. Ovuga, 'Rebuilding Psychiatry in Uganda', *Psychiatric Bulletin*, 21, 10 (1997), 649–55; Cole P. Dodge, 'Uganda - Rehabilitation, or Redefinition of Health Services?', *Social Science & Medicine*, 22, 7 (1986), 755–61; Sam Agatre Okuonzi and Macrae, Joanna, 'Whose Policy Is It Anyway? International and National Influences on Health Policy Development in Uganda', *Health Policy and Planning*, 10, 2 (1995), 122–32; Pringle, *Psychiatry and Decolonisation in Uganda*, ch. 6.

[88]*African Mental Health Action Group, Tenth Meeting*, 11–12.

[89]WHO M4/370/15LES, letter from N. Sartorius to Regional Director, AFRO, 13 March 1981.

[90]See eg. correspondence in WHO M4/370/11(D) Jkt 1 (WHO Programme on Psychosocial Factors and Health Aspects of War).

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health development towards selective primary healthcare.[91] More significantly, many African countries had to contend with the effects of structural adjustment policies, currency devaluation and inflation.[92] For some within the AMHAG, this brought on feelings of resentment at the unevenness of cooperation. As one psychiatrist in Zambia stressed to the WHO: 'Please remember, that unlike Tanzania we have so far had to develop everything without outside assistance while, unlike (for example) Botswana at the moment, the economic constraints are gradually crippling us'.[93] Even those countries who had received significant levels of bilateral assistance struggled to sustain activities, as was the case for Tanzania, whose national mental health programme stalled after DANIDA failed to renew their contract.[94]

The search for increased levels of international assistance for health and social welfare services – areas where national spending was severely constrained – saw AMHAG membership increase by at least fifteen countries in 1989 alone.[95] These countries highlighted shared concerns over the effects of economic and political insecurity not only on health services, but on mental health. In Zaire (now Democratic Republic of Congo), the political situation, and particularly university closures, was noted as having significant implications for student mental health.[96] In Benin, moreover, the Centre Yacquot saw an increase in outpatient consultations from 490 in 1990 to 860 in 1992, something explained as resulting from the 'deteriorating socioeconomic situation in the country'.[97] It was not regional cooperation that these new AMHAG member countries sought, however. By July 1991, the WHO had amassed a long list of requests from both old and new AMHAG members for extra-budgetary funding for mental health, reflecting the increasingly competitive policy space and budgetary constraints of the WHO as much as national difficulties.[98] Whereas some asked for funds to develop new programmes for HIV/AIDS patients, whose mental health psychiatrists claimed was being neglected by national governments, others asked for consultants to fill otherwise absent specialist positions, or to address the psychiatric and psychological fallout of war.[99] Among the proposals, only AFRO centred cooperation between AMHAG countries. They stressed the need, more than ever, for new 'Plans of Action' which, in contrast to earlier activities, would be coordinated directly by AFRO.[100]

Despite political and economic difficulties raising the profile of mental health and the possibilities offered by the AMHAG, it proved too difficult to sustain the earlier regional cooperation on mental health. Financial crises within both the WHO and AFRO left little money for activities beyond annual

[91]One of Sweden's goals of development assistance was to reduce the dependence of southern African countries on South Africa. From the early 1980s, there was growing concern about closer ties between Swaziland and South Africa, such as on trade and security. Samuel Falle and Karlis Goppers, '*Looking Both Ways: Swaziland between South Africa and SADCC. An Evaluation of Sweden's Development Co-Operation with Swaziland', SIDA Evaluation Report, Development Co-operation, Swaziland* (Stockholm: SIDA, 1988). On selective primary healthcare, see especially: Marcos Cueto, 'The Origins of Primary Health Care and Selective Primary Health Care', *American Journal of Public Health*, 94, 11 (2004), 1864–74; Oscar Gish, 'Selective Primary Care: Old Wine in New Bottles', *Social Science and Medicine*, 16, 10 (1982), 1049–54.

[92]WHO M4/370/15SWA Jkt 2, letter from B. Kalfors to N. Sartorius, 18 April 1986.

[93]WHO M4/370/15ZAM Jkt 1, f. 22, 'Progress Report on Mental Health in Samfya District', 3 August 1988, postscript.

[94]WHO M4/370/15TAN Jkt 8, 'Community Mental Health Activities in Tanzania – up to April, 1993', 1.

[95]WHO M4/370/15AF Jkt 12, 'WHO Workshops Promoting Cooperation Between African Countries: Members of the African Mental Health Action Group', 4.

[96]WHO M4/370/15AF Jkt 12, 'Comments made by speakers at fourth AMHAG technical meeting, Geneva, 11 May 1993', 2.

[97]WHO M4/370/15AF Jkt 12, African Mental Health Action Group, Fourth technical meeting, Geneva, 11 May 1993, 'Progress in the Implementation of Community Mental Health Services in Countries of the African Region: Summary of Reports from Countries', 1.

[98]WHO M4/370/15AF Jkt 12, memo from S. Calvani to T. Kawaguchi, 3 July 1991. On the WHO's financial difficulties, see: F. Godlee, 'The World Health Organisation: WHO in Crisis', *BMJ*, 309, 6966 (1994), 1424–8.

[99]See eg. WHO M4/370/15BOT Jkt 3, letter from Botswana Ministry of Health to R.J.M. Namboze, 18 December 1990; WHO M4/370/15KEN Jkt 3, W.J. Muya, 'Project Proposal: Baseline Survey on "Psychiatric Illness Among Offenders in Kenya Penal Institutions"'; WHO M4/370/15LIB, AFRO WHOGRAM from T. Ruth Tshabalala to G.L. Monekosso, 8 May 1991; WHO M4/370/15LIB, 'A W.H.O. proposed framework for National Counselling Programmes, submitted by Dr T. Ruth Tshabalala, WHO Representative, Monrovia, Liberia, January 1992'.

[100]WHO M4/370/15AF Jkt 12, WHO Summary of Proposal for Extra-Budgetary Funding, 11 October 1991, 'Workshops Promoting Cooperation'.

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meetings, and other African health networks and bodies increasingly exerted their influence on national and regional health policy, particularly with regard to financing. While later criticised for its role in introducing user fees, the Bamako Initiative had since September 1987 seen many African Ministers of Health, through AFRO's Regional Committee, pursue broad goals of providing basic health infrastructure through community co-financing and participation.[101] Cooperation within the AMHAG continued until 1994, yet offered little by way of comment on the changes being made to healthcare systems, or their implications for psychiatry and mental health. Instead, AMHAG meetings became themed around single issues, including HIV/AIDS and the mental health of refugees and victims of disasters. The value of the AMHAG remained in its role as a transnational network, yet without funding for cooperation activities even in this role the AMHAG was limited. When AMHAG activities ceased altogether in 1994, they did so with little comment. As Wankiiri reflected, 'the situation in AFRO gives me the impression that there is no body co-ordinating mental health activities…May be I am mistaken, but I have not heard from anybody in the last few years…Otherwise I have not yet been affected by "burnout"; only a sense of isolation and/or perhaps being out of touch'.[102]

Conclusion

The failure of the AMHAG was in the immediate sense a result of the financial difficulties faced by the WHO in the early 1990s, combined with a wider reorganisation of WHO priorities in line with donor objectives. Yet, it was also indicative of longer-term problems of sustainability, as well as a lack of coordination and a failure to recognise and develop African expertise within the AMHAG. It was a prime example of wider critiques of TCDC in the early 1990s, which drew attention to the limitations of technical assistance, an over-reliance on external consultants, and a lack of transparency and accountability.[103] When Elliot J. Berg published his 1993 UNDP review of technical cooperation programmes in Africa, its critique was hardly new: it highlighted the increasing impatience with technical assistance among political leaders, health administrators, and intellectuals in African countries, who resented the large sums of money directed towards technical assistance personnel in projects that were often ineffective at fostering self-reliance and strengthening local capacities.[104] It echoed AFRO's long-held concerns about the ways WHO-directed technical assistance was undermining the purpose of the AMHAG, as well as calls from psychiatrists, health administrators and AFRO for greater coordination and control over cooperation. As a review of TCDC by WHO Director-General Hiroshi Nakajima pointed out in relation to Africa in 1994, few countries had focal points for planning or cooperation, little attempt had been made to involve NGOs, civil society or the private sector, and more work was needed to identify in-country expertise.[105]

As a regional project and transnational network, the AMHAG reflected shifting geographies of expertise in international health cooperation, particularly in the contexts of decolonisation, self-determination, and the NIEO. While the skills and knowledge of the 'outside expert' had long been privileged in the bureaucratic and organisational structures of the WHO, as well as in the late colonial and early post-colonial state, much of what came to be established as policy within international health, at least from the 1960s, was shaped by a different expertise – localised knowledge and experience.[106] The

[101]Stephen W. Jarrett and Samuel Ofosu-Amaah, 'Strengthening Health Services for MCH in Africa: The First Four Years of the "Bamako Initiative"', *Health Policy and Planning*, 7, 2 (1992), 164–76.

[102]WHO M4/370/15BOT Jkt 3, letter from V. Wankiiri to J. Orley, 10 March 1993.

[103]Elliot J. Berg, *Rethinking Technical Cooperation: Reforms for Capacity Building in Africa* (New York: UNDP, 1993); Stephen Browne, *Developing Capacity Through Technical Cooperation: Country Experiences* (New York: Earthscan, 2002).

[104]Berg, *Rethinking Technical Cooperation.*

[105]WHA 47, Provisional agenda item 19, *Improving technical cooperation among developing countries: Report by the Director-General*, A47/4, 21 March 1994 (Geneva: World Health Organization, 1994), 9.

[106]Randall Packard, *A History of Global Health: Interventions into the Lives of Other Peoples* (Baltimore: Johns Hopkins University Press, 2016), 109.

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AMHAG marked a more systematic approach to older processes of knowledge exchange, policy discussion and sharing of information on mental health services, yet tied mobilities closely to the WHO's organisational priorities and structures, even as TCDC promised 'ownership' over development. Direct experience also did not always equate with expertise, however, something that represented a point of conflict between the WHO, AFRO, national governments and individual psychiatrists. Not only did experience on the continent serve as a justification for continuing to use expatriate rather than African consultants, but also the relationship between the AMHAG and other professional networks was never clear. Race was never made explicit here. Instead, it was barriers to participation for those on the continent that more often came to the fore, if the question of structural racism was certainly not lost on those in AFRO.

The AMHAG sits at the transition between 'international' and 'global' health during the 1980s and 1990s, a shift often located in the context of challenges to the WHO's authority and efficacy in the wake of budget shortfalls and the rise of competition from the World Bank.[107] This period did not see any significant increase in international actors interested in the South–South cooperation envisioned by TCDC or the AMHAG, and indeed many of the shifts during this period served to undermine this very cooperation. AMHAG countries needed to negotiate bilateral development assistance with donors whose priorities and resources were always changing, not least towards comprehensive primary healthcare as a goal. Moreover, with countries differently committed to mental health in primary healthcare, and in receipt of different levels of bilateral assistance, the regional struggled to take precedence over the national, and the AMHAG was never in a position to speak with a unified voice. This conclusion somewhat obscures the resilience, innovation and experimentation that this period also saw, however. The AMHAG may have been ineffective, but psychiatry and mental healthcare were not stagnant spaces. Government officials and psychiatrists were creative in their attempts to secure additional funding and support for mental health, exploring new avenues and mobilising politically salient arguments. It confirms the ongoing ability of psychiatry in Africa to shape international health and development agendas, and challenge international perceptions of Africa as a space for intervention.

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[107] Anne-Emanuelle Birn, 'The Stages of International (Global) Health: Histories of Success or Successes of History?', *Global Public Health: An International Journal for Research, Policy and Practice*, 4, 1 (2009), 50–68; Theodore M. Brown, Marcos Cueto and Elizabeth Fee, 'The World Health Organization and the Transition from "International" to "Global" Public Health', American Journal of Public Health, 96, 1 (2006), 62–72; Kanazawa, 'Disease in a Debt Crisis'.

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