

Global knowledge-power asymmetries and student mental health in sub-Saharan Africa: A case study from South Africa

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ABSTRACT

In the past decade concern about the mental health of university students has been growing worldwide. Yet epidemiological data and intervention research on student mental health comes predominantly from high income western countries in the Global North, with a relative scarcity of studies from sub-Saharan Africa and other countries in the Global South. While universities in the Global North and Global South face similar challenges to provide accessible, acceptable, and effective mental health services to students, there are also important historical, cultural, economic, and political issues that make it necessary for context-sensitive research which is responsive to the needs of students in the Global South. Using South Africa (SA) as a case study, this commentary aims to explore the relevance and appropriateness of uncritically importing knowledge and “evidence-based” strategies to student mental health challenges from the Global North into sub-Saharan Africa. The article draws on research from South Africa to illustrate how distinct and varied contextual issues create unique challenges to promoting student mental health that cannot be solved with foreign knowledge. Recommendations are made for how equitable partnerships between countries in sub-Saharan Africa could support student well-being in the region. Key to creating equality in the global provision of appropriate student support services is a strategy and funding to redress global knowledge-power imbalances and set research agendas from within the Global South.

Keywords: University students, Mental health, South Africa, Global South, sub-Saharan Africa, Higher Education

In the past decade concern about the mental health of university students has been growing worldwide, with increasing awareness of the need to provide appropriate, accessible, and sustainable campus-based mental health services (Duffy et al., 2019; Mortier et al., 2018). The global COVID-19 pandemic, which started in December 2019, exacerbated concerns about student mental health and intensified the urgency to identify appropriate responses and implement effective campus-based interventions to help address these concerns (Copeland et al., 2021; Li et al., 2021; Zapata-Ospina et al., 2021). There are already a wide variety of evidence-based interventions to promote student mental health, including psychoeducational programmes (e.g., psychological literacy (Reis et al., 2022) and psychological first aid training (Ruzek et al., 2007).), group interventions (Peden et al., 2000, 2001; Vázquez et al., 2012), indicated interventions (Cuijpers et al., 2021), and digital interventions (Sharma et al., 2020). Yet there is a significant treatment gap on university campuses, even when free services are available, in large part because students face a number of barriers to accessing treatment, including attitudinal and psychological barriers (e.g., stigma and perceptions about confidentiality), contextual and structural barriers (e.g., scheduling problems, insufficient information about where and how to access services), and a lack of perceived need for treatment (e.g., failing to recognise when professional help is needed) (Dunley & Papadopoulos, 2019). In many parts of the world, the key challenge universities face is not so much identifying effective interventions, but rather how to implement interventions in ways that are acceptable and accessible to students by overcoming common barriers to treatment seeking (Lui et al., 2022).

Universities in sub-Saharan Africa (as is true in many other low- and middle-income countries in the Global South) face the additional challenge of significant resource constraints, which impedes the implementation of campus-based interventions and prevent scale-up of existing services (Bantjes, Saal, Lochner, et al., 2020). Nonetheless, promoting the mental health of students in sub-Saharan Africa is important given the strong associations between mental health and academic attainment (Eisenberg et al., 2009; Jeffries & Salzer, 2021; Wyatt et al., 2017), and given that higher education is a key driver of economic development (Schendel & McCowan, 2015). But it is not only resource constraints that hinder the promotion of student mental health in sub-Saharan Africa; there are also a range of global knowledge-power asymmetries and epistemic injustices that stand in the way of promoting student mental health in the region and (more broadly) achieving equality in students' access to mental health services across the globe. While universities in the Global North and South face similar challenges regarding the provision of student mental health services, there are important historical, contextual, political, and cultural issues that make it inappropriate to simply “cut-and-paste” solutions from the Global North into sub-Saharan Africa. Using South Africa (SA) as a case study, this commentary explores the relevance and appropriateness of uncritically importing knowledge and “evidence-based” strategies to student mental health challenges from the Global North into sub-Saharan Africa. The article draws on research from SA to illustrate how distinct and varied contextual issues create unique challenges to promoting student mental health that cannot be solved with foreign knowledge. The article concludes with a discussion of the implications of these knowledge-power asymmetries and the possibilities for collaborations in sub-Saharan Africa to promote student mental health in the region.

STUDENT MENTAL HEALTH IN SOUTH AFRICA

There are five clear examples from research on student mental health in SA that illustrate how contextual, historical, and political factors create unique challenges that cannot easily be solved with knowledge from the Global North, namely : (1) psychiatric hegemony and global power asymmetries; (2) politicization of student mental health; (3) inadequate public adolescent mental health services; (4) historical inequalities across universities; and (5) widespread exposure to trauma. Below I provide a brief overview of current epidemiological research on student mental health in SA before discussing how these five contextual factors illustrate the need for authentic and contextually relevant research from the Global South.

Epidemiology of student mental health in SA

The mental health of SA university students is a serious public health and educational concern (Bantjes et al., 2019; Makhubela, 2021), as is the case in many other parts of the world (Duffy et al., 2019; Storrie et al., 2010). A recent national student mental health survey across 17 of the 26 publicly funded universities in SA ($n = 28,268$) reported 30-day prevalence estimates of 16.3% for mood disorders and 37.1% for anxiety disorders (J. Bantjes, Kessler, Lochner, et al., 2023). Similarly, the 30-day prevalence of suicidal ideation was 24.4% ($SE=0.3$), with 1.5% ($SE=0.1$) of students reporting that they were very likely to act on their suicidal ideation and 3.9% ($SE=0.2$) reporting they were somewhat likely to act on these thoughts (J. Bantjes, Kessler, Hunt, et al., 2023). Crucially, only 21.3% ($S.E.=0.4$) of students with mental disorders received any treatment in the preceding 12-months, with students reporting multiple barriers to treatment including psychological/attitudinal barriers (too embarrassed; afraid might adversely affect school or professional career; worried people would treat them differently) and practical barriers (unsure where to go; too expensive; problems with time, transportation, or scheduling), in addition to wanting to handle problems on their own, preference to talk to family/friends; and being unsure of treatment effectiveness. The results of the national survey echo findings in previous smaller scale studies which show high rates of mental disorders among SA students (Bantjes et al., 2019; Bantjes et al., 2016). One study of first year students at two well-resourced universities in SA found strong associations between mental health and academic success, with a population attributable risk analysis suggesting that providing effective treatment to students with major depressive disorder and/or attention deficit hyperactivity disorder could yield a 6.5% absolute reduction (equivalent to a 23.0% proportional reduction) in prevalence of academic failure (Bantjes, Saal, Gericke, et al., 2020), highlighting the need to address student mental health as an integral component of strategies to promote academic retention and throughput. Data show clearly that rates of mental disorders among SA students have been increasing steadily since 2015, although the increases in prevalence rates observed in the first year of the COVID-19 pandemic were no larger than increases observed in previous years (J. Bantjes, Swanevelder, et al., 2023). While there is a clear need for appropriate interventions on SA university campuses, it is less clear how to provide scalable and relevant services which are acceptable to students. Even though there are evidence-based interventions that have been developed and tested

in the Global North, there are important contextual factors in SA that call into question the appropriateness of uncritically importing these strategies.

Psychiatric hegemony and global power asymmetries

It is noteworthy that the epidemiological data collected in the SA national student mental health survey (J. Bantjes, Kessler, Lochner, et al., 2023) was grounded in a western psychiatric biomedical model of psychological distress, using the language of symptoms and disorders, and the diagnostic system of the American Psychiatric Association's Diagnostic and Statistical Manual for Mental Disorders (DSM) (American Psychiatric Association, 2013). The use of the DSM as the basis of the SA national student survey probably reflects (at least in part) the dominance of western ideas about mental health (Kirmayer, 2020), psychiatric hegemony (Cohen, 2016), and the ever increasing global trend towards psychiatrization (i.e., the increasing tendency to view everyday struggles as mental disorders) (Haslam et al., 2021). While epidemiological research within a biomedical framework can be helpful, it often rests on assumptions about what constitutes psychological distress, while conflating psychological distress with disorders (i.e., pathologizing and medicalizing students' everyday stress and struggles) (Haslam et al., 2021). Crucially, epidemiological studies like the SA national survey (J. Bantjes, Kessler, Lochner, et al., 2023) start with predetermined ideas about what problems students experience and how these challenges will manifest in particular symptoms, without acknowledging that idioms of psychological distress are culturally grounded and that SA students may face context driven struggles that are not neatly captured in psychiatric diagnostic categories (Cork et al., 2019).

While psychiatric epidemiological research is essential for international benchmarking, planning targeted interventions, and planning formal treatment programmes, the findings of the SA national survey may not necessarily reflect what is important to students. There is clear value in more open-ended research that begins by asking students, "What are the kinds of problems you experience and what kinds of support do you need?" without a priori assumptions that students need western psychiatric interventions.

Politization, weaponization and democratisation of student mental health

In October 2015, the #FeesMustFall student protests started at the University of Witwatersrand, University of Cape Town, and Rhodes University before rapidly spreading to other universities across SA (Hodes, 2017). Although the protests were initially triggered by announcements of student fee increases, the movement grew to encompass other issues including the decolonisation of universities and the need to support the mental health of students (Kaminer & Shabalala, 2019; Shai & Molapo, 2018). These protests disrupted learning at all SA universities, caused widespread property damage, and led to the cancellation of exams (Mavunga, 2019; Shepherd, 2020). Military and riot police were deployed to campuses resulting in violent clashes with students and student deaths (Xaba, 2017). Protests continued intermittently until 2017 and have had a marked enduring impact on the higher education landscape in the country. By linking mental health to broader political issues, such as free education and decolonisation, the students involved in

#FeesMustFall weaponised mental health by employing the rhetoric of mental health to communicate discomfort, distress, and political dissatisfaction. One enduring impact of the #FeesMustFall movement is that student mental health and wellbeing has become politicized in SA.

The politicization of student mental health has created an imperative for universities to democratise student mental health services by actively consulting students about how, what, where, and when support services should be offered. Hearing the voices of students and actively aligning services with students' expressed needs and preferences has become integral to the student mental health agenda in SA, making it impossible to import solutions developed in the Global North without extensive consultation with students and cultural adaptation of these interventions to ensure they are acceptable and appropriate.

The politicization of student mental health in SA has also brought with it the added complication of needing to differentiate when the discourse of "mental health" is used by students to point to problems that need psychiatric interventions, when it is used to signal that something is challenging or uncomfortable, and when it is used to draw attention to contextual socio-economic or political issues (like financial pressure, housing insecurity and inadequate academic preparation for tertiary education). Of course, the provision of mental health services is always political and entails complex (if not always visible) power dynamics and the exercise of biopower (Roberts, 2005). The point here, however, is the need to be aware of how using the language of mental health (e.g., depression, anxiety, and suicide) to communicate all manner of distress faced by students could obscure the socio-political and economic determinants of students' struggles and create the impression that psychiatric interventions are needed rather than eco-systemic reforms and political disruption.

An inadequate public adolescent mental health system

A distinctive feature of the landscape in which SA universities operate is an overburdened public healthcare system with very poor access to public adolescent mental health services (Flisher et al., 2012; Petersen & Lund, 2011). Campus-based student counselling services thus operate in relative isolation with no easy and efficient way to refer students into a functional public mental health system. This has profound implications for the delivery of student mental health support services, putting universities under significant pressure to provide extensive wrap around services, including support groups for high risk populations, such as LGBTQ+ youth and first-generation students (i.e. students whose parents have no tertiary education), on-demand counselling services for the problems of daily living, ongoing therapy for students with common mental disorders, 24-hour crises and suicide preventions services, and acute and chronic care for students with severe mental illnesses (such as bipolar mood disorders and psychotic illnesses). The absence of an efficient and functional public mental health system makes it challenging (if not impossible) to implement evidence-based student interventions that were designed for settings where students have access to a broad array of other mental health services, community-based resources, and social support. For example, many of the evidence-based campus suicide prevention programmes (such as the Question, Persuade, Refer programme and other Gatekeeper Training programmes) assume that there is a larger functional healthcare system that is willing and able to accept referrals of young people with suicidal ideation,

but this is not always the case in SA or indeed in many other low- and middle-income countries (Breet et al., 2021).

Universities in SA were not created equal

The political history of segregation in SA has had an enduring impact on institutions of higher learning (Bozalek & Boughey, 2012). The government's apartheid era policies of differential spending on Black and White students, and the creation of universities for different population groups has created a system in which historically white institutions (HWIs) continue to be better resourced than historically disadvantaged institutions (HDIs). Although considerable advances have been made to transform universities (at least in terms of increasing representation of students historically excluded from universities, such as students who identify as Black, female, and/or disabled), inequalities persist across institutions, particularly with respect to resource endowments, research output, and infrastructure to support teaching and learning (Bawa, 2018; Somers et al., 2013). These inequalities shape the support needs of students and the kinds of interventions that can be implemented.

The SA national student survey (J. Bantjes, Kessler, Lochner, et al., 2023) showed significant differences in the distribution of mental disorders across the various universities although there was some consistency in terms of risk factors, except for population group. Prevalence estimates for common mental disorders varied significantly by historical segregation status of institutions, with prevalence estimates for all disorders consistently higher in HWIs (J. Bantjes, Kessler, Lochner, et al., 2023). Across all institutions, risk of any disorder was lower among older students, and elevated among gender non-conforming, female, and sexual minority students. Black students attending HWIs had elevated risk of any disorder relative to White students (J. Bantjes, Kessler, Lochner, et al., 2023). These data highlight how even within a country there can be important differences in the prevalence of mental health problems and the risk profile of students across institutions, highlighting the need for context sensitive data and caution in extrapolating results from one setting to another.

Exposure to trauma

SA's political history has created on-going difficulties with inequality, as well as high rates of trauma, violent crime, and gender-based violence (Enaifoghe et al., 2021; Obagbuwa & Abidoye, 2021). In one study, 48.4% of SA university students reported childhood maltreatment, the most common type being emotional abuse (26.7%) (Myers et al., 2021). It is thus unsurprising that 21.0% of SA university students screen positive for post-traumatic stress disorder (PTSD) in the preceding 30-days, which far exceeds that typically reported among students in other countries (Boals et al., 2020). Similar elevated rates of PTSD among SA students have been reported in other studies (Bantjes et al., 2016; Padmanabhanunni & Wiid, 2021). These data suggest that PTSD may be as much of a problem as depression and anxiety disorders among SA students, and that there is a need for interventions to help students who have survived traumatic events. Typically, discussions of student mental health focus narrowly on depression, anxiety, and suicide, as

if these are always the most common mental health problems students experience, but this may not be true everywhere and certainly does not appear to be true in SA.

DISCUSSION

The case study from SA and examples presented above illustrate how cultural, historic, and political factors create a need for context-sensitive student mental health research and highlights the need for caution when uncritically importing strategies developed in the Global North to countries in the Global South. There are several important implications of this case study for research and practice to promote student mental health in sub-Saharan Africa, including the need to collect reliable epidemiological data while simultaneously questioning and resisting psychiatric hegemony, promoting trans-national research collaborations within the region, distinguishing mental disorders from other idioms of distress, and developing indigenous evidence-based interventions which are responsive to the contextual needs of students in the region.

Many countries in sub-Saharan Africa do not have reliable epidemiological data about the prevalence and distribution of mental disorders among university students. While there have been some small studies, these have tended to be limited in the scope of the disorders they assess, rely on small samples typically from only one university, and/or make use of poorly validated instruments (January et al., 2018). Without accurate epidemiological data it is difficult to advocate for resources to support student mental health in the region and hard to set priorities or plan targeted interventions. The lack of reliable epidemiological student mental health data in most of sub-Saharan Africa compared to countries in the Global North, highlights the much bigger problem of global knowledge asymmetries, which is a key obstacle to achieving global equality in student mental health. Research collaborations between countries in sub-Saharan Africa could help to address global knowledge asymmetries, but only if the research is responsive to the needs of students in the region and does not reproduce the dominance of western psychiatric hegemony.

While it is important to collect epidemiological data on student mental health problems it is also important for researchers in sub-Saharan Africa to resist the hegemony of western diagnostic systems in the field of student mental health and to think more critically about the starting assumptions of student mental health research in the region. There are, of course, problems associated with resisting western psychiatric hegemony in student mental health research. For one thing, researchers in the Global South often must speak the language of the Global North to gain international legitimacy, secure funding, and publish in high impact academic journals. Furthermore, researchers focusing on student mental health in sub-Saharan Africa may find it easier to secure international funding, collaborate with “leading” international scholars, and advance their academic careers if they work within a western psychiatric paradigm. This reflects the much larger issue of global power asymmetries in the production of knowledge and in the setting of research agendas in many fields of science, not just student mental health (Bradley, 2017).

One potential solution to this problem is for governments within sub-Saharan Africa to ear-mark local funding dedicated to student mental health research that is responsive to problems that students in the region identify as important, and to establish a network of researchers to undertake this work. Local funding would free scholars in the

region to be responsive to the context and needs of local students without having to fit their research into an agenda set by funders in the Global North or work tightly within the framework of diagnostic systems like the DSM (Bradley, 2017). Furthermore, establishing a network of student mental health researchers in sub-Saharan Africa, led by researchers within the region, would enable economies of scale and resource sharing to undertake sophisticated and rigorous research with large representative samples. This kind of strategic resource sharing is particularly important in sub-Saharan Africa's resource constrained higher education environments where strong research networks and equal partnerships are needed.

While epidemiological research focusing on the aetiology of mental disorders among students in the region is important, there is also a need to be aware of how using psychiatric language to communicate any distress faced by students could obscure the socio-political and economic determinants of students' struggles and create the impression that psychiatric interventions are needed rather than eco-systemic interventions. Student mental health research in sub-Saharan Africa should not only take account of cultural idioms of distress but should explicitly consider how contextual factors (such as gender-based violence, housing and food insecurity, and inadequate preparation for tertiary education) could adversely affect student wellbeing (Klerk & Dison, 2022).

Local context-sensitive solutions and strategies that do not rely on referrals and/or professional psychiatric intervention need to be developed. These might, for example, include peer-to-peer support (Dick et al., 2022) and other task sharing approaches developed for university students. There are already a number of examples of effective and sustainable context-sensitive and culturally appropriate mental health interventions which have been developed in sub-Saharan Africa, including for example the Friendship Bench in Zimbabwe (Chibanda et al., 2016), culturally adapted positive psychology interventions in Ghana (Appiah, 2022), and the application of the African philosophy of ubuntu to mental healthcare practices (Chigangaidze, 2021). While developing and evaluating these "home-grown" solutions and interventions, it will be important for researchers and service providers to take cognisance of key scientific advances in understanding the mechanisms through which interventions lead to change and the expanding knowledge about the active ingredients (i.e., effective elements) of interventions (Wolpert et al., 2021). The challenge here is how to harness the best scientific evidence about what aspects of interventions drive changes to develop context-sensitive and culturally appropriate interventions for students in sub-Saharan Africa (Sithaldeen et al., 2022).

While the discussion above has focused on the implications of global knowledge-power asymmetries for student mental health research and practice in sub-Saharan Africa, many of the recommendations and arguments apply equally to other low- and middle-income countries in the Global South and are thus relevant to achieving equality in access to student mental health globally.

CONCLUSION

While universities in the Global North and South face similar challenges to provide accessible, acceptable, and effective mental health services to students, there are also important historic, cultural, economic, and political factors that make it difficult to rely exclusively on foreign knowledge to advance student mental health in sub-Saharan Africa.

The examples from SA discussed above show how global knowledge and power asymmetries, the hegemony of western psychiatric theory and praxis, the politicisation of student mental health, an inadequate public mental health system, historical inequalities, and ubiquitous rates of trauma create unique contextual challenges in student mental health that cannot be solved with foreign knowledge. Similarly, other countries in sub-Saharan Africa face unique context-sensitive challenges that require indigenous responses and research from within the region. Opportunities exist for researchers and clinicians in sub-Saharan Africa to collaborate, establish networks and share knowledge and resources to drive advances in student mental health that are responsive to the needs of students in the region and sensitive to the various cultural, political, and economic contexts. Key to creating equality in the global provision of appropriate student support services is a strategy and funding to redress global knowledge-power imbalances and set research agendas from within the Global South.

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