KUVEZA NEKUUMBA

THE ZIMBABWE EZEKIEL GUTI UNIVERSITY JOURNAL OF DESIGN, INNOVATIVE THINKING AND PRACTICE

ISSN 2957-8426 (Print)

Vol. 3 Issues (1&2), 2024

Published by the Zimbabwe Ezekiel Guti University Press
Stand No. 1901 Barrassie Rd,
Off Shamva Road
Box 350
Bindura, Zimbabwe

Typeset by Divine Graphics
Printed by Divine Graphics

SUBSCRIPTION AND RATES
Zimbabwe Ezekiel Guti University Press Office
Stand No. 1901 Barrassie Rd,
Off Shamva Road
Box 350
Bindura, Zimbabwe
Telephone: ++263 8 677 006 136 | +263 779 279 912
E-mail: zegupress@zegu.ac.zw
http://www.zegu.ac.zw/press

About the Journal

JOURNAL PURPOSE

The purpose of the *Kuveza neKuumba - Zimbabwe Ezekiel Guti University Journal of Design, Innovative Thinking and Practice is* to provide a forum for design and innovative solutions to daily challenges in communities.

CONTRIBUTION AND READERSHIP

Planners, engineers, social scientists, business experts, scholars and practitioners from various fields.

JOURNAL SPECIFICATIONS

Kuveza neKuumba - Zimbabwe Ezekiel Guti University Journal of Design, Innovative Thinking and Practice

ISSN 2957-8426 (Print)

SCOPE AND FOCUS

The journal is a forum for the discussion of ideas, scholarly opinions and case studies of multidisciplinary perspectives of design and innovative thinking. The journal is produced bi-annually.

Guidelines for Authors for the Kuveza Nekuumba Journal

Articles must be original contributions, not previously published and should not be under consideration for publishing elsewhere.

Manuscript Submission: Articles submitted to the *Kuveza neKuumba - Zimbabwe Ezekiel Guti University Journal of Design, Innovative Thinking and Practice are* reviewed using the double-blind peer review system. The author's name(s) must not be included in the main text or running heads and footers.

A total number of words: 5000-7000 words and set in 12-point font size width with 1.5 line spacing.
Language: British/UK English
Title: must capture the gist and scope of the article
Names of authors: beginning with the first name sand ending with the surname
Affiliation of authors: must be footnoted, showing the department and institution or organisation.
Abstract: must be 200 words
Keywords: must be five or six containing words that are not in the title
Body: Where the authors are more than three, use *et al.,*
Italicise *et al., ibid.,* words that are not English, not names of people or organisations, etc. When you use several authors confirming the same point, state the point and bracket them in one bracket and ascending order of dates and alphabetically separated by semi-colon e.g. (Falkenmark, 1989, 1990; Reddy, 2002; Dagdeviren and Robertson, 2011; Jacobsen *et al.,* 2012).

Referencing Style: Please follow the Harvard referencing style in that:
— In-text, citations should state the author, date and sometimes the page numbers.
— the reference list entered alphabetically, must include all the works cited in the article.

In the reference list, use the following guidelines, religiously:

Source from a Journal

Anim, D.O and Ofori-Asenso, R. (2020). Water Scarcity and COVID-19 in Sub-Saharan Africa. *The Journal of Infection, 81*(2), 108-09.

Banana, E, Chitekwe-Biti, B and Walnycki, A (2015). Co-Producing Inclusive City-Wide Sanitation Strategies: Lessons from Chinhoyi, Zimbabwe. *Environment and Urbanisation*, *27*(1), 35-54.

Neal, M.J. (2020). COVID-19 and Water Resources Management: Reframing Our Priorities as a Water Sector. *Water International*, *45*(5), 435-440.

Source from an Online Link

Armitage, N, Fisher-Jeffes L, Carden K, Winter K *et al.,* (2014). Water Research Commission: Water-sensitive Urban Design (WSUD) for South Africa: Framework and Guidelines. Available online: https://www.greencape.co.za/assets/Water-Sector-Desk-Content/WRC-Water-sensitive-urban-design-WSUD-for-South-Africa-framework-and-guidelines-2014.pdf. Accessed on 23 July 2020.

Source from a Published Book

Max-Neef, M. (1991). *Human Scale Development: Concepts, Applications and Further Reflections,* London: Apex Press.

Source from a Government Department (Reports or Plans)

National Water Commission (2004). Intergovernmental Agreement on a National Water Initiative. Commonwealth of Australia and the Governments of New South Wales, Victoria, Queensland, South Australia, the Australian Capital Territory and the Northern Territory. Available online: https://www.pc.gov.au/inquiries/completed/water-reform/national-water-initiative-agreement-2004.pdf. Accessed on 27 June 2020.

The source being an online Newspaper article

The Herald (2020). Harare City Could Have Used Lockdown to Clean Mbare Market. *The Herald,* 14 April 2020. Available online: https://www.herald.co.zw/harare-city-could-have-used-lockdown-to-clean-mbare-market/. Accessed on 24 June 2020.

A Thematic Review on the African Perspective on Caregiver Experiences

BAZONDILE DUBE[1], MANASE CHIWESHE[2] AND JACOB MAPARA[3]

Abstract

Caring for patients with mental disorders brings many challenges for informal/unpaid carers, especially relatives. This article provides a brief overview of the literature on caregivers' experiences in caring for a relative with mental illness. The areas identified and discussed that may impact the caregivers include gender and caregiver burden, patriarchy, gender differences in caregiving, economic factors and policy frameworks in caregiving in different African countries. The following databases were searched to identify studies for the literature review: Google Scholar, Medline, Pub Med and HINARI. Studies eligible for inclusion were all those published in English about caregiving in Africa among families of individuals with mental illness. Family caregivers were found to be primarily females who experience the burden of caregiving. The study concludes that the socioeconomic factors hurt the caregiving process, with consequential negative health outcomes for family caregivers.

Keywords: caregiving, mental disorders, economic burden, patriarchy, gender differences, Africa

INTRODUCTION

The cases of mental disorders are increasing in the 21st century and are everywhere, including homes and workplaces (World Health Organisation (WHO), 2023). The burden of mental disorders is on the rise globally and impacts the health, socio-economic status and human rights of individuals (WHO, 2020). It is estimated that 25% of the world's global population is

---

[1] Department of Mental Health, Faculty of Medicine and Health Sciences, University of Zimbabwe, Harare, Zimbabwe

[2] Department of Community and Social Development. University of Zimbabwe, Harare, Zimbabwe

[3] Institute of Lifelong Learning and Development Studies, Chinhoyi University of Technology, Chinhoyi, Zimbabwe

suffering from some mental disorders (Cheah *et al.*, 2020). However, an estimated 6% have been found to have a serious or severe mental disorder (Ndlovu and Mokwena, 2023). The figures presented the total estimated number of people with severe mental disorders in the world, considering that another research confirmed that there are an estimated 450 million people in total (Walke *et al.*, 2018). A further breakdown of the figures show that one (1) out of four (4) people suffers from a mental disorder. That disorder is catered for by relatives of the affected individuals (Ntuli *et al.*, 2019; Redubla and Cuaton, 2019; Ndlovu and Mokwena, 2023).

Recent studies have stated that a growing number of people experience mental disorders (Fernando, 2014; Bruffaerts *et al.*, 2015; Polanczyk *et al.*, 2015; Hanna *et al.*, 2018). Mental disorders contribute an estimated 14% of the global burden of diseases, even though they are responsible for as little as 1% of deaths, with the highest burden being in developing countries (Global Burden of Disease (GBD), 2019). The burden negatively impacts the affected countries' economic profile, resulting in a decline in productivity at both the individual and national levels (Maresova *et al.*, 2020; Tristiana *et al.*, 2018; Opoku-Boateng *et al.*, 2020;). Some overwhelming evidence of the negative impacts of mental disorders on caregivers’ well-being and health continues to emerge and are reported to be worse, more embarrassing and more depressive to the caregivers (Gupta *et al.*, 2015; Maresova *et al.*, 2020).

Due to a global deinstitutionalisation of the treatment of mental disorders, only a small proportion of those suffering from mental disorders are admitted to hospitals (WHO, 2017). This has led to a shift in care roles from health professionals who provide institutionalised care, to an integrated community-based approach, with family members now being the primary caregivers (Tamizi *et al.*, 2020:12). Since then, it is estimated that the caregiver roles of 50-90% of people with mental disorders are now a responsibility of family members (Grover and Pradyumna, 2014). These responsibilities include physical company, monitoring intake of medications, assisting with activities of daily living, psychological and emotional support and active listening, resulting in those individuals being dependent on their carers (Grover and Pradyumna, 2014; Mavingire, 2019). At the same time, those caregivers are not properly trained to deal with those challenges and are unpaid, especially in Zimbabwe and other developing countries (Bhandari *et al.*, 2015; Mavingire, 2019). Thus, their burden is a double tragedy where they are forced to use their skills to adapt to the caregiving roles and assume a full-time unpaid job that is risky and depressive (Trepel, 2010; Mavingire, 2019).

Despite facing such lifetime burdens, caregivers continue to play the important role of supporting family members suffering from mental disorders or the disabled (Abraham *et al.*, 2010; Maresova *et al.*, 2020). The families of patients with mental disorders are undoubtedly affected by the conditions of their loved ones. Those demands of the affected family members can bring significant stress levels to the caregivers and affect their work, relationships and quality of life (Mavingire, 2019). Some research on the impact of caregiving has proved that most caregivers experience psychological distress and increased rates of ill health than the general population (Sharma *et al.*, 2016; Norris *et al.*, 2018). Caring for a family member with a mental illness has been found to have unlimited financial difficulties, social isolation and negative emotions (Lamont and Dickens, 2021). There is also risk of reduced life expectancy and less time for social and leisure activities among family caregivers (Hsiao *et al.*, 2020; Mckee, 2020). This is an additional albatross in the lives of the caregivers, especially within the African context, because socialising and spending time with others is valued (Mavingire, 2019).

In African societies, taking care of a family member with a chronic mental disorder and in need of constant care has been traditionally shared among family members and the extended family (Marimbe *et al.*, 2016; Ntuli and Madiba, 2019). Sharing the responsibility of caregiving within the extended family has been found to be beneficial to caregivers and persons with chronic illnesses in terms of social support. However, changes in the social structures continue to shrink the extended family space, thereby driving towards the nuclear families (Kartalova, 2008). These nuclear families are left without social support, unlike in extended families. As a result, many caregivers are left to bear their physical, emotional, financial and spiritual burdens in isolation, missing their traditional family support (Dussel *et al.*, 2011; Cameron *et al.*, 2015;).

METHODOLOGY

SEARCH STRATEGY

Four themes were identified based on key themes from studies conducted in developed countries. They included patriarchy, gender and caregiving, gender differences and caregiver burden, economic factors and policy frameworks in caregiving in different African countries. The Medical Subject Headings (MeSH) database was used as a controlled vocabulary for search strategy formulation (Remacle, Jean François and Shephard, 2003). The study adopted the Participants, Concept and Context framework from the Joanna Briggs Institute on conducting systematic literature search and used the following search strategy:

Keyword	**Alternative Terms**
Caregivers (Participants)	"Caregivers"[Mesh] OR Family Caregiver OR Carers OR Care giver OR Informal caregivers OR Spouse caregiver OR Primary Family Caregiver OR Caregiver, Informal
AND	
Mental Illness (Concept 1)	"Mental Disorders"[Mesh] OR Psychiatric Illness OR schizophrenia OR dementia OR Psychiatric Disorders OR bipolar disorders OR depression OR drug induced psychosis patients OR Severe Mental Illness
AND	
Impact on Caregivers (Concept 2)	Impact on Caregivers OR Patriarchy OR "Family Structure"[Mesh] OR Family Roles OR gender and caregiving OR "Gender Identity"[Mesh] OR Gender "Caregiver Burden"[Mesh] OR Caregiver Stress OR Caregiver Strain OR Caregiver Burnout OR "Economic Factors"[Mesh] OR Policy frameworks
AND	
Africa (Context)	(("Africa South of the Sahara") OR "Africa, Eastern") OR "Africa, Northern") OR "Africa, Southern") OR "Africa, Western") OR "Africa") OR "African") OR "Angola") OR "Botswana") OR "Cameroon") OR "Cape Verde") OR "Central African Republic") OR "Egypt") OR "Ethiopia") "Ghana") OR "Kenya") OR "Lesotho") OR "Malawi") OR "Mozambique") OR "Namibia") OR "Nigeria") OR "South Africa") OR "Swaziland") OR "Tanzania") OR "Uganda") OR "Zambia") OR "Zimbabwe"))

The search for the relevant literature was conducted across the following databases: African Journals Online, PubMed, Scopus, Embase and CINAHL.

ELIGIBILITY CRITERIA

The following inclusion and exclusion criteria were used to identify the relevant studies for the literature review:

Include	**Exclude**
All studies published in English language	Non-English studies
Studies on informal/family caregivers	Studies on formal caregivers
Studies on mental illness in adults	Studies on mental illness in children
Studies discussing patriarchy; economic factors; policy framework; gender and burden of care	Studies that exclude any of the four pillars
Studies from any country in Africa	Studies done outside Africa
All peer reviewed studies including reports and grey literature	All non-peer reviewed publications such as newspaper articles, blogs, letters
Articles published regardless of the publication date	

FINDINGS

GENDER AND CAREGIVER BURDEN IN AFRICA

Women are often the main informal caregivers for the elderly in many parts of the world (Morris, 2001; Prince, 2009; Akpinar, 2011) and are often seen as the best caregivers in a situation where care is more intense and requires more problem-solving skills (Swinkels, 2019). The finding that most family caregivers were female was previously reported in other studies conducted both in developing and developed countries, where care-giving responsibilities were assumed mostly by females (Prince, 2009; Powell and Hunt, 2013; Ntuli and Madiba, 2019) and the burden of care was higher among females (Rezende *et al.*, 2017). Generally, the burden of care is predominantly high among middle-aged females who may be obligated to care for their children and their aging parents (Rezende *et al.*, 2017; Mavingire, 2019). A cross-sectional study conducted by Sebit and Nyati (2002) in Zimbabwe sought to explore burden of mental illness on family members, caregivers and the community. Findings reveal that most of the caregivers were females, who experienced more burden than males. In another study conducted in the same country by Marimbe *et al.* (2016), most caregivers were mothers who experienced more burden of care than their male counterparts. These studies have also found that women experience greater mental and physical strain, greater caregiver-burden and higher levels of psychological distress while providing care.

It is important that as humans move around through life with changing demographics that some will have to function as caregivers. Family members are expected to take on the caregiving role that is expected of them (Collins and Kishita, 2020; Grover *et al.*, 2015). However, the indisputable strength of informal caregiving lies on female family caregivers, whose roles are often directed by African traditional beliefs and endorsed by culture and religion. It has been declared that caregiving is feminised and women are socialised into nurturing roles (Aronson, 1992; Haralambos and Holborne, 2004). The African traditional gender norms exclude men and boys from caregiving and assign that role to females. The role of women in Africa extends from the reproductive role to nurturing infants and sick family members and continues throughout their lifetime. The importance of this role is often not recognised by the family except by the care recipients themselves (Parks and Pilisuk, 1991; Bhandari *et al.*, 2015). Women then sacrifice to fulfil this role and some of them leave school or their jobs to provide that care (Maresova *et al.*, 2020). This added responsibility may affect one’s coping mechanisms and manifest as psychological distress or burden. It appears that women are often concerned about the wellbeing of the people they take care of and this attachment is the one that motivates them to continue providing care (Ajibade *et al.*, 2016; Olagundoye and Akhuemokhan, 2017; Walke *et al.*,2018).

Higher levels of caregiver-burden, psychological morbidity, stress, burnout and poorer quality of life among female caregivers of those with mental disorders have been reported in a number of studies (Jenkins and Schumacher, 1999; Wancata*et al.*, 2008; Mavundla *et al.*, 2009; Zahid, Ohaeri, 2010; Powel *et al.*, 2013; Collings, 2015; Marimbe *et al.*, 2016; Ntuli and Madiba, 2019). However, a qualitative study conducted in Uganda reveals that women had better coping skills than men, something attributed to the fact that women provide most of the day-to-day caregiving roles which comes from their nurturing and upbringing (Kipp *et al.*, 2007) through which they gain skills on how to handle stressful situations and learn problem-solving skills (Kagwa *et al.*, 2021). The reduced burden of caregiving reported by women in this study could also be due to the social desirability bias related to cultural and social expectations of women in most African settings, where women are expected to provide care and put everyone first before putting themselves (Oduyeyo, 2009; Lorber, 2018).

Psychological burden of caregiving in Sub-Saharan Africa was reported to be higher among female caregivers of patients with a long history of illness and severe and debilitating symptoms (Tajudeen *et al.*, 2010; Yusuf, Nuhu, 2011). Female caregivers report both subjective and objective burden because of caring for a family member with mental illness (Ambikile and Outwater, 2012; Monyaluoe, Mvandaba, 2014; Flyckt, Fatouros-Bergman and Koernig, 2015); Rezende *et al.*, 2017; Ofovwe and Osasona, 2022

GENDER DIFFERENCES IN CAREGIVING

In the context of Africa, specifically Zimbabwe, Nkomo (2014) reveals that caring for someone with a mental illness has been a family endeavour. This is true of developed and developing countries. Social and health-policy changes have placed greater emphasis on home and family-care for the chronically mentally ill in both developed and developing countries. In contrast, families have always been the mainstays of care for the mentally ill in developing countries (Leggatt, 2002; Shankar and Rao, 2005).

The pattern of living arrangements in developing countries is multi-generational in nature, that is an advantage to the patient in terms of the large number of potential caregivers. Family caregivers aid the member with mental illness more than the help provided under normal circumstances (Fenech and Scerri, 2014; Venkatesh *et al.*, 2016). Not only is most informal care provided by the family members, but the majority of family-caregiving is also carried out by women (Sebit *et al.*, 2006;

Mavundla, Toth and Mphelane, 2009; National Alliance for Caregiving and AARP, 2009; Marimbe *et al.*, 2016). Women all over the world are the major providers of this informal caregiving responsibility for family members with disabilities, chronic medical conditions and the elderly (Prince, 2009; Sharma, Chakrabarti and Grover, 2016). A number of societal and cultural factors demand that women adopt the role of caregivers in different families. Women have been found to be at greater risk of stress according to the stress and coping model.

In most Sub-Saharan African communities, females are the traditional caregivers for patients with chronic illnesses (Yusuf, 2009; Muchinako *et al.*, 2013). This is despite the fact that there have been changes in the social structures, norms and demographics, where men are gradually assuming roles as caregivers (Baker and Robertson, 2008). The differences in caregiving between men and women is also mediated by several factors such as marital status, education, employment status, socioeconomic status, relationship with the patient, characteristics of the patient, severity of the illness, behavioural problems and associated disabilities among other things (Pinquart, Sorensen, 2006; Etters *et al.*, 2008; Papastavrou *et al.,* 2009). Most of the research has been conducted over the years among family caregivers of the elderly population and physical conditions, whilst gender differences among caregivers of other mental illnesses have been neglected.

Sociological explanations have emphasised more on the expectations of traditional gender roles, whereby women are expected to assume the role of a caregiver. The social constructionist theory is clear on how young girls are socialised to assume caregiving responsibilities from young ages. This is entrenched in females through their social and cultural experiences, starting from childhood and leads to a different approach to caregiving compared to men (Magezis, 1996; Haralambos and Holborn;). Women are most likely to become the principal family caregivers of chronically ill spouses or family members. According to the theories of labour and segregation, women are more likely to stay at home whilst men go to seek employment, makinh it natural for women to take up caregiving roles (Papastavrou *et al.,* 2009). Men are not traditionally expected to become caregivers which leads to a different approach towards caregiving among them. Due to their role-socialisation, men usually become less capable at expressing their difficulties or emotions. This could result in a response-bias, in that men may be less likely to report problems in providing care than women (Papastavrou *et al.,* 2011). It is, however, important to note that caregiving among males has not been adequately explored in terms of research.

PATRIARCHY AND CAREGIVING IN AFRICA

Africa is a patriarchal society, whereby the role of women is guided by ethno-religious ideologies and economic and sociocultural factors (Gaidzanwa, 2004; Kambarami, 2006). Patriarchy is defined as a custom that provides more privileges to men than women and is a strong aspect of most cultures, including African culture. Privileges given to men are in all areas of human endeavours and communications. These factors inform distribution of resources and responsibilities which is often overloaded with discriminations between men and women (Akinola, 2018).

ROLES

The role of the woman in a patriarchal society is to be subservient and submissive to men. They are supposed to cater to all the hopes and desires of men without complaint. In a patriarchal society, women are expected to stay in the household as a mother and homemaker, usually completing hours of unpaid labour and maintaining these tasks (Hartmann, 1979). Real women are seen as dependent, vulnerable, weak, supportive, nurturing, emotional and empathetic that makes it arguably difficult to be oneself. The roles of women include the reproductive role, caring for the children and sick family members (Proctor and Phimister, 1995; Mavingire, 2019). These roles are very exceptional and are dictated by culture, religion and beliefs. Despite these, their contributions in caregiving remain unrecognised by anyone else except by the beneficiaries of the care. This is shown by them performing this role and not being paid for it (Bhandari *et al.*, 2015). Again, this must be attributed to the fact that culturally, the role of caregiving is the duty of the women. Caregiving is a role expected of family members but the undisputable strength of informal caregiving lies on female family caregivers, whose roles are often designated by values and endorsed by culture (Kambarami, 2006; Maphosa and Chiwanza, 2021). It has been emphasised that caregiving is feminised and women are socialised into nurturing roles through cultural scripts.

EXPECTATIONS

A woman is expected to surrender all her rights to her husband to gain respect from the community (Okome, 2003; Kambarami, 2006). Miller (2016) states that in nature, the patriarchal culture is resolute as a system of power relationship where men control women and possess more social wealth and power over resources than women (Chipunza, 2003; Chinyani, 2010). Men also have control over women’s reproductive rights and health. The men decide how many children women should have, especially in issues to do with child spacing/family planning methods. If a woman gets sick, the husband is the one who decides the type of treatment that she should receive, either in informal or formal health services. The woman’s belief system is overridden by her husband’s after marriage. Some aspects of control of men over women are expressed as psychological and physical violence.

CONTROL

Patriarchy allows men to hold positions of power over women (Beker, 1999). Males take undue advantage over women, which is viewed in developed countries as gender discrimination. According to Walby (1994), patriarchy is a system of practices and social structures where men oppress, exploit and dominate women. Women in these social structures are marginalised by men. According to the African culture, an ideal woman should be innocent, passive, calm and sacrificial and should not raise her voice at any male (Nwokocha, 2019). This means that men are in control of all family and social situations; they make all decisions regarding the family’s health, education and finances. In many instances, the woman must ask for permission from her husband before deciding. Some men may even go a step further by oppressing the women in their family to gain more control over them. A woman who tries to reclaim some power or control for herself may be at risk of being oppressed, exploited, or even abused by men in the family, to bring her back down to a submissive level.

IMPACT ON CAREGIVING

Some studies affirm that around the world, women make up about 57 to 81% of informal care givers for family members with chronic disabilities (Tang *et al.*, 2013; Sharma, 2016). Most often their caregiving roles are not recognised by family members or the health care system (Reinhard *et al.*, 2019). This is likely because women are culturally supposed to take up caregiving roles that may not be considered important by the family and the health care system. On clinical observations, caregivers who accompany patients for review or for treatment are not being asked how they are coping with the caregiving process. Health care providers are concerned mostly about the patients' welfare and recovery. They are concerned about whether the patient is complying with the medication regime and overlook the challenges the caregivers experience in ensuring that the patient takes their medication.

ECONOMIC STATUS AND CAREGIVING

Though family caregiving is critical to the management of all severe mental health conditions, the economic costs borne by family caregivers often go unnoticed. A qualitative study conducted in South Africa by Vukeya *et al.* (2022), that explored experiences of family members caring for a sibling with mental illness in Giyani, Limpopo Province, reveals that some family caregivers had to quit their jobs to take care of their mentally ill relatives full-time. This concurs with the findings of studies from both developed countries like the USA, and developing countries like Uganda (Verity *et al.*, 2021), where circumstances often compel family caregivers and demand to care for their mentally ill relatives, to the extent that they often have to quit their jobs to offer full-time care despite the poverty this decision could expose them to (Mavundla, 2009; Chang, 2010; Lund, 2013). Employment is a key element of social production and social participation and plays a major role for the caregiver in addressing financial, emotional and social needs. In Uganda, transport to attend health facilities impedes access to help outside the family care system. Underpinning these experiences is the impact of low economic resources (Ae-Ngibise *et al.*, 2015; Verity *et al.*, 2021).

A systematic review conducted by Addo *et al.* (2018) shows that the caregiver's level of income and employment status, severity of the patient's condition and duration of mental illness were reported to affect negatively economic burdens experienced by caregivers. Indirect costs in the form of productivity losses constitutes the largest portion of the total economic burden (Suleiman *et al.*, 1997; Ohaeri, 2001; Mavundla, Toth and Mphelane, 2009; Addo, Nonvignon and Aikins, 2013). In the same study, seven papers were reviewed and all of them reported moderate to severe caregiver burden characterised by financial constraints, productivity loss and lost employment (Addo, *et al.*, 2018). The caregiver's level of income and employment status, severity of patient's condition and duration of mental illness were reported to negatively affect the economic burden experienced by caregivers. Direct and indirect costs were also found to affect the quality of life of the caregiver either directly or indirectly (Esan and Esan, 2016). Some caregivers spent most of their money seeking care and losing some days of work for caregiving and travelling to seek care for relatives (Suleiman *et al*, 1997; Ohaeri, 2001; Mavundla, Toth and Mphelane, 2009; Addo, Nonvignon and Aikins, 2013; Addo *et al.,* 2018). Demographic characteristics of the caregivers, such as those who were separated or divorced, experienced higher and persistent financial distress and difficulty in caring for the family member with mental disorder than caregivers who were married (Ohaeri, 2001).

In a qualitative study by Opoku-Boateng *et al.* (2017), that sought to explore caregivers' experiences of looking after a family member living with severe mental disorders in Ghana, findings show that caregivers experienced economic costs categorised as direct costs. They included medical and non-medical costs of seeking care, indirect costs of productivity losses to caregivers and intangible costs like non-monetary costs such as stigma and pain. Direct costs included costs of medical supplies, consultations and travel. Indirect costs were estimated as the value of productive time lost (in hours) to primary caregivers. The key components of direct costs experienced by caregivers were drugs (about 50%) and transportation (about 27%) (Opoku-Boateng *et al.*, 2017; Mavingire, 2019;

Most studies showing an association between mental disorders and reduced income have been conducted in high-income countries (Kessler *et al.*, 2008). In low- and middle-income countries (LMICs), little is known regarding the links between mental disorders and reduced income, despite evidence of a substantial burden of mental illness (Lopez *et al.*, 2006; Kessler and Ustun, 2008). The findings support other research that indicates that mental illness, through its strong association with reduced earnings, appears to have a major socio-economic impact in LMICs (Iseselo, Majula and Yayha-Malima, 2016).

In a qualitative study by Marimbe *et al.* (2016), many caregivers expressed the financial burden in Zimbabwe. It took several forms, for some, the financial burden was experienced due to the caregivers leaving their jobs to take a caregiving role. Caregivers stated that, although treatment is free at government psychiatry hospitals in Zimbabwe, some had to buy medication for the patient, as it was frequently unavailable at the hospitals. This supported the findings by Nyati and Sebit (2002), who found that 63.6% of caregivers experienced financial constraints and spent a lot of money (56.1%) on food and medication. In Tanzania, a qualitative study among 14 caregivers that set to explore the psychosocial problems of families caring for relatives with mental illnesses and their coping strategies, reveals that caregivers experienced financial burden among other things, as a result of caring for their relatives with severe mental disorders (Iseselo, Kajula and Yayha-Malima, 2016).

In South Africa, a qualitative study conducted by Silaule, Nkosi and Adams (2023) notes that employed and unemployed informal caregivers reported higher levels of objective burden. This could be because the informal caregivers struggled to meet the household's expenses and provide for the needs of the care recipients despite their employment status. These results are similar to rural Ethiopia's findings that caregivers reported higher levels of burden related to financial problems, often due to the cost of treatment (Asher *et al.*, 2015). The informal caregivers in this study needed to deal with the additional cost of providing care, which included covering the transport costs to and from the hospital for follow-ups and were expected to meet basic household expenses. Marimbe *et al.* (2016) highlight that the increased financial burden might be related to some informal caregivers frequently foregoing economic opportunities to fulfil their caregiving responsibilities. Caregivers require assistance from the Zimbabwean government to cope with financial needs (*ibid.*). Financial support for caregivers can include direct income payments and supplements, public assistance, other social security programmes and grants to cover care-related activities and costs (Maresova *et al.*, 2020). However, there is paucity of studies reporting the financial burden of severe mental illness on caregivers in sub-Saharan Africa , including Zimbabwe.

POLICY FRAMEWORKS IN CAREGIVING FOR MENTAL ILLNESS IN AFRICA

Many African countries have struggled to design adequate policy frameworks and systems to address the health and needs of their citizens in the past. This has been attributed to their long colonial history and economic challenges. Sodi *et al.* (2021) reviewed mental health policies and system preparedness to respond to COVID-19 and other health emergencies in four African countries. They found that legislation and policies which make provision for mental health services and the psychology profession existed. However, there was no mention of caregiver support in all four policies, which is a major limitation of the framework in line with addressing the plight of caregivers.

The South African National Mental Health Policy Framework and Strategic Plan for 2023-2030 was reviewed to explore the availability of plans for caregivers (Sodi *et al.* (2021). This document covered only the needs of service users regarding mental health services, treatment and rehabilitation. There is no mention of caregiver support. The Mental Health Care Act of South Africa (2002) also highlights the rights of mental health users, which includes their right to proper care and treatment. While it focuses on the care of the patients, it indirectly recognises the importance of caregiver support in ensuring the effective mental health care.

The Kenyan Policy Framework of 2015-2030 speaks to the roles and responsibilities of individuals, families and communities that they should play a key role in promoting mental health, prevention, treatment and rehabilitation of persons affected by mental disorders. However, caregiver support guidelines are not mentioned (Kenya Mental Health Policy, 2015-2030). Kenya also has the Mental Health Act of 1989, revised in 2010. The act provides a legal framework for the delivery of mental health care services. The act also focuses on different aspects of mental health care, which includes rehabilitation and treatment, but does not have provisions that specifically address caregiver support. In Nigeria, there is the National Mental health Policy that was developed in 1991, revised in 2003. The aim of the policy also is to guide the provision of mental health services. However, it does not have explicit provisions of caregiver support, though it emphasises the involvement of the community in mental health care (Federal Ministry of Health Nigeria, 2003). Similarly, Ghana has a mental health act that provides a legal framework for delivery of mental health care to mental heath users, but does not have specific provision for caregiver support (Parliament of the Republic of Ghana, 2012).

CONCLUSION AND RECOMMENDATIONS

Women are key in caregiving for family members with severe mental illness. Their contributions to caregiving remain less recognised by families and the community, excluding the beneficiaries of care. This is likely because their role in the African context is influenced by patriarchy. There is need for further studies to determine the role of men in caregiving and the influence of the economic status of individuals on the caregiving process, as these areas have been studied intermittently. To attain an effective shift in caregiver policies, the focus should be on supporting individuals to excel in their lives, instead of focusing on the person being cared for.

In developed countries, where caregiver policies exist, the focus is mainly on relieving burdens associated with caring or the needs of the person being cared for (Brian-Beach, 2022). They fail to fully support caregivers, thereby hindering their ability to achieve their well-being through positive functioning, irrespective of their responsibilities as caregivers (*ibid.*). To attain an effective shift in caregiver policies, the focus should be on supporting individuals to excel in their lives, instead of focusing on the person being cared for. As in many other areas of policy-making, a more integrated and holistic approach to policy development would be advantageous, particularly in a global context. A coherent framework for capturing the diversity of policies across various cultural, economic, political and social contexts would be useful for understanding how caregiver policies successfully address caregiver needs. Addressing mental health requires a supportive policy framework and careful planning to coordinate and scale up mental health services and access to treatment (Savage *et al.*, 2004). Yet, most countries in Africa do not have a comprehensive mental health policy and plan that also caters for caregiver needs.

REFERENCES

Addo, R. *et al.* (2018). Economic Burden of Caregiving for Persons with Severe Mental Illness in Sub-Saharan Africa: A Systematic Review. *PLoS ONE, 13*(8): e0199830. https://doi.org/10.1371/ journal. pone.0199830

Ajibade, B.L. *et al.* (2016). Burden Experienced by Family Caregivers of Patients with Mental Disorders at Selected Hospitals in Ekiti State, Nigeria. *International Journal of Health and Psychology Research*, *4*(2), 14-41.

Akinola, A.O. (2018). Women, Culture and Africa's Land Reform Agenda Psychology. *Frontiers in Psychology, 9*: https://doi.org/10.3389/fpsyg.2018.02234

Aronson, J. (1992). Women's Sense of Responsibility for the Care of Old People: But Who Else is Going to Do It? *Gender and Society*, *6*(1), 8-29.

Asher, L. *et al.* (2015). Development of a Community-based Rehabilitation Intervention for People with Schizophrenia in Ethiopia. *PLoS One*, *10*(11): e0143572.

Baker, K.L. and Robertson, N. (2008).Coping with Caring for Someone with Dementia: Reviewing the Literature about Men. *Aging and Mental Health.* *12*(4), 13-422.

Becker, M. 1999). Patriarchy and Inequality: Towards a Substantive Feminism. *University of Chicago Legal Forum*, *1* (Article 3), 21-88

Bhandari, A.R. *et al* (2015). Caregiving Burden among Family Members of People with Mental Illness. *Journal of Psychiatrists' Association of Nepal, 4*(1), 36-42.

Cain, M. 1994). Women's Status and Fertility in Developing Countries: Son Preference and Economic Security. World Bank Staff Working Paper No. 682. Population and Development Series No. 7.

Chang, H.-Y., Chiou, C.-J. and Chen, N.-S. (2010). Impact of Mental Health and Caregiver Burden on Family Caregivers' Physical Health. *Archives of Gerontology and Geriatrics, 50*(3), 267-271.

Cheah, Y.K. *et al.* (2020). Sociodemographic, Lifestyle and Health Factors Associated with Depression and Generalised Anxiety Disorder among Malaysian Adults. *Journal of Primary Care and Community Health, 11*, https://doi.org/10.1177/2150132720921738

Cochrane, J.J., Goering, P.N. and Rogers, J.M. 1997). The Mental Health of Informal Caregivers in Ontario: An Epidemiological Survey. *American Journal of Public Health. 87*, 2002-2007

Collings, S. (2009). Who Cares for People with Schizophrenia: Family Carers' Health, Circumstances and Adjustment? Blue Skies Report. [Accessed 2015 May 15] Available from: http//www.mentalhealth.org.nz/…/Who-Cares-for-People-with-Schizophrenia.

Esan, O. and Esan, A. (2016). Epidemiology and Burden of Bipolar Disorder in Africa: A Systematic Review of Data from Africa. *Social Psychiatry and Psychiatric Epidemiology, 51*(1), 93-100.

Etters, L., Goodall, D. and Harrison, B.E. (2008). Caregiver Burden among Dementia Patient Caregivers: A Review of the Literature. *Journal of the American Academy of Nurse Practitioners, 20*(8), 423-428.

Flyckt, L., Fatouros-Bergman, H. and Koernig, T. (2015). Determinants of Subjective and Objective Burden of Informal Caregiving of Patients with Psychotic Disorders. *International Journal of Social Psychiatry, 61*(7), 684-692.

Forever Young Information. (2013). Survey Confirms Women Assume Major Burden as Caregivers. Available from: http://foreveryoungnews.com/posts/2086-survey-confirms-woman-assumemajor-burden-as-caregivers

Gaidzanwa, R. (2004). Women and Land in Zimbabwe. Paper presented at the Conference on Why Women Matter in Agriculture. Stockholm, Sweden.

Gonani, C.G. (2019). Family Caregiving in Mental Health: Experience of Family Caregivers of People Living with Severe Mental Illness in Rural Malawi. Master's Thesis. Harvard Medical School.

Gran, M. (2019). The Global Role of Women — Caretakers, Conscience, Farmers, Educators and Entrepreneurs. Development Impact, Reaching Children's Potential. 2019. Available from: https://globalvolunteers.org/global-role-of-women/

Grover, S. *et al.* (2015). Comparative Study of Caregivers Perceptions of Health-care Needs and Burden of Patients with Bipolar Affective Disorder and Schizophrenia. *Nordic Journal of Psychiatry*, *69*(8), 629-636.

Haralambos, M. and Holborn, M. (2004). *Sociology: Themes and Perspectives*. London: Collins Educational.

Haraway, D. 1991). *Simians Cyborgs and Women: The Reinvention of Nature*. New York: Routledge.

Hartmann, H.I. 1979). The Unhappy Marriage of Marxism and Feminism: Towards a more Progressive Union. *Capital and Class*, *3*(2), 1-33.

Jenkins, J.H. and Schumacher, J.G. 1999). Family Burden of Schizophrenia and Depressive Illness. Specifying the Effects of Ethnicity, Gender and Social Ecology. *British Journal of Psychiatry*, *174*, 31-38.

Kambarami, M. (2006). *Femininity, Sexuality and Culture: Patriarchy and Female Subordination in Zimbabwe*. Fort Hare: University of Fort Hare.

Kessler, R.C. and Ustun, T.B. (2008). *The WHO World Mental Health Surveys: Global Perspectives on the Epidemiology of Mental Disorders*. New York: Cambridge University Press

Kessler, R.C., Heeringa, S.G., Lakoma, M.D. *et al.* (2008). Individual and Societal Effects of Mental Disorders on Earnings in the United States: Results from the National Comorbidity Survey Replication. *American Journal of Psychiatry*. *165*(6), 703-711.

Kipp, W. *et al.* (2007). Family Caregivers in Rural Uganda: The Hidden Reality. *Health Care Women International*, *28*(10), 856-71.

Leggatt, M. (2002). Families and Mental Health Workers: The Need for Partnership. *World Psychiatry*, *1*(1), 52-54.

Lopez, D.A. *et al.* (2006). *Global Burden of Disease and Risk Factors*. New York: Oxford University Press.

Lund, C. *et al.* (2013). Mental Illness and Lost Income among Adult South Africans. *Social Psychiatry and Psychiatric Epidemiology*, *48*(5), 845-851.

Lynne, S. 1987). *Is the Future Female? Troubled Thoughts on Contemporary Feminism.* London: Virago.

Maphosa, N. and Chiwanza, V. (2021). Caregiver Experiences and the Perceived Role of Social Workers in Caring for People with Disabilities in South Africa. *African Journal of Social Work 11*(3), 155-163.

Maresova, P., Lee, S. and Fadeyi, O.O. (2020). The Social and Economic Burden on Family Caregivers for Older Adults in the Czech Republic. *BMC Geriatrics*, *20*(1), 171.

Marimbe, B.D. *et al.* (2016). Perceived Burden of Care and Reported Coping Strategies and Needs for Family Caregivers of People with Mental Disorders in Zimbabwe. *African Journal of Disability 5*(1), 209.

Mavingire, F. (2019). The Experiences of Caregivers of Mental Health Care Users with Bipolar Disorders in Harare, Zimbabwe. Masters Thesis. University of Pretoria. South Africa.

Mavundla, T.R., Toth, F. and Mphelane, M.L. (2009). Caregiver Experience in Mental Illness: A Perspective from a Rural Community in South Africa. *International Journal of Mental Health Nursing*, *18*(5), 357-367.

Morris, M. (2001). Gender-sensitive Home and Community Care and Caregiving Research: A Synthesis Paper. Centres of Excellence for Women's Health. Available from: http://www.womenandhealthcarereform.ca/publications/synthesis.pdf.

National Alliance for Caregiving and AARP. (2009). Caregiving in the US. Available from: http://www.caregiving.org/data/FINALRegular ExSum50plus.pdf.

Ndlovu, J.T. and Mokwena, K.E. (2023). Burden of Care of Family Caregivers for People Diagnosed with Serious Mental Disorders in a Rural Health District in Kwa-Zulu-Natal, South Africa. *Healthcare*, *11*, 2686. https://doi.org/10.3390/healthcare11192686

Okome, O. (2003). What Women, Whose Development? In: Oyewumi, O. (ed.). *African Women and Feminism: Reflecting on the Politics of Sisterhood*. Trenton: Africa World Press.

Olagundoye, O., Akhuemokhan, V. and Alugo, M. (2017). Towards Caring for Caregivers: Assessing the Burden of Care and Experience of Associative Stigma among Caregivers of Patients with 17 Chronic Mental Illnesses at a Mental Health Care Facility in Lagos Metropolis, Nigeria. *Family Medicine and Primary Care Review*, *19*(2), 149-155.

Opoku-Boateng, Y.N., Kretchy, I.A., Aryeetey, G.C. *et al.* (2017). Economic Cost and Quality of Life of Family Caregivers of Schizophrenic Patients Attending Psychiatric Hospitals in Ghana. *BMC Health Services Research 17*(2), 697.

Oppong, C.M. 1980). A Synopsis of Seven Roles Status of Women: An Outline of a Conceptual and Methodological Approach. World Employment Working Paper. Geneva International Labor Force.

Papastavrou, E. *et al.* (2009). Gender Issues in Caring for Demented Relatives. *Health Science Journal*, *3*(1), 41-53.

Parks S.H. and Pilisuk, M. 1991). Caregiver Burden: Gender and the Psychological Costs of Caregiving. *American Journal of Orthopsychiatry*, *61*(4), 501-509.

Prince, M.J. (2009). The 10/66 Dementia Research Group - 10 Years On. *Indian Journal of Psychiatry*, *51*(1), S8-S15.

Proctor, A. and Phimister, I. (1995). *People and Power Book 1*. Harare: Academic Books.

Reinhard, S.C. *et al.* (2019). Valuing the Invaluable: 2019 Update Charting a Path Forward. AARP Public Policy Institute. Available from: https://www.aarp.org/content/dam/aarp/ppi/2019/11/valuing-the-invaluable-2019-update-charting-a-path-forward.doi.10.26419-2Fppi.00082.001.pdf

Saha, K.B. and Chatterjee, U. (1998). Reproductive Rights in Contraceptive Practices. *Health for the Millions, 24*(5), 31-2.

Savage, S. and Bailey, S. (2004). The Impact of Caring on Caregivers' Mental Health: A Review of he Literature. *Australian Health Review*, *27*(1), 111-117.

Shankar, R. and Rao, K. (2005). From Burden to Empowerment: the Journey of Family Caregivers in India. In: Sartorius, N. (eds.). *Families and Mental Disorders*. 259-290. Chichester: John Wiley and Sons, Ltd

Sharma, N., Chakrabarti, S. and Grover, S. (2016). Gender Differences in Caregiving among Family - Caregivers of People with Mental Illnesses. *World Journal of Psychiatry*, *6*(1), 7-17.

Sharma, N. *et al.* (2014). Attitudes toward Transitioning in Youth with Perinatally Acquired HIV and their Family Caregivers. *Journal of the Association of Nurse in AIDS Care*, *25*(2), 168-75.

Silaule, O., Nkosi, N.G. and Adams, F. (2023). Extent of Caregiver Burden among Informal Caregivers of Persons with Severe Mental Disorders in Rural South Africa. *Rural and Remote Health*, *23*, 7509.

Sodi, T., Modipane, M., Oppong Asante, K. *et al.* (2021). Mental Health Policy and System Preparedness to Respond to COVID-19 and other Health Emergencies: A Case Study of Four African Countries. *South African Journal of Psychology*, *51*(2), 279-292.

South African Government. (2002). Mental Health Care Act, 2002.

Swinkels, J. *et al.* (2019). Explaining the Gender Gap in the Caregiving Burden of Partner Caregivers. *The Journals of Gerontology Series B*. *74*(2), 309-317.

Tajudeen Nuhu, F. *et al.* (2010). The Burden Experienced by Family Caregivers of Patients with Epilepsy Attending the Government Psychiatric Hospital, Kaduna, Nigeria. *The Pan African Medical Journal*, *5*, 16.

Tang, B. *et al.* (2013). Clinical Characterisation and the Caregiver Burden of Dementia in China. *Value in Health Regional Issues*, *2*(1), 118-126.

Taylor, L., Seeley, J. and Kajura, E. (1996). Informal Care for Illness in Rural Southwest Uganda: The Central Role That Women Play. *Health Transition Review*, *6*(1), 49-56.

Walke, S.C., Chandrasekaran, V. and Mayya, S.S. (2018). Caregivers Burden among Caregivers of Mentally Ill Individuals and their Coping Mechanism. *Journal of Neurosciences of Rural Practice*, *9*(2), 180-185.

Wancata, J. *et al.* (2008). Gender Aspects of Parents' Needs of Schizophrenia Patients. *Social Psychiatry and Psychiatric Epidemiology*, *43*(12), 968-974.

WHO (2023). *World Mental Health Report.* Geneva: WHO.

Yusuf, A.J. and Nuhu, F.T. (2011). Factors Associated with Emotional Distress among Caregivers of Patients with Schizophrenia in Katsina, Nigeria. *Social Psychiatry and Psychiatric Epidemiology*, *46*(1),11-16.

Zahid, M.A. and Ohaeri, J.U. (2010). Relationship of Family Caregiver Burden with Quality of Care and Psychopathology in a Sample of Arab Subjects with Schizophrenia. *BMC Psychiatry*, *10*, 71.