Beyond mad, bad and sad: A case for considering community mental health and the means to assess it

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Abstract

Where non-western communities are exposed to economic development and modernization, negative psychosocial outcomes have been clearly demonstrated. This paper begins by noting the manner in which mental health is commonly construed by health professionals in the South Pacific, argues for a change in perspective, and justifies the use of a less clinically-oriented social-process vitamin model to audit mental health outcomes. A framework suitable for use with tightly knit, culturally homogeneous communities is proposed followed by an outline of how relevant psychosocial characteristics within the environment might be audited to provide an assessment of community mental health. (PHD, 2005 Vol 12 No 2 Pages 145 - 154)

Introduction

For over fifty years, a clinical view of mental health has dominated the thinking of most health professionals in many Pacific Island countries and territories (PICTs).[1] Based on a western disease-oriented biomedical model, this approach focuses on individual behaviour and assumes psychological disorder has the same meaning and etiology across different cultures [Note 1]: a culturally-biased assumption capable of generating bizarre views of mental illness and by implication, mental health. From this perspective, mental illness is the domain of white-coated professionals in psychiatric establishments for persons regarded as mad, "bad" or extremely sad - a common perception with colonial overtones in many PICTs [Note 2].

Where an attempt is occasionally made to assess community mental health, morbidity rates for major mental disorders like schizophrenia and other psychotic disorders, depression, anxiety disorders and alcoholism are generally used. However, since reported admission rates are often "low" by Western standards, the mental health of that community is presumed to be essentially "positive" and not a matter for concern. This perception was and remains instrumental in generating a dangerous complacency in many PICTs, especially among health professionals and governments. However, over twenty-five years ago a ground-breaking report on thirteen PICTs noted that sanguine conclusions about group-level mental health based on clinical criteria (for individuals) was culturally compromised and the aggregation of these data to assess community mental health was inappropriate and misleading.[2] At least two factors contributed to this situation: (i) the intellectual dominance of a narrow clinical definition of mental health; and (ii) lack of a culturally 'neutral' instrument capable of auditing group-level mental health. The first, is considered next; the second, later in this paper.

A case for change

Recently, definitions of mental health have become less clinically pedantic, more socially-oriented with greater awareness of ecological validity and dangers associated with the use of unmodified clinical criteria to non-western settings.[3,4,5] With transactional social-process approaches to mental health more widely accepted6, these changes are generally reflected in contemporary primary health care [Note 3]. However, an illness-oriented clinically-based (individual-level) view of mental health remains strong in many PICTs: a characteristic unintentionally illustrated by a recent review of major mental disorder in the Pacific.[1]

While reasons for this emphasis are complex and beyond the scope of this paper, a number of contributing factors might be cited, including: (i) remnants of dated colonial attitudes toward mental health; (ii) the hubris of some medical practitioners; (iii) influence of neoliberal economic philosophies in relation to national development including emphasis on economic priorities to the neglect of social development; (iv) some governments withdrawing from important community services in favour of privatization [Note 4]; (v) advocacy for "narrow" economic development by influential stakeholders like

the World Bank (WB) and International Monetary Fund (IMF); and (vi) uncritical application by some PICT governments of "blueprints for economic development" and structural readjustments without considering adequately their psycho-social consequences. As long as mental health is defined from an individually-oriented (clinically-based) biomedical perspective and economic development remains the major development priority of government, community mental health will remain a neglected area.

If change is to occur, at least five issues require attention: (i) the reformulation of 'mental health' to reflect a broader social-process perspective; (ii) audits to assess group-level mental health need to be conducted in addition to clinical (individual-level) assessment; (iii) development of a methodology to audit community-level mental health similar to environmental impact studies designed to evaluate the effects of development projects; (iv) Governments and their Ministries of Health to genuinely focus on socio-cultural determinants of health, disease and illness; and (v) national development priorities need to place social, health and education development on a par with narrowly construed economic development.

As long as mental health is defined from an individually-oriented (clinically-based) biomedical perspective and economic development remains the major development priority of government

The first three relate directly to the health professions and are considered in the remainder of this paper. The last two relate to issues of government policy. Changes in policy will require strong, well-informed, consistent advocacy from more than one sector of the community with health professionals especially responsible for informing and educating policy makers.

Reformulating mental health

Contemporary concepts of mental health are typically built around a stress-and-coping framework that acknowledges (sometimes implicitly), socio-cultural, economic and political considerations including notions of equity and justice.[6] Sometimes referred to as a dynamic equilibrium model of mental health,[7] a biopsychosocial perspective combines environmental considerations with notions of functional efficacy and psychological resilience. Thus, mental health might be defined as:

The integration of one's social, emotional, cognitive and spiritual elements in a manner that promotes subjective well-being, provides the vitality necessary for active constructive living, fosters a capacity to identify and achieve appropriate goals, and facilitates effective coping and problem-solving while encouraging a desire to interact with one another in ways that are respectful and just.[8]

Derived from a transactional (social-process) model of stress, coping and psychological well-being,[9] this definition helps demystify mental health by placing it back into the wider community where it arguably belongs. Chronic debilitating stress, a primary source of diminished mental health, is minimized by encouraging self-motivation (including realistic and appropriate goal-setting), effective constructive coping and problem-solving, and the encouragement of responsible social behaviour.

This perspective dramatically changes one's view of mental health. Among other things, it identifies circumstances likely to facilitate or diminish it and interventions most likely to succeed. It also enables mental health to be audited at a community-level by focusing on selected psychosocial characteristics within the environment. This means phenomena like economic development, globalization and cultural-change are no longer tangential to community mental health. Instead, they become primary considerations because they generate major lifestyle changes and "health transitions" [Note 5] – important contributors to chronic stress.[10,11,12,13]

While earlier research sought to identify a small number of primary sources of chronic stress and diminished mental health [Note 6], more recent analyses have identified three sets of overlapping and interacting pathologies sometimes referred to as "problem clusters":[10] (i) social symptoms (substance abuse; violence; suicide; and the abuse of women and children); (ii) health problems (heart disease; depression; stress-related conditions; smoking; and high levels of alcohol consumption); and (iii) exacerbating conditions (high unemployment; poverty; limited formal education; stressful work conditions; and systematic ethnic and gender discrimination).[10] Together, these exercise powerful detrimental influences on individual and group health,[12,14,15] underscoring the importance of community mental health as an area unequivocally deserving national attention.

Before outlining a vitamin model of mental health and its translation into an instrument capable of auditing the psychosocial environment, evidence relating to mental health outcomes typically associated with economic development/modernization in low income developing countries is briefly considered.

Economic development, social change and mental health

Since European contact, social change has become a fact of life in PICTs. Although each community has a different history, change has been multidimensional, penetrating almost all areas of community life [Note 7]. Today, many communally-oriented indigenous communities are experiencing extensive socio-cultural stress attributable to modernization and rapid change driven by globalization in its contemporary economic and political forms.

While economic development/modernization and globalization might be justified in narrow economic terms, by definition they are socially disruptive stressful processes.[16] Their negative psychosocial consequences are supported by considerable research and sound theory. Both indicate that if and when psychosocial consequences of development and modernization are ignored or neglected by authorities, diminished community mental health follows.[10] Where this neglect is systemic, communities typically pay a heavy social and economic price in the form of diminished health, psychosocial tension including family conflict, political instability and reduced productivity.[8,17,18,19]

Modernization disrupts established ways of thinking and behaving which generates substantial stress along the way

It has become equally evident that social and political isolation are no longer possible. Even in once isolated PICTs it is impossible to escape the effects of globalization, and those who hold the levers of power can do little more than moderate the rate of change. Attempts to reverse or halt this trend are unrealistic and ultimately damaging to a community.[20]

When developing communities become "modernized", two contrary outcomes typically follow. While standards of living, physical health and life-expectancy generally improve [Note 8], mental health deteriorates.[10,21] Reasons for this are not difficult to find. Modernization disrupts established ways of thinking and behaving which generates substantial stress along the way. This typically evokes two primary responses: some individuals and groups welcome change and perceive it as a stimulating challenge; others resist, regarding it as a threat. Both responses contain important implications for mental health,[6, 17, 22] and three observations derived from archival evidence are relevant.

First, although superficially attractive, as a general rule, the idea that change can be both welcomed and resisted is sometimes perceived to be logically inconsistent: a view articulated in Fiji some years ago by Nayacakolou.[23] Nayacakolou referred to those who advocated the pursuit of both within the indigenous Fijian community as "perpetrators of a monstrous nonsense" that would generate confusion and conflict within that community. Where 'core' cultural beliefs and values are concerned, archival evidence indicated indigenous Fijians generally adopted a non-negotiable either/or position: examples of initial resistance followed by progressive assimilation were difficult to find. The Fiji coups of 1987, 2000 and subsequent events support this contention.

Second, those individuals and communities who perceive change as a positive and stimulating challenge typically welcome and embrace it. Studies conducted in other countries and limited research in Fiji indicate those in this category commonly possess a robust sense of cultural and personal identity, have confidence in themselves, are psychologically "resilient" and demonstrate an ability to apply flexible and effective coping strategies.[7, 24, 25] Such individuals are typically positive, optimistic, innovative, and although sometimes anxious, appear to thrive in a changing, comparatively unpredictable and challenging environment with mental health rarely an issue.[8, 26, 27] Indo-Fijians appeared to be overrepresented in this group.

Third, individuals and communities lacking in confidence and a clear identity (cultural and personal), typically perceive modernization and change as a cultural and personal threat. They generally believe change contributes to cultural decay and/or social disintegration: something to be feared and resisted. They typically yearn for alleged "certainties" of the past; fear unpredictability and cope poorly with stress;[26] are usually less happy/more discontented than the first group; and commonly possess an easily threatened sense of cultural identity.[20,24] Members of this group usually exhibit identity confusion or a negative identity and show symptoms of chronic anxiety and depression with paranoia typically replacing trust, and aggression overriding nurturance and support.[20,28] Indigenous Fijians appeared to be overrepresented in this group.

At a personal and group-level, coping by those in this latter group generally involves resisting, blocking, denigrating or denying change and a preference for negative and reactionary coping.[8,25,26] These individuals typically cope with change by emphasizing ethnicity and culture, tribalism, nationalism, isolationism and various forms of political and religious fundamentalism in the hope they will keep the group together (enhance social bonding) and provide stability in the face of change.[20] However, since these strategies offer little more than

temporary respite, mental health at an individual and group level typically exhibits a downward spiral.[10, 29, 30] In the longer term, these strategies incur an enormous social, psychological and economic cost to a community: an outcome well documented by studies from almost half a century of research in parts of Africa, Asia and the Pacific.[2, 8, 10, 18, 19, 25, 26, 31, 32, 33, 34, 35]

These findings underscore the importance of conducting psychosocial audits where a community is undergoing modernization and change. Ability to conduct such audits requires an appropriate methodology based on a defensible model of mental health and both are considered in the remainder of this paper.

A vitamin model of mental health

A vitamin model of mental health is grounded on transactional theory with an emphasis on stress, coping and functional efficacy.[36] Based on a dynamic equilibrium concept, this model uses a vitamin analogy from human nutrition and transcends a simple deficit formulation. It proposes that an "excess" of certain environmental circumstances or "affordances" (ie., "vitamins") generate circumstances detrimental or toxic to mental health (analogous to an excess of some vitamins for physical health). At the same time, the presence of certain affordances beyond a minimum or "sufficiency" level, produces no additional advantage. Regarded as culturally neutral or "context free", and within limitations inherent in the notions of "deficit", "sufficiency" and

Appendix 1

Psycho-social Audit: Five Psycho-social Indicators of Positive Mental Health

(1) Affective well-being
- Comfortable (v's anxiety)
- Contented (v's discontent)
- Pleased (v's depressed)

(2) Coping competence
- With life-problems
- With work problems
- Evidence of self-esteen/confidence

(3) Sense of autonomy
- Internal locus of control or independence
- External locus of control or interdependence
- Sense of potency (non-sexual)

(4) Clear realistic goals and aspirations regarding
- Family
- Work/employment
- Social life
- General level of motivation
- Sense of optimism

(5) Integrated functioning
- Family relationships and bonding
- Work & employment
- Leisure activities
- Overall satisfaction with life

Derived from Warr (1987)

Assessment Rating

Each item is rated in terms of its perceived presence by respondent:

(a)	Low/few	= 1
(b)	Medium/moderate	= 2
(c)	High/many	= 3
(d)	Unable to say	= 0

"excess", the model provides reasonably objective criteria for systematic assessment of group-level mental health: a precondition if intervention strategies are to be defensible, relevant and focused.

The model contains two main elements. Part A identifies five psychosocial characteristics shown by theory and research to be necessary for positive mental health; Part B consists of nine environmental features, affordances or "vitamins" found to facilitate the development and maintenance of positive mental health. The elements of each part are briefly described.

Part A contains five psychosocial characteristics typically found in: (a) mentally healthy individuals; and (b) supported by relevant psychological theory and research. The five characteristics are: (i) affective well-being including psychological feelings and physiological responses; (ii) coping competence as personal, social and environmental mastery; (iii) a sense of autonomy and locus of control including "successful interdependence" (opposite to a sense of helplessness); (iv) possessing clear goals and aspirations; and (v) integrated functioning in terms of an ability to function as an "effective individual" (ie., showing "balance", "harmony" and "inner-relatedness") with respect to love, work and play.

Mental health is jeopardized when affective well-being is threatened by excessive stress and anxiety; effective

Appendix 2

Environmental Audit: Nine Environmental Opportunities/Affordances "Required" for Positive Mental Health

(1) Opportunity to control activities and events (3)
- By decision
- By prediction
- By action

(2) Opportunity to use skills (2)
- Current skills
- To acquire new skills

(3) Presence of externally generated (3)
- Personal goals
- Work demands
- Social obligations

(4) Environmental variety (2)
- Physical settings available
- Roles and tasks available

(5) Environmental clarity (3)
- Feedback of consequences
- Predictability
- Normative expectations

(6) Resource availability (2)
- Physical/material
- Financial

(7) Personal security in the environment (2)
- Freedom from intimidation
- Freedom from physical threat

(8) Opportunity for interpersonal contact (5)
- Level of contact
- Level of social support
- Opportunity for social comparison
- Opportunity for group membership
- Opportunity for privacy

(9) Valued social position carrying social esteem (3)
- In social roles
- In work/occupation
- In leisure activities

Derived from Warr (1987)

Assessment Rating

Each item was rated in terms of its perceived/reported presence:

(a)	Absent or miminal presence	= 1
(b)	Moderate presence	= 2
(c)	'Excessive'	= 3
(d)	Unable to determine	= 0

coping is endangered by inhibited cognitive functioning, poor coping skills and feelings of low self-esteem and low self-efficacy; a sense of autonomy is compromised by excessive inter-dependence and over-conformity or excessive independence; clear goals and aspirations are threatened by "wants" over-riding "needs", unrealistic goals and an inability to achieve them; while integrated functioning requires all of the above while maintaining balance and harmony between the demands of love, work and play. Appendix 1 refers.

Although research shows these five characteristics are universal, their relative priority and value differs from one culture to another.[36] In a collectivist culture (eg., indigenous Fijian), a sense of autonomy will reflect a stronger group focus, stronger group conformity, stronger interdependence and more external control than a more individualistic setting (eg., Indo-Fijian). It is important to acknowledge these psychological nuances if comparisons are made between different cultural groups.

Part B, identifies nine psychosocial features of the physical environment shown to facilitate the development and maintenance of positive mental health and referred to as "opportunities", "vitamins" or "affordances". The nine environmental vitamins are: (i) opportunity and ability to control activities and events sometimes referred to as a sense of "potency" in a non-sexual sense; (ii) opportunity to use one's skills; (iii) the presence of externally-generated goals in the form of obligations and other normative requirements; (iv) environmental variety as distinct from one that is excessively repetitive, unchanging and lacking in stimulation; (v) environmental clarity in terms of predictability, clear role requirements and feedback from peers; (vi) availability and opportunity to use financial resources – the opposite to poverty; (vii) a physically and psychologically secure environment; (viii) opportunity for interpersonal contact; and (ix) a valued social position carrying esteem and respect.[36] (See Appendix 2).

Figure 1: Outcomes of "adequacy", "deprivation" and "excess" with respect to environmental affordances

Adequacy of 1 – 9	= Psychological well-being
Deprivation of 1 - 9	= Psychological impairment
Excessive presence of 1,2,3,4,5,8	= Psychologically detrimental
Excessive presence of 6,7 and 9	= No detrimental outcome

Derived from Warr (1987)

The objective presence of these features is not sufficient for positive mental health: each needs to be recognized and used by an individual or group, underscoring the importance of perception, appraisal and functional availability.[9]

While all nine affordances need to be present to ensure positive mental health, like vitamins in human nutrition, they need not occur in equal amounts. Although an absence or lack of any one leads to impairment, its presence beyond a certain minimal level ('sufficiency'), produces no further advantage (ie., their benefit reaches a plateau). For some of the above, an excess becomes psychologically toxic, analogous to vitamin poisoning in human nutrition. Research and theoretical evidence indicates the following six environmental characteristics ('vitamins') become toxic and detrimental to mental health when experienced in "excess". They are: (i) excessive control; (ii) excessive opportunities to use one's skills; (iii) excessive externally imposed goals; (iv) excessive environmental variety; (v) excessive environmental clarity; and (viii) excessive interpersonal contact. On the other hand, an excess of the other three affordances, namely: (vi) financial resources; (vii) a physically and psychologically secure environment; and (ix) a valued social position, esteem and respect; generally produce no detrimental outcomes. Figure 1 refers. Although different cultures generates differences in emphasis, these represent cultural nuances rather than fundamental psychological differences: hence the "context free" claim.[36]

The audit procedure

Audit procedures require identifiable, reasonably homogeneous cultural groups or communities similar to those typically found in most PICTs. Each characteristic identified in Parts A and B are rated on a four-point scale (low/minimum; medium; high; unable to say) by informants from a particular group/community in terms of their perceived presence or availability. To avoid overgeneralization, the audit procedure is restricted to a specific time period (eg., during the past six months; one year etc.) and limited to readily identified focal areas. The two focal areas used successfully in Fiji were: (a) cultural characteristics and norms; and (b) exposure to economic development and change.

Audit information might be gathered from informants either contemporaneously or retrospectively. (i) Contemporary data is gathered by interviewing a representative cross-section of the target community with interviews based on all items in Parts A and B. (ii) Retrospective information is gathered by examining a representative sample of archival material relating to the target group(s) and applying the criteria in Parts A

and B. One advantage of this procedure is that primary sources of information need not be overtly psychological or clinical in nature but are based on reported/observed behaviour: an advantage where groups are non-western and culturally different. Acceptable levels of validity and reliability are maintained by applying the principles of interpretative phenomenological analysis (IPA).[37] However; audits are subject to the same disadvantages inherent in any self-report technique.

Results from audits may be extended to calculate Community Coping Ratios (CCRs) which provide a crude but helpful indication of a particular community's adaptive and coping capacity. Expressed as a simple score, CCRs permit relatively objective comparisons between two or more cultural groups.[8] While this statistic contains disadvantages similar to those inherent in other macro-level indicators in common use (eg., fertility rates [FR]; infant mortality rates [IMR]; under five-year old mortality rates [U5MR]; literacy rates [LR]; and gross national product [GNP]), these indices are widely accepted when and where macro-level comparisons are required. The CCR is a similar indicator.

A social process equilibrium model not only provides important insight into a community's adaptive capacity, it facilitates identification of vulnerable sub-groups

Length limitations for this paper preclude detailed descriptions of the audit procedure and computation of CCRs. A description of both in greater detail including results obtained for two culturally different communities in Fiji is presented in a separate paper and might be obtained from the author on request.

To summarize. A social-process approach to mental health in PICTs was proposed to represent more accurately detrimental psychosocial outcomes commonly associated with economic development, modernization and globalization. It was noted these phenomena typically generate three overlapping and interacting pathological outcomes associated with chronic stress and detrimental to community mental health: certain social symptoms; health problems; and exacerbating conditions. A theoretically defensible empirically validated vitamin model of mental health based on a stress and coping paradigm was advocated which incorporated notions of toxic excess as well as deprivation. As well as providing a different way of thinking about community mental health, it provides a framework for auditing this at a group-level either contemporaneously or retrospectively. While facilitating a better understanding of mental health from a stress and coping perspective, it provides for systematic surveillance of mental health enabling identification of vulnerable sub-groups. An extension of this auditing technique also allows the calculation of a macro-level Community Coping Ratio (CCR): a statistic designed to facilitate reasonably objective comparison across different cultural groups and communities.

Conclusions

The aggregation of individual-level clinical measures of mental health in a non-western setting to assess community mental health is a flawed procedure prone to erroneous and misleading conclusions. Apart from reinforcing a narrow construction of mental health incongruent with closely-knit, socially-oriented Pacific Island communities, this is inconsistent with contemporary theory and research. A procedure designed to audit systematically the psychosocial environment and selected psychological outcomes from a transactional stress and coping perspective, provides valuable group-level information on mental health. A social process equilibrium model not only provides important insight into a community's adaptive capacity, it facilitates identification of vulnerable sub-groups in a more culturally appropriate manner. In turn, this enables a better fit between psychosocial needs and the provision of services: an important consideration if intervention strategies are to be relevant, focused and cost effective.

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Notes

1. Psychological assessment was and still remains dominated by two sources of clinical authority: The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-I, 1952, through to DSM-IV, 1994; and the World Health Organization's *International Classification of Diseases* (especially ICD-7, 1958 to ICD-10, Vols. 1-3, 1992-1994).

2. A biologically-focused, technologically-based emphasis in health was compounded by colonial policies and practices. These included an intellectual disdain for indigenous medicine; preoccupation with curative care for colonizing and colonized urban elites; and the maintenance of a few "showplace" hospitals which attracted the lion's share of health funds and human resources. Although exceptions existed in some PICTs, the provision of primary health care in former colonies has been described by some commentators as failing the urban poor and many in rural communities.[38]

3. A change in thinking was reflected by the Alma-Ata Declaration in 1978 and the Ottawa Charter in 1986. The Alma-Ata declaration triggered a philosophical shift within primary health care by emphasizing three principles: (i) a focus on appropriate technology with health resources shifting from urban hospitals to the needs of disadvantaged groups and rural communities. (ii) A critique of "medical elitism" involving lesser reliance on highly specialized doctors and nurses and mobilization of community members to take responsibility for health work. (iii) Recognition of an explicit linkage between health and social development (including educational, economic and political development).[21] In 1986, the Ottawa Charter on health promotion identified eight enabling factors ("prerequisites") for good health. They were: peace; shelter; education; food; income; a stable ecosystem; sustainable resources; and social justice and equity.[39]

Pivotal in nature, these reports were followed by a comprehensive international review of mental health in low-income countries;[10] a detailed analysis of the global burden of disease;[39] and more recently, *Social Psychological Foundations of Health and Illness*[14] and similar publications. The World Health Organization (WHO) has encouraged related initiatives including the *Social Determinants of Health: The Solid Facts*[15] and a Commission on Social Determinants of Health (CSDH) (2004/5).

Ottawa Charter on health promotion identified eight enabling factors ("prerequisites") for good health. They were: peace; shelter; education; food; income; a stable ecosystem; sustainable resources; and social justice and equity

4. Since the 1980s, neoliberal doctrines (advocating globalization, "free markets", and the retreat or withdrawal of governments from the provision of major services), have became a powerful force in developing countries. Major stakeholders like the World Bank (WB), the International Monetary Fund (IMF) plus sundry "experts" and "advisers" have argued that economic development should be the major priority for national development. This implies at least two things: that social outcomes (including health consequences) are of lesser importance than agricultural products and manufacturing outputs; and a belief that wealth creation enables other more socially-oriented benefits to emerge further down the line – an assumption trenchantly criticized by some.[19] A neoliberal approach argues that less money for health and education represent "necessary" possibly "painful" short-term strategies that in the longer term are supposed to translate into various social "gains". Unfortunately, the logic behind this doctrine has failed in most developing countries. In practice, economic development and structural readjustments almost always advantage political and economic elites who appropriate the benefits for themselves and their cronies. Today, approximately eighty-percent of each community in most developing countries remain poor, have became poorer and/or continue to be severely disadvantaged.[19, 21, 40]

5. Some commentators have identified nine transitions facing Pacific people: economic; religious; environmental; social; political; food and nutrition; health services; demographic; and morality.[11]

6. These included urbanization and urban drift; economic growth; unemployment and economic poverty; inequalities in educational opportunity including gender and ethnicity; political instability and corruption; weakening of traditional cultural and social supports; and disjunctions between traditional cultural attitudes and behaviour and those "required" for survival in modern market-driven economies.[26, 41, 42]

7. Multidimensional in nature, change included new forms of administration and governance, Christianity, different ways of explaining and treating disease and illness, literacy and a system of formal mainly academic education, and modern modes of communication and transport.

8. Improvements in living standards come at a cost. Within PICTs, many are now suffering from a range of degenerative physical diseases associated with modernization and associated lifestyle changes (eg., coronary heart disease, obesity and diabetes and certain cancers).[43]

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In practice, economic development and structural readjustments almost always advantage political and economic elites who appropriate the benefits for themselves and their cronies

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Improvements in living standards come at a cost. Within PICTs, many are now suffering from a range of degenerative physical diseases associated with modernization and associated lifestyle changes

Rarely has the world witnessed such capricious and vacuous venality dressed up as 'enterprise; rarely have so many been gulled by such duplicity.
(Will Hutton – 2000)