

**Strengthening Mental Health Care in Southern Malawi:  
Contested meanings and the search for culturally embedded approaches**

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## **ABSTRACT**

Mental health problems represent a significant burden of disability worldwide and there is mounting attention on how best to develop health care responses that are acceptable, effective and deliverable to scale. Alongside resource constraints, concerns have been expressed about the extent to which Western biomedical models of healthcare are transferable to other cultural settings, especially in the Global South.

This integrative chapter introduces a body of published work describing a task-shifting initiative in Malawi to test the feasibility and acceptability of health surveillance assistants (HSAs) delivering culturally appropriate mental health interventions across one district. With the overall aim of strengthening HSAs' care responses, the four papers describe structured evaluations of the pilot and scaled-up interventions, a qualitative study of stakeholder perspectives and experiences and a further historical and socio-cultural analysis of the key findings.

The bespoke mental health training initiative, delivered to scale, led HSAs to offer assessment, advice, counselling, practical support and signposting for people in distress and their families. The initiative also demonstrated a vast reach within communities. However, pluralistic and negotiated beliefs concerning mental health and illness, and its place within the sociocultural space and community mores, were evident and revealed the rich indigenous cultural philosophy of *umunthu* underpinning HSAs' work. Navigating between biomedical understandings of mental illness and traditional African understandings, the HSAs fashioned supportive interventions attuned to cultural norms under both the gaze and guise of biomedicine.

While HSAs responded therapeutically and strengthened support for people in distress, their efforts to do so typify wider tensions over the dominance of particular knowledge systems, such as biomedicine. These findings add to evidence signalling the importance that mental health care initiatives are co-created with respect for communities' historical and contemporary sociocultural contexts through establishing collaborative partnerships respectful of social justice and culturally negotiated meaning.

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## **AUTHOR'S DECLARATION**

This integrative chapter is based on a collection of four papers listed below. While all the papers are co-authored with others, as the first author for each paper, I made the significant individual contribution to each. Details of these contributions are provided below, signed by myself and one of the other contributory co-author for each paper.

1. Wright J, Common S, Kauye F, and Chiwandira C (2014) Integrating Community Mental Health Within Primary Care in Southern Malawi: A Pilot Educational Intervention to Enhance the Role of Health Surveillance Assistants. *International Journal of Social Psychiatry* 60: 2; 155–161.

**Contribution of the candidate:** Leadership of design, development and conduct of the pilot intervention and evaluation; analyses, preparation of the manuscript and subsequent revisions.

*Jerome Wright*

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Jerome Wright

*Stephanie Common*

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Stephanie Common

2. Wright J and Chiwandira C (2016) Building Capacity for Community Mental Health Care in Rural Malawi: Findings from a District-Wide Task-Sharing Intervention with Village-Based Health Workers. *International Journal of Social Psychiatry* 62: 6; 589–96.

**Contribution of the candidate:** Leadership of design, development and conduct of the scaled-up intervention and evaluation; analyses, preparation of the manuscript and subsequent revisions.

*Jerome Wright*

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It has not been possible to contact Mr Chiwandira (MHIZ Project manager)

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Chikayiko Chiwandira

3. Wright J and Maliwichi-Senganimalunje L (2020) Pluralism and Practicality: Village Health Workers' Responses to Contested Meanings of Mental Illness in Southern Malawi. *Anthropology and Medicine* 27: 1; 32-48.

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4. Wright J and Jayawickrama J (2020) "We need other human beings in order to be human": Examining the Indigenous Philosophy of *Umunthu* and Strengthening Mental Health Interventions. *Journal of Culture, Medicine & Psychiatry*. <https://doi.org/10.1007/s11013-020-09692-4>

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Jerome Wright



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The accompanying integrative chapter is the sole work of the candidate. The work in the chapter has not been submitted for examination at this or any other institution for another award.



## **1. INTRODUCTION**

This integrative chapter integrates a research experience examining the challenge of how best to strengthen health care responses for people in psychological distress in Southern Malawi. Originating from health care practice with individuals in distress, the research question explores an ever-increasing stratum of concerns encompassing local and global understandings of mental ‘health’ and ‘illness’, and their accompanying historical, socio-cultural and epistemic implications.

Since a recognition that mental health problems present the most significant burden of disability worldwide (Demyttenaere et al., 2004), there has been mounting attention towards how best to develop health care responses that are acceptable, effective and deliverable to scale (WHO, 2001; WHO/WONCA 2008; Prince et al., 2007; Daar et al., 2014; Patel, Saxena, Lund et al., 2018). Concerns have also been expressed about the extent to which Western biomedical models of healthcare are transferable to other cultural settings (Kleinman, 1980; Fernando, 2014; Davar, 2014; Whitley, 2015). This creates a ‘credibility gap’ (Patel 2014), in which a Western derived universal, struggles with the ‘local’ when generating meaningful outcomes for those experiencing distress. Consequently, an articulation of more culturally pluralistic and distinct approaches has been emerging (Siddiqui, Lacroix and Dhar, 2014; Kpanake, 2018; Bemme and Kirmayer, 2020). Such debates resonate throughout this chapter and represent a suitable corollary to advancing support for people in distress in Southern Malawi.

By their nature, low and middle-income countries (LMICs) have limited means to establish formal mental health care with which to bridge the ‘treatment gap’ (Kohn et al, 2004) and the last decade has seen increased efforts to develop suitable strategies through various global and local initiatives directed by the WHO and in partnership with international and national affiliates (Lancet Global Mental Health Group (LGMHG), 2007; Murray et al., 2011; Patel et al., 2013). For Malawi, as one low-resource country facing such challenges, this drive provided the opportunity for the Government mental health service to trial its first mental health task-shifting initiative, whereby existing non-mental health specialist community workers could be trained to deliver mental health interventions (WHO, 2008). The resulting initiative, with financial support from UK Department for International Development’s Health Partnership Scheme, pioneered a pilot project where the capability and acceptability of village-based health workers (health surveillance assistants, HSAs) delivering culturally appropriate community mental health interventions were examined. The experience and results from this endeavour, constitute the foundation for this integrative chapter.

My own role in leading the design, implementation, scale-up and evaluation of the task-shifting initiative is described, as well as an exploration of the ways in which the HSAs navigate the socio-cultural landscape of competing understandings of distress. I then further examine the HSAs' approach and interventions within an historical and situational analysis that, by exploring the relationship between biomedicine and indigenous knowledge systems, generates fresh insights with implications for strengthening mental health care both locally and globally. The overall aim and objectives of this research can be described as follows:

Aim: To strengthen HSAs' care responses for people in psychological distress in Southern Malawi.

Objectives:

1. To test the feasibility of training HSAs to provide mental health support to people in psychological distress through the design of a bespoke mental health curriculum and implementation using a task-shifting model.
2. To undertake a structured evaluation of the learning and impact of the mental health task-shifting initiative and its scale-up.
3. To analyse the HSAs' interactions with patients, their interventions and decision-making in order to understand the HSAs' role and context in the delivery of mental health support and implications for strengthening such a role.
4. To undertake a closer analysis of HSA interventions to bring to light their historical, sociocultural and situational context as evidence to inform approaches to mental health care at local and global levels.

Addressing the research aim developed iteratively across the four papers (Table 1) as the inquiry progressed and utilized appropriate methods. The full published papers are found in Appendix 1.

This chapter articulates an account of the research approach and situates the overall research aim and objectives within the wider contested frame of global mental health initiatives and debates over the appropriateness of different approaches. My primary purpose is to show how the use of original empirical evidence, contextualised within Malawi's historical, political and socio-cultural experience of health and mental health care provision can inform new participatory and inclusive approaches to strengthening the support for people in psychological distress.

**Table 1: List of papers included as part of the integrative chapter**

<b>Paper No.</b>	<b>Citation</b>
Paper 1	Wright J, Common S, Kauye F, and Chiwandira C (2014) Integrating Community Mental Health Within Primary Care in Southern Malawi: A Pilot Educational Intervention to Enhance the Role of Health Surveillance Assistants. <i>International Journal of Social Psychiatry</i> 60: 2; 155–161.
Paper 2	Wright J and Chiwandira C (2016) Building Capacity for Community Mental Health Care in Rural Malawi: Findings from a District-Wide Task-Sharing Intervention with Village-Based Health Workers. <i>International Journal of Social Psychiatry</i> 62: 6; 589-96.
Paper 3	Wright J and Maliwichi-Senganimalunje L (2020) Pluralism and Practicality: Village Health Workers' Responses to Contested Meanings of Mental Illness in Southern Malawi. <i>Anthropology and Medicine</i> 27: 1; 32-48.
Paper 4	Wright J and Jayawickrama J (2020) “We need other human beings in order to be human”: Examining the Indigenous Philosophy of <i>Umunthu</i> and Strengthening Mental Health Interventions. <i>Journal of Culture, Medicine &amp; Psychiatry</i> , Nov 19, doi: 10.1007/s11013-020-09692-4

## **2. BACKGROUND**

This section introduces the background to the research setting, including the context of Malawi, the demographic and socio-economic conditions and organisation of formal and informal health care sectors involved in mental health care, and my own positionality within the field.

### **i) The Context of Malawi**

#### ***a) Socio-economic conditions***

Located in Southern Africa, Malawi is landlocked, sharing its borders with Mozambique, Zambia and Tanzania (World Bank, 2020). The country has an estimated population of 18.6 million (2019) and remains one of the poorest countries in the world. At the time of this task-shifting project, Malawi's development index was ranked 173 out of 188 nations worldwide with more than 50% of Malawians living in poverty (UNDP, 2021). The economy is heavily dependent on agriculture, employing nearly 80% of the population, and is vulnerable to external shocks, such as from climatic threats and pandemics like COVID-19 (World Bank, 2020). Within the District of Zomba in the Southern region of Malawi, the majority of the 600,000 population are living in high density at 184 persons per km<sup>2</sup> and engaged in a rural subsistence economy (NSO, 2011) residing in villages of between 200 to 1000 people, small trading centres and one urban centre in Zomba, the district's administrative capital. Malawi is predominantly a Christian country (83%), while 13% are Muslim, 2% of other religions and 2% of no religion (NSO, 2011). Chichewa is spoken by all and is recognised – along with English – as the national language.

#### ***b) Health care sector***

Malawi's Government healthcare provision comprises of primary, secondary and tertiary care facilities. Primary care is provided through health posts/dispensaries, health centres and community hospitals. Secondary care is found at district hospitals and Christian Health Association of Malawi (CHAM) hospitals, and tertiary care is provided at central hospitals and specialist care facilities, including Zomba Mental Hospital. The Ministry of Health (MoH) oversees the development of all health policies, development and monitoring of Malawi's health sector.

Within each of Malawi's twenty-eight districts, services are administered within a number of health clusters, each of which contain health centres at which basic primary care, maternity services and public health are provided. Alongside the clinical officer, nurses and medical attendants, each health centre is the base for up to ten HSAs who are assigned to community catchment areas across districts employing health promotion activities and individual care activities, including facilitating public health,

vaccination and cholera campaigns, programmes of directly observed therapy for T.B. patients and coordinating home-based care (Kadzandira and Chilowa, 2001). HSAs represent Malawi's largest cadre of health worker, numbering around 10,000 nationally (Kok et al., 2016).

### ***c) Mental health care***

The availability of mental health care for Malawians is reflected in two different narratives. First, formal mental health service provision, afforded primarily through MOH and CHAM, reflect the challenges facing other African countries, where competing priorities for limited resources result in a gap between policy rhetoric and achieving adequate funding (Malawi Ministry of Health, 2011; Udedi, 2016). Malawi's mental health services are centralised and not integrated into primary healthcare (Udedi et al., 2013). Three mental health units with around 600 inpatient beds are spread across northern, central and southern regions, and are where only a small fraction of people experiencing the most severe mental illness are taken, often following criminal actions. Minimal community mental health outreach work extends from these centres (Kauye and Mafuta, 2006). While medical care is available at health centres throughout Malawi's districts very few mental health professionals' practice in the country (Kauye and Mafuta, 2006). General health care workers have limited competency and capacity for identifying and managing mental health problems (Udedi, 2016). This limited availability of mental health facilities and training and support for staff at health centres severely affects accessibility of services. High levels of societal stigma towards people suffering from mental health issues have also been noted (Crabb et al., 2012), including stigma attached to mental institutions and can be seen as another obstacle to the provision of accessible mental health services. As in other LMICs, this paucity of provision is however, less of a constraint for individuals with wealth and urbanity, who have increased opportunities to access Western-type psychiatry and psychotherapy on a privately funded basis (Lwanda, 2008).

A second narrative is articulated from an appreciation of informal mental health care offered through organisations influenced by African traditional religious practice, Christian churches and mosques (Steinforth, 2009). These forms of mental health care offer understandings of causation, classification and treatment of distress, different from that of biomedical perspectives, and are embedded in people's religious, social and cultural context (Kleinman, 1980). Networks themselves are pluralistic and often blended and range from healing practices based on religious text and traditions to distinctive forms of personhood and agency that manifest from connections between a person's spiritual, social and individual worlds (Kpanake, 2018). Nevertheless, together, the activities of traditional healers and Christian healing ministries represent an omnipresent discourse about 'mental illness' in everyday life and in media reports in Malawi (Englund, 2011; Simwaka, Peltzer and Maluwa-

Banda, 2007) and an almost universal provision with reports of up to 80% of the population accessing traditional healers (Ministry of Health, 2005).

These two separate narratives reveal a dislocation of perceptions between the public's views of mental health and illness and those of mental health professionals. The separate and parallel functioning of the two provisions is illustrated by the (at the time) only Malawian textbook on mental health – the Malawi Mental Health Handbook (Wilkinson, 1991) – a publication 'approved' by the Ministry of Health – which has just one brief entry on traditional medicine. This tension and ambivalence between different healing approaches in Malawi is discussed in more detail later but at this stage it can be seen to produce a very practical dilemma for people seeking help whereby access to biomedical health care is scarce and the 'less-authorized' traditional approaches more plentiful.

## **ii) Engagement and positionality within the research field**

My engagement with Malawi – and of the Southern region in particular – started in 2002 when I was appointed as a nurse lecturer as part of an institutional partnership between the University of York and the National Health Services of the UK and Malawi, to support the professional development of staff members working in the Government's mental health service. Listening and observing the experiences of patients and their interpretations of what staff termed 'mental illness' triggered an interest in moving beyond the confines of the mental health service and assertions of Western orientated biomedical frameworks and diagnoses, into an understanding of indigenous and local ways in which distress is recognized and responded to, akin to the second narrative described above, that occupied more centrality to people's lives. Working for the following few years with a Malawian NGO on issues of HIV/AIDS and adolescent mental health brought me closer to an appreciation of local community resources and resilience and to a recognition that people's context was key to their understanding of distress in the same way that any attempts to respond to distress needed to appreciate this context. A chance to translate at least some of this appreciation into practical application came in 2010 with the Malawi mental health service's readiness to commit resources to pilot a mental health task-shifting initiative in the district that involved HSAs; the cadre of health staff whose work was most embedded in the community.

From the outset when approaching cross cultural research one of the essential aspects of reflexivity, my positionality to the research field, is an important feature (Jacobson and Mustafa, 2019). While conscious to avoid both asserting certain Western ideas and ways of working or of proffering a romanticism of Malawian social values and practices – both of which can be ascribed to essentialism and 'orientalism' (see Said, 1991) – I am equally aware of the implausibility of these standpoints and

the need to reconcile them, when presenting experience. Such a balance, if it was to exist, is further complicated by the European-North American model of psychiatry as the dominant conceptual framework informing all Malawian medical education and health services (Fernando, 2014). Nevertheless, as both researcher and lead for the task-shifting initiative, the influence of my own values and personality on the studies cannot be overlooked. As a white British-born nurse and university lecturer I am steeped in traditions of evidence-based healthcare and education, laden with culturally acquired assumptions about the nature of health, illness and what is considered 'effective' care and learning. Although equally, my experience in Africa has educated me about the historical legacy of colonialism and its post-independence continuities, and I retain a self-consciousness and vigilance to the abuses of the 'civilising mission' of Western countries (Mills, 2014). That said, and even with nearly two decades working on projects in Malawi, including extended periods of time living in the country, I remain an 'outsider'. Further discussion of both the colonial impact on psychiatry and the place of the 'outsider' in research are offered in Sections 4 and 5.

Another important factor to acknowledge in my positionality is as a health professional, which itself potentiates a conflict of interests in undertaking research. The nurse's role has the inclination to utilize knowledge and skills to respond therapeutically to health problems, whether at individual or population level, while being a researcher directs my efforts towards observing and understanding phenomena and their context without the necessity for intervention. My own beliefs too on the value of mental health support are important. I was personally and professionally invested in the work – to intervene positively to reduce suffering. This enthusiasm to improve services for people who are distressed may at times limit my appreciation of alternative viewpoints or practices, although at the same time, I was equally invested in accurately portraying the views and needs of people, including recognising the long-term benefit of obtaining such understandings (Chambers, 1983).

As a white health professional leading a task-shifting initiative in Malawi I was also aware of the uneven power dynamic that existed and impacted on interactions and in particular the expression of critical views that might locally be considered unorthodox or disloyal to the 'project' of advancing biomedical health care. These cautions became apparent in interactions with patient participants and local Malawian health professional colleagues and signal disparities of class, education as well as ethnicity.

Given this positionality when conducting research among communities in Malawi I consciously paid attention to development theory and the research design to reduce the likelihood of non-representative and exploitative research (Chambers, 1983). I took steps to mitigate as many of the power imbalances as possible by working alongside professional colleagues, undertaking shared tasks,

valuing and taking an interest in colleagues' professional and personal lives. At times I would also take deliberate steps to reduce risk of misinterpretation by emphasizing my separateness from Government mental health services, especially when collecting survey data and engaging interviewees. But such imbalances can never be eliminated and will have impacted the findings. It is equally clear that my positionality itself changes over time and in undertaking different roles within the project (Day, 2012). The inclusive method of task-shifting curriculum design and research design for instance provided some power to participant HSAs and patients to express their own views and opinions, although again it is implausible that people's contributions were not impacted by conformity at various levels. Throughout, working closely with Malawian co-researchers facilitated not only translation (for I have only a limited grasp of Chichewa) and contextual advice, but also the most valuable insights through the exchange of ideas, of assumptions and interpretations, which it is hoped increased the acuity of our findings. As the research progressed, many of my assumptions about the phenomena also shifted and evolved and this can be traced within the four papers as I remain acutely aware of the importance of being open about my own understandings and interpretations (Aamodt, 1991). These issues of positionality and the insider/outsider perspectives are discussed further in Section 5.



### **3. THEORETICAL FOUNDATIONS FOR THE STUDY**

This section sets out the theoretical background to the research including the challenge of strengthening mental health care globally and locally in Malawi, and the development of task-shifting as an approach to training health workers. This background provides the basis for the philosophical approach from which the research aim, questions and methods were framed and conducted.

#### **i) The contested field of Global Mental Health**

All societies possess notions of normality and health, and the constructs of mental illness that derive are a product of social definitions from historical and cultural understandings (Helman, 2007). Two different perspectives emerge, which emphasise either the consistency of a universal experience and attribution across societies in the form of an illness model (Mechanic 1999), or the experience as rooted within the cultural frame, relative to a particular local setting (Kleinman and Good, 1985). These ‘universalist’ and ‘relativist’ positions, represent distinct conceptual perspectives offering a critical, and some would argue a polarising and paralysing debate (Bemme and Kirmayer, 2020), which 15 years ago was interposed by the activist ‘Movement for Global Mental Health’ (MGMH) approach and their call to respond to the mental health ‘treatment gap’ by increasing the supply of biomedical mental health provision (LGMHG 2007). With its unapologetically grounded biomedical thinking and accompanying epidemiological research based on estimates of the global burden of disability (Kohn et al., 2004), the global mental health agenda, has drawn attention to the needs of vulnerable populations and has used human rights-based rhetoric to inspire action at government and intergovernmental levels through a series of action plans and intervention guides (WHO, 2013 and 2016).

However, the problems inherent in the universalistic assumptions upon which such action is based remain. Fernando (2014) summarises the two major difficulties when a biomedical approach defines particular ‘life problems’ as mental health problems. Firstly, a categorical critique suggests that identifying the same ‘symptom’ in two distinct settings does not mean that both carry the same understanding, experience or meaning. Proposing one such medicalised worldview through which to frame these experiences risks a ‘categorical fallacy’ (Kleinman, 1977; Clarke, 2014) so that cross-cultural reliability and validity are questioned. This over-reliance on a concern for measurement and diagnosis rather than the social and cultural context results in a narrow and exclusive determining of distress (White and Sashidharan, 2014). Universalistic assumptions implicit in the biomedical approach to mental illness would be less contested if the evidence for the effectiveness of such approaches was more compelling. Initial and long-term follow-up studies from the 1970s showed superior rates of

recovery in many low-resource countries, when compared to Western countries (WHO, 1973; Sartorius et al., 1996). This questioned the appropriateness of offering psychotropic medication, with all its iatrogenic effects, and Western premised ‘talking treatments’ where there is no evidence of local effectiveness (Moncrieff, 2009; Bentall, 2010; Summerfield, 2008; Kirmayer, 2012).

Secondly, an ethical justice argument offers a critique of medicalising and individualising distress, by emphasising how such an approach not only diverges from the many communal ways of understanding the nature, cause and effects of peoples’ distress, but also diverts attention from the social, economic and political environments like poverty, violence, inequality and discrimination that have been shown to cause such distress (Allen and Feigl, 2017). As a result, structural social determinants of distress are submerged by the development of individualised therapeutic interventions (Saxena et al., 2006) and consequently, risk becomes de-politicised (Mills and Fernando, 2014).

## **ii) Malawi’s colonial and post-colonial mental health legacy**

The historical legacy of psychiatry in Africa – including Malawi – cannot be overlooked when seeking to understand the way that mental illness is defined, problematized and ‘treated’. The State psychiatric institution – Zomba Mental Hospital – was built in 1910 as “a part of the infrastructure of colonialism” (Akyeampong, 2015 p.28), which, like many others throughout Africa, was originally an extension of the local prison. Megan Vaughan’s work on mental health care in Malawi shows how the ‘colonising mission’ of psychiatry across the nineteenth and twentieth centuries was fuelled by racist science and biology (Vaughan, 1991) in attempts to fortify the superiority of the colonisers. Such positions were used by colonial powers to exert political power and justify oppression through social control and human rights abuses (Mahone and Vaughan, 2007) and in what some have specifically described as the colonial process of objectification and subjectification (Fanon, 1952 pp.120-184).

It would be misleading though to suggest that all African countries suffered the same colonial and post-colonial experience of European psychiatry and there are several notable examples of indigenising efforts (for example Thomas Lambo in Nigeria in the 1950s, and Henri Collomb in Senegal in the 1960s and 1970s). Akyeampong (2015) traces the ebb and flow of initiatives to integrate indigenous psychologies into mental health care in the latter half of the twentieth century. However, Malawi experienced no such renaissance of African thought in mental health care post-independence, and instead was influenced by the ambivalent positions of the first president Dr Banda. Although a Western medically trained doctor himself, Banda showed little inclination to develop Malawi’s health services or to grow indigenous medical doctors (King and King, 1992), preferring a reliance upon expatriate technocratic leadership (Lwanda, 2008). Consequently, traditional medicine’s retreat into village localities, where traditions were protected and fortified, and a Western medicine reserved for

the elite, all mirrored the colonial era (Vaughan, 1991). At the same time Banda's appropriation of traditional medicine and other indigenous cultural practices, including the employment of *ufiti* (witchcraft) discourse, can be seen as calculated political decisions to create a potent post-independence national unity and pride while managing limited resources.

As a result, traditional healing received strong endorsement at the expense of investment in public, and particularly rural, health development (Forster, 1994; Baker, 1976; Lwanda, 2004). The legacy of such dissonance between medical traditions continue to resonate in contemporary discussions of mental health and mental health treatments in Malawi and the significant resource challenges (Malawi Ministry of Health, 2011).

### **iii) Task-shifting as a method**

To progress the WHO de-centralising agenda to strengthen primary care health services (WHO/WONCA, 2008) and as part of the MoH development of community mental health provision, the Malawi Mental Health Service looked to undertake a mental health task-shifting initiative. Honed by the HIV/AIDS pandemic and promoted by the LGMHG (2007) as a key instrument in their armoury of scaling-up, task-shifting has become a central feature of health care in resource poor countries (WHO, 2008). The term task-shifting as "a method of strengthening and expanding the health care workforce by redistributing the tasks of delivering services to a broad range of individuals with less training and fewer qualifications than traditional health care workers (e.g., doctors, nurses)" (Kazdin and Rabbitt, 2013 p.173), carries with it assumptions about the privileging of certain knowledge and skills, of professional and lay expertise and competence, and of power relations. So, although clear that the task-shifting approach has inherent limitations and contested areas that demanded closer scrutiny, it offers a rare opportunity to strengthen at least a part of the approach to supporting people in distress and as such could be afforded some compromise (Fernando 2014). The critical buy-in from the MoH was testament to the commitment of the local mental health service team and although clearly a top-down strategy, the absence of any previous such mental health projects in Malawi, meant there was no direct template for task-shifting, the intended recipients or the content of the mental health programme. A small number of psychological therapies had been trialled in similar settings elsewhere in Africa and appeared to be building an evidence base. These, however, were entirely based on Western therapeutic approaches (Bolton et al., 2003; Bolton et al., 2007) and not suitable for delivery by the non-mental health specialist grade cadre of staff available in Malawian primary care. Version 1 of the mhGAP intervention guide (WHO 2010) had just been published, but the accompanying teaching resources were yet to be drafted. At the same time, while LGMHG (2007) recommended task-shifting as a promising approach, the first papers evaluating mental health projects were only just

emerging (Lund and Flisher, 2009). While the constraints of limited project funds and the complex task of piloting new roles within the health delivery system made undertaking implementation research extremely challenging, these conceptual uncertainties over content and delivery method provided an opportunity to develop the project in a way that was, on reflection, more conducive to the needs of the mental health services and to the cultural landscape of the chosen district in Southern Malawi.

#### **iv) Summary of the challenge**

This section has highlighted the contested field of global mental health where certain universalistic assumptions about the way that psychological distress is understood and responded to are promulgated, including through task-shifting initiatives. And yet “medical knowledge and practice of all kinds is deeply social” (Lock and Nguyen, 2010, p.59), and psychiatry is expressly situated in the social world (Kleinman, 1980). While the supremacy of particular forms of knowledge has endured through colonial and post-colonial Malawi, at the same time help-seeking has clearly demonstrated that indigenous understandings and practice have equally prevailed. The existence of these two entities throws up the challenge of whether it is possible to design a task-shifting initiative that is suited to the local understandings of distress and it is into this contested area in 2010 that the mental health study described in the four papers was conceived.

#### **4. MALAWI'S MENTAL HEALTH TASK-SHIFTING PROJECT**

This section describes the way that the task-shifting approach was adapted for the context of rural Malawi, including its design and delivery.

##### **i) Project design and development**

The initial pilot project was undertaken between 2010 and 2012, funded through a grant of £29,000 from the UK International Health Links Funding Scheme and trained 271 HSAs from across three clusters of health facilities which were randomly selected to participate from the 32 health centres across all seven clusters of Zomba District in Southern Malawi.

The later scale-up of the pilot project – the 'Mental Health in Zomba Project' (MHIZ Project) (2013-15) – was funded through the UK Health Partnership Scheme grant of £121,000 and trained over 430 HSAs from across all seven clusters of Zomba district serving a population of over 600,000.

These two projects represent the first mental health task-shifting initiatives undertaken in Malawi, supported by the MoH and District Health Office and Environmental Health Office to build the potential for sustainability. The target group chosen to receive the training and deliver interventions to people in distress were HSAs.

##### **ii) Health Surveillance Assistants**

Numbering over 10,000 nationally, HSAs represent 30% of the Malawi's health workforce. Initially recruited as vaccinators for public immunisation campaigns in the late 1950s, the role of this Government paid cadre of health worker has expanded greatly to the current position where HSAs are considered frontline workers and the "point of contact between the formal health service delivery system and the community" (Kadzandira and Chilowa, 2001 p.12). With ten-week's initial biomedical training on a range of individual and public health promotion interventions, HSAs have a particularly significant role in promoting maternal and child health and the prevention of childhood diseases. Together with village health committees of volunteers that they coordinate, HSAs have an extensive appreciation and practical knowledge of a range of health problems and how these are experienced and managed in the community (Kadzandira and Chilowa, 2001). Their established position within the local community and the primary health care structures ensures HSAs constantly work at the interface of biomedical and traditional health care practice where formal and informal provisions of care converge, including insights into how people are impacted by the hardships of life and illness that may lead to psychological distress. While within the formal health care system HSAs occupy a comparatively low-level position, the fact that they reside in the local community and have a respected social standing, contributes not only to an appreciation of local concerns, but also

sponsors both a physical and social accessibility, credibility and trust with those they serve (Kok et al, 2016). As such, HSAs themselves may be viewed as occupying both insider and outsider roles within the health system as ‘intermediaries’, connecting the community to services in the formalised health care system through their home and workplace visits, report to primary healthcare centres and liaison with other healthcare professionals (Perry et al., 2019). While not without its challenges (Kok et al, 2016), such a role is immersed in the pluralistic understandings of health and so was critical to the decision to approach HSAs for this task-shifting project.

As a part of ‘outreach’ from the hospital-based services at Zomba in 2008, HSAs had been identified as health workers who both observed patients’ significant emotional or psychological distress and saw how this impacted upon their lives and those of their families and community. At that time, the HSAs’ 10-week national training programme contained nothing on mental health and yet in consultation the HSAs were motivated to learn more about how their care of patients can be enhanced. This, together with emerging evidence of the importance of non-specialist health workers (van Ginneken, *personal correspondence 2009*) became the stimulus for identifying HSAs as the ideal cadre of health care staff to participate in a pilot mental health task-shifting project.

### **iii) Curriculum development and delivery**

Curriculum design and training materials were generated from a week-long collaborative workshop with nurses, clinical officers, psychologists and psychiatrists from Malawi’s Mental Health Services, and representatives from HSAs, the local District Health Office and the Mental Health Users and Carers’ Association of Malawi.

The training highlighted multifactorial pathways to experiencing mental health problems, encompassing biopsychosocial causations, and in line with the HSAs’ designated role, the course was designed to enable HSAs to support individuals to identify solutions to their difficulties, with the emphasis on listening and responding supportively rather than seeking to make a psychiatric diagnosis and refer on to mental health services. The programme addressed risk of harm to self or others by seeking to provide HSAs with the knowledge and skills to manage such risks in the community context. Curriculum materials were derived from real-life clinical examples encountered in Malawi and were made linguistically accessible to HSAs. The training method for the three-day course emphasised interactive and skills-based learning as well as the distribution of a bespoke HSA mental health handbook to reinforce learning and support the HSAs’ when they returned to practice. The deliberate scheduling of two consecutive days training and one further day six months later sought to assist HSAs with embedding learning within their practice. The increased funds available for the ‘scaled-up’ MHiZ Project enabled HSAs’ learning to be further reinforced through monthly supervision at practice settings.

## **5. RESEARCH DESIGN AND METHODS**

This section provides a summary of the methodological approaches adopted to respond to each of the research objectives in the study.

### **i) Study design**

Across the four papers a 'mixed methods' approach was adopted, undertaking both quantitative and qualitative data collection sequentially over a period of time (Johnson et al., 2007). While in itself, mixed methods can cause a clash of paradigmatic assumptions (both deductive and interpretive), in practice, this clash was moderated as the enquiry sequentially adopted suitable methods to track the increasing depth of understanding of the task-shifting initiative and the experience of distress and support more generally.

A survey method was conducive to the practical undertaking of an evaluation of the task-shifting interventions. Important empirical findings described the delivery of a new mental health service by HSAs, including quantitative data on the extent, distribution, and activity of HSAs. However, such data, although valuable, fails to capture any broader and potentially pertinent perceptions (Robson, 1993) and there was a need to deliberately seek out a deeper understanding of the motivations and different perspectives of those involved (HSAs, patients/carers).

As such, I adopted a qualitative approach that was flexible, adaptable and sensitive to different subjectivities and multiple perspectives (Chambers, 1983). The approach to the qualitative study, for example, challenged the universalistic assumptions of biomedicine and was directly influenced by Kleinman's (1980) critique of Western psychiatry's ethnocentrism and psychocentrism. This critical approach to the field allowed for a focus on Malawi's pluralistic healthcare environment and interactions. Colonial and postcolonial scholarship (Fanon, 1952; Vaughan, 1991) as well as critical race theory (Rodney, 2018; Delgado and Stefancic, 2017), were each drawn upon in the analysis to understand the socio-cultural position of mental health problems and their care in contemporary Malawi, as well as a way to understand the position of HSAs within the health system and how they adapted their interventions to meet patients' needs.

Appreciating these complexities and contested areas informed the design of the qualitative interviews and critical analysis in capturing "a sense of the rules for culturally constituted behaviour" (Aamodt, 1991 p. 42). Such ethnographic sensibilities highlight the importance of an appreciation of both insider and outsider perspectives (Kleinman, 1980), which can be seen to have resonated across the study in discussion of the global mental health approach and local understandings and experiences of distress, and in the research process itself. Such methodological transparency equally necessitates discussion

of how my own positionality (described earlier) influences the findings. As an ‘outsider’ to Malawi, researching the socio-cultural spaces of Malawi’s formal and informal healthcare practice and education systems, exposes linguistic, cultural and intellectual limitations that an ‘insider’ would not face. This oppositional view of insider/outsider stances can be reconsidered to assume Merriam et al.’s (2001) more nuanced view whereby each culture has multiple entities within which every person will be an ‘insider’ and ‘outsider’ of each (e.g., woman, Malawian, Chichewa speaking, nurse, patient). The assumption that an ‘insider’ has more access to certain truths than others is certainly possible, although there are equally occasions where some informants may prefer to disclose to an ‘outsider’ (Lipson, 1991). The constructivist or post-modern argument also in turn attests to there being different truths anyway, some of which an ‘outsider’ may reveal.

Equally critical to positionality are the power-based dynamics inherent in all research (e.g., greater methodological or cultural knowledge, or the way certain positions are foregrounded rather than others). Cross-cultural mental health or psychiatry has a long and ignoble history of excluding ‘insider’ views. Africans especially have been – and continue to be – ‘othered’ in psychiatry in the UK and internationally with racist presumptions of inferiority and pathology (Carothers, 1953; McCulloch, 1995; Fernando, 2010). Assuming critical race theory and postcolonial study perspectives within this social constructionist framework (Rodney, 2018; Fanon, 2001), and recognising historic and current inequalities and injustices, is therefore part of that positionality and underpins my philosophical approach to research activities. Contingent on the shift of such power differentials (and relationships), Chambers (1983) plots a course for the complementary knowledge of both the insider and outsider to “achieve advances that neither could alone” (p. 101).

## ii) Summary of research methods

The research methods and analyses are briefly described here as more detailed descriptions as to their effectiveness and limitations are provided within the relevant papers. The three research methods are listed in Table 2.

<b>Table 2: Research aim and method for each paper</b>		
<b>Paper No.</b>	<b>Aim</b>	<b>Method</b>
Papers 1 & 2	To undertake structured evaluation of the educational intervention (pilot and scale-up interventions)	Survey method
Paper 3	To uncover learning from different perspectives of key stakeholders	Qualitative interview method
Paper 4	To distil and refine key findings and locate within wider theoretical and practitioner knowledge	Comparative review and analysis of extant data



### ***a) Survey method***

The survey method adopted to evaluate the impact of the task-shifted educational initiative was made from a pragmatic decision to focus on the essential questions of pre- and post-training changes to HSAs' knowledge, confidence and practice. While still within the frame of implementation science (Betancourt and Chambers, 2016) the resource constraints and, at the time, the relatively underdeveloped process evaluation methodologies (Moore et al., 2016), made this the most achievable format. Two self-completing questionnaires were devised by the research team from aspects of the HSA training materials. One 11-item questionnaire sought true/false or multiple answers to measure 'knowledge' of mental health problems deriving from the training and the other – a 14-item questionnaire – used a summated rating (Likert) scale to quantify HSAs' perceived 'confidence' in providing mental health care and support. Once designed, a panel survey method offered an efficient opportunity to record changes over two different time periods, pre- and post-training. The standardised questionnaires, while not externally validated, provided for straightforward comparison of results and basic statistical analysis from within the sample (Robson, 1993).

### ***b) Qualitative interview method***

The qualitative interview method was undertaken over two month-long periods and drew on the centrality of understanding the individual experience of stakeholders (HSAs and patients or carers). The 'pairing' of an HSA with a patient or carer with whom the HSA had worked allowed for an exploration of congruence and different perspectives of the same episode of distress. The themes for inquiry at interview were derived and refined from Kleinman's (1980) explanatory model and discussion of help-seeking with the research team in Malawi. The semi-structured interview method therefore focused upon accumulating an understanding of how each stakeholder gave meaning to their experiences of mental distress or their response to others' distress. Emphasis throughout was on encouraging interviewees to describe their subjective thinking and experiences and the interviews were audio-recorded and transcribed to permit repeated analysis of verbatim text (Morse and Field, 1996). Findings from the interviews were complimented by researchers' field note observations of HSAs in their everyday clinical work, and patient and carers' attendance at health centres.

### ***c) Comparative review method***

The comparative review of primary data deriving from the surveys and interviews, field notes, and from contemporary research literature and reflexive discussion situates this as an action research method as accidental ethnography (Poulos, 2009). The continuity of the same researcher accessing their own previously collected data, plus the overt employ of personal experiences and reflections

differentiates this from a simple secondary analysis method (Silverman, 2010). The explicit retrospective focus on past data from “practitioner’s work” and inclusion of work not originally intended as research data, locates the method more towards Leviton et al.’s (2017) approach to accidental ethnography. As does the co-development of questions, the meanings made in practice and reflection, an engagement with scholarship as a means towards social justice and a deep reflection on positionality (Leviton et al., 2017), which are all demonstrated within the work.

### **iii) Ethical considerations**

As a practice development project integrated within the local community healthcare provision, the MHiZ Project itself benefitted from the ease of access to the field by being incorporated into the existing professional and ethical governance of the Malawi’s community healthcare system. The research elements of these studies however needed to ensure that ethical oversight was extended to the care of all participants and data, and this was obtained from the National Research Council of Malawi and the Department of Health Sciences Research Governance Committee at the University of York.

A number of key ethical issues arising from the research methods proved critical and included the care of participants, consent and confidentiality. Members of the local MHiZ Project team working in the area made the initial approach to HSAs and asked if they would consider participating in an audio-recorded interview. Having agreed in principle, the HSAs then nominated and approached a patient or carer who they had previously worked with and who might be willing to be interviewed. Such an approach to recruitment, while having some limitations of sample bias acknowledged in Paper 3, nevertheless afforded both the required depth of study and ensured that appropriate care for vulnerable participants was preserved.

Obtaining informed consent is a major pillar of securing the highest ethical standards of research and this was as attainable in a low-resource setting as anywhere else; however there were both language and practical adaptations that needed to be made to achieve this standard in the setting of rural Malawi. Research information and consent documents were made available in Chichewa and English, and simple language and terms were used to convey the points meaningfully to prospective participants whose level of education was more limited. All prospective participants were provided with oral and written explanations of the study before providing confirmation of their written informed consent to the researcher/interviewer when they attended for interview a few days later.

Particular sensitivities were required with regards to the chosen research method whereby the individual HSA and patient or carer were 'paired' in order to examine the same episode of distress. To engage and safeguard trust in the interview experience a number of assurances were included in the verbal and written information to participants and were emphasised verbally at the commencement of every interview. HSA participants were assured that the research enquiry was not an assessment of their performance or abilities, and that their anonymity was protected. For patients and carers, where participants may encounter anxiety or concern about expressing their views or experiences when at the same time seeking the support of HSAs, they were assured that their participation or non-participation in the studies would have no impact on the continuance of their health care and support. Explicit reassurance was given that patients' and carers' views and opinions would not be disclosed to the HSAs and nor would the HSA or health centre have access to these views and comments.

To protect the identity of participants, all names or identifying data mentioned in the recordings were omitted from transcripts so that anonymity was ensured throughout data analysis and writing up phases of the study. Access to the data was limited to the immediate research team and the use of unique identification codes, password protected files, recording devices with built-in encryption facility and encrypted memory sticks for transfer and storage of data, all preserved confidentiality throughout the research process. In the write-up and publication phases too, the use quotations from participants was fully anonymised and any additional references to people or place names that could identify participants were also omitted.

Overall, while the study explored sensitive and at times highly emotionally charged topics, the fact that the research was nested within the established MHiZ Project provided both a long-term sustained engagement with the field and access to a robust health support system to ensure the ongoing well-being of HSAs and patients/carers.

## **6. RESEARCH PAPERS**

This section presents the four published papers that reveal key juncture in the unfolding narrative exploring the research aim: to strengthen HSAs' care responses for people in psychological distress in Southern Malawi.

### **PAPER 1**

**Wright J, Common S, Kauye F, and Chiwandira C (2014) Integrating Community Mental Health Within Primary Care in Southern Malawi: A Pilot Educational Intervention to Enhance the Role of Health Surveillance Assistants. International Journal of Social Psychiatry 60: 2; 155–161.**

Paper 1 advances research objective 1. To test the feasibility of training HSAs to provide mental health support to people in psychological distress through the design of a bespoke curriculum and implementation using a task-shifting model.

The paper details the process and evaluation of the pilot mental health task-shifting intervention aimed at integrating mental health work into the HSAs' role. Box 1 presents a summary of the main findings.

#### **Box 1: Summary of main findings from Paper 1**

##### **1. Task-shifting intervention**

- 10 training courses delivered; 271 HSAs completed 3-days of training

##### **2. Impact of training**

- Pre- and post-training (at 12 month) self-completed measure of mental health 'knowledge' (n=266) demonstrated a significant increased knowledge on mental health.
- Pre- and post-training (at 12 month) self-completed measure of 'confidence' in delivering mental health interventions (n=207) demonstrated a significant increased confidence.
- HSA post-training measure of activity (12 months) recorded by HSAs on 'Client Intervention Report' and 'Mental Health Promotion Activity' forms.

##### **3. HSA interventions**

- 132 individual assessments and interventions undertaken with people in distress from across age-ranges and severity of distress.
- 8% assessed as suicidal and 24% as threatening violence to others
- HSA assessments were discerning: 75% of people assessed as likely to have a mental health problem and 8% assessed as likely NOT to have a mental health problem. HSAs consulted health centre colleagues on the remaining 17%.
- HSA interventions included suicide risk assessment and management, information-giving and encouraging self-help and help from the community, referral to health centre for further support.

#### 4. HSA mental health promotion

- 496 mental health promotion activities undertaken within communities, including talks, meetings and support groups.
- Attended by 22,289 people (196 patients known to the HSAs, 686 relatives or carers and 21,407 attendees from the local communities).
- Meeting themes included mental health and drug and alcohol awareness raising, human rights, the need for care and support and reducing stigma to referral and how HSAs can work with church leaders and traditional healers.

The brief educational intervention, together with supervision, stimulated considerable HSA mental health care and health promotion activity. The HSAs' focus of support upon the individuals' concerns and levels of 'distress' and 'risk', rather than to proffer a psychiatric diagnosis, appears to have prepared the way for HSAs to deliver community-based therapeutic interventions that were conducive to the environment and settings in which they work. In responding to peoples' distress, HSAs were able to adopt a discerning approach to recognizing mental health problems and to deliver a range of responses, including for those at high risk of suicidal or violent behaviour.

Only a relatively low number of individual client interventions were recorded (n=132) considering the number of HSAs trained (n=271). However, as a novel educational intervention this was not an unexpected return, especially when HSAs are being asked to recognise and respond to what is for them a new health issue. Issues of language, confidence and supervisory prompting to record such novel interventions are also likely to have influenced these returns.

While there are methodological limitations to the study design described in Paper 1, including the lack of standard outcome measures for HSA interventions and biases inherent in the self-reporting of activity, the project strongly points to the feasibility and potential of the mental health task-shifting intervention to positively impact on HSAs' mental health care knowledge, confidence and activity.

#### ***What does this study contribute to the body of knowledge?***

This study of Malawi's first mental health task-shifting initiative demonstrated that within their role HSAs engage with people in distress and that this training programme informed and strengthened the HSAs therapeutic approach and responses. Indeed, such a transdiagnostic approach has increasingly become standard for 'shifted' mental health interventions, including within the WHO's Problem Management Plus intervention (Dawson et al. 2015) and most recently in the Friendship Bench initiative in Zimbabwe (Verhey et al., 2020).

HSA's are in a unique position to recognise and respond to people's distress and contribute to the understanding of mental health/illness within the community. With 81% of people in the study having already sought previous help from the services of agents such as traditional healers, spiritual advisors or church ministers, it was also clear that pluralistic health traditions are active within the community in responding to people in distress. This finding underlined that HSA's are at the interphase of traditional and Western constructs of a 'health' model of mental health and reinforced the decision for the HSA mental health training not to adopt an entirely diagnostic approach to distress (Jacob and Patel, 2014). Instead, it appeared that appreciating a range of explanatory models and a focus on providing core person-centred, practical interventions freed the HSA's to offer what they considered relevant community-based interventions. In his paper on avoiding the medicalisation of mental health in primary care, Ventevogel (2014) cited Paper 1 to reinforce the importance that initiatives should not contribute to a narrow biomedical approach and instead empower community health workers "to find practical solutions for people with psychosocial distress" (p.6). At the same time as offering a level of critique of the emerging MGMH approaches, adopting mhGAP language would situate HSA's as attending to both the supply and demand elements of the 'treatment gap' by being both responsive and credible (Patel, 2014).

HSA's are clearly a key cohort of health workers in Malawi with the potential to expand and legitimise their role supporting people in distress and engage the public in discussion at health promotion events. While the pilot study has provided a proof of this concept, questions remained as to whether similar findings will be attained if repeated to scale.

## **PAPER 2**

**Wright J and Chiwandira C (2016) Building Capacity for Community Mental Health Care in Rural Malawi: Findings from a District-Wide Task-Sharing Intervention with Village-Based Health Workers. International Journal of Social Psychiatry 62: 6; 589 96.**

Paper 2 advances research objective 2: To undertake a structured evaluation of the learning and impact of the mental health task-shifting initiative and its scale-up.

The paper describes the scale-up of the pilot initiative – the MHIZ Project - to establish a district-wide HSA mental Health promotion and care service through the refinement, development and implementation of a task-sharing project and an evaluation of the impact of the intervention on HSA's' practice.

A major refinement from the pilot project to support the sustainability of the HSAs' role was the introduction of ten one-day mental health briefings for 231 health centre clinicians across the district and who worked at the health centres that HSAs reported to. This aimed to enable clinicians to become familiar and more closely supportive of the mental health work of HSAs, in line with the apprenticeship model advocated by Murray et al. (2011). Box 2 presents a summary of the main findings.

**Box 2: Summary of main findings from Paper 2**

1. Task-shifting intervention

- 10 3-day training courses delivered; 430 HSAs completed 30-days of training
- Team of mental health practitioners provided monthly group supervision for 700 HSAs at health centres for 24 months.

2. HSA interventions: analysis of HSA reported consecutive client cohort (n=240).

- 93% (n=224) of people were assessed by HSAs as experiencing distress that was significant enough to warrant an immediate intervention from themselves or referral to health centre.
- HSAs delivered four types of intervention:
  - (a) reducing clients' risk of harm to self or others,
  - (b) providing client focused psychoeducation,
  - (c) providing clients with psychological and emotional support and
  - (d) promoting psychosocial support through families and the wider community

3. HSA mental health promotion: analysis of HSA reported activities across 24 months.

- 850 mental health promotion activities undertaken within communities, including
  - (a) mental health information during general health talk
  - (b) psychoeducation information exchange
  - (c) group activity or drama presentation
  - (d) mental health promotion advice to family groups
  - (e) mental health patients or carers' support group (8%; n=62).
- Attended by 43,049 people (1732 patients known to the HSAs, 3741 relatives or carers and the majority were from the general population (at public meetings) or from those attending a health facility (at meetings held during HSAs' clinics).

Overall, the scale-up of this task-shifting project for all 850 HSAs across the 32 health centres in Zomba district was successfully achieved and sustained over 24 months. The impact and monitoring data likewise produced larger data sets, but at similar proportions, to the pilot project. The mental health interventions delivered by the HSAs appeared to have created a new service offering a 'health' model to people in distress, optimising help-seeking, and operating practical and person-centred support. The HSA-facilitated mental health promotion activities attracted many attendees and, similar to the pilot project, revealed the extensive reach that HSAs have within their communities, demonstrating the impact this can have on sensitising people to a concern for people in distress. Again, the MHiZ

Project appears to have created new opportunities for dialogue within the community on mental health and human rights concerns.

However, this was just a first step at strengthening the mental health support within the primary care environment of Malawi. In MGMH terms, Patel, Flischer and Cohen (2012) described the effectiveness-efficiency conundrum whereby what are seen as effective interventions cannot be delivered to scale. The MHiZ project on the other hand has shown an ability to scale an intervention which itself represents a therapeutic approach to distress rather than a specific model and has sought to harness the HSAs knowledge of context and supportive motivations. This lack of fidelity does limit the understanding of how generalised such mental health work was across the sample of HSAs and how effective they were at reducing patients' distress. But the growing appreciation of the complexity of the task being shifted onto HSAs within this pluralistic health environment and the appropriateness of imposing essentially one lens through which distress is viewed encouraged a greater depth of investigation rather than resorting to measure one or two isolated factors (Kleinman, 1977). There remained little known of exactly how acceptable these HSAs' interventions are within the community, including how people in distress respond to them. Understanding the 'interventions' from within the context of the 'healing system' – that of the HSAs' interactions with patients - needed further exploration (Kleinman, 1980).

### ***What does this study contribute to the body of knowledge?***

The MHiZ project reinforced the crucial role that village-based health workers such as HSAs have within health systems of LMICs and demonstrated how a task-shifting intervention can equip such cadre of staff to respond supportively to people with mental health problems. As respected members of the communities in which they live, HSAs can be regarded as key opinion-formers with influence over perceptions of health and ill-health, although exactly how HSAs communicate the biomedical views of mental health and navigate the health pluralism within their communities was unclear.

One particular finding, the way that HSAs recorded the person's 'problem' – which focused on certain behaviours and situations – gave an indication of how such problems were being discussed with both the distressed person and with health care colleagues. On the surface, the interventions reported, match that learned in training and those from psychosocial packages of care designed for other low-resource settings, such as offering individual psychological and emotional support and mobilising community psychosocial resources (Lund et al., 2015). However, descriptions of distressing emotions were found to be present in just 6% (n=13) of records. At the same time while HSAs reported acknowledging people's differing causal attributions for their distress, and including bewitchment



attributions within their formulations, exactly how these discussions steer towards the 'practical' and even 'credible' interventions that are claimed was not fully apparent. While these findings may result from artefacts of the way HSAs recorded entries onto the 'client intervention report' forms or the limitation of relatively perfunctory survey-type data (Robson, 1993), it nevertheless indicated the need to explore these types of interactions further. How were the HSAs helping? For the way in which HSAs and people in distress interact, and the relationship that is co-created between them, provides a frame from which the complexity of the pluralistic health landscape and the mental health role of HSAs can be understood.

### **PAPER 3**

**Wright J and Maliwichi-Senganimalunje L (2020) Pluralism and Practicality: Village Health Workers' Responses to Contested Meanings of Mental Illness in Southern Malawi. *Anthropology and Medicine* 27: 1; 32-48.**

Paper 3 advances research objective 3: To analyse the HSAs' relations with patients, their interventions and decision-making in order to understand the HSAs role and context in the delivery of mental health support and implications for strengthening such a role.

The paper expands the issue of 'credibility' of the HSAs' interventions for the people with distress that they are seeking to support. What was going on in interactions between HSA and patients and carers? This qualitative study used a semi-structured interview method to explore:

1. HSAs' views of the nature and causes of psychological distress in persons presenting to them and how this influenced their therapeutic responses, and
2. How patients and carers understand the nature and causes of psychological distress and how this understanding influenced their help-seeking.

Emphasis throughout was on encouraging interviewees to describe their subjective thinking and experiences. Interviewed separately, the patients or carer and HSAs were asked to describe their experience of distress or responding to the person with distress. Kleinman's (1980) explanatory model provided the initial themes for structuring the interviews and these were refined by the research team to prompt questions on the trigger, attribution, action/behaviour, outcome and reflection on the episode of distress. The matching of HSA with patient or carers they had worked with enabled the same episode of distress to be explored from different perspectives – allowing comparisons to be made. In all, seven HSAs and eight patients or carers described their experience of eight episodes of

distress. Findings from the interviews were complimented by observations of HSAs in their everyday clinical work and patients' and carers' attendance at health centres over two month-long periods. Box 3 presents a summary of the main findings.

**Box 3: Summary of main findings from Paper 3**

1. HSAs and the community share a common recognition of 'mental illness' (*misala*) derived largely from perceptions of the behaviour of patients such as bizarre speech, actions, inactions (self-neglect) or attempting suicide.
2. Pluralistic explanatory beliefs evident but not held exclusively. Causative assumptions of distress included a mix of psychosocial stresses and spiritual attributions from Christian and Traditional African Religions.
3. Help-seeking was influenced by individual agency and access to help, the influence of social norms, and a pragmatism based on previous success or failure at reducing the distress.
4. Help-seeking decisions occurred beyond the reach of HSAs and health centres. Patients' use of traditional medicine was an 'open secret' - selectively disclosed to HSAs but not shared at health centres.
5. In line with the biomedical orientation at health centres, HSAs reported discrediting supernatural attributions and help-seeking which created tensions where the biomedical approach was not helpful or the traditional medicine was proving supportive.
6. This 'navigating between' health practices, rather than any discussion of integrating traditions, was a response by HSAs to reconcile the clear hierarchy of legitimated knowledge and their own beliefs and help-seeking.

The findings provide an insight into the community's construction of normal and abnormal behaviour, the influence of social pressures to conform to communities' expectations and norms, and the functioning of indigenous knowledge and beliefs like *umunthu* and healing through traditional medicine. The exploration found that, while acceptable to patients and carers, the psychosocial causation of mental illness was also introducing a health/illness model into situations previously considered a part of life. The shift in the conception from *kukumudwa* (a severe yet sane reaction to life's hardships) to *nkhawa* (low mood/despair and potentially a precursor to *misala* or 'madness') indicates a subtle shift towards a medicalisation of life (Summerfield, 2008). Similarly, the view of drug or alcohol dependency as an illness is being introduced where previously the community tended to assert moral judgement over how a person was expected to deal with life problems.

Traditional medicine was an ‘open secret’ since many HSAs also used the services of traditional healers. The privileging of biomedicine though meant that patients were reluctant to disclose their use of traditional medicine to health centre staff. Where this had been disclosed to HSAs, they responded by discrediting traditional medicine and promoting biomedical understandings and this created tensions for HSAs and patients when biomedical interventions were not working or traditional medicine was proving beneficial.

### ***What does this study contribute to the body of knowledge?***

This qualitative study explored the plurality of decision-making and helping traditions within the community consistent with wider literature (Orr and Bindi, 2017) and exposed the dilemmas that this raised for HSAs. The task-shifting approach and work of HSAs had impacted on the way mental health is perceived by privileging a biopsychosocial understanding, which, while compelling for many, did not inform any drive for integration with other healing systems (Musyimi, 2016). Instead, it appears to have reinforced the demarcation of the biomedical from traditional health systems whereby HSAs and patients navigate around the two parallel systems, rather than to explore or negotiate different meanings.

So, despite the expedient growth of task-shifting initiatives with non-specialist workers like HSAs in the last decade (van Ginneken, 2013) and the claim that traditional modalities of healing involving the family, social normalisation and spiritual approaches are being acknowledged (Whitley, 2015), there remains a danger within such initiatives that nuanced understandings are being side-lined by essentialist thinking dominated by biomedicine. What exactly was supportive about the HSAs’ interventions? What was informing their approaches?

## **PAPER 4**

**Wright J and Jayawickrama J (2020) “We need other human beings in order to be human”:  
Examining the Indigenous Philosophy of *Umunthu* and Strengthening Mental Health Interventions.  
*Journal of Culture, Medicine & Psychiatry*, Nov 19, doi: 10.1007/s11013-020-09692-4**

Paper 4 advances the research objective 4: To undertake a closer analysis of HSA interventions to bring to light their historical, sociocultural and situational context as evidence to inform approaches to mental health care at local and global levels.

This paper returns attention to three interventions most commonly reported by HSAs' in the MHiZ Project and explored their origin, attributes and explanation for their repeated use. Utilising the discipline of accidental ethnography (co-developing questions, re-examining data from the task-shifting initiative and previous qualitative study, articulating uncertainties, and engaging reflexively with historical and situational analysis from literature) enabled new insights to be offered and critiqued (Leviton et al., 2017). Box 4 presents a summary of the main findings.

**Box 4: Summary of main findings from Paper 4**

1. 'Psychosocial interventions' are demonstrably not exclusive to one epistemology and will carry different meaning and emphasis and the healing process does not exist outside of a health system which includes an understanding of the illness experience and patient-practitioner transaction (Kleinman 1980).
2. An historical and socio-cultural analysis and review of the MHiZ Project survey and qualitative data uncovers *Ubuntu* (or in Malawi *Umunthu*) as the normative philosophy and value system that operates across much of Sub-Saharan Africa and informs aspects of living that promote the well-being and personhood of individuals and the community.
3. Three prominent interventions employed by the HSAs are re-contextualised within *umunthu* and scrutiny reveals their close affinity with *umunthu* philosophy rather than the psychosocial frame described by biomedicine. HSAs are shown to have attuned their interventions to the cultural framework of their patients so that: practical help called on traditional village structures of patronage and obligation, counselling was delivered as an opportunity for regaining 'personhood', and support groups enacted the value of both providing and receiving support within a collectivist culture.
4. The MHiZ task-shifting project is located within the context of MGMH initiatives that similarly promote an exclusivity and universality of biomedical understandings of psychological distress.
5. The HSAs' response to this hegemony is positioned within the colonised experience – including an 'invisibility' and a 'sly normalisation' (Mills 2014) or subversion of interventions - and contrasted with approaches to mental health promotion that empower and embody a respectful dialogue rather than the deprecation of local ways of understanding distress and healing traditions.

Pluralistic and negotiated beliefs concerning mental health and illness, and its place within the sociocultural space and community mores, were evident and revealed both the rich indigenous cultural philosophy of *umunthu* underpinning everyday life in rural Malawi and the resultant complexities in the HSAs' role and delivery of interventions. Navigating between biomedical understandings of mental illness and traditional African understandings created tensions in relationships with patients and illustrated the way HSAs fashioned their supportive interventions to attune to cultural norms under both the gaze and guise of biomedicine.

***What does this study contribute to the body of knowledge?***

The HSAs' situation is contextualized within the wider provisioning of biomedicine through the MGMH and associated projects. This was examined alongside the core existing indigenous African belief and knowledge system of *umunthu*, which underpinned how the interventions were delivered and offered a unique glimpse into the role and functioning of indigenous modes of support under the gaze of and despite the dominance of the biomedical epistemology.

The paper provides contemporary evidence of not only the privileging of certain knowledge and the subsuming of other, but also how different actors adapt and respond in this environment – patients, HSAs and mental health professionals (or “interpreters”). A similar thread is found in the work of Mills and Lacroix (2019) and Read (2019).

Implications are offered towards the future direction of mental health research and practice development that values and seeks to maximize multiple ‘outsider’ and ‘insider’ understandings and a co-producing of responses to people’s distress that are culturally acceptable (Campbell and Burgess, 2012; Fernando, 2014; Burgess and Mathias, 2017).

## **7. DISCUSSION**

*“Biological beings become human beings through their engagement with the meanings and practices of their social world” - Markus and Hamedani (2007, p.32)*

This sociocultural approach to psychology proposes that cultural meanings and practices are not phenomena that operate outside us as individuals and to which we relate, but they represent aspects of our internal world by informing the way we think and the lens through which we understand and experience life (Markus and Hamedani, 2007). Such a proposition renders problematic attempts to assert particular ways of understanding and responding to something as nuanced and socially constructed as ‘distress’ (Horwitz, 2012). Alternatively, aligning perspectives of patients and providers creates a framework of trust and positive expectancy that increases positive outcomes (Asay and Lambert, 1999). All factors are culturally interwoven.

This structured evaluation of the mental health task-shifting intervention has established the potential of HSAs to provide a response to people in psychological distress that is integrated within primary health care in one district of Malawi and follows an implementation model that has since gained increasing traction within the MGMH (Patel et al., 2013). At a health system level, HSAs showed how their intermediary role can provide a critical bridge between formal and informal networks of mental health care. However, a closer investigation of the interactions between patient and HSA, revealed the important complexities inherent in such initiatives and a further examination of the HSAs’ interventions themselves offered an insight into the functioning of the indigenous African belief and knowledge system of *umunthu*, and how HSAs negotiated their role despite the dominance of the biomedical epistemology. The way that HSAs delivered their psychosocial interventions reflected their own culture and understandings.

On reflection, the non-diagnostic approach and appreciation of different causative explanations adopted within the project curriculum perhaps accommodated HSAs’ refashioning of their interventions to be more attuned to the local understandings characterised by *umunthu* more than approaches demanding a greater fidelity to Western psychiatric models. Nevertheless, it is still of interest that HSAs reacted with the “sly normalization” (Mills 2014, p.117) illustrative of the power discordances that are integral to such task-shifting initiatives (Mills and Hillberg, 2019) and where local actors lack the confidence to dispute “expert guidance” (Eaton, 2019 p.294).

This study therefore adds important empirical evidence to the emerging critique of the pedagogy of mental health task-shifting and related approaches in international contexts (Mills and Lacroix, 2019; Mills and Hilberg, 2019; Read, 2019) by bringing to light the experiences of different actors. Such evidence can be set alongside the consistent reports of fated attempts at collaboration between biomedical and traditional healing approaches (Davar, 2014; Musyimi et al., 2016; Sood, 2016; Akol et al., 2018; Herman et al., 2018; Solera-Deuchar et al., 2020). The continued dominance of biomedicine

within the formal healthcare sector, in the face of manifest pluralistic understandings within communities' informal care and traditional health care systems, is indicative of the colonial endeavour by representing the explicit hierarchy of Western over non-Western knowledge systems (Ibrahim, 2014; Fernando, 2014) and rendering powerless indigenous understandings such as the role of *umunthu* in fostering mental health in Malawi. The impact on people experiencing psychological distress will be a continued dislocation of formal from informal mental health care and help-seeking.

So if to counter epistemic injustice (Cox and Webb, 2015; and see Fricker, 2007), a case is made that multiple voices and sources of knowledge need to be acknowledged (Kirmayer & Swartz, 2013), then where do such biomedical approaches fit with this narrative? Miller (2014) has critiqued the essentialising of certain cultural practice and warns of the dangers of a preservationist ethic, an argument frequently deployed by MGMH, to emphasise the human right of access to care (Patel et al. 2010). Few, however, support the notion that culture is static and most acknowledge the impact of change from globalization (Arnett, 2003). Traditional medicine in Malawi itself is a contemporary and evolving practice (Steinforth, 2009; Englund, 2011). As has been shown by the changed language used to articulate distress in Paper 3, individual experiences are subjective and necessarily shifting, contradictory and inconsistent (Siddiqi, Lacroix and Dhar, 2014). But to return to Markus and Hamedani's argument, all interventions – whether from traditional medicine or biomedicine (or any other tradition) – emerge from the way that distress is understood. Biomedicine is no different and some self-effaced reflection on the limitations of mental health care in high income countries – from treatment effectiveness to the insensitivity to cultural diversity - might well be afforded before exporting such “expertise” (Fernando, 2014). For what has been exposed in the papers are testimonial and hermeneutic injustices (Fricker, 2007) employed by the power disparities being enacted when biomedicine engages other traditions. It is no coincidence that in Malawi the Chewa term for biomedicine is “mankhwala achizungu” (white man's medicine) which carries with it all the class and racial implications (Lwanda, 2004 p.29).

As Paper 4 emphasises, the significance of combating epistemic injustice cannot be underestimated and in Malawi, while there has been an increase in interest in traditional and indigenous approaches to mental health care, overcoming the powerful vested interests in maintaining the dominance of the biomedical approach, cannot be supposed. Yet, engaging postcolonial and critical perspectives offers a context from which indigenous theories and responses to psychological distress can be promoted and legitimised (Cohen 2020). Such perspectives position *umunthu* as not only a vibrant contemporary philosophical tradition but also locate the HSAs' adapted interventions as a form of resistance to a dominant epistemology and from which alternative understandings and responses to distress are being generated. Presenting empiric evidence from these studies alongside similar calls (Campbell and Burgess, 2012; Burgess and Mathias, 2017; Bedi, 2018) initiates a dialogue within which the universalistic assumptions can be questioned, and the appreciation of local knowledge and experiences

strengthened.

To revisit my own positionality, both continuing the evaluative work alongside HSAs and research colleagues and engaging in this dialogue with different 'insider' actors (HSAs, mental health user groups, religious and civil society groups, NGOs), including local mental health service 'interpreters' (Paper 4), represents an inclusive and participative approach to addressing the shared challenges (Chambers, 1983). In a small and practical way, such an approach chimes with both Sen's (1999) fostering of the capabilities necessary for development - beyond narrow economic criteria - to ensure choices are local and connected, and at the same time with Olivier de Sardan et al.'s (2017) caution against external normative and protocol-driven practices which otherwise obscure such capabilities.



## **8. CONCLUSION**

From the structured evaluations, the practice aim of strengthening village health workers' care responses for people in psychological distress in Southern Malawi has clearly been achieved. HSAs engaged in supporting people in psychological distress and this role was strengthened through the bespoke mental health training and supervision. Delivered to scale, this training led to HSAs offering assessment, advice, counselling, practical support and signposting for people in distress and their families and demonstrated a vast reach for the discussion of 'mental health' within communities.

However, pluralistic and negotiated beliefs concerning mental health and illness, and its place within the sociocultural space and community mores, were clearly evident and revealed both the rich indigenous cultural philosophy of *umunthu* underpinning everyday life in rural Malawi and the resultant complexities in the HSAs' role and delivery of interventions. Navigating between biomedical understandings of mental illness and traditional African understandings created tensions in relationships with patients and illustrated the way HSAs fashioned their supportive interventions to attune to cultural norms under both the gaze and guise of biomedicine. Therefore, while HSAs have demonstrated the potential to respond therapeutically and to strengthen support for people in distress, their efforts to do so typify wider tensions over the dominance of particular knowledge systems such as biomedicine and are indicative of postcolonial theory.


These four papers add to the body of evidence pointing to the limitations of this approach, signalling the importance that mental health care initiatives are co-created with respect for communities' historical and contemporary sociocultural contexts through establishing collaborative partnerships respectful of social justice and culturally negotiated meaning. Consequently, they contribute to international understandings of mental health provision by reconciling the 'local' within broader global commitments to 'health for all'. The findings provide a framework from which to develop accessible and appropriate mental health support.

This work has stimulated further research collaborations with UK and international academic and practice partners to use realist review methodologies to characterize 'participative' approaches and explore their impact on outcome and sustainability of mental health projects in the Global South. Whilst an unwelcome critical voice to many in the MGMH programmes, and one that can lead to suspicion and paralysis, I have found that being mindful of insider/outsider positionality and perspectives and engaging in a respectful dialogue with all stakeholders creates a space that encourages an open and active learning environment. In a recent large UK funded mental health programme in Bangladesh and Pakistan for instance, undertaking a qualitative study at the start of a process evaluation, revealed significant structural and contextual factors that required attention prior

to the establishment of any individualised psychological intervention (Wright et al., 2020). For engaging such dialogic approaches to reveal the voices of those in distress and to constitute culturally embedded therapeutic responses represents a critical endeavour, and one that in its inclusive process generates new partnerships, understandings and possible solutions.

**APPENDIX – Papers 1 to 4**

# Integrating community mental health within primary care in southern Malawi: A pilot educational intervention to enhance the role of health surveillance assistants

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## Abstract

**Background:** In response to the significant contribution of mental health problems to the global burden of disease, the World Health Organization (WHO, 2008) renewed its call for the integration of mental health services within primary care. The operationalization of this within resource-constrained settings such as rural Malawi, however, presents a challenge, not least the cultural acceptance of approaches to responding to psychological distress.

**Aim:** This study reports on the development, implementation and evaluation of a mental health care training programme for 271 health surveillance assistants (HSAs) designed to overcome such challenges.

**Method:** A structured evaluation of the impact of training on HSAs' provision of mental health care was undertaken.

**Results:** Results demonstrated a statistically significant positive effect on HSAs' knowledge and confidence in providing care and analysis of patient records revealed considerable mental health care and health promotion activity wherein HSAs initiated a new dialogue with the community on mental health and human rights concerns.

**Conclusion:** The HSAs' focus on the psychosocial concerns of individuals' 'distress' and 'risk' prepared the way for a practical set of culturally sensitive and therapeutic interventions and offers a potential path towards increasing the capacity of primary care mental health provision that is responsive to local understandings and experiences of distress.

## Keywords

Community mental health care, Malawi, Africa, village health worker, mental health promotion

## Introduction

Mental health problems of depression, anxiety, alcohol and substance misuse and psychoses contribute significantly to the global burden of disease (Lopez, Mathers, Ezzati, Jamison & Murray, 2006; WHO, 2001). Evidence linking such problems with poverty emphasizes the chronically disabling nature and cyclical impact of such concerns in low-resource settings (Lund et al., 2010). In response, the Global Movement for Mental Health is drawing attention to the treatment gap (Kohn, Saxena, Levav & Saraceno, 2004) and demand for the strategic scaling-up of services (Patel, Boyce, Collins, Saxena & Horton, 2011; Patel et al., 2008; Prince et al., 2007) and the World Health Organization (WHO, 2008) has renewed its call for the de-centralization and integration of mental health services within primary care. This approach aims to enable the largest number of people to access services at an affordable cost and in a way that minimizes stigma and discrimination (WHO, 2001).

However, the operationalization of this within culturally diverse and resource-constrained countries and the development of an effective mental health care training programme to support primary care workers throw up a number of significant challenges that the current project sought to address within the specific context of southern Malawi.

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## Background

Holding alternative explanatory beliefs about the origin of individuals' distress (e.g. bewitchment, violation of taboos or spiritual crisis) reduces the likelihood that people will access primary care or mental health services (Goldberg & Huxley, 1992; Odenwald, van Duijl & Schmitt, 2007). Attributions of mental health problems are known to be culturally determined and often complex (Asuni, Schoenberg & Swift, 1994; Maclachlan, Nyirenda & Nyando, 1995). In one of the few contemporary explorations of traditional beliefs and mental health in Malawi, Steinfeldt (2009) found no resonance of western psychiatry within the communities and even its attribution as a 'health' problem was rare.

In contrast, the Mental Health Gap approach (Patel et al., 2008) uses a 'health-illness' model that centres on the identification of psychiatric disorders as described in the International Classification of Diseases (WHOCRTMH, 2000) and has the rationale that, once identified, the patients will have access to psychopharmacological and psychosocial treatments (WHO, 2010). Currently, the *mhGap Intervention Guide* (WHO, 2010) offers an intricate matrix to guide the assessment and management of mental, neurological and substance use disorders with an emphasis on pharmacological treatments and a number of brief structured psychotherapies, delivered by non-specialist health workers, have been successfully trialled (Bolton et al. 2003; Patel et al. 2010; Rahman, Malik, Sikander, Roberts & Creed, 2008). However, these approaches have so far tended to reveal an 'efficacy-effectiveness' gap, whereby benefits from trials have not necessarily translated into everyday practice (Patel, Flisher & Cohen, 2012). While organization and resource constraints play a part, most significantly these types of approaches still assume both the cultural applicability of diagnostic categories and trust in the transferability of western-evidenced therapeutic treatments. It is also of note that while there are calls to acknowledge local cultural understandings and beliefs (Joel et al., 2003; Kermode, Bowen, Arole, Joag & Jorm, 2009; Muga & Jenkins, 2008; Ravi Shankar, Saravanan & Jacob, 2006), there are also emerging problems where such approaches have an over-reliance upon pharmacological solutions to address psychosocial concerns and have a 'silencing' and disempowering effect on communities (Jain & Jadhav, 2009). This, coupled with the resource constraints affecting adequate supervision of safe prescribing, further emphasizes the need for community mental health provision to go beyond simply increasing access to psychiatric care, and to develop a culturally meaningful and integrated primary mental health care service (Peterson, 2000).

For primary care is at the interface between the public's perception and expression of mental health problems and their encounter with health care services. As village-based health workers and occupants of that interface in Malawi,

health surveillance assistants (HSAs) were thought likely to be best placed to illuminate indigenous constructs (Patel & Mann, 1997), cultural understandings and nuanced expressions of psychological distress and respond accordingly. As a large cadre of health workers in Malawi, HSAs employ health promotion activities and individual care for a range of physical health issues within their communities, including facilitating public health, vaccination and cholera campaigns, programmes of directly observed therapy for tuberculosis patients and coordinating home-based care. Their established position within local communities and the primary care structure ensures that HSAs are consistently at the interface of traditional and western constructs of health care and have regular links with both traditional and spiritual healers and different specialist health workers and units. However, HSAs had not previously received any education on mental health problems, therefore their training needed to advance both an emic and pragmatic approach to mental health care that put the HSAs at the centre of identifying and responding to people experiencing psychological distress.

## Project development and implementation

The project was conducted in Zomba District in the southern region of Malawi. Zomba District has a total land area of 2,580 km<sup>2</sup>, with a population of around 580,000 and a health delivery system that is divided into seven clusters: Chingale, Thondwe, Zomba Central, Ngwelero, St Luke, Likangala and Jali. Three clusters (Chingale, Thondwe and Zomba Central) were randomly selected to participate in the pilot programme and all health centres falling under these three clusters were included, serving a population of approximately 218,000. HSAs and assistant environmental health officers (AEHOs) reporting to these health centres were trained. AEHOs were included because they work closely with HSAs and they are the focal persons between HSAs and the district environmental health officer (DEHO).

Mental health professionals from Malawi and the UK, representatives of the Mental Health Users and Carers Association of Malawi (MeHUCAS), HSAs and representatives from the local District Health Office all collaborated in designing and developing the curriculum. A number of training packages for primary and community mental health workers developed in different countries were reviewed and, as an approach with considerable cross-cultural utility (Jorm, Minas, Langlands & Kelly, 2008), the Mental Health First Aid approach (University of Melbourne/BasicNeeds, 2009) was chosen as the platform from which HSAs could develop these mental health interventions. The emphasis premised a client- and practitioner-assessed adjudication of 'psychological distress' and 'risk to self or others', rather than identifying psychiatric diagnoses. Risk of cultural relativism was tempered by the endorsing of a human rights

**Table 1.** HSA mental health care training course.

Unit	Curriculum content
Unit one Understanding mental health and mental illness	Concepts of mental health and mental illness, including stress–vulnerability model, the impact of mental health problems, help-seeking behaviour and the organization of care for people with mental health problems. Link between mental and physical health problems
Unit two Working with individuals with mental health problems	Mental health needs and treatments and the enactment of an enhanced Mental Health First Aid approach in recognizing and responding to people with a range of common and severe mental health problems
Unit three Working with communities	Ways of promoting mental health, combating stigma and advocating for people with mental health problems, facilitating groups and mobilizing community resources

framework (Arboleda-Florez, 2008; WHO, 2003) as the arbiter of prioritization and acceptability of HSAs' responses and interventions. Such frameworks are in line with other health approaches such as for those living with HIV/AIDS (UNAIDS, 1996). The training highlighted multifactorial pathways to experiencing mental health problems, encompassing biopsychosocial causations, and the course was designed to enable HSAs to support and empower individuals to identify solutions to their difficulties, with the emphasis on listening and responding supportively rather than seeking to make a psychiatric diagnosis. The programme addressed issues of risk of harm to self or others by seeking to provide HSAs with the knowledge and skills to manage such risks in the community context. Additional curriculum materials were derived from real-life clinical examples encountered in Malawi and were made linguistically accessible to HSAs.

More detail of the curriculum content is found in Table 1.

The three days of training were delivered in two phases, with units one and two delivered on two consecutive days and the second phase (unit three) scheduled for six months later. Unit three also served as a platform for the HSAs to share their experiences over the preceding six months. The training was facilitated by local mental health professionals, including psychiatric clinical officers, psychiatric nurses and one psychologist, and a service user, and the format for the training sessions consisted of short lectures, group discussions and role-play.

The trained HSAs were then supervised by the project manager and trainer on a monthly basis in their clinic catchment areas.

## Methods

Two questionnaires were designed to assess the impact of the training on the HSAs. One assessed HSAs' 'knowledge' of mental health problems and one their 'confidence' in providing aspects of mental health care and information. Both questionnaires were completed by each HSA before commencement of the first training session and were

planned to be repeated on day three after six months. In the event, funding delays meant that the follow-up days were postponed until 12 months following the initial courses.

In addition, two specially designed monitoring tools – the Client Intervention Report Form and the Mental Health Promotion Activity Report Form – were devised to record the HSAs' activity in order to assess the impact of the programme on their practice. The data were collected from clinics during monthly supervision and monitoring visits.

## Results

### *HSAs' 'knowledge' and 'confidence' in mental health care*

In all, 10 separate training sessions were completed, with 271 community health workers trained including 264 HSAs, four AEHOs plus the three 'cluster' managers. The group of HSAs was composed of 68% females and 32% males.

Pre-course data revealed a number of gaps in the HSAs' overall knowledge of mental health problems and care; however, results show a statistically significant improvement in knowledge post-training ( $N = 266$ ,  $M = 13$ ,  $SD = 2.29$ ) compared to pre-training ( $N = 266$ ,  $M = 8$ ,  $SD = 2.29$ ) ( $t(265) = -26.797$ ,  $p < .0005$ ,  $r = 0.85$ ).

Pre-course measures of confidence, interestingly, and despite deficits in knowledge, showed that the HSAs expressed considerable confidence in their abilities around mental health care. Despite this, and out of the 207 matched questionnaires completing all 14 questions, the post-training results still showed a statistically significant improvement in confidence ( $N = 207$ ,  $M = 34$ ,  $SD = 5.29$ ) compared to pre-training ( $N = 207$ ,  $M = 26$ ,  $SD = 9.53$ ) ( $t(206) = -10.039$ ,  $p < .0005$ ,  $r = 0.57$ ).

### *HSAs' mental health interventions*

Over the 12-month data-collection period, HSAs in the three clusters recorded assessments and interventions with 132 individuals (73 male and 58 female + 1 not recorded) from 11 separate health centres.

**Table 2.** Previous help sought for psychological distress.

Source of support	<i>n</i>	% of total
Health professional	69	52.27
Traditional healer	64	48.48
Spiritual adviser	25	18.93
Church minister	21	15.90
Village elder	8	6.06
Schoolteacher	3	2.27
Friend	2	1.51
Marriage counsellor	1	0.75
Church fellowship member	1	0.75
Herbalist	1	0.75
Victim support worker	1	0.75

For 117 (89%) of the individuals, this was their first presentation to the HSA. However, data also showed that 107 (81%) individuals had previously sought assistance for their distress from other sources (Table 2), most commonly a health professional, traditional healer and spiritual adviser or a combination of these.

The profile of the individuals reveals an average age of 27 years (range 4–72 years). Forty-one individuals were below the age of 16 years and 91 were adults, with seven where age was not recorded. Of the adults, only 16 (17.5%) were married, while 20 (22%) were recorded as separated and one widowed (1%). Ninety-two (70%) were accompanied on their visit to the HSA, usually by a relative or carer.

The HSAs reported the individuals as presenting with a range of psychological distress symptoms. The unusual or changed behaviour of individuals was the most significant factor leading to the consultation, although, in line with their training, the HSAs recorded the individuals', the relatives' and their own understanding of the individuals' distress. This included the likely source of the difficulty, its duration and its severity in terms of risk of harm to self or others. With the uncertainties expected in all 'first contact' mental health presentations, these interactions yielded a range of descriptions of biopsychosocial difficulties that reflect the anticipated common mental health problems described in literature (WHO, 2001). Life stress, relationship stress and bereavement, drug or alcohol abuse, problems of learning disability, epilepsy and (acute and ongoing) psychosis were all described. Indeed, the complexities and uncertainties are evidenced by the fact that following the first consultation the HSAs considered that while 99 (75%) of the presenting individuals had a 'mental health problem', 10 (8%) were thought not to be mentally ill and, for the remaining 23 (17%), the HSAs were unsure and would seek guidance from other health professionals.

Recognition of the severity of distress experienced by individuals is demonstrated by the fact that 10 (8%) were assessed as suicidal and 32 (24%) as potentially violent

towards others and this influenced their subsequent interventions.

The HSAs reported using a range of interventions including assessing risk of suicide or self-harm (61 (46%)), listening without judging (81 (61%)), providing information and reassurance (73 (55%)), encouraging the person to get appropriate help (81 (61%)) and devising community and self-help treatments and support (69 (52%)). After the first consultation, the HSAs provided follow-up interventions to 88 (67%) individuals; for 36 (27%) individuals, they either sought further advice, or encouraged attendance at or referred them on to the health centre or a mental health professional.

Examples of types of presenting problem and HSA interventions recorded on the Client Intervention Report Forms are provided in Table 3.

### *HSAs' mental health promotion activity*

In addition to their interventions with individual patients, over the 12 months of the project, HSAs held 496 separate mental health promotion activities within their communities. HSAs recorded the venue, number and persons attending and an outline of the content of the village-based mental health awareness-raising meetings on the Mental Health Promotion Activity Forms.

Data revealed that activity consisted of 184 talks or presentations, 192 meetings or consultations, four support groups and one drama group. These were held at health posts, health centres, village meeting places, patients' homes, schools, churches, grounds of mosques, village headmen's residences and orphanages.

Topics ranged from awareness raising about mental health and drug and alcohol problems, human rights, the need for care and support and reducing stigma to referral pathways for health and mental health facilities and how HSAs could work together with village health committees, church leaders and traditional healers.

A sample of individual HSAs' records of their mental health promotion activity is provided below:

The meeting went on well with the help of traditional leaders. At this meeting people were assured of total support for people with mental health problems. I promoted the need to care, listen, understand and support anyone with (a) mental health problem. Lastly I register all people with mental health problems in my health post for proper follow up whenever necessary. (HSA 125, Chingale)

People welcomed the programme and promised to stop keeping indoors people with mental health problems but to refer them to health workers like us. (HSA 57, Thondwe)

Members from my health post and beyond, as well as [village headman], attended the meeting. All these people now know the difference between mental health and mental health



**Table 3.** Three examples of case presentations and HSA interventions.

Description	HSA intervention
<p>An 18-year-old mother of a six-month-old child had been abandoned by husband three months previously and, with her family also not assisting her, she now worries intensely about how she will manage. Her worries are making her feel weak and she is doing less and less, including not preparing food for herself or her baby. She is contemplating taking poison to kill herself.</p>	<p>The HSA listened to her worries and asked her when she thought most about killing herself. The woman identified times when she was alone and thinking about her husband and the HSA helped her to identify some people in the village that she could call upon to support her and with whom she might share her worries. The HSA encouraged the woman to attend a church group for practical and spiritual support and to join other friends in shared activities. The HSA followed up a few days later.</p>
<p>A 20-year-old pregnant single woman complained to the HSA of general body pains and headache for the last three weeks. These pains are experienced most acutely when people are talking with her, so she no longer goes out and spends all the time inside her home, not eating or talking to people.</p>	<p>When interviewed by the HSA it became clear that the woman's boyfriend was not supporting her and her father was extremely angry at this. The woman felt frightened and 'caught in the middle' and was unsure what she would do. The HSA explained that her worries were the likely cause of her pains. He encouraged her to seek support from others in her family and discussed how she and her unborn baby could remain healthy, including the need for adequate food. The HSA arranged to meet her again in a few days to see if there had been change.</p>
<p>A 21-year-old man attended with his brother and described seeing people chasing him every day and making him feel very frightened. He had previously consulted a church minister, a spiritual adviser and a teacher about the problem, but there had been no improvement and the brother had become so concerned about the man running off that he frequently tied him up at his house.</p>	<p>The HSA listened to the account of the man's fears and how frequently they occurred and explained that he might be experiencing a mental health problem. The HSA suggested that for advice he refer the man to a mental health professional who visits the clinic every month. The HSA advised the brother not to use restraint but handle him with care and reassure the man that he is safe with him.</p>

problems. They also know how to support people with mental health problems because these people have rights to a good life. (HSA 82, Zomba Central)

Attending these events were 196 patients known to the HSAs, 686 relatives or carers and 21,407 attendees from the local communities. In all, a total of 22,289 people accessed these mental health promotion activities.

## Discussion

This educational intervention has been shown to positively influence the knowledge and confidence of HSAs in an area of health care in which they had not previously been active.

The brief educational intervention, together with regular supervision, has also stimulated considerable HSA mental health care and health promotion activity. Rather than to proffer psychiatric diagnoses, the HSAs' focus upon the psychosocial concerns of individuals' 'distress' and 'risk', appears to have prepared the way for a practical set of culturally sensitive and therapeutic interventions.

HSAs attended to the range of mental health presentations expected in primary care, offering an early assessment and assimilating appropriate community-based responses. The relatively low number of client interventions ( $N = 132$ ) in relation to the number of HSAs trained and

numbers of population they engage with for other health problems requires further analysis and explanation. It is perhaps not an unexpected return when health workers are being asked to recognize and respond to what is for them a 'new' health issue. It is also likely that the HSAs used the Client Intervention Report Forms to record only 'discrete' mental health presentations rather than for those people presenting with concurrent health problems such as HIV/AIDS, malaria and so on. The requirement to complete the forms in English rather than the local language of Chichewa may have restricted recording still further. Encouragingly however, while evaluation of the effectiveness of each HSA intervention was beyond the scope of the present study, the fact that not all presenting persons were assessed as mentally ill indicates a critical and discerning approach to recognizing mental health problems and the HSAs' identification of people with high risk of suicidal or violent behaviour underlines the essential and life-saving nature of much of their mental health work. A more detailed analysis of the HSAs' discernment of clients' 'distress' and the effectiveness of each of the interventions will, however, be a vital element of further investigation as the project is refined.

Finally, community mental health promotion suggests that a better understanding of mental health problems is likely to allay public fear and mistrust of mentally ill persons in the community (Kabir, Iliyasu, Abubakar & Aliyu,



2004) and this project appears to have utilized the reach that HSAs have within their communities and demonstrates a significant potential for large-scale public mental health sensitization and promotion. Accessing populations of over 22,000 has been shown to be feasible and there are strong indications that education in this format can stimulate culturally attuned discussion on mental health and illness within the community, with the capacity for combating stigma and promoting the dignity and human rights of people with mental health problems.

## Limitations

While the successful implementation of the project strongly points to the feasibility and potential of HSAs' mental health activity and demonstrates a positive improvement in their knowledge and confidence, there are methodological limitations to the study design.

First, as a novel role, standard outcome measures of HSA activity are not yet developed and, as a result, the effectiveness of HSAs' interventions was not objectively assessed. The study's reliance upon outcomes recorded in the Client Intervention Report Forms (Table 3) and Mental Health Promotion Activity Forms, although used as a record for clinical purposes, may well be subject to bias in the direction of being overly optimistic. Such indefinite findings reinforce the limitations of a pre/post study design as opposed to a randomized controlled trial.

In the same way, representativeness of HSAs within the project against the wider population of HSAs in Malawi was not controlled for, which again limits the generalizability of findings. Further investigation and scrutiny of the sample and a systematic recording of outcomes (including from clients, carers and traditional healers) in the future will provide a valuable resource from which a controlled study of effectiveness may be undertaken.

## Conclusion

This pilot study has demonstrated a potential path towards increasing the capacity of primary care mental health provision that is responsive to local understandings and experiences of distress at the vital intersection between health services and the community. The study has shown that, with the support of a brief educational intervention, village-based health workers can provide their population with an accessible source of culturally attuned, humane and therapeutic mental health support with links to secondary mental health services and can initiate a new dialogue with the community on mental health and human rights concerns.

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# Building capacity for community mental health care in rural Malawi: Findings from a district-wide task-sharing intervention with village-based health workers

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## Abstract

**Background:** The mental health ‘treatment gap’ is at its widest in low-resource countries where the vast majority of its people have no access to mental health services and where developing effective models of primary mental health care that can expand from research pilot sites to large-scale population-based services is a major research and practice imperative.

**Aim:** The Mental Health in Zomba initiative builds upon an earlier pilot project to establish and sustain a district-wide scale-up of a village-based health workers’ mental health task-sharing intervention in Southern Malawi across a population of more than 600,000 people.

**Methods:** The article describes the development, implementation and structured evaluation of the impact of this task-sharing initiative.

**Results:** Results from an examination of the care for 240 consecutive attendees show how the village-based workers recognised and responded to the needs of people experiencing both common and severe mental health problems and how they facilitated 850 mental health promotion events to more than 40,000 people within their communities.

**Conclusion:** A new and essential district-wide tier of mental health service was established at the crucial intersection between health centre and the community. Within the socio-cultural context of rural Malawi with its diverse explanatory models for psychological distress, the approach of the village-based health worker was found to be both credible and practical in meeting the needs of the population and therefore responding to both the ‘supply’ and ‘demand’ elements of the mental health treatment gap.

## Keywords

Community mental health care, Malawi, village health workers, task-sharing, culture, evaluation

## Background

The gap between the number of people experiencing mental health problems and their access to services is recognised as a major contributing factor to the ongoing global burden of disability (Kohn, Saxena, Levav, & Saraceno, 2004). This mental health treatment gap is at its widest in low-resource countries where it is estimated that more than 75% of people with severe mental illness (SMI) do not receive any treatment (Demyttenaere et al., 2004). Worldwide, common mental disorders (CMDs) such as anxiety, drug and alcohol use disorders and unipolar depression contribute over 22% of the overall years lived with disability (Vos et al., 2012). System-wide insufficiencies in the provision of care include the shortage of mental health workforce; lack of training, evaluation evidence of

innovative, scale-able models of care delivery and limited political will to support policy, research, training and infrastructure (Becker & Kleinman, 2013). Developing effective models of primary mental health care that can expand from research pilot sites to large-scale population-based services is a major research and practice imperative (Patel,

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Flisher, & Cohen, 2012) and work is beginning to uncover the opportunities and challenges of integrating mental health into district-wide primary care in low-resource country settings (Lund, Tomlinson, & Patel, 2015).

This article describes results from the Mental Health in Zomba (MHiZ) Project which designed, delivered and evaluated a district-wide mental health task-sharing project in Southern Malawi. It builds upon a pilot project in 2010–2012 (Wright, Common, Kauye, & Chiwandira, 2014) where proof of concept was established to develop the mental health promotion and care capacity of over 700 village health workers (known as Health Surveillance Assistants (HSAs)) across the district serving a population of more than 600,000 people.

The Zomba district of Southern Malawi consists of villages of 200–1,000 people, small trading centres and one urban centre in Zomba town with a population of approximately 90,000 people (National Statistical Office (NSO), 2008). The majority of the District population are engaged exclusively in agriculture (70% of women and 57% of men) with others occupied by part-time or full-time waged employment in different sectors and supplemented by their own small-scale farming (NSO & ICF Macro, 2011). More than 45% of women and 30% of men receive no monetary income. Nearly 19% of the population receive no formal education, only 6.5% complete primary schooling and 24% are unable to read (NSO & ICF Macro, 2011). The population customarily hold strong traditional spiritual attributions for all health problems and misfortune (Ott, 2000) and, despite a normative recognition of local prevalence of mental health problems (Udedi, Swartz, Stewart, & Kauye, 2014), Western mental health perspectives have limited resonance (Steinforth, 2009). Yet, it is within this environment over the past 40 years that HSAs have established a key position within the Malawi Government's primary health care system (Ministry of Health & Population, Malawi, 2004), implementing public health initiatives particularly in communicable diseases and infant and maternal health.

The decision to develop the work of HSAs recognises both the 'supply' and 'demand' sides of the mental health treatment gap at community level. Limited resources generate major challenges to the supply of mental health services in primary care and hence conceive the importance of task-sharing initiatives (Lund et al., 2015; Peterson, Lund, Bhana, & Flisher, 2012). Equally crucial is the low demand for mental health care and support. Contributory factors include socio-cultural factors such as diverse explanatory models for mental health problems that exist in some communities and high levels of stigma and discrimination associated with mental health problems (Sorsdah, Flisher, Wilson, & Stein, 2010). The perceptions that such problems might be considered 'health' problems, as opposed to spiritual, moral or criminal problems, in turn influences help-seeking through biomedical health services.

The HSAs' brief biomedical training and accessibility within local populations mean they have experience of navigating differing perspectives of causation and treatment for health problems. Through the pilot project (Wright et al., 2014), HSAs demonstrated their potential to develop an enhanced role in recognising and responding to the mental health needs at community level, using a health model that appeared 'credible' to the population as a 'pragmatic classification' of distress (Jacob & Patel, 2014). However, whether this model could be scaled up to provide community-based interventions to a significant number of vulnerable mentally ill people in their communities and retain its 'credibility' remains unknown. The project therefore sought to establish a district-wide HSA mental health promotion and care service with a focus on developing community mental health sensitisation and promotion work and mental health care interventions.

## Method

The research project comprised two components: (1) the design, development and implementation of the task-sharing project and (2) an evaluation of the impact of the intervention on HSAs' practice.

### *Project design, development and implementation*

An HSA mental health curriculum that was designed and implemented in the pilot project was reviewed and refined by a team of 10 trainers who facilitated ten 3-day courses in 2013, for 430 HSAs (275 men and 155 women). The training was delivered in two phases. The first phase consisted of two consecutive days covering understandings of mental health and mental illness, help-seeking and the organisation of care for people with mental health problems, mental health 'first aid' and the HSA role in recognising and responding to people with a range of common and severe mental health problems. The second phase took place 6 months later covering HSAs' work with communities, mental health promotion, combating stigma and advocating for people with mental health problems and their carers. Most importantly, the mental health approach of HSAs sought to identify people's distress and risk, rather than reach a mental health diagnosis, and to respond with community-based psychosocial interventions. Pluralistic attributions and explanations for the distress were acknowledged, but support from a health model was proffered. These trained HSAs, together with those trained as part of the pilot study, represent all HSAs currently working within the district.

In addition to the training, a team of eight MHiZ Project trainers and clinicians provided monthly supervision visits to HSAs at each of the 32 health centres to support the HSAs in their role, to monitor their activity and to offer

**Table 1.** Descriptions of clients' presenting problems.

Presenting problem	HSAs' descriptions	Number of records
'Abnormal' behaviours <sup>a</sup>	'not speaking', 'not eating', 'not washing', 'wears dirty clothes', 'not sleeping', 'isolating self', 'wandering', 'running off', 'hiding in the bush', 'not working', 'wanting to commit suicide', 'stopping taking medication', 'stopping treatment' (e.g. 'ARVs'), 'talking to self', 'laughing to self', 'becoming angry and violent', 'taking off clothes', 'walks naked'	67% ( <i>n</i> = 151)
Difficult situations and environments	'relationship problems', 'marital problems', 'bereavement', 'being orphaned', 'abused by' another or others, e.g. 'parents ill-treat', 'not being loved', 'learning of HIV status', 'extreme poverty'	32% ( <i>n</i> = 71)
Distressing emotions/feelings	'thinking too much', 'worried', 'not happy and worried', 'depressed', 'had stress', 'so distressed', 'disturbed', 'uncomfortable'	6% ( <i>n</i> = 13)
Fits/epilepsy	'experiencing fits', 'started epilepsy as a child'	10% ( <i>n</i> = 22)
Drugs and alcohol misuse	'smoking chamba', 'smoking Indian hemp', 'drinks beer too much'	5% ( <i>n</i> = 11)
Nonspecific medical problem	'sick', 'seriously ill', 'collapsed'	3% ( <i>n</i> = 6)
Not recorded		8% ( <i>n</i> = 19)

HSAs: Health Surveillance Assistants; ARVs: antiretroviral drugs.

<sup>a</sup>The term 'abnormal' behaviours derives from the common use of the expression by HSAs, however, in replicating it here, authors acknowledge both its social construction within the specific setting and limitations of cross-cultural generalisability.

advice on client interventions and developing mental health promotion opportunities. These sessions were to provide opportunities for HSAs to discuss individual cases and their efforts to engage and work with clients and their families. Ten 1-day Mental Health briefings were provided for 231 health centre clinicians within Zomba District to enable clinicians to more closely support the mental health work of HSAs at the health facilities.

### *Evaluation of the impact of the project on HSAs' mental health practice*

Two specially designed monitoring tools – the Client Intervention Report Form and the Mental Health Promotion Activity Report Form – were devised to record the HSAs' activity in these two key aspects of their enhanced role. These records were collated over 24 months to assess the impact of the programme on their practice. Within the reports, HSAs recorded the demographic profile of clients presenting to them, clients' previous help-seeking, the nature and severity of the clients' presenting distress, the HSAs' interventions and follow-up in order to gain a picture of the extent to which approaches were seen as feasible, appropriate and credible to the population. The HSAs' reports of mental health promotion activity recorded information on the number of attendees, the types of sensitisation activity and content of presentation and discussions. The data were collected from clinics during monthly supervision and monitoring visits.

Additionally, in order to examine any wider impact that the increased HSAs activity might have on referrals to the government psychiatric hospital (situated within the same geographical district), an audit of both first and repeat admissions to the facility was administered for the first

6 months of two consecutive years (January–June 2013 and 2014). The data were collected from the routine hospital records, and the same calendar months were chosen to account for the known fluctuations in admissions across the year due to factors such as inaccessibility during rainy seasons.

## **Results**

The Client Intervention Report Form records of the first consecutive 120 male and 120 female (*n* = 240) client presentations to HSAs experiencing 'distress' were analysed, and the following four tables provide an illustration as to how HSAs recognised and responded to clients in distress.

### *Client characteristics*

*Help-seeking and HSAs' recognition of distress.* Of the cohort of clients presenting to them, HSAs considered 93% (*n* = 224) people were experiencing distress that was significant enough to warrant an immediate intervention from themselves or referral on. For 85.3% (*n* = 191) clients, this was their first presentation to a health worker for this problem, 8.4% (*n* = 19) were already in receipt of mental health care from the health centre and for 6.3% (*n* = 14), this was not recorded. Clients' previous help-seeking included consulting a traditional healer (33%; *n* = 74), a spiritual advisor (18%; *n* = 40) and church minister (8%; *n* = 19), illustrating the plurality of explanation and support for such distress that exist within the community. Table 1 shows the HSAs' descriptions of clients' presenting problems verbatim which were themed by the researchers into six consistent categories.

**Table 2.** Severity of distress.

Risk	Number of clients
Risk of harm to self	29 (13%)
Risk of harm to others	61 (27%)
Risk of harm to self and others	16 (7%)

**Table 3.** Duration of 'distress'.

In infancy	26 (11%)
<1 year ago	74 (33%) (60 (27%) <6 months)
1–5 years ago	45 (20%)
6–10 years ago	33 (15%)
>11 years ago	45 (20%)
Not recorded	1 (0.5%)

The presenting difficulty was described most frequently by HSAs as abnormal behaviours (67%;  $n=151$ ), followed by difficult social context or environment (32%;  $n=71$ ) and the inclusion of both were described in the records of 25% ( $n=56$ ) clients. The behaviours are listed in order of their reported frequency which, as can be seen, ranged from reduced communication and self-neglect through to disturbed and violent actions. Descriptions of distressing emotions or feelings were present in just 6% ( $n=13$ ) records, although each of these did also contain references to the social context or difficult situation. Drug-taking ('smoking chamba') and alcohol ('drinking too much beer') were cited within the presenting difficulty of 5% ( $n=11$ ) clients and medical problems and epilepsy or recurrent seizures in a further 10% ( $n=22$ ) of client records. Risk of harm to self and others was used as an indication of the severity of the clients' distress (Table 2).

Within their assessment, HSAs also enquired as to when the problem had first started. Table 3 charts a range of time since onset of difficulties, with 35% commencing over 6 years ago and a similar proportion (27%) experiencing problems over the last 6 months. While these figures do not provide an indicator of the level of distress or whether distress is continuous or episodic, they nevertheless suggest HSAs are working with people experiencing both acute and ongoing mental health problems.

**HSAs' interventions.** HSAs described the interventions undertaken within four categories: (1) reducing clients' risk of harm to self or others, (2) providing client-focussed psychoeducation, (3) providing clients with psychological and emotional support and (4) promoting psychosocial support through families and the wider community (Table 4).

Of the 224 clients seen by the HSAs, only 20 were seen on just one occasion during the 24 months, January 2013–December 2014. Of these 20 clients, 12 were referred urgently to the health centre and 3 to a mental health

professional who was visiting the health centre (5 were not recorded). The vast majority of clients presenting to them (91%,  $n=204$ ) were followed up by the HSAs on at least one occasion. Frequency of follow-up is recorded in Figure 1.

**HSAs' mental health promotion activities.** HSAs' mental health promotion records from January 2013 to the end December 2014 showed they had facilitated 850 mental health promotion activities. These events, either as a single issue mental health meeting or integrated within HSAs' usual health promotion activities, often attracted extremely large numbers of attendees. Records show that, in total, 43,049 people attended these 850 mental health promotion events, including 70% ( $n=29,999$ ) women and 30% ( $n=13,050$ ) men. The high proportion of female-to-male attendees reflects the role that women have in child care and increased exposure to health facilities where HSAs are active. On average, 50 people (range: 9–429) attended the mental health promotion activities and, while the majority were from the general population (at public meetings) or from those attending a health facility (at meetings held during HSAs' clinics), attendees also included 4% ( $n=1,732$ ) clients and 9% ( $n=3,741$ ) carers of people known to the HSAs to be experiencing distress.

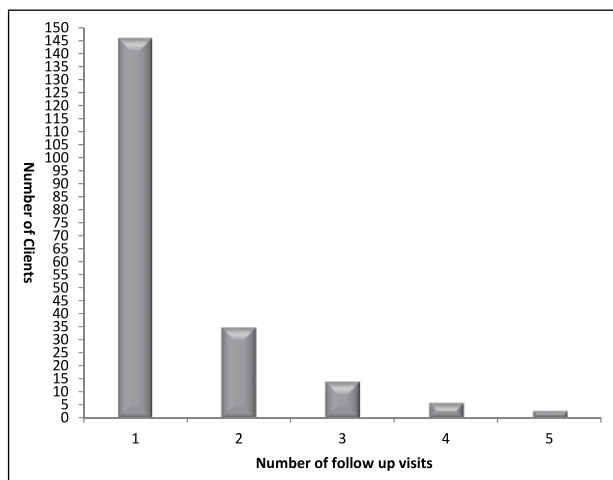
HSAs described their mental health promotion activities in different ways: (1) the inclusion of mental health information during a more general health talk that HSAs frequently conduct on issues such as maternal health, child development, illness, sanitation and other public health measures (46%;  $n=388$ ); (2) a discussion and information exchange about the types of mental health problems experienced and how these are managed in the community (22%;  $n=189$ ); (3) a talk, group activity or drama presentation to highlight mental health issues and how these are experienced and managed (16%;  $n=133$ ); (4) mental health promotion advice tailored to the needs of client and or carers during a home visit (8%;  $n=67$ ); and (5) establishing a mental health clients or carers' support group (8%;  $n=62$ ). Figure 2 illustrates the frequency the HSAs facilitated each of these events as a proportion of total mental health promotion activity.

Health promoting activities were held in a variety of community venues including assembly grounds, schools, villages, clinics, churches, market places or trading centres, mobile clinics, hospitals, village headman's grounds or residences, village health committee meetings and clients' homes. HSAs described how the activities generated much interest within the communities, providing occasions for participants to discuss issues such as the causes of severe distress and mental health problems and signs that a person might be experiencing a mental health problem. These fora conferred opportunities for HSAs to share the 'health' model whereby biopsychosocial causation was proposed and deliberated by the participants, and in particular, for HSAs to describe how people and their families can be supported.

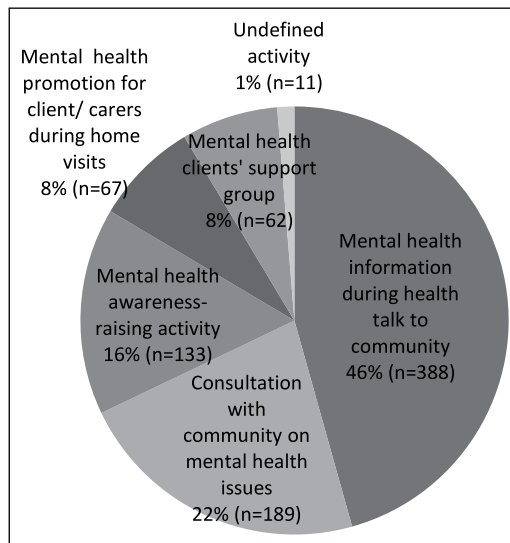
**Table 4.** Range of HSA mental health interventions.

Intervention	HSAs' descriptions of interventions
1 Risk reduction/suicide prevention	Practical steps to keep client and others safe, removing objects, access to insecticides/poisons, etc. Advice to family and friends on need for close observation and calm environment Counsel client on alternatives to suicide Make urgent referral to health centre
2 Psychoeducation	Inform that mental health problems can affect anyone, can be treated and do not mean the end of life Advice to reduce smoking chamba and drinking alcohol Advice to exercise Advice on managing medication
3 Psychological and emotional support	Reassure that the client will get better Advice to client to socialise and not to isolate self Counsel to reduce conflict/marriage counselling
4 Promoting family and community psychosocial support	Advice to family on how to care/respect Encourage family to support client's care needs for safety, food, drink, clothing, social life and education Advice to seek support from Church/pastor/spiritual adviser Encourage to participate in activities/play football Recommend and facilitate client joining 'support groups' Request permissions, advice and practical support to improve resources from chief or village elders

HSAs: Health Surveillance Assistants.



**Figure 1.** HSAs' follow-up visits.



**Figure 2.** HSAs' mental health promotion activity.

**Impact on admissions to mental hospital.** The number of inpatient admissions to the government mental hospital conducted before and after the HSA trainings are presented in Table 5.

Comparison of the total admissions in Year 1 with those in Year 2 showed a slight increase in overall admissions (from  $n=200$  to  $n=217$ ). However, it is not clear whether the increase is within a normal range since there are likely to be year on year fluctuations in admissions due to many variables including socio-economic conditions and reduced

access to transport, health resources and personnel and climatic conditions. A longer period of data collection is required to establish a clear baseline from which any trends might be measured.

From the data collected however, it is of interest that the number of people admitted to hospital for the first time rose from  $n=97$  in Year 1 to  $n=111$  in Year 2, suggesting an increase in case detection of severe mental illness. But



**Table 5.** Hospital admissions from district.

Month	Total number Year 1	Total number Year 2	Total number of first admissions Year 1	Total number of first admissions Year 2
January	40	42	19	21
February	22	26	11	15
March	44	51	21	24
April	43	37	23	14
May	24	25	7	13
June	27	36	16	24
Total	200	217	97	111

again, this finding is subject to the same limitation and variables.

Overall, the audit failed to reveal a consistent pattern of change in overall numbers admitted from the district over the period 2013–2014, indicating that the increased HSA mental health activity in the district did not appear to influence in-patient admissions.

## Discussion

The study's findings illustrate substantial mental health activity employed by the HSAs as a result of this task-sharing initiative. Integrating mental health within their work has led to the establishment of a new service within the community, with reach far beyond the previous mental health service. Crucially too, the HSAs' activity has been shown to be sustained over the 24-month period of the study. HSAs have demonstrated their capacity to recognise people presenting to them experiencing both common and severe mental health problems and suggests that the task-sharing initiative has equipped them to work effectively with clients at the community–health centre interface of the pathway to care. Where required, HSAs also made appropriate and timely referrals to health centres and mental health professionals. This forged an entirely new provision and resource for public mental health promotion across the district.

Although HSAs did not ascribe mental health diagnoses, their descriptions of clients' difficulties and severity of distress, including the suicide and harm risks, indicate mental illness within this population. Although further research to map diagnoses or assess functioning may assist in further validating this, the decision for HSAs to adopt a non-diagnostic approach at the community level recognises the limits to training and expertise of this cadre of staff, but most importantly optimises help-seeking, case finding and treatment demand.

The results emphasise that the majority of clients seen by HSAs appeared to be experiencing common mental health problems rather than SMI and that the vast majority of these clients were being cared for in the community with support from HSAs and health centres. This appears in line with

evidence proposing that common mental health problems are most effectively managed within non-specialist settings in community (van Ginneken et al., 2013) and is likely to explain why the project saw little influence on admissions to the psychiatric hospital. The interventions seen here, such as psychoeducation, offering individual psychological and emotional support and mobilising community psychosocial resources, are all essentially community based and match psychosocial packages of care designed for other low resource settings (Lund et al., 2015). It is also of interest that HSAs differentiated CMDs from SMI by their impact on the clients' functioning rather than diagnoses and showed an ability to treat and refer on based upon their assessment of 'distress'. The HSAs' health approach itself therefore appears suited to the pragmatic classifications of distress accepted within the community (Jacob & Patel, 2014) and sat alongside more lofty attributions of bewitchment or indeed purely biological understandings. HSAs overwhelmingly recorded clients' distress as relating to life stresses and described the context of clients' difficulties from which solutions and support were mobilised. Interventions included practical and client-focussed interventions that tended to promote the community's capacity to support people, to provide access to medication and individual or group social support and to refer on for further health professional assessment as required. Again, this appears essential to promote access to the first tier of formal health care in an area where pluralist attributions for mental health problems prevail. Indeed, to maximise mental health promotion and increase the demand for care, the HSAs' 'healthcare' model has been seen to acknowledge the context, culture and local survival strategies of the populations they serve and enlist the communities as partners in care (Campbell & Burgess, 2012; Ventevogel, 2014).

The 'health' approach adopted by the MHIZ Project has therefore been shown not only to be congruent with HSAs' biomedical training but also offering clients a 'credible' explanation and responsive service, even where clients may hold concurrent alternative beliefs. Records of the client interventions indicated that the HSAs documented clients' and families' explanations of their difficulties and differing causal attributions without disparagement. In line with their training too, by recognising and responding to



the clients' problems as within their scope of care, HSAs were offering clients and their families a 'healthcare' model through which their distress could be understood. Adopting a health approach and normalising clients' distress within the context of their lives reinforces the utility of the social causation hypothesis for mental health problems (Lund et al., 2011) and seeks to combat the stigma of both mental illness and bewitchment.

Where the community itself strongly equates 'madness' with abnormal or antisocial behaviours, it is interesting to note that while HSAs descriptions recognised and recorded these behaviours, they also contributed understandings of cognitions, emotions and the environment (Table 1). This may be an indicator of increased HSA mental health literacy that is so crucial to strengthening the 'demand' element of the treatment gap. Significant also was the inclusion by HSAs of 'bewitchment' not as a causal explanation of mental health problems but acknowledged as part of the presenting understanding of client or carers experience and therefore included within a formulation of the clients' distress.

Within geographically remote, rural environments, with their limited and overburdened health and welfare systems, HSAs provide an essential mental health service for individuals that would otherwise either never be in receipt of care or would do so only having reached a severe state, often via the criminal justice system. Table 3 shows the range in duration of clients' distress before presenting to the HSAs which, with ongoing recording, may provide a broad indicator of the HSAs' success in early detection and increasing demand for care.

The large number of attendees at mental health promotion events indicates the extensive reach that HSAs have within their communities and the significant impact this can have on populations' understanding and appreciation of mental health problems. This reach into the population mirrored the proportions encountered during the pilot project (Wright et al., 2014), where the mobilisation of even just small numbers of opinion formers among these attendees suggests a significant potential in combatting stigma and discrimination as well as engaging communities (Campbell & Burgess, 2012).

The finding that the activity of HSAs had no discernible impact on admissions to the government psychiatric hospital is an interesting finding requiring closer scrutiny and involving a more rigorous study design and extended period of data collection to establish trends. While it might have been hoped that either an increased HSA activity would improve community awareness and case detection and increase the number of referrals to the mental health service or that improved community awareness and capacity building would reduce the need for hospital admission, the findings reveal a more nuanced and complex picture, suggesting several possibilities. Most obvious is that SMI and CMDs represent discrete populations, and it is clear that the majority of those cared for by HSAs were experiencing CMDs, and thus

rarely required hospitalisation. While it is also true that only a small proportion of people experiencing SMI might require admission to hospital at certain crisis points, the study's findings suggest that people with SMI found their way to the mental hospital independent of HSA activity. While HSAs did successfully detect people with severe mental health problems and referred them to the health centre, it was the health centre clinician or nurse who made the referral to the hospital, obscuring the HSAs' input from the hospital record of admissions. Also, as in most low-resource countries, the rate of admissions too was found to be subject to significant variation in access to mental health care due to scarcity of provision, remoteness to health centre and hospital, as well as other barriers in the pathway that HSAs are beginning to tackle. An optimistic hypothesis in this study is that the work of the HSAs provided more supportive environments both for people with existing serious mental illness and also for people who might be vulnerable to mental health problems and thus prevented deterioration. The fact that HSAs provided public information on community interventions might be seen as promoting a more conducive environment for people with mental health problems of whatever severity. Interestingly, during the course of the MHiZ Project, the mental hospital began to develop its out-patient facility as an alternative to admissions and mental health professionals there reported that the increased HSA activity had made the most impact by increasing this as a therapeutic opportunity. Although this element of evaluation requires closer scrutiny, the improved community awareness, challenge to stigma and increased capacity for community support initiated by the HSAs appears to have provided increased opportunities to support patients on discharge from the mental hospital.

## Limitations

Although a consecutive client cohort was selected for analysis, issues of fidelity to the taught model, intensity of delivered interventions, quality of care and patient outcomes are shrouded by the fact that the findings are based on the records of HSAs themselves rather than upon objective measures. Limited project resources constrained a structured examination of patient outcomes which might have provided a more objective evaluation of HSAs' 'effectiveness'. The HSAs' approaches too cannot be generalised as consistently adopted by all HSAs, as variation in engagement and activity with mental health work within their roles is highly likely. Table 1 illustrates, for instance, how some HSAs were more able to integrate abnormal behaviours, difficult situations and distressing emotions within their formulations of clients' distress than others. HSAs' mental health promotion work too relied upon HSAs records of these activities and may be subject to recording bias, although the monitoring and supervisory element of the project certainly validated the extent of the HSAs' standing and reach within communities.

The design and output of the MHiZ project also focussed on increasing the sensitisation and enhancing the mental health response at community level where health services meet community, rather than assessing the feasibility of a whole system approach to improving community mental health promotion and care (Lund et al., 2015). While this clearly limits the ability of the findings to inform the approaches of other cadres of staff or how the wider systems of mental health support are affected, it nevertheless concentrates attention towards the approach of the health worker at the crucial health centre-public interface.

## Conclusion

Overall, the MHiZ project has successfully demonstrated a sustained district-wide scale-up of the integration of mental health care within the work of HSAs. The detection of people experiencing mental health problems is a vital step in addressing the mental health treatment gap and HSAs have demonstrated success in recognising and responding to the needs of people experiencing varying severities of mental distress. Equally importantly, the study has demonstrated how, within a socio-cultural context of diverse explanatory models for distress, HSAs have been able to offer a health model for mental health promotion and care that is both credible and practical in meeting the demands of the people they serve.

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# Pluralism and practicality: village health workers' responses to contested meanings of mental illness in Southern Malawi

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## Pluralism and practicality: village health workers' responses to contested meanings of mental illness in Southern Malawi

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### ABSTRACT

The individual and social construction of psychological distress is fundamental to help-seeking and the extent to which interventions are seen as credible. Where pluralistic attributions for mental health problems predominate, the development of global mental health (GMH) interventions in the form of task-shifting approaches create increased access to new ways of understanding and responding to distress. However, little is known about how participants in these initiatives manage these encounters. This qualitative study in Malawi explored village-based health workers' (HSAs) and patients' and carers' views of the causes of distress and how these beliefs influenced help-seeking and the health workers' response.

Eight HSAs and nine paired patients/carers were interviewed separately to enable each of nine experiences of distress to be explored. Findings revealed a complex set of personal, social and cultural influences that informed causative attributions and help-seeking decisions. Patients/carers viewed psychosocial stresses as compelling explanations and readily reported others attributing their distress to supernatural causes (bewitchment). Yet attributional beliefs alone were not the only influence over help-seeking, which evolved pragmatically in response to the impact of treatments and social pressure for conformity. In turn HSAs navigated the interactions with patients/carers by emphasising the biomedical approach and discrediting bewitchment attributions. This caused tensions when biomedical interventions were unhelpful or the traditional healers' approach proved beneficial.

Conclusions add to the call for such task-shifting approaches to work with communities to discern authentic and practical responses to mental distress that mirror the 'pluralism and pragmatism' found in the communities they serve.

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Malawi; mental health; causal attributions; help-seeking; traditional beliefs

## Introduction

With the worldwide impact of mental illness estimated to account for more than 30% of years lived with disability (Vigo, Thornicroft and Atun 2016), few doubt the importance of efforts to address this global challenge (Becker and Kleinman 2013; WHO 2013). Biomedicine

has become the dominant discourse through which to understand and respond to the issue of mental illness and a focus on epidemiological data, treatment recommendations and evidence-based strategies to scale up health services, are seen as essential components to improving both the human rights and access to care for people with mental health problems (Lancet Global Mental Health Group 2007; Patel et al. 2011). Such global initiatives are regarded as bringing important contributions to global mental health (GMH) policy and practice (Patel et al. 2010) and are manifest in service-led responses such as the mental health task-shifting approach whereby mental health assessment and care is integrated into the work of primary care health workers (WHO 2008; Petersen, Lund and Stein 2011).

However, the universalistic and homogenous notions contained in the biomedical construction of mental distress has been a central and frequently polarising critique from both medical anthropology and critical psychiatry (Summerfield 2008; Fernando 2014), and the last decade has brought widespread challenges to the GMH project ranging from ‘specific aspects of implementation, to stark rejection of foundational assumptions’ (Jain and Orr 2016, 687). Although there is evidence that such analyses have gained traction in healthcare practice (Kohrt et al. 2014; White and Sashidharan 2014), a quandary remains: while the GMH position has increasingly espoused more responsiveness to local traditions and idioms of distress (Patel 2014; Ventegal 2014), largely through emphasising the premise that help-seeking is mediated by how people give meaning to their experience (Kleinman 1980), it also continues to advance the explicit project of increasing ‘mental health literacy’ (Ganasean et al. 2008). GMH, by locating mental health task-shifting approaches within the biomedical domain – even with an emphasis on psychosocial influence – implies that these are distinct diagnoses requiring particular interventions. It carries with it certain assumptions about health and illness and delineates it from wider processes that may be central to an individual or community’s perspective. How, in practice, a health worker, charged with delivering ‘shifted’ tasks, navigates these tensions therefore becomes a crucial area of inquiry. This study seeks to explore one such example; how village health workers in Malawi – Health Surveillance Assistants (HSAs) who were trained as part of a mental health task-shifting approach – view and interact with people experiencing psychological or emotional distress.

By extending a focused examination of HSA and patient interactions, (at the point of consulting an HSA, the person is assumed to take on the role of a ‘patient’, with all its accompanying meaning and impact for the HSA, attendee and community), the study seeks to gain an understanding of how the HSAs and patients and carers view the nature and causes of the psychological distress and how such beliefs influence patients’ help-seeking and the response of the HSAs. Within such a pluralistic cultural environment, of particular interest is the way in which HSAs negotiate the biomedical and traditional approaches in seeking a therapeutic response to peoples’ distress.

## Study area

Malawi’s development index was ranked 173 out of 188 nations worldwide and 50.7% Malawians live in poverty (UNDP 2013). The large majority of the 600,000 population of Zomba district of Southern Malawi (where fieldwork was undertaken) are engaged in a rural subsistence economy (NSO 2011). The population reside in villages of between 200 to 1000 people, small trading centres and one urban centre in Zomba town. The most

prevalent ethnic groups are the *Mang'anja*, *Nyanja*, *Yao*, *Ngoni*, *Lomwe* and *Sena*, although, as Steinforth (2009, 27) has pointed out, there is both a rich cultural pluralism and 'a broad cultural common ground (that) transcends ethnic affiliation'. While each group has its distinct language, Chichewa is spoken by all and is recognised – along with English – as the national language. Eighty-three per cent of the population of Malawi are Christians, 13% Muslims and 2% other religions, with 2% with no religious affiliation (NSO 2011). Similar proportions are thought to constitute the religious make-up of Zomba District.

## Mental illness and health care in Malawi

Similar to other low resource countries, attention has been drawn in Malawi to the gap between the prevalence of mental health problems in primary care and the limited health resources available (Udedi et al. 2014) and models are being developed to improve the recognition and management of mental illness (Kauye, Jenkins and Rahman 2013). Biomedical health resources are organised in a system of health centres, district and regional hospitals. With only three psychiatric in-patient units available nationally, the vast majority of people experiencing mental health problems reside in their home communities.

HSA's have established a key position within the Malawi Government's primary health-care system where they implement public health initiatives, particularly around communicable diseases and infant and maternal health (APC 2014). Residing in the populations they serve, the HSA's are versed in both their biomedical training for particular health concerns and their own personal experience and perspective on the plurality of understandings of health, disease and help-seeking that exists in their communities. This has led to an appreciation that HSA's are in daily contact with people with a range of mental health problems and are therefore apposite recipients of a task-shifting initiative. In 2013 over 700 HSA's across Zomba district received 3 days training aimed at assisting HSA's to identify people experiencing mental health problems, including common mental disorders, epilepsy and severe mental illness, and to respond with a balance of biomedical and community-based psychosocial interventions. An evaluation and further details of the initiative can be found in Wright and Chiwandira (2016).

Yet despite a normative recognition of local prevalence of mental health problems (Udedi et al. 2014), biomedical mental health perspectives have been reported as having limited resonance within rural Malawian communities (Steinforth 2009). Both Christian healing ministries (principally through Pentecostal and Apostolic churches) and indigenous medicine in the form of Traditional African Religion occupy a central component of cultural and social life in Malawi (Simwaka et al. 2007) as the population customarily hold strong traditional spiritual attributions for all health problems and misfortune (Ott 2000). The continued strong allegiance to Traditional African Religion even where people might formally describe themselves as Christian is a particular feature (Barrett, Kurian, and Johnson 2001). Although only a cursory and over-simplified account of traditional spiritual understandings can be provided here, central to indigenous beliefs about illness are the presence of three main causative agents – a supreme being (God), the ancestors (spirits of the dead) and witches. The attribution for illness results when a spirit's displeasure at an individual or family member's neglect or failure to uphold social taboos and customs (*miyambo*) leads to the affliction (*mdulo*) from a curse or bewitchment (Morris 1986, van Breugel 2001).

Healing practices rely on traditional healers (*sing'angas*) or prophets to identify the causative agent and facilitate the necessary treatment in the form of herbal remedies, rituals of observance, prayer or sacrifice to appease the ancestors or expel spirit possession (Simwaka et al. 2007; Steinforth 2009). Treatments (including by biomedical treatments) are believed to be ineffective unless the causative agent has been identified and appeased (Simwaka et al. 2007).

The Ministry of Health (2005) approximated that 80% of Malawians utilise the services of traditional healers and such consulting has been linked to delays in biomedical 'help-seeking' in Malawi (Chilale et al. 2014) reinforcing the Government's drive for mental health task-shifting initiatives in primary care.

## Methods

A qualitative method of inquiry was undertaken over 2-month-long periods in September 2013 and April 2014 and drew on the centrality of understanding the individual within their broader context (Brewer 2000). HSAs were interviewed individually and separate interviews undertaken with either a patient or carer to pair with each HSA interview. The interviews focused upon accumulating understanding of how the informants gave meaning to their experiences of mental distress or their response to others' distress. The themes for inquiry at interview were derived and refined from Kleinman's (1980) seminal explanatory model and discussion with the research team in Malawi. The 'pairing' of both HSAs and patients/carers was intentional in order to explore congruence and different perspectives of the same episode of distress – enabling ready comparisons. Findings from interviews were complimented by observations of HSAs in their everyday clinical work and patient and carers' attendance at health centres.

HSAs were randomly selected from the 32 health centres in Zomba District and invited to take part in the study. A pragmatic convenience sampling strategy was adopted to secure the involvement of patients and carers, whereby each HSA was required to select a patient or carer with mental health problems, with whom they were working and who were willing to take part in the study. Whilst asking HSAs to select the patient or carer for interview risks some recruitment bias whereby certain patient characteristics, such as familiarity or living geographically closer, may influence their choice, it was made clear to HSAs that the perceived effectiveness of their interventions was not being evaluated. Nevertheless, some sample bias cannot be excluded. In the event however, heterogeneity across patients' age, gender and presenting type of distress was achieved (Table 1) and enabled shared patterns and diversity to emerge (Palinkas et al. 2015).

In all, within the 2-month-long study periods, a total 17 interviews from HSAs from eight different health centres across Zomba district were achieved (one HSA was working with two patients). Interviews were audio-recorded, transcribed and translated, creating material in both Chichewa and English. Five HSAs were male and three were female and, as well as the 3-day mental health training, all had completed their basic 10-week training in biomedical health, although for many this had been undertaken many years previously. Service as an HSA ranged from 1 to 13 years (median =5 years). Of the patient/carer sample, three patients were male, three were female; and the three carers were female. While patients presented for interview experiencing a variety of mental health problems, the emic nature of the inquiry also meant that no attempt was made to select or identify patients with specific problems or psychiatric diagnoses.



**Table 1.** Contextual features of interviewees' distress.

Health centre/HSA	Interviewee: patient or carer	Description of patients' presenting distress
1	Patient	Man aged in his 30s with repeated episodes of elevated mood and beliefs of being powerful and all-knowing.
2	Carer	15-year-old girl dropped out of school, believes she has been specially chosen by God. Carer is worried she is acting strangely and cannot communicate with her.
3	Patient	Man aged in his 20s exhibiting strange behaviour such as talking and singing to himself and no longer taking part in family life.
4	Patient	Woman aged in her 30s feeling fatigue and bodily discomfort and has become low in mood and feeling hopeless.
5	Carer	13-year-old girl with intellectual impairment since birth and unable to perform tasks expected by parents.
5	Patient	20-year-old young woman who became suicidal following still-birth of her child.
6	Carer	10-year-old girl experienced repeated epileptic fits
7	Patient	Man aged in his 40s became low in mood, feeling hopeless and stopped taking his anti-HIV medication.
8	Patient	Teenage girl attempted suicide following relationship breakup.

## Data collection

Face-to-face interviews lasting between 45 and 60 min were undertaken by the authors in English or Chichewa, according to the interviewees' preference. Interviews explored the following two main topics:

- (1) How HSAs view the nature and causes of psychological distress in persons presenting to them and how this influences their therapeutic responses.
- (2) How patients and carers understand the nature and causes of psychological distress and how this understanding influences their help-seeking.

Emphasis throughout was on encouraging interviewees to describe their subjective thinking and experiences.

As mental health professionals now working in academic environments (one (JW) a 'white' UK national and the other (LM) a Malawian, fluent in Chichewa), both interviewers and observers were aware that their presence introduced personal, cultural and socio-economic characteristics that would influence how they were viewed by HSAs, patients and carers. Both, however, benefitted from a reflexive engagement with the wider research team consisting of additional health care and academic colleagues who provided critical feedback and oversight of the study. As the study progressed it became clear that the interview approach and method provided an opportunity for interviewees to 'tell their story' from their own perspective – including disclosure of sensitive areas of beliefs and experiences – and that this affords some confidence as to the ability of participants' narratives to reflect their experience. One carer for instance described how she was wary of returning her child to the care of the health centre since the previous biomedical treatment had made her son seriously ill. Here too, contemporaneous field notes of observations provided context to the interview material.

## Data analysis

A collaborative approach to analysis was undertaken and commenced concurrently with data collection (Robertson and Boyle 1984). The authors and research team debated the



emanating cultural patterns and norms of patients and carers and of HSAs and their work from the interview transcripts and exchange of observations. Once translated into English, the authors independently undertook multiple line-by-line readings of each interview transcript and developed category codes. These codes were shared between researchers and the texts re-examined until themes were identified and saturation was reached where no new data of values or patterns of behaviour emerged from the transcripts (Morse and Field 1996). While it was appreciated that direct translation of transcripts may not convey the precise contextual meaning and connotation that the individual participant originally intended (Temple and Young 2004), a ‘back translation’ into Chichewa was undertaken for repeated key words and phrases to arrive at the closest approximation of intended meaning. In presenting the findings, a decision was made to detail the Chichewa terms directly from the original recordings so that our translations are exposed. Continuous iterative discussion within the research team enabled an interpretive analysis to be developed that sought to generate explanations for the social patterns and behaviour of HSAs and patients/carers in response to distress (Geertz 1973). All emergent findings and meanings were independently reviewed by a third researcher not involved in the original data collection.

## Findings

Interviewees readily responded to the opportunity to describe their perspectives of the recent experience of distress and in so doing connected themes of the nature of their problem; how it was experienced or observed and what they and others considered the cause or causes of the problem.

### Identification and expression of the distress

There was consensus amongst interviewees that the distress experienced represented a type of ‘mental illness’ where people behaved differently from the norm or from what was expected in the community. Consequently, individuals were primarily identified as mentally ill by their behaviour and descriptions of ‘madness’ (*misala*) such as ‘roaming around’ and ‘wandering naked’ were consistent with some of the earliest psychiatric reports of mental illness in Africa (Field 1960).

(He) would just be singing randomly, talking uncontrollably, roaming around without telling the parents where he is going. HC3;HSA

Patients’ descriptions of their experience also tended to emphasise their own unusual behaviour when severely distressed.

I was very sick, weak, sometimes not able to see properly, roaming around. HC3;Patient

And

I would suddenly become strong. I would just get up and start running, or sleep. I would feel sleepy and find it hard to see’ and ‘I would have pangs like a dying animal. And so people would come to hold me. HC1;Patient

Examples of madness (*misala*) and intellectual impairment (*kugona* – ‘being foolish’ and *kuzerezeka* ‘slow learning’) and the experience of epileptic fits (*khunyu*) were all readily identified by HSAs and patients/carers as representing examples of mental illnesses.

However, the interviews also revealed that HSAs rather than patients/carers included less extreme and more subtle behaviours as constituting mental illness, such as low mood, despair and anxieties (summarily translated as *nkhawa*). For instance an HSA saw an HIV-positive patient’s refusal to continue to take anti-retroviral (HIV) medication (ARVs) as indicative of mental illness.

I decided that the person has a mental health problem because he could not value his life. He thought his life was worthless. HC7;HSA

In this situation the patient came to the attention of the HSA because of his behaviour – he had stopped attending the health centre to receive his ARVs – not because the patient or his relatives were concerned at his despairing and suicidal mood.

Overall, there was consensus amongst both HSAs and their patients/carers that mental illness could be identified from patients’ strange or unusual behaviour, whether that was bizarre speech, actions, inactions (self-neglect) or attempting suicide (Table 1). The link between stressful life events, (such as living with HIV, bereavement or relationship problems), and mental illness and the extent to which the communities considered these to be mental health problems is discussed later.

## Interpretation and explanation of distress

Explanations for the experiences of distress described by HSAs and patients/carers provided insights on how each was understood. Interviewees expressed four distinct categories of causative explanation.

### (i) Psychosocial stressors

The majority of presentations identified by HSAs could be described as common mental disorders – not coping, alcohol use, suicidal, unhappiness and despair. Both HSAs and patients/carers most frequently cited the explanation for this distress as a response to experiences such as bereavement, divorce and extreme poverty.

Both HSAs and patients frequently described the mechanism for the connection between their inner thinking and feelings and expression of distress through the Chichewa term *kuganiza kwambiri* (similar to the idiom of ‘thinking too much’ (Kaiser et al. 2015) and which led to *nkhawa* (worry)).

For example, as an explanation for a young woman’s acutely disordered thinking following her grandmother’s death.

I think that maybe it’s because she was thinking too much about her grandmother’s death. Because she was there when the grandmother fainted and was taken to the hospital where she died...she is too young to have witnessed that. HC2;HSA

While in itself, the experience of *nkhawa* (low mood/despair) was not routinely considered a mental illness, prolonged *nkhawa* was said to lead to *misala* (‘madness’).

### (ii) Drugs and alcohol

The way that a patient’s mind is altered by imbibing substances such as smoking *chamba* (marijuana) or drinking alcohol was cited as a cause of mental health problems.

...when he was in school with his friends he had bad companies, peer pressure and maybe there's a possibility he started smoking cannabis so it might have contributed to the problem. HC3;HSA

The precise causative process by which this occurs is less clear, since smoking was not only seen as causing changes to thinking, but also as an expression of 'bad behaviour' that would lead to mental illness through a downward drift of apathy and neglect.

The notion of 'addiction' – including intra-psychic problems such as craving – was not voiced, but the outward expression of addictive behaviour was clearly recognised. It appears that while the community viewed these behaviours as 'bad' and would lead to a deteriorating physical and mental condition, the HSAs viewed the behaviour as both the expression of and the explanation for the mental health problems. Such differing views exemplify Helman's (2007) cross-cultural model of different perceptions of social behaviour.

(iii) Physical illness

Interviewees indicated that from a biomedical perspective, certain physical illnesses, including infections like cerebral malaria, were responsible for mental illnesses, especially where patients had experienced fits in childhood. One HSA also described how he thought poor health in pregnancy can lead to mental health problems in the child being 'born that way' (HC5,HSA). However, unlike HSAs, patients and carers tended not to separate physical illness or disability from mental disorder, seeing them instead as different components of the same malady arising from bewitchment.

(iv) Supernatural cause

A reluctance to disclose traditional understandings of illness was apparent from the fact that at interview no patients/carers volunteered at interview that they considered bewitchment to be a cause of their problems. Nevertheless, six out of the eight patients/carers claimed that others in their family or community thought that they or their child had been bewitched, with more than half of interviewees reporting attending a *sing'anga* (healer) on at least one occasion. In this sample, attendance at traditional healer, rather than Christian faith healer predominated and yet at interview none admitted to any benefit from these consultations.

Interviews with HSAs however confirmed that patients or carers had told them that they believed that bewitchment was a cause for the distress.

He (patient) believed that his aunt bewitched him... the family took him to traditional healers for help. HC3;HSA

They (relatives) said it developed since when he was young. He was growing up with that spirit of an abnormal situation in the head. HC3;HSA

One of her relatives told me that he thinks she was bewitched because he doesn't see what could have caused it. All of her siblings are just fine; she is the only one with problems. HC5;HSA

It is clear, that both a sample and response bias was in operation. As health centre attendees, patients and carers may already be self-selected as likely to be more open to biomedical understandings of their distress and the assumed biomedical 'orientation' of the health centre made patients and carers reluctant to articulate any alternative attributions for fear of rejection. This is coupled with the notion in many parts of Malawi that, while spiritual beliefs in the form of Christianity or Islam were seen as complementing educated and 'modern' thinking, Traditional African Religion represented older and more outdated traditions (Lwanda 2004). In addition, within Malawi society, the mysterious and sometimes

malevolent nature of bewitchment (*matsenga* (magic) and *ufiti* (sorcery)), which can only be interpreted and handled by *sing'angas* (healers), means that people are wary as to whom they express such personal beliefs (Lwanda 2004). It's likely that such suppressions were operating during the interviews.

In describing the nature of supernatural explanations in this study it would also be wrong to convey that patients universally accepted these or held them to be the only cause. HSAs described patients and carers frequently appearing to hold more than one explanation concurrently. As a Christian, one patient professed to attribute his own mental health problems as 'God's will' alongside his sense that he had been studying too much at school:

Since I wasn't smoking or drinking, the people thought it was the studying that started it. It could just be God's will. But I went to the hospital not the traditional healers. HC1;Patient

This inductive and extremely practical approach to achieving an explanation and effective treatment can also be found in an HSA's description of one patient:

She came here when she was sick. They (traditional healers) didn't help. So eventually they (family) got advice that they should come to the health centre. HC4;HSA

And after receiving effective pharmacological treatment at the health centre, the same patient offered:

I suffered for a long time but the medication I get from here helped me, slowly I started feeling better up to now. HC4;Patient

The interviews therefore reveal a pluralism of meaning of experience and patients and carers appear to seek help pragmatically based on the success of treatment.

Nevertheless, the interviews show that HSAs identify supernatural attributions through their interactions with patients, carers and wider community. While reluctant to disclose their own traditional beliefs at interview, many of the patients and carers had previously felt able to disclose these to the HSAs. This suggests that while the HSAs are an established part of the biomedical health system, there is something about their position and status that allows them to be viewed as more genial and accepting of pluralistic beliefs. Yet as an established part of the biomedical health system, and charged with offering therapeutic responses consistent with this outlook, this was not without a number of complications.

## HSAs' responses to pluralistic explanations for distress

### (i) Promotion of psychosocial and downplay of the supernatural

In identifying the causes of clients' distress, all HSAs subscribed to psychosocial attributions and linked these to the biomedical model of illness. Overwhelmingly too, HSAs tended to ignore or challenge supernatural explanations from patients, carers or members of the public. At health promotion talks HSAs describe how they challenge ideas of bewitchment.

I asked them what they think causes mental problems in one of the meetings, and they said witchcraft and other things like drugs. I agreed with others but I didn't agree about witchcraft... so I said that maybe she was just born like that or maybe there were birth complications, or maybe there were some things that happened like not following safe motherhood and whatnot ... and so I just gave alternative explanations. HC6;HSA

What effect the discrediting of supernatural explanations has on such individuals and communities is unclear. Tensions are noticeable and the potential to alienate patients and carers and to influence help-seeking is apparent. However, this study provides only limited insight into these concerns since by virtue of being in contact with biomedicine through HSAs, the interviewees represent a discrete population from those patients/carers who either do not present for help or do so exclusively from *sing'angas* or faith healers. Nevertheless, HSAs were clearly aware that spiritual attributions and their influence on help-seeking are a reality within their communities and one that conflicts with their promotion of distress within a biomedical model.

(ii) Navigating challenges to the biomedical explanation

When promoting the biomedical model within such a pluralistic environment two specific challenges arose for the HSAs.

First, where biomedical interventions have been ineffective or damaging.

In one instance, where previous treatment for a 2-year old child's fits had caused drug toxicity and life-threatening illness, a mother was reluctant to attend the health centre for fear her son would receive the diagnosis and stigma of madness.

HSA: 'The mother still has doubts...that it's going to help'

Interviewer: 'So you're thinking maybe there are reasons why she's frightened and concerned that things might not get better by coming to the health centre?'

HSA: 'Maybe because she thinks it's madness and believes that it has no cure? And also she thinks that if she comes here they will refer him to the mental hospital so she gets frightened with that.' HC6;HSA

Second, where a spiritual approach via the *sing'anga* or faith healer is considered to be beneficial.

Sometimes they (patients) go to the traditional healers for help and sometimes they go for prayers. So if we notice that there hasn't been any change, we tell them that they still have to go to the hospital...But if there has been some change, you just leave them. HC7;HSA

This example shows that HSAs will not pursue patients who appear to be improving through traditional healing and this leaves them with no logical alternative but to tolerate such help-seeking and yet see themselves as available if the patient/carer changes their mind.

## Social conformity and the function of traditional healing

While it is clear that patients, carers and the communities frequently signal a number of causative attributions, a case example recorded in field notes demonstrates a wider social influence over the choice of help-seeking:

A 14 year old boy recently became disturbed and violent – damaging a market stall and threatening people. People in the village were becoming alarmed by his unpredictable behaviour and, suspecting he may have been 'bewitched', suggested his uncle takes him to consult a traditional herbalist. The uncle considered the boy had a mental illness and was very uncertain that the consultation would help. However, not taking the boy to the herbalist risked him being seen as neglecting the boy's (and the community's) best interests which would lead to social disapproval. Also, because certain members of the community had started to accuse the boy of being a maleficent 'wizard' (rather than the victim of witchcraft), ascertaining the specific nature of the spiritual explanation through the opinion of the traditional herbalist was vital since the latter accusation might lead to the boy being subjected to serious physical

harm or banished from the community. In the event, the uncle accompanied the boy to the *sing'anga* (healer), together with several elders of the community (to vouch for the *sing'anga's* opinion), and following a short consultation, received the avowal that the boy was not a wizard but had been bewitched. A ritual was performed to appease the family spirits, who had been agitated by an episode of violence early in the boy's life, and the boy was accepted back into the community, with community members vowing to provide love, care and security to the boy. Whilst expressing scepticism whether attending the traditional herbalist would help, the uncle nevertheless was able to secure the boy's safety and care and his own status within the community.

### From HC4: field notes

This example demonstrates the influence that community mores and customs have over help-seeking behaviour and illustrates a motive for seeking help from traditional healers that may be irrespective of personal attribution. Attendance affords a social function that is vital in collectivist communities and confers Kennedy's (1969) earlier observations in Malawi of the psychosocial dynamics of witchcraft. Fundamentally, this example highlights substantial help-seeking decision-making and activity that is beyond the reach of both HSAs and health centres, as patients/carers themselves navigate the plurality of mental health provision with all the stresses and uncertainties that accompany such a search.

### Discussion

The qualitative method has generated descriptions of the recognition of and explanations for mental health problems and has procured insights into how HSAs navigate the traditional and biomedical understandings of mental illness in rural Malawi.

Findings indicate that both HSAs and the community share a common recognition of mental illness derived largely from perceptions of the behaviour of patients as 'uncontrolled and abnormal' (Helman 2007). As explanations, patients, carers, and HSAs were seen to acknowledge pluralistic attributions from different epistemologies and differing emphases from biological, psychosocial and spiritual domains.

For the framework used to understand the experience of distress is crucial and this study suggests that the biomedical model for distress, espoused by HSAs through this task-shifting initiative, with its emphasis on how psychosocial pressures can result in mental illness, was seen among the interviewees as a credible attribution. The majority of interviewees expressed particular receptiveness to 'stress causality', suggesting that this appeared to make 'real world' sense to them. This shared recognition of the influence of life events and situations, experienced most profoundly by those living in extreme poverty and deprivations, represent a valuable insight into the way that the distress of vulnerable individuals and populations might be considered. The same acceptability of the stress attribution has been found to be concordant with traditional African understandings elsewhere (e.g. Okello and Neema 2007 in Uganda; Irankunda et al. 2017 in Burundi).

Yet introducing a new way of framing experiences that had previously been considered a part of life (e.g. the challenge of continuing to take ARVs) is also an example of where local understandings are subject to change. The shift in the conception from *kukumudwa* (a severe yet sane reaction to life's hardships) to *nkhawa* (low mood/despair and potentially a precursor to *misala* or 'madness') may be a small indication of how cultural understandings



evolve in the same way Peltzer (1989) previously observed differences between ‘traditional’ and ‘transitional’ understandings of mental illness among rural and urban Malawians.

Within such pluralistic and shifting environments too, framing distress as ‘illness’ deriving from a person’s internal mediation of stressful events (Slavik and Croake 2006) may be seen as at variance with traditional collective customs where a breach of social behaviour and mores (*miyambo*) is viewed as leading to illness in a third person (*mdulo*) (van Breugel 2001; Steinforth 2009). In this way, a biomedical illness model may be interpreted as challenging the resort by the community to moral judgement over how a person was expected to deal with life problems, since the breach of behavioural norms is traditionally seen as central to the cause (Simwaka et al. 2007). This was most clearly observed in the way that treatment for people misusing drugs and alcohol was viewed and resonates strongly within the Chewa tradition of *uMunthu* – the life-long journey of developing the person’s character, replete with expectations and responsibilities that are central to the Malawian view of healthy living (Bandawe 2010). Yet, as Bandawe’s contemporary writings reveal, notions of culture and tradition are never static and tensions are present in all societies’ delineation of ‘madness’ from ‘badness’ (Helman 2007). Certainly, how the relationship between normality and *uMunthu* is correlated in Malawi will be fundamental to people’s determining of such behaviour in the future (Steinforth 2009).

Significantly, the study has exposed other ways to understand patient and carers’ help-seeking. Successful treatment from either biomedical or traditional medicine promoted satisfaction and reinforced the causative attribution, indicating more pragmatic motivations for help-seeking (Read 2012). Patients and carers contemplate more than one causative explanation for their distress. Predictably, this informed diverse and concurrent help-seeking within both biomedical and traditional health systems, and underlines previous research on dualistic systems (Friedson 1996; Simwaka et al. 2007). Yet, although the HSAs directed their efforts in accordance with biopsychosocial medicine and accommodated social and psychological influences, this did not extend to the social influence of spiritual beliefs or expectation. Discussion of alternative ‘non-allopathic’ epistemologies appears to have been effectively silenced in patients’ interactions with HSAs (Whitley 2015). Instead HSAs remained rooted in their allegiance to the biomedical model, retaining the distinctiveness of the two parallel systems, with any referral pathway between the systems found to be unidirectional – similar to previous findings in Malawi (Peltzer and Machleidt 1992) and Kenya (Musyimi et al. 2016).

The issue of the limitations of both traditional medicine and biomedicine has been shown in the study to introduce dilemmas for HSAs in deciding the appropriate method of support. In contrast to the significant medical advances for many communicable diseases, the challenge for the biomedical approach to demonstrate similar effectiveness in treating mental illness is perhaps most profound. Effective treatments rely on psychological and social environments for recovery and are challenging to both operationalise and scale-up (Patel et al. 2012). Incomplete explanations of illness, non-specific medications, problems in follow-up, the lack of training and infrastructure have all been implicated in ineffective mental health treatment, which in turn leads to reduced help-seeking (Khoury et al 2012). All can compound a community already sceptical or resistant to such biomedical approaches, and adds complexity to the HSAs’ promotion of a biomedical understanding and response (Okello and Musisi 2015). In contrast, the embedded status of traditional beliefs that inform every aspect of people’s personal and social lives makes attentiveness to this far more compelling (Simwaka et al. 2007).

In the same way, the study has drawn attention to the ‘social conformity’ (Asch 1955) influence on help-seeking highlighted by the community pressure to conform to traditional explanations and consult with a *sing’anga* (healer), consistent with Simwaka et al.’s (2007) notion of the local cultural definition of disease. While social desirability is a universal phenomenon and is fundamental to how societies function (Bond and Smith 1996), this study has brought into sharp focus the critical and life-preserving choices facing patients and carers within such pluralistic, and at times perilous, environments. It emphasises the delicate path to tread in navigating mental health attributions where beliefs and sanctions can so significantly impact on people’s lives and well-being.

The rationalist interpretation that beliefs would predict behaviour has been shown to be far from straightforward and the study has exposed mediating factors from a complex set of psychological, social, cultural and structural environments that inform help-seeking decisions (Kirmayer 2004). The pragmatic and socially desirable actions of patients and carers accords with previous findings that a focus on ‘beliefs’ alone is neither neutral or an adequate explanation (Read 2012) and ‘tend(s) to obscure the many crucial aspects of wellbeing and recovery that are important to patients and their families and which shape the therapeutic choices they make’ (Cooper 2016, 708).

A number of implications for task-shifting approaches and the mental health work of HSAs can be derived from this study. HSAs have introduced into the community new ways of understanding and responding to distress (psychological and social) that are seen as credible and accessed by patients. While HSAs appear to hold a privileged position from which to understand the range and potency of people’s different attributions and treatment options, their status, training and supervision might be seen as far too limited to minister to such complex and multi-faceted challenges. As a result the task-shifting approach has not informed any drive for integration with other healing systems. Instead, it appears to have reinforced a demarcation of biomedical from traditional health systems whereby HSAs and patients navigate around the two parallel systems, rather than to explore or negotiate different meanings. While a pressure for symmetry of different epistemologies and practices has been seen as misleading (Langwick 2007), within task-shifting, it appears equally improbable.

While there is growing evidence that non-specialist workers such as HSAs can make a substantive contribution to reducing distress (Patel 2012) and when it appears that traditional modalities of healing involving the family, social normalisation and spiritual approaches are being acknowledged (Whitley 2015), there remains a danger in some task-shifting approaches that nuanced understandings are being side-lined by essentialist thinking. This study tentatively offers that it is only by extending an appreciation of the uneven and multiple influences on individuals’ help-seeking decisions and encouraging dialogue, that non-specialist workers such as these would be able to offer a response that becomes more attuned to peoples’ lived experience and needs.

## Conclusion

This study has explored interactions between village health workers and their patients and carers, where the practices of GMH can be seen to be meeting diverse social realities and contrasting experiential frameworks (Jain and Orr 2016). The way that the study has revealed understandings of mental health problems and help-seeking that are not only pluralistic but pragmatic and open to the influence of social pressures and the impact of interventions, reinforces that the care for people with mental health problems can be



advanced most effectively when they are ‘connected to local histories and relationships’ (Cooper 2016, 709). This study proposes that if initiatives such as task-shifting approaches can guard against essentialism and oversimplifications and instead mirror the ‘pluralism and pragmatism’ found in the communities they serve, then they are well placed to discern authentic and practical responses to human suffering.

## Ethical approval

Ethical clearance was obtained from the National Research Council of Malawi and the Department of Health Sciences Research Governance Committee at the University of York. Further written approval was obtained locally from each health centre and all participants were provided with oral and written explanation of the study before providing their informed consent. No patient in acute mental health crisis was interviewed and confidentiality was underlined, including, in particular, explicit reassurance that patients’ and carers’ views and opinions would not be disclosed to the HSAs.

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# “We Need Other Human Beings in Order to be Human”: Examining the Indigenous Philosophy of *Umunthu* and Strengthening Mental Health Interventions

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**Abstract** This paper examines how cultural, historical and contemporary perspectives of mental health continue to inform ways of understanding and responding to mental distress even under the biomedical gaze of the Movement for Global Mental Health (MGMH). Based on experiences in Malawi, the authors explore three prominent interventions (practical support, counselling and support groups) employed by village health workers within a mental health task-shifting initiative and reveal how the ancient philosophy of *Umunthu* with its values of interconnectedness, inclusion and inter-relationships informs and shapes the direction of these interventions. Practical support is marshalled through traditional village structures, counselling provides advice and an encouragement to hope, and support groups provide a place for emotional exchange and a forum for the enactment of values, reflection and reinforcement of *Umunthu*. What are pronounced as biomedical psychosocial interventions are in fact the delivery of culturally embedded therapeutic approaches. Historical and socio-political evidence is offered to explain the dominance of biomedical perspectives and the HSAs’ responses and a call is made for a transformation of MGMH to embrace rich philosophies such as *Umunthu* and enact respectful, inclusive and democratic values to enlist collaborations between equals to develop relevant and effective knowledge and local responses to mental distress.

**Keywords** *Umunthu* · Malawi · Mental distress · Collaboration · Health Surveillance Assistants

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## Introduction

The aim of this article is to show how cultural, historical and contemporary perspectives of mental health beyond the Movement for Global Mental Health (MGMH) inform ways of understanding and responding to mental distress. Through the case of a mental health task-shifting initiative in Malawi as the central theme, this article examines underlying indigenous understandings that underpin positive ways of responding to peoples' experience of distress and the different lenses through which these interventions can be understood. In this article, the use of the word indigenous means the worldviews developed at a specific society, by people through their generational, geographical and traditional experiences. The word 'distress' has been adopted to describe a cumulative experience that biomedicine would term a mental health problem or mental disorder. Although it is accepted that the term is unspecific and can denote a range and severity of experience, it is also used here to acknowledge social conceptions of a phenomenon where local classifications do not differentiate biomedical categories (for instance, between disability and mental health problems). Equally, since all cultures define nosologies of cognition, reasoning, behaviour and social interaction, the terms mental illness and disorder are also used within the paper to denote such phenomena in its widest sense, despite its conspicuous link to biomedicine.

Specifically, the paper explains how the African philosophy of *Umunthu* continues to resonate as a contemporary, sophisticated yet pragmatic approach, despite—and in fact under the gaze of—western biomedical approaches in Southern Malawi. Suggestions will be advanced as to the implications of this for MGMH approaches and the importance of developing an inclusive, respectful and democratic approach to understanding and responding to distress.

## Background

Life is uncertain and impermanent (Kleinman 2019; Lindekens and Jayawickrama 2018). In response, all societies have developed their own epistemologies and approaches to dealing with these realities which are specific to the social, political, cultural, economic and environmental contexts of each society (Jayawickrama 2018; Scott 1979). And 'mental health' itself is a concept with its own socially produced history (Bertolote 2008).

Since their first global summit in Athens in 2009, the Movement for Global Mental Health (MGMH) aims to improve the availability, accessibility and quality of services for persons with mental disorders by scaling up services through the fundamental principles of scientific evidence and human rights (MGMH 2020). Yet this declaration presents a huge incongruity by on the one hand drawing much needed attention to the distress and suffering of a large proportion of vulnerable people, but at the same time presenting one medicalised worldview through which to frame these experiences (Clark 2014).

Aside from difficulties with the scientific validity of this approach, where particular ‘life problems’ are defined as mental health problems (Summerfield 2008) and are seen as most effectively responded to by ‘health services’ rather than wider social, welfare and educational sectors (WHO 2014), to assume that everyone experiences suffering in the same way has been deemed as morally wrong (Kleinman 2006). Specifically, the reluctance of biomedicine to acknowledge and explore ‘healing’ from other perspectives, because entertaining such notions “strips away the illusion that biomedical research, is the only scientific approach to healthcare problems” (Kleinman 1980:312).

For from the MGMH position (MGMH 2020), it is evident that there is at best a lack of understanding, or, at its worst, no acknowledgement that people in many countries outside Europe and North America have their own existing, sophisticated yet pragmatic approaches to dealing with life and suffering. ‘Civilizations’ as a series of global, historic and current entities are replete with examples of systematic approaches to peoples’ suffering. From Ayurveda (3300 BCE to 1300 BCE), Chinese Medicine (14th–11th centuries BCE), Persian Medical Sciences (224–651 CE) as well as other approaches in Africa (Lindekens and Jayawickrama 2018), explanations and approaches to mental health problems and challenges to the overall wellbeing of people have been developed. While the history of mainstream modern medicine can be traced to Hippocrates (400 BCE), the rise of this practice in Europe and North America only arose in the 19th Century and the contemporary concept of mental health, originating from the mental hygiene movement, was only instigated in 1908 (Beers 1937). Indeed, if health systems such as the Ayurvedic or Chinese Medical explanations on health, including mental health, or all other approaches are disregarded or erased from certain ‘histories’, it would be reasonable to ask how humanity survived the past 300,000 years before the “invention” of mental health concepts and interventions that the MGMH now advocate. But given this current ‘global’ emphasis, more specifically it may now be asked, what might be the impact of these biomedical assumptions and emphases on peoples’ experiences of ‘distress’ and on those charged with their support? Or, to what extent is the articulation of distress and the way that support is provided mediated through the lens of biomedicine or other understandings?

## Case from Malawi

Recent approaches to mental health in Malawi have aligned with the MGMH and placed an emphasis on reducing the ‘treatment gap’ through employing a combination of pharmacological and particular psychological interventions (WHO 2016). As has been shown, the deployment of pharmacological treatments and their political, socio-economic and physical effects and side effects have received often highly charged critiques, yet increasing access to such treatments has been seen as a major imperative for Malawi (Udedi 2016). However, aside from arguments as to their efficacy (overwhelmingly undertaken in high resource countries), the underlying assumptions of the ‘psychological interventions’ have, it seems, received far less attention. One initiative to promote mental health integration



within primary health care in rural Malawi provides an interesting example of the deployment of such ‘psychological’ interventions and how, through these encounters, the interaction between different assumptions and understandings of distress and effective responses can be clearly illuminated. The first author of this article (JW), a white British nurse and researcher, has worked for the last fifteen years with Non-Governmental Organisations (NGOs) and Government sectors in Malawi on a number of HIV/AIDS and mental health initiatives—including leading the primary care mental health project described here. These experiences have offered the opportunity to gain an understanding of both formal and informal help-seeking and provision within Malawian life. A Sri Lankan by birth and disposition, the second author (JJ) has been collaborating with disaster, conflict and uneven development affected communities in Asia, Africa and the Middle East over the last 26 years. He was initially trained in an individual model of psychological care but soon realised that many communities value the collective rather than the individual. He engaged with refugees in Malawi to assess the mental health and wellbeing interventions during May to November 2006. In this, he closely collaborated with traditional healers in Malawi, with whom the refugees heavily drew upon to deal with mental health challenges and improve their wellbeing. Whilst immersed in the field during each project assignment, both the authors are ‘outsiders’ to Malawi and the continent of Africa. Instead, the authors collaborated with Malawian project partners and research colleagues for direction and in-depth discussion and on our own curiosity and reflexivity based upon years researching mental health and wellbeing in different cultures across Africa, Asia and the Middle East. That said, within explorations of ‘everyday life’, there may be advantages that an ‘outsider’ may have in discerning phenomena that can in turn be subjected to interpretive and collaborative discourse with ‘insiders’ and literature. Such reflective processes may be indicated in the fact that, while engaged with Malawi in separate projects and at different times, the authors’ independent conclusions about the importance of *Umunthu* to mental health and wellbeing became the foundation for this collaborative article. This unreservedly retrospective analysis of data deriving from project participant observation notes, survey and interview data and contemporary research literature places the method as accidental ethnography (Leviton, Carr-Chellman and Carr-Chellman 2017). The explicit focus on past information and experiences and, through reflexive discussion, to develop theory and practitioner knowledge, serves an ethnographic purpose to influence future directions – in this case, the strengthening of mental health support.

A district-wide task-shifting project utilised village-based health workers—Health Surveillance Assistants (HSAs)—to undertake mental health assessments, interventions and health promotion in an area previously renowned for its limited resonance of psychiatry (Steinforth 2009). Within the community, the identification and treatment of persons with *misala* (madness) or other mental health problems were managed as they have done for centuries through both family and community resources. Formal structures of traditional authorities, from healing approaches derived from Traditional African Religions and from Christian Churches provide the recognised care. Within the initiative, the determination of ‘mental illnesses’ was based on HSAs’ assessment of level of ‘distress’ and ‘risk’ (to themselves and



others), and there was no attempt to offer a psychiatric diagnosis (Wright and Chiwandira 2016). The training of HSAs did, however, incorporate education on common mental health problems, psychosis, epilepsy and intellectual impairment; approaches to assessment of peoples thoughts, feelings and behaviour, their context, vulnerability and strengths; and interventions ('responses') in the form of listening, identifying the problem areas, sign-posting to further help locally and through government health services and providing emotional support individually (counselling) and group support. The key interventions, offering individual psychological and emotional support and mobilising community psychosocial resources, were essentially community based and matched psychosocial packages of care commonly designed for low resource settings (Lund, Tomlinson and Patel 2015).

From the evidence of engagement and outcomes, the project showed that HSAs were able to offer a practical and acceptable health model for mental health promotion and care and was seen as contributing to the evidence-base for the benefits of a biomedical approach. Yet closer analysis through a further qualitative study (Wright and Maliwichi-Senganimalunje 2019) revealed a more complex and nuanced picture. The pluralistic nature of mental health attributions and help seeking were clearly operating, with both patients and HSAs retaining a veiled and apparently ambivalent relationship with traditional forms of healing. Patients consulted traditional healers but were not inclined to disclose this to biomedical health professionals, yet health professionals themselves both accessed traditional healers for their own ills and felt the need to ignore or denigrate any patients' use of traditional healing, even where interventions had proved a success (Wright and Maliwichi-Senganimalunje 2019). So given this pluralistic context, where different positions and approaches to healing coexist, it seems appropriate to look again at the 'mental health interventions' that the HSAs had employed in their work with patients in distress. The data reveal that three interventions in particular were most prominent:

1. Practical assistance mobilised through community structures and governance—e.g. keeping people safe from harm, tracing guardians, accessing food, shelter through chief/elders.
2. 'Counselling'—e.g. providing advice on lifestyle (reducing drinking alcohol or smoking *chamba* (marijuana) and advice to gain spiritual support and guidance),
3. Encouragement to join support groups, community gatherings and activities. (Wright and Chiwandira 2016:593).

It was clear that each of these interventions can be articulated from a biomedical mental health perspective (WHO 2016) and derive from the range of 'psychosocial mental health interventions' consistent with a MGMH approach. However, given the pluralistic context that HSAs were a part, there may be something more to the prominence and repeated use of these interventions which suggest that the HSAs hold particular attachment and significance not fully explained by an allegiance to the biomedical model. Indeed, defining the activity of HSAs in these interventions through the lens of a global mental health psychosocial intervention may be a less than convincing description. Clearly, 'psychosocial interventions' are not exclusive to one epistemology and will carry different meaning and emphasis. Kleinman

(1980) points to the interrelated nature of health care activities where the healing process (in this case particular ‘psychosocial interventions’) does not exist outside of a health system which includes an understanding of the illness experience and patient-practitioner transaction (p. 24). For, if the HSAs (and patients) were drawing on existing indigenous knowledge—whether from traditional structures or spiritual understandings—where does this come from and what informs and sustains this approach? How do these approaches resemble or differ from a biomedical approach? And, might the articulation of interventions through MGMH terminology and classifications be obscuring indigenous philosophies, ways of understanding distress and helping approaches much closer to home and which carry their own assumptions and interventions? A response must surely begin with an exploration of the existing philosophy of *Ubuntu* (or in Malawi, *Umunthu*) ubiquitous throughout the country and the rest of sub-Saharan Africa.

### Defining *Umunthu*

“A person is a person through other persons. None of us comes into the world fully formed. We would not know how to think, or walk, or speak, or behave as human beings unless we learned it from other human beings. We need other human beings in order to be human.”

Tutu, 2004:25.

The word *Umunthu* is derived from an Nguni (isiZulu) aphorism: *Umunthu Ngumuntu Ngabantu*, which can be translated as “a person is a person because of or through others” (Moloketi 2009:243; Tutu 2004:25–26). *Ubuntu* can be described as the capacity in an African culture to express compassion, reciprocity, dignity, humanity and mutuality in the interests of building and maintaining communities with justice and mutual caring (Khoza 2006:6; Luhabe 2002:103; Mandela 2006:xxv; Tutu 1999:34–35).

Samkange and Samkange (1980) highlight the three sayings of *Umunthu*. The first saying asserts that to be human is to affirm one’s humanity by recognising the humanity of others and, on that basis, establish respectful human relations with them. And the second saying offers that if and when one is faced with a decisive choice between wealth and the preservation of the life of another human being, then one should opt for the preservation of life. The third saying is a principle deeply embedded in traditional African political philosophy that says that the ruler owes their status, including all the powers associated with it, to the will of the people under them.

*Umunthu* can be considered as both an expressive account of value systems that operate across much of Sub-Saharan Africa as well as a normative philosophy of how people should relate to one another. These perspectives contain three points that are relevant understanding the conceptualisation of mental health and wellbeing in Sub-Saharan Africa.

1. Interconnectedness: *Umunthu* as a philosophy can only be operationalised through relationships. The expression, *I am because we are*, is the best example of this aspect. This points towards an individual's sense of being cannot be separated from the family, community and social context. It also highlights the importance of a subjective and emotional appreciation of human experiences including disasters, conflicts and uneven development.
2. Inclusion: As a collective philosophy and operational methodology, *Umunthu* promotes the oneness with everyone and everything around the individual. In this realisation, compassion, care, respect and dignity are shared values. *Umunthu* advocates the moral value of the importance of collaboration in the face of crisis. It is important to understand that in a region where populations have experienced colonial looting, social, political, economic, cultural and environmental disorder, the collective action and mutual assistance have been essential for survival.
3. Inter-relationships: *Umunthu* provides a pragmatic framework for the relationship between the individual and the collective. Within this framework, there is no space for dissecting life into fragmented pieces but to realise life in inclusion. This realisation of inclusion does not facilitate an understanding of mental health as a separate concept, but as an integral part of wellbeing of the individual that exists within the collective.

Unsurprisingly with a philosophy so central to the culture of the world's oldest human civilisation, it is impossible for any scholar to convey every characteristic and component of *Umunthu*, not least due to its essentially oral tradition and lack of written commentaries (Nussbaum 2003). However, this examination of *Umunthu* within interconnectedness, inclusion and inter-relationships, highlights the collective agency that supports the individual and where the operationalising of separate 'mental health interventions' represent unfamiliar terrain.

The facilitation of compassion, reciprocity, dignity, and mutuality is an internal process within the individual to realise that we share a common humanity. A person who possesses *Umunthu* attitude is capable of compassion, reciprocity, mutuality and caring for their fellow human beings without discrimination (Goduka 2000). In this understanding, the realised person of *Umunthu* is capable of dealing with external challenges of life including gender, class, social structures, disasters, conflicts or uneven development. This goes beyond the social, political, economic and cultural structures of the community.

Although an ancient philosophy, *Umunthu* also represents a contemporary approach to living (Bandawe 2010). And while, as in any culture, there are traditional lines of thinking and expression, these are continually influenced by wider social changes, such as from globalisation or moves to urbanisation, which demand a re-examination of people's lives, of their relationships with others and their environment. Culture is "neither homogenous, nor determinative nor unchanging" (Kleinman 1995:58) and active 'cultural engagement' has been shown to shed light into challenges of contested issues like gender, age and illness. Scholars such as du Plessis (2019) for instance have demonstrated that *Umunthu* provides a community-centred and collective sense of care, which can be operationalised into dealing with gender-based challenges, with principles of

*Umunthu* being incorporated into practical programming to prevent gender-based violence and improve human security (du Plessis 2019). Similarly, Benhabib (2003) and Masolo (2010) have shown the potential of *Umunthu* as a philosophy beyond mental health and wellbeing to assist with developmental challenges such as urbanisation and globalisation where the lives of communities can be positively transformed.

### ***Umunthu*: Understandings of Mental Health and the HSAs' Interventions**

As a 'life force', it can be seen that every living person possesses *Umunthu*, and this is realised within their own internal capacities. While there are some differences of interpretation as to whether a person can be alive without it, one strand of traditional thought in Malawi suggests that mental illness temporarily affects *Umunthu* (Steinforth 2009). "*Mzimu wa umunthu*" literally means a de-socialisation where a person retains their vital life force but no *Umunthu*. However, a person's *Umunthu* can be redeemed dependent on the cause of the current difficulty. Any mental disorder can be attributed to a number of different causes from social factors to internal functions. In traditional medicine in Malawi, a diagnosis is achieved once the traditional healer (a *sing'anga*) has identified the origin (or culprit, if bewitchment is suspected), the affected person takes prescribed potions, and the person or family have undertaken the required ritual. If the cause is diagnosed from moral transgression (going against traditional *miyambo*), then the traditional healer will advise on particular combinations of herbs, potions and rituals. If, however, the origin of the mental illness is considered God's will, then this may be seen as more difficult to treat (and 'palliative', since no man can overturn God's will) but nevertheless re-gaining a person's *Umunthu* remains the goal. For example, in situations of epilepsy (*khunyū*), thirty different remedies are variously effective (Steinforth 2009).

Clearly, living communally and holding as vital particular ways that a person should behave in his or her personification of *Umunthu* is a significant factor that differentiates perceptions of effective treatment from much western and biomedical approaches where the individual is treated. Traditional healers treat the whole person/family/community in a collective healing process. Indeed since 'formulations' include understanding and identifying the source of the problem, a person is not considered treated until having undertaken traditional rituals that satisfy social requisites (Kirmayer 2004; Steinforth 2009).

In the same way, the practical interventions the HSAs employed to engage and mobilise support through the existing traditional and community structures appear to access the 'moral economy' (Scott 1979) of the community. The traditional systems of exchange, reciprocity and social insurance are accessed and underpinned by *miyambo* on an individual and collective basis. As a result, through village chiefs, clan-based distribution and village health committees, HSAs were able to respectably and successfully access patronage for their patients in the form of

protection, food, shelter, money and the assistance of family or community elders, with the positive benefit this will have to their ‘mental health’.

Within such a setting, the HSAs’ intervention of counselling too becomes adapted to its cultural context. A person in distress is looking for a way to relieve their distress and—in the European and North American culture from which humanistic psychotherapy has derived—this is seen as most effectively achieved through a non-judgemental non-directive approach whereby a person generates their own solutions to their difficulties (Rogers 1961). However, in less individualistic cultures, the solution may be better informed through a reminder of his or her place within the community and reinforced by the importance of *miyambo* as a way of regaining *Umunthu*. The fact that *Umunthu* fundamentally involves behaving in a way that promotes the harmony, and wellbeing of the group informs this more directive form of counselling that the HSAs employed. Hence, within the community, the HSAs hold and are perceived to hold a certain knowledge and expertise around ‘health’ means that they are obliged (through *Umunthu*) to share this wisdom and advice. For within the collective cultural setting, there is an individual responsibility and duty towards everyone within the community, which allow the HSAs to advise, guide and directly be involved in the lives of the people that are seeking help. Of course, this is a messier and more complicated affair than the individualistic counselling model proposed by Rogers (1961). Normal and shared practices of this type are so troubling to ‘outsiders’ precisely because what looks so wrong from the outside, does not look that way from ‘within’—from the perspectives of HSAs and their patients (Kleinman 2006).

Finally, a commonly mistaken stereotype in such cross-cultural comparisons is the notion that, given the communal inclination of a Malawian, their treatment for mental illness needs to involve collective or group approaches. While a surface understanding of *Umunthu* accurately points to the general command that it values communal notions of living in contrast to the alternative individual-centric western approach, and therefore obliges group and community support responses—‘convenient’ also where resources are limited! A closer study of *Umunthu*, however, reveals a far more sophisticated and multifaceted philosophy that never loses sight of the individual in their relationship with others. Wilson and Williams (2013) note that in Akan philosophy originating from West Africa, the ontological completeness of the individual is centred in the appreciation of his/her obligation to members of their group while his/her individuality is in no way displaced by the collectiveness of the group (Gyekye 1996). Thus, although HSAs established many group interventions—health promotion and support groups—the tight facilitation, didactic presentation and scrupulous respect for hierarchies of age, gender and community status made the events very different from the egalitarian/person-centred and demonstrably challenging support groups in western societies. Yet again, such styles of facilitation and group processes reflect the nature of *Umunthu* and what it is to be simultaneously offering and receiving support in a collectivist culture. Crucially, since it is through our own cultural lens that we see and interpret the world, gain our understandings of mental illness and how best to respond, any effective interventions must draw on these substantive and nuanced understandings.

## What Can We Learn from These Experiences in Malawi?

MGMH approaches to mental health problems can provide value, as evidenced in many parts of the world, but through closer examination of a specific task-shifting initiative, this paper has begun to expose the integral assumptions operating within the therapeutic interactions between patient and health worker. Adopting an exclusively biomedical framework around the causes, experience of and response to distress when people's cultural lens differs risks alienating the 'distressed' from the helper. Future exploration with HSAs themselves would elaborate further the nature and properties of the interventions they are employing, through which it is envisaged adaptations, derivations and "often contradictory and inconsistent" experiences will expose new ways to understand and provide support for people in distress (Siddiqui, LaCroix and Dhar 2014:294).

For while what drives the universalistic assumptions about effective responses to distress has been examined and critiqued for two decades, the explanation for why local health workers such as HSAs act in this way may be equally revealing. Mills (2014) speaks of the 'pretending' of patients confronted with the power of the psychiatric gaze—and links this to the mimicry and subversion of the colonised. Perhaps the same is happening here for HSAs: they are operating a 'sly normalisation' and 'invisibility', whereby what may be heralded as biomedical interventions are in fact the delivery of culturally embedded therapeutic approaches. For the HSAs, practical help is marshalled through traditional structures, counselling becomes advice to provide the person hope and a steer, and support groups become more than providing a safe place for emotional exchange, to a forum for the enactment of values, reflection and reinforcement of *Umunthu*; of positive social capital and obligation.

These responses are entirely functional and embedded in the language and culture in which Malawians operate, and, just as in other societies and cultures, they derive from a rich seam of indigenous philosophy and knowledge that represent ways to promote wellbeing and personhood so that collective norms and values can survive in a globalised world. Interestingly, Mills has recently noted a similar departure from theory to enactment in mhGAP interventions in India (Mills and Lacroix 2019).

Indeed, this recognition of difference is vital for any 'movement' seeking to extend a reach across the globe. As this paper reminds us, communities around the world provide a large treasury of knowledge and understandings that need to be not only acknowledged but also engaged with. The alternative risks a repeat of the colonial endeavour. For while from a political and ideological perspective, the membership and structure are somewhat different, there are parallels between the MGMH and the colonial project where, originating from a European context, local societies, cultures and most importantly knowledge systems are looted and destroyed. The discrediting of the 'local' and replacing with the 'scientific' mimic colonialism (Fernando 2014), as people are cutoff from indigenous knowledge and agency.

The statement by Macaulay—the British politician and historian, dated the 2nd February 1835—sums-up parallels between the MGMH and the colonial project. His words also unwittingly alert us to the chilling danger of producing certain types of ‘interpreters’:

“I have never found one among them who could deny that a single shelf of a good European library was worth the whole native literature of India and Arabia. ... neither as the languages of law nor as the languages of religion have the Sanscrit and Arabic any peculiar claim to our encouragement. We must at present do our best to form a class who may be interpreters between us and the millions whom we govern,—a class of persons Indian in blood and colour, but English in tastes, in opinions, in morals and in intellect.”

(Macaulay 1835).

From: Bureau of Education. Selections from Educational Records, Part I (1781–1839).

From a political ecology perspective, Macaulay’s statement explains the way that the colonial project shatters the relationships between social, political, cultural and economic structures and the environment of the colonies (Castro-Gomez 2003; Said 1994; Mudimbe 1988). Similarly, the biomedical approach to health facilitates a strong disconnection between the human systems and the environment (McLeod 2000; Brown 1985; Illich 1976), instead installing a particular epistemology and frame.

An incident during a workshop with different stakeholders in Malawi facilitated by the first author (JW) to design the bespoke HSA mental health curriculum illustrates the same assumed status of different epistemologies and the embodiment of a new ‘interpreter’ role by local mental health professionals. Traditional Chewa culture includes a number of *miyambo* that reflect the *Umunthu* philosophy of respect for personhood instructing people not to ridicule or denigrate people with disabilities. Traditional proverbs encourage the social integration of people with mental health problems and even ascribe particular value and competence (Steinforth 2009). However, a suggestion to refer to such instruction as a part of anti-stigma messages within the HSA curriculum was immediately dismissed by all mental health professionals present as not suited to an evidenced biomedical position. It was clear that a local protective measure for the disabled was being disparaged and dismissed, with the loss of a potential bridge between epistemologies. At the same time, the mental health professionals openly expressed concern that their own status, and that of the HSA mental health curriculum, would be negatively perceived if it was in any way associated with traditional ways of thinking. So, whilst genuine and heartfelt, the health professionals’ concern for patients was being expressed through the modernising mission or colonising of biomedicine and silencing of traditional knowledge (Ibrahim 2014).

For what is important here was the lack of room for discussion and debate. Biomedicine is underwriting a process of cultural change and devaluation of traditional instructions without consideration that “services (should) reflect the beliefs and practices of local people” (White and Sishidharan 2014:416). Instead MGMH terminology and classifications are obscuring indigenous philosophies, ways of understanding distress and helping approaches, of which *Umunthu* is just



one example. By contrast in the real world, in communities, HSAs do not have the luxury of adopting learned or elevated positions, and instead use their versions of psychosocial interventions to engage with problems as their community sees them and drawing on culturally embedded knowledge and approaches to inform their support for distressed people. Here, *Umunthu* is presented, not as an unqualified elucidation of a philosophy for positive mental health, but simply as the cultural framework underpinning the lives of local people. If MGMH approaches are to live up to their promise of promoting mental health and reducing suffering across the world, then a dialogue needs to happen in a manner that shows a willingness to collaborate as equal partners (Kirmayer and Pederson 2014; Campbell and Burgess 2012) where questions are asked rather than always providing answers.

While attempts to widen the range of scientific disciplines within the MGMH evolution have been evident (Bemme and Kirmayer 2020) and are reflected in part by the emergence of particular psychosocial interventions in publications like the *mhGAP* intervention guide (WHO 2016), it nevertheless retains a disease-orientated model with psychocentric and related therapeutic assumptions. Instead a meaningful and concerted approach to understand the fundamental philosophical basis and cultural norms of a community, based on humility, openness and respect, would provide the platform for a different kind of ‘movement’ that would demonstrate a more democratic and inclusive dialogue from which to develop responses that contribute rather than depreciate or eclipse local indigenous healing.

## Conclusion

This article has demonstrated how HSAs have responded to people’s distress with psychosocial interventions that are attuned to their patients’ cultural framework of *Umunthu* and have done so under the gaze of a biomedically informed mental health initiative. For the person in distress and the HSA, their sense of being cannot be separated from their own sense of personhood within the family, community and social context. The authors acknowledge the contribution of the biomedical model and appreciate that the individualistic clinical model of psychological care provides helpful insights and directions. However, the argument here is that the biomedical model is demonstrably not the only model of care informing mental health interventions yet it has become the authoritative understanding of distress deriving from all uncertainty and dangers in life. Like the colonial project, it assumes superiority to all the other models of care and its domination functions on different levels and through various methods that focus on the individual without understanding the social, political, cultural, economic and environmental contexts. As a frontline organisation spreading this ‘gospel’, the MGMH has the capacity not only to form a class of “interpreters” but also to destroy the existing philosophies and knowledge systems that remain rooted and relevant to local populations. Resisting such destruction and preserving and mobilising these indigenous understandings become a question of social justice (Croft et al. 2016). For, as Bertolote (2008) argues, mental health is more than a scientific discipline and instead has strong political and ideological origins that seek to promote human rights and quality care for all. In this, a truly respectful collaboration as equal partners with



village health workers, traditional healers, faith practitioners and witch doctors is possible. Such collaboration will allow the ‘external’ biomedical practitioners and ‘internal’ healing practitioners to learn from each other and together develop responses to distress that are most effective and relevant to the populations they serve.

### Compliance with Ethical Standards

**Conflict of interest** On behalf of all authors, the corresponding author states that there is no conflict of interest.

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## **GLOSSARY**

AIDS	Acquired Immune Deficiency Syndrome
CHAM	Christian Health Association of Malawi
HIV	Human Immunodeficiency Virus
HSAs	Health Surveillance Assistants
LGMHG	Lancet Global Mental Health Group
LMICs	Low and Middle Income Countries
MGMH	Movement for Global Mental Health
mhGAP	Mental health treatment gap
MHiZ Project	Mental Health in Zomba Project
MoH	Malawi Ministry of Health
NGO	Non-governmental Organisation
TB	Tuberculosis
UK	United Kingdom
WHO	World Health Organisation
WONCA	World Organisation of Family Doctors

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