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Article

Understanding the benefits and challenges of community engagement in the development of community mental health services for common mental disorders: Lessons from a case study in a rural South African subdistrict site

Inge Petersen and Kim Baillie
University of KwaZulu-Natal

Arvin Bhana
Human Sciences Research Council, South Africa and University of KwaZulu-Natal

Mental Health and Poverty Research Programme Consortium[1]

Abstract

Against the backdrop of a large treatment gap for mental disorders in low- to middle-income countries (LMICs), the 2007 Lancet series on global mental health calls for a scaling up of mental health services. Community participation is largely harnessed as one strategy to facilitate this call. Using a participatory implementation framework for the development of mental health services for common mental disorders (CMDs) in a rural subdistrict in South Africa as a case study, this study sought to understand the benefits and challenges of community participation beyond that of scaling up. Qualitative process evaluation involving interviews with service providers and users was employed. The results suggest that in addition to promoting mobilization of resources and actions for scaling up mental health services, community participation can potentially contribute to more culturally competent services and personal empowerment of recipients of care. In addition, community participation holds promise for engendering

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Corresponding author:
Inge Petersen, School of Psychology, Howard College, University of KwaZulu-Natal, Durban 4000, South Africa.
Email: peterseni@ukzn.ac.za

community-led public health actions to ameliorate some of the social determinants of mental ill health. Challenges include that community members involved in these activities are mainly marginalized women, who have limited power to achieve structural change, including cultural practices that may be harmful to the mental health of women and children. We conclude that in addition to contributing to scaling up mental health services, community participation can potentially promote the development of culturally competent mental health services and greater community control of mental health.

Keywords
community participation, mental health, low-income countries, middle-income countries, culturally competent services, community control

Introduction

There is a large treatment gap for mental disorders in LMICs, with 70% of African countries contributing less than 1% of their health expenditure to mental health (World Health Organization, 2005). In the context of the increasing burden of disease posed by mental disorders (Prince et al., 2007), the call to scale up mental health services in LMICs was given impetus by the landmark 2007 Lancet series on global mental health. Community participation was largely emphasized as a strategy to facilitate scaling up. Strengthening and mobilization of user and carer groups was highlighted to bolster advocacy for raising the public health priority of mental health. Capacity building of community members and the families of people with mental disorders to more effectively care for people with mental disorders was also emphasized to supplement formal health care. Less attention was given to promoting acceptability through engendering greater cultural competence of services or to promoting empowerment of individuals, families, and communities to have greater control over their mental health. We deal briefly with both.

With respect to cultural competence, services are more likely to be acceptable if they are responsive to explanatory models of illness and social realities of communities served (Feierman, Kleinman, Stewart, Farmer & Das, 2010). This requires service providers to be reflective of their cultural incompetence (Swartz, 2007) and open to including community members' voices in the development of packages of care. Community members can provide meaningful insight and local knowledge on interventions that may mediate pathways to health. In addition, understanding different explanatory models of illness provides the platform to begin to negotiate collaborative treatment (Kleinman, 1980). While consensus on intervention approaches may not always be possible given different world views, planning together and the establishment of workable relationships between the different systems of healing is, however, of prime importance in the quest for culturally competent services (Swartz, 2007). Biomedically trained service providers may not always be supportive or understanding of the cultural and social realities of service users. Education of healthcare providers from both traditional and Western systems of healing and culture-centred care involving illness negotiation are important (Katon & Kleinman, 1980), as are referral pathways between the two systems of healing (Campbell-Hall et al., 2010). Indeed, Simon, Chang, and Dong (2010) argue that developing culturally competent services is an ongoing process that requires health professionals to enter into conversations with patients, communities, colleagues, and themselves. Given the power relations that operate between researchers/health staff and community members, formalizing community participation in the development and delivery of services is important to ensure that community voices are heard (Feierman et al., 2010). This requires specific organizational, system, or service attributes (Garrett, Dickson, Whelan, & Roberto, 2008).

With respect to community control, in addition to the practical value of participation of community members in self-help groups, community participation provides opportunities for greater individual and collective control of mental health. Using Carpiano's (2006) understanding of social capital, at an individual level, supportive social networks afforded by self-help groups provide opportunities for increased social support and personal empowerment which is protective of mental health (Rappaport, 1985). There is ample evidence of the role of social support in promoting mental health (Brownwell & Schumaker, 1984) through the provision of emotional support such as empathy and caring; instrumental support such as lending resources; informational support in the form of information, suggestions, and advice; and appraisal support such as constructive feedback (Heaney & Israel, 1997). Enhanced social capital as a result of increased social networks also provides opportunities for social leverage which may provide opportunities for accessing opportunities. This may assist in addressing the social determinants of mental ill health for individuals in marginalized communities, promoting social inclusion through opportunities to develop new skills, income-generating opportunities, etc.

When individuals and communities engage collectively in thinking, discussing, and helping one another with mental health and social problems, they are also more likely to develop collective agency to act on their problems and environment (Campbell & Murray, 2004), thus developing greater efficacy to exert control of mental health within their communities. Using Carpiano's (2006) understanding, this would involve public health actions to create more health-enabling environments through increased informal social controls and activities or through more formal channels which provide opportunities to begin to address the structural drivers of mental ill health. In both instances, community engagement engenders increased control of mental health, individually and collectively, which may involve public mental health efforts as well as increased efforts to improve access to mental health services. Indeed, Kleintjes, Lund, Swartz, Flisher and The Mental Health and Poverty Project (MHaPP) (2010) suggest that community participation holds potential for enhancing social inclusion and reducing stigma and discrimination through empowering those with mental disorders and their families to manage and change their social environments towards being more socially inclusive.

The need to embrace these opportunities is amplified in scarce resource contexts. The rate of mental disorders is highest in economically marginalized populations, especially the least educated, women and young people (Saxena, Thornicroft, Knapp, & Whiteford, 2007). Financial stress, low education, and food insecurity play an important role in the development of common mental disorders (CMDs) (Lund et al., 2010). While the notion of empowerment of communities to take responsibility for their own health has received criticism for being a smokescreen for the lack of service provision (Cornish & Campbell, 2009; Swartz, 2008), on the other hand, the absence of capacity development has the potential to entrench dependency on overstretched healthcare services.

In summary, as emphasized in the 2007 Lancet series, community participation is important for scaling up mental health services. In addition, we suggest that it is also important for promoting culturally competent services and engendering greater community control of mental health.

Using a participatory implementation framework for the development of mental health services for common mental disorders (CMDs) (see Table 1) in a rural scarce-resourced subdistrict in South Africa as a case study, the aim of this study was to understand the benefits and challenges of community participation beyond that of scaling up, especially promoting culturally competent mental healthcare and greater community control of mental health.

Background to mental health services in South Africa, project setting, research approach, and implementation framework

Background to mental health services in South Africa

With the shift to a democratic political dispensation in 1994, the concept of universal primary healthcare became central to the restructuring of healthcare (Department of Health, 1997a). In keeping with this, South Africa embarked on a programme of de-institutionalization and integration of mental healthcare into primary healthcare. This is framed within the first postapartheid policy guidelines for mental health (Department of Health, 1997b) and more recently stipulated in the new Mental Health Care Act, No 17, of 2002 (MHCA) (Department of Health, 2004). Progress and remaining challenges with respect to these policy and legislative imperatives include that: (a) decentralization and integration efforts focused largely on severe mental disorders, which are largely chronic and recurrent and result in a high disability for sufferers and their families (Lund, Kleintjes, Kakuma, & Flisher, 2010); (b) there is still a large treatment gap for common mental disorders (CMDs), mainly depressive, anxiety, and substance use disorders (Seedat et al., 2008), also mirrored in the study site in the KwaZulu-Natal province (Petersen et al., 2009); and (c) despite stakeholder, legislative, and policy support for user participation in mental health policy development and service implementation, actual user participation in these processes in postapartheid South Africa has been poor (Kleintjes et al., 2010).

Table 1. Participatory implementation framework

Components of participatory framework	Purpose	Activity	Output
Establishment of a multisectoral community collaborative forum	1. To provide a forum to create awareness of mental ill health 2. To mobilize resources from stakeholders 3. To ensure political support and legitimacy from community leaders for the research and interventions at a community level 4. To provide a forum for discussion of possible collaborations between service providers and interventions and research to ensure they were in line with beneficiary needs so as to ensure acceptance, feasibility, and sustainability and enhance beneficiary use value	1. A District Mental Health Advocacy Group (DMAG) was formed comprising key managers and service providers from the provincial, district, and local departments of health, representatives from the provincial and local departments of social development, local schools, local South African police services, local municipality, and the research institute through which we worked in the area. Community representatives included community health workers, traditional healers, community leaders 2. Met 3–4 times a year	1. Raised awareness of the importance of mental health at community meetings 2. Facilitated meetings of western and traditional practitioners 3. Provided guidance on the focus of the interventions which was on common mental disorders (CMDs) and specifically depression 4. Mobilized resources for mental health services • More dedicated specialist resources for mental health (2 additional nurses and a permanent post for a psychologist) • Community hall for depression groups
Involvement of service users and service providers in the development of interventions	To promote culturally competent services that were responsive to the existential dilemmas of marginalized communities	In-depth focus group discussions and consultations were held with PHC clinic service providers and users as well as CHWs. This was to understand factors influencing the onset of depression and help-seeking behavior amongst women to inform the most appropriate treatment modality and service delivery approach	The development of an adapted peer-facilitated group intervention based on the principles of interpersonal therapy (IPT) for people with depression in the area

(continued)

Table 1. Continued

Components of participatory framework	Purpose	Activity	Output
Capacitating existing community health workers with knowledge and skills to identify and assist people in mental distress in the community through referral, counselling, the establishment of self-help support groups or other community interventions	To facilitate greater community involvement and control of mental health	1. Thirty existing CHWs who serviced the area were trained in the identification of depression, supportive counseling, and problem management over 4 days 2. Monthly group-based debriefing and supervision of existing CHWs	1. Three self-help groups for people with CMDs were formed by CHWs providing peer counselling and income-generating projects
Capacitating community members to deliver peer-facilitated psychosocial interventions	To facilitate greater community involvement in mental healthcare	1. Two community members were trained to facilitate the adapted psychosocial support groups for people with depression over 4 days 2. Weekly debriefing and in-service training provided to the community members facilitating the psychosocial support groups	1. Four 12-week psychosocial support groups for women with depression (30) were facilitated by trained community members

Project setting

The study was part of the Mental Health and Poverty Project (MHaPP), a multisite research programme consortium focused on understanding how policy development and implementation could contribute to breaking the cycle of poverty and mental ill health (Flisher et al., 2007). Located in northern KwaZulu-Natal, on the eastern seaboard of South Africa, the subdistrict case study site is fairly typical of most rural areas, having large variations in population density, with township, peri-urban, and more remote rural areas. The bulk of the project activities fell within a Demographic Surveillance Area (DSA) within the subdistrict which collects demographic and health information on a regular basis with the view to monitoring and tracking health threats. These areas also provide sites for action-oriented research aimed at testing and evaluating health interventions. The DSA area had a population of 85,000 resident and nonresident people at the time of the investigation, and was serviced by six primary health care clinics linked to a subdistrict hospital (Tanser et al., 2008).

Participatory implementation framework for the development of district mental health

The project facilitated community participation in the development of district mental healthcare using the framework outlined in Table 1. The framework comprised four components: (a) the development of a community collaborative multisectoral forum, called the District Mental Health Advocacy Group (DMAG) to create a dialogical space for different stakeholders, raise awareness of mental illness, mobilize resources for mental healthcare, ensure political support and legitimacy of interventions from the community, and identify intervention priorities in line with beneficiary needs; (b) involvement of service users and service providers in the development of interventions to enhance cultural congruence of services developed; (c) capacitating and supporting existing community health workers (CHWs) with knowledge and skills to identify and assist people with CMDs in the community through referral, counselling, the establishment of self-help support groups, or other community actions to increase community control of mental health; and (d) training and supporting community members to run peer-facilitated specific psychosocial interventions within a task-shifting approach. The provision of technical and emotional support for CHWs and trained community facilitators, highlighted in the Lancet series (Saraceno et al., 2007), was also provided. The actions and outputs of the implementation of this framework are described in Table 1.

Methodology

Qualitative process evaluation methodology was used to develop an understanding of the successes and challenges of using the participatory implementation framework to promote the participatory outcomes of culturally competent services as well as community control of mental health.

Participants and data collection

Purposive volunteer sampling was used to gain the perspectives of a range of stakeholders involved in the delivery and receipt of services. Focus group interviews (four) were held with a sample of community health workers (15) who had been trained in the identification and management of CMDs through supportive counselling, problem management, and establishment of self-help support groups.

Individual interviews were held with the two community members who were trained to facilitate a specific psychosocial group intervention, as well as nine of the participants from these groups. A total of 29 community members were interviewed. In addition, interviews were held with four primary health care (PHC) clinic nurses, two psychiatric nurses servicing the district referral hospital, a mental health counselor, the provincial and district mental health coordinators, and community representatives (two) on the DMAG.

Interview questions varied depending on the stakeholders being interviewed, but focused on exploring the utility of the intervention they had been exposed to in relation to people's social realities and needs, helpfulness to beneficiaries, and whether it had promoted greater community control over mental health in the area. Key challenges still confronting the various stakeholders were also explored. Interviews were conducted by research assistants who all had psychological training to various degrees. Interviews were recorded and transcribed verbatim. Those conducted in isiZulu were translated into English and back-translation checks applied by an independent bilingual English–isiZulu speaker to ensure correctness of the translations (Birbili, 2000).

Data analysis

The data collected on each intervention was analyzed separately using thematic analysis. More specifically a framework approach was used (Lacey & Luff, 2001) with the assistance of NVIVO8 (NVivo qualitative data analysis software, Version 8). This approach incorporates five stages of familiarization; development of a thematic framework; coding or indexing; identification of themes or charting; and interpretation (Lacey & Luff, 2001). The thematic framework was developed using the participatory outcomes that guided the line of questioning in the interviews described above. Feedback meetings were held with the various stakeholders that participated in the interviews to substantiate interpretation of the data.

Ethics

Ethical approval was obtained from the University of KwaZulu-Natal Research Ethics Committee. Informed consent was obtained from each participant prior to the interviews which included information ensuring the anonymity of the data, the usefulness of their participation for informing the development of district mental health services, what the interviews would entail, as well as confirming the voluntary nature of their participation in the interviews.

Results

The findings are grouped according to the different interventions within the participatory framework.

Establishment of a community collaborative forum

The DMAG functioned in the first instance, to strengthen awareness and mobilization of resources for mental health from within the health sector and by community leadership structures. Both were fairly well represented throughout the duration of the project. At the health facility level, during the life of the project there was an increase in dedicated human resources for mental health. An additional two nurses were dedicated to mental health and a full-time post for a psychologist was created. Greater awareness amongst community representatives of the importance of mental health also translated into mobilization of community resources. Through community representatives on the DMAG, community leadership structures identified and made available a community hall for project activities.

Second, the DMAG provided a space for dialogue between western biomedical health practitioners and traditional healers, with at least one meeting being organized between the two sectors of healing to discuss collaboration. Third, through the DMAG, the focus on depression in women for the development and delivery of the specific psychosocial intervention, was decided upon, ensuring that this was in line with beneficiary needs. Regular feedback to community leadership structures by community representatives on the project activities also ensured political support.

Involvement of community members in the development of specific psychosocial interventions for CMDs

Involvement of community members in the identification and development of an appropriate psychosocial intervention for depression through stakeholder consultations resulted in the adaptation of a manualized group-based interpersonal therapy (IPT) approach. The quotation below suggests that the manualized intervention was indeed responsive to the cultural and social realities of the beneficiaries of the intervention:

> The manual was very helpful because it spoke about things that we have experienced . . . it went hand in hand with what we were dealing with . . . it was as if you saw what was in us and then put it in that book. It assisted us a lot. (Group participant)

Capacitating community members to deliver specific psychosocial interventions for CMDs

Participants reported that having peers facilitate the psychosocial group interventions was nonthreatening and enabled them to share their own stories. There was a sense that they would be understood, given that they shared similar circumstances.

> I thought it was great to have it [the programme] delivered by ordinary people who are not that different from me, not like doctors or nurses. (Group participant)

> There was no *downsizing* [emphasis added] of anyone ... we all sat quietly and listened then we gave our suggestions one by one. That is what I think helped me. (Group participant)

Having group members in the psychosocial group intervention who shared similar cultural and social challenges was also reported as helpful in that they were able to share approaches to dealing with issues and situations that were congruent with their existential realities. As the following excerpt reveals, in the context of prevailing cultural and patriarchal realities, and where economically marginalized women are often dependent on men, the group participants assisted in ameliorating a group member's distress, helping her to cope with her husband's polygamy. In the context of women's lack of access to symbolic (perceived respect and recognition from others) and economic power, challenging the situation was deemed impossible and, as suggested in the excerpt below, may even have potentially aggravated the woman's situation.

> There is a woman who lost her cattle in a group. But the cattle were taken by her husband and her sons to go and pay for another wife. The woman confronted her husband but the husband said they are going to look for the cattle. Then she went to the police. The family of the second wife hid the cattle. Then the woman told the group that she is very hurt. The [other] women in the group advised her to calm down because this is a family matter. Because if she doesn't calm down she might find herself doing more harm than good ... The woman really got help because she said that the situation at home is serious. Her husband came and confessed that he took the cows. It was painful to the woman but she accepted because she now knew what happened to the cattle. But if she over reacted she might have done something terribly wrong. (Group facilitator)

The above excerpt suggests that capacitating local women to assist in the amelioration of mental distress holds promise. The participants' structural positioning as economically marginalized women, however, limited their capacity to directly challenge those determinants of mental ill health which involved, amongst other influences, unequal gender relations. Instead, as revealed in the above excerpt, they grappled with their cultural and existential realities in a manner that retained the safety of the woman and her children, but did not directly challenge the structural inequalities underpinning the distress.

The psychosocial support groups for depressed women also showed promise for facilitating a greater sense of personal empowerment amongst the participants which, in turn, has the potential to strengthen their individual capacity to cope with stressful life events. As reflected in the following quotations, social support, including emotional, material, appraisal and informational support afforded by the groups played a potentially important role in this process:

> There is this woman whose child died. She came back to share in a group that her child died. The women in a group comforted her, telling her that ... what happened to

> her can happen to anybody else including themselves and that death is part of life. (Group facilitator)
>
> Sometimes you find that a group member would say that I have money problems and my child is sick. Then you would find them putting together something. (Group facilitator)
>
> What the group helped me with is that they were able to correct me [and tell me] the right ways in which to say things. (Group participant)
>
> The other woman in the group lost her son. She told us in the group that she lost her son and he had been gone for a very long time. We started raising suggestions as to how she could start looking for her. She would try the suggestions and she would come back and tell us that she didn't get help. Then we would come up with other suggestions as a group... At the end she came back and told us that she had found a lead where her son is. She found her son at last. (Group facilitator)

Further, participation in the groups assisted participants with their individual coping styles through promoting improved interpersonal skills, cognitions, and problem-solving capacities. As illustrated below, personal empowerment of some participants was reported, with some participants reportedly taking actions that were health promoting, including actions to address some of the social determinants of their own depression as well as assisting others.

> [Before] I was scared, I cried... got angry at that time... making uninformed and wrong decisions but now after attending these sessions... I have learned how to handle these things better. (Group participant)
>
> A person would come and you would see that every time when she has to talk she cries... But by coming to the group you see that she is better. When the group was almost finished, they would come with good news. They would say that I have done this and this. Even when a person was no longer studying she would think of going back to school. You find that she has found a job. She is thinking of selling things for herself. By doing that it showed that they got help. They grew. Their minds are thinking differently. Like a person would come and say I am thinking of killing myself. You can see that that person's mind is disturbed. But as time goes on, you ask her if she still has thoughts of killing herself and she doesn't. She would explain that it's because she can see that if she does this, things will be ok. (Group facilitator)
>
> It enabled me to give advice to someone else if she told me something... even if it is something painful. I'm able to advise them the way I learned in the group. And I noticed that they appreciate that. Even my child at home, I am now able to advise him accordingly. (Group participant)

The psychosocial groups were also reported to facilitate the development of supportive networks that group members could draw on for coping with stress in the future, which bodes well for the promotion of mental health, as illustrated by the following quote from one of the participants from the group.

> It was nice, we were together . . . and really . . . we still keep in contact. If you have money you call others and find out how they are doing, because now we are relatives. This is the family we came to know in the group session. You made us into a family in the group. (Group participant)

Capacitating existing CHWs

Training provided to existing CHWs also holds promise for empowering this cadre of workers to engage in public mental health actions at the community level. Collectively this has the potential to promote greater community-led control of mental health. Reported public mental health actions by CHWs involved providing practical support for people in need, such as helping people in crises gain help from other community members or government services, particularly departments of health, welfare, and the criminal justice system. As one community health worker put it, "Others they call us ambulances." They also reported establishing self-help groups. These self-help groups have the potential to promote mental health through addressing some of the poverty-related social determinants of mental ill health through the inclusion of livelihood-generating projects as well as building socially supportive networks for people. This has the potential to promote individual empowerment and coping, thus enhancing mental health. The latter is illustrated in the following quotations from the CHW focus groups.

> I would say that it [the training] helped me a lot in the community. We started a group for old people there at *kwa* [M . . .]. I found that old people have many different problems at their homes. Others have sick children, others their children died. Others are abused by their children. Then I used the knowledge I received from the training. I talked to them. I heard all about their problems. The group is still going on. We try that they do handwork. We pray. They open up and we talk about their problems. (CHW Group 3)

> When a person dies, you find that a family does not have money for burial. Then we formed a support group for burial, where we collect money. We are burying tomorrow. There was a child who got stabbed six times. We support each other, when a person arrives we talk. You know if someone close to you dies, you don't even feel that much pain anymore. You eventually accept everything. People die these days. It's not only this child who got stabbed. A lot of people die sometimes of HIV/AIDS. After we have formed a support group a person can be strong and at peace. (CHW Group 4)

However, CHWs are themselves economically marginalized women. This appeared to limit their capacity to engage in public mental health actions at a community level to address the structural underpinning of mental ill health, especially when it involved unequal gender relations. Within a deeply patriarchal society, they often reported fearing for their own safety, particularly in instances where there was abuse of women and children.

> It's difficult for us to enter family matters because it's not safe for us. The man might turn around and hurt his family for reporting private matters to the caregiver. It's also not safe for us to report matters to the police . . . Because most of the time [with] the thugs, if only one of them gets arrested and another one was left behind finds out that it's the CHW that reported the case . . . we get scared because I and my family might die. (CHW Group 1)

This issue is illustrated further by the following case of child sexual abuse and how a CHW dealt with the issue.

> I came across a problem . . . A man of a house is raping a child. This woman told me and she asked me how far do we take our work . . . The caregiver of the child does not even want to hear when the child reports to her. The caregiver says if I take him to court who is going to support us in this house. The child is eleven years. The man is a priest. It was heavy, but I spoke to them. First I spoke to the child to make sure that she is telling the truth. What does the man do? How does she know that he is raping her? She told me the whole story that the man started like this, when the caregiver is gone. He would send the other children to the shop and send the girl to the bedroom . . . She said it's painful. Then I went to the woman who told me and asked how did she hear about this? She said the child came to speak to her and the caregiver of the house does not want to hear anything about it, she just got angry and she stopped talking to her.
>
> Then I asked the child if she had a relative that lives close to her house. The child said her uncle does. I told the child, after he has done this, don't bath, just go straight to your uncle's house and tell him. The uncle asked me if there was any news about rape that I heard from the child. I said yes. I asked him what to do. He said don't worry he will fix it. Then the uncle saw the caregiver going in the taxi and he saw the children going to the tea room. Then he came to the house and saw that he [the priest] was at home . . . He entered the house and found him [the priest] busy with the child. He told him that it doesn't matter that you are my brother but I am calling the police. This was then a family issue and I had to step out.
>
> Interviewer: What happened to the priest?
>
> Group participant: He got arrested for two weeks then he got out on bail. But he is back. I never asked what happened in court. All I know is that they have moved the child from home. The priest who was raping this child was her uncle. (CHW Group 3)

The manner in which the CHW dealt with the problem shows how she negotiated a solution within the constraints imposed by her cultural and social positioning so as to retain the safety of women and children. Her structural positioning, however, precluded her from directly challenging the structural inequalities underpinning the problem of child sexual abuse in her community.

In this context it is understandable that CHWs complained of having too little power, not being respected by community members and government departments alike, which hampered their efforts to assist others.

> We see ourselves as nothing. Even in clinics when you go there to fetch medication for people. You will be in the queue and you sit like everybody else. They don't regard you as a person with a job. We feel offended . . . the way they do things, they look down on us as if we are stupid, we are something useless. But we do play an important role. (CHW Group 2)

The need for acknowledgement within communities and government departments of the important public health and welfare activities of CHWs, including those related to mental health is thus highlighted. In addition to better remuneration and education of health and welfare personnel of the importance of their efforts, CHWs requested more formalized referral arrangements be established. Further, they suggested that symbols, such as badges or uniforms, that distinguish them from other community members, may also assist to increase their profile and assist people to talk to them about their problems.

> Even if we get a little difference like a name tag. So that we can be known that we are doing work . . . You see, when someone comes wearing a uniform, it makes a difference . . . To have something different that will highlight us in the community. That we are CHWs and we are also educated. Because if I just come wearing an apron to talk. People sometimes feel that I will judge them. (CHW Group 1)

One of the criticisms of a shift to community mental healthcare has been that the increased burden of care placed on families and communities can stretch them financially and emotionally (Swartz, 2008). This is often a reality for communities, especially when resources do not follow patients, who have previously been in institutional care, to assist with community care. The need to ensure specialist support for community caregivers, a feature of participatory intervention framework, is clearly supported in the following quotation:

> It helps because you may find a house that has got problems. You take them and make them your own. Even when you are at home, you find these problems ringing in your head. You feel like this problem is facing you directly. Then you go and explain to the mental health counselor what you encountered in the field and how you feel that this is beginning to depress you and I wish to get help. (CHW Group 4)

Discussion

The findings suggest that the development of community collaborative forums, in this case the DMAG, at a local level are useful for strengthening awareness amongst stakeholders of the importance of mental health services. Concrete evidence of this was provided through increased resources for mental health services. The forum was also useful for providing a dialogical space for engagement between traditional and western health practitioners as well as ensuring political support for project activities and that services provided were in line with community needs.

With regard to the involvement of community members in the development and delivery of specific psychosocial interventions for CMDs, the findings, in the case of the group intervention for women with depression, illustrate the potential usefulness of community consultation in the development and delivery of psychosocial interventions for promoting cultural congruence. Community members themselves emerged as being well placed to provide local knowledge on interventions that would mediate pathways to health as well as how to manage problems within the constraints of their cultural and material realities. The potential for social support afforded by participation in the groups to enhance participants' individual coping capacities and personal empowerment was also highlighted, supporting previous evidence of the merits of peer-facilitated groups for improving the mental health and quality of life of women in other LMICs (Kermode et al., 2007).

Building capacity of existing CHWs to identify and assist people with CMDs as part of their daily home visitation programme was reported to strengthen their capacity to respond to people in mental distress. Much of their response involved networking people and the establishment of self-help groups. These networking and community development actions on the part of CHWs are important public mental health actions which have the potential to build social capital and promote social inclusion which is enhancing of mental health (Kermode et al., 2007).

In the case of both the peer-facilitated psychosocial support groups as well as capacity building of CHWs, the economically marginalized position of rural African women in South Africa, however, appeared to limit their power to address the structural drivers of mental ill health. The help and support provided by both interventions was largely limited to support and ameliorative care. Under apartheid, Black South Africans were marginalized from the formal economy and opportunities for autonomous livelihoods. Under this system opportunities for Africans were limited through, inter alia, poor schooling and legislated racial segregation policies whereby the African population were required to reside in Bantustans with limited employment opportunities. Entry into White designated areas, which afforded employment opportunities, was controlled through the pass laws which controlled the movement of African workers. In addition, women were doubly discriminated against because of their gender, with women's traditional childbearing and childcare role continuing to promote their systematic exclusion from the formal economy. The legacy of this legislated racial discrimination lives on.

Given these limitations, the project was thus not able to develop what Campbell, Wood, and Kelly (1999) identify as "perceived citizen power," which they suggest is the mark of a "health-enabling community." Such a community is where people are sufficiently empowered to have their voices heard and where they are able to participate in decision making that impacts on them as individuals, families, and communities (Campbell & MacPhail, 2002).

While CHWs are potentially a valuable community resource for engaging in activities to promote mental health, their capacity to do so is limited in the absence of their psychological and political empowerment. In addition to incorporating critical consciousness raising into their technical skills training programmes, there is also the need for an elevation of their roles within communities to enhance their political power. They complained of a lack of respect from the community and service departments alike. This problem can be addressed by increased recognition of their training and roles through symbols of power, such as uniforms and badges; as well as better remuneration. While this issue has been acknowledged by the WHO (2007) and others (e.g., Lehmann, van Damme, Barten, & Sanders, 2009) as being important to facilitate retention of CHWs, it is also important from the perspective of increasing the success of participatory health promotion programmes (Campbell & MacPhail, 2002).

Osborne, Baum, and Ziersch (2009) also caution about the potentially negative impact that efforts to increase community participation through imposing stressful caregiving efforts on women, in the main, can have on their mental health. This is especially so if they remain unsupported, reinforcing the need for the provision of technical and emotional support for community-based caregivers as highlighted in this study and emphasized in the Lancet series (Saraceno et al., 2007). The need for reorientation and diversification of roles of specialist staff to provide this support within a task-shifting model in LMICs is essential given the dominance of the clinical case orientation of specialist training programmes (Saraceno et al., 2007).

Conclusion

This case study suggests that adopting community participatory processes in the development of district mental health services for CMDs in LMICs can assist, firstly, to mobilize resources for mental health through strengthening awareness. Second, it holds promise for promoting more culturally competent care through (a) providing a space for dialogue between western and traditional practitioners; as well as (b) the development and delivery of psychosocial interventions that are responsive to the cultural and social realities of beneficiaries. Third, it can potentially facilitate less dependency on overstretched healthcare services through peer-facilitated group-based psychosocial interventions for CMDs which harness the benefits of enhanced social capital to promote personal empowerment of participants. Fourth, it holds promise for promoting community-led public mental health actions to ameliorate some of the social determinants of CMDs through capacitating community members such as CHWs to engage in such actions.

Harnessing the potential of CHWs to promote mental health, however, remains a challenge. It will require reflection on power relations inherent in the healthcare system which are disempowering of CHWs, as well as financial investments by those engaged in policy development and planning to promote symbolic and economic empowerment of this community resource. As suggested by Yang, Farmer, and McGahan (2010) investment in health is likely to yield far more sustainable results than investment in health services.

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Inge Petersen, PhD, is a Professor in the School of Psychology at the University of KwaZulu-Natal. Her research activities and interests are in public mental health, particularly mental health promotion in low- and middle-income countries as well

as health systems reform for integrated primary mental health care and developing community-based models for the delivery of mental health services. Address: School of Psychology, Howard College, University of KwaZulu-Natal, Durban, 4000, South Africa. [Email: peterseni@ukzn.ac.za]

Kim Baillie, MSocSci, was formerly a research officer for the Mental Health and Poverty Project. Her research activities and interests include mental health services research and clinical issues. Address: Child Guidance Clinic, University of Cape Town, Chapel Road, Rosebank, 7700, Cape Town, South Africa. [Email: kim.baillie@uct.ac.za]

Arvin Bhana, PhD, is the Executive Director (Acting) of the Human and Social Development Research Program of the Human Sciences Research Council and an Associate Professor in the School of Psychology at the University of KwaZulu-Natal. His research activities and interests include a focus on risk and resilience in youth, positive youth development, public mental health and substance use. Address: Human Sciences Research Council, Private Bag X07, Dalbridge, 4014, South Africa. [Email: abhana@hsrc.ac.za]