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Title:

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.

Keywords:

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

Main Text

Introduction

With the world-wide 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' (Ganasen 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. 2013) 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.

HSAs have established a key position within the Malawi Government's primary healthcare 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 HSAs 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 HSAs 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 HSAs across Zomba district received three days training aimed at assisting HSAs 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. 2013), 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 1989, 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 two 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 two 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 = 5years). 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.

Data collection

Face-to-face interviews lasting between 45 and 60 minutes were undertaken by the authors in English or Chichewa, according to the interviewees' preference. Interviews explored 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, 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 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.

Ethical issues

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.

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.

Firstly, where biomedical interventions have been ineffective or damaging.

In one instance, where previous treatment for a two 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

And secondly, 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 confirms 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 Breugal 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 and Peltzer 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 appear 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. And yet 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.

So 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.

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TABLE 1Contextual 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.