Int Health 2013; **5**: 38–42
doi:10.1093/inthealth/ihs016

ORIGINAL ARTICLE

Understanding the local context for the application of global mental health: a rural South African experience

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Received 16 August 2012; revised 23 November 2012; accepted 10 December 2012

Background: The global mental health movement has supplied ample evidence of treatment gaps for mental health care in low and middle-income countries. It is also clear that substantial progress has been made in developing an evidence base for innovative treatments which have been shown to work. It is only through rich and detailed understandings of local contexts and individual experiences that the challenges global mental health faces can be fully appreciated.

Methods: In this article, we use a single, qualitative case study from one context and of one family affected by mental disorder. This is to elucidate core issues which we regard as key to further developments in the global mental health agenda.

Results: Core issues are poor mental health literacy, transport and lack of outreach, limitations of formal health care, challenges at the interface with indigenous health care and lack of follow-up and rehabilitation.

Conclusion: We propose shifting the focus of mental health care from cure to promotion and prevention, using an interdisciplinary team of lay and trained health workers from the professional, folk and popular sectors. The challenges are complex, as this small study shows, but it is only by looking closely at local conditions that it is possible to develop interventions which are contextually appropriate and make optimal use of local resources.

Keywords: Mental disorder, Mental health service, Rural, Poverty, South Africa, Community mental health

Introduction

The global mental health movement has supplied ample evidence of treatment gaps for mental health care in low and middle-income countries (LMICs).[1–7] It is also clear that substantial progress has been made in developing an evidence base for innovative treatments which have been shown to work in low-income contexts.[8,9] Despite these improvements, and while there is now good evidence of cost-effective mental health interventions, there is as yet little evidence of how to implement these in real-life settings beyond those already identified in innovative recent studies.[8,9] The questions at stake are far broader than simply those of scale-up of transportable technologies: they involve issues of cultural contexts, health systems challenges, and interfaces between seemingly incompatible sets of demands and needs. There is good evidence for the importance of addressing mental disorders as part of infectious and non-communicable disease care and treatment.[10,11] In overburdened health care settings far removed from centres where there is a critical mass of expertise around mental health, however, mental health issues may continue to be seen as ephemeral and unimportant.

Africa has the greatest disease burden of any continent but has the poorest health services.[12] Despite the relative wealth of South Africa, compared to other countries in the region, universal and equitable access to health care is yet to be attained,[13] and the country is still grossly underserved in terms of mental health services compared to wealthier countries.[5–7] Poverty is still rampant for a large majority of the South African population, and rural areas in South Africa, in particular areas in the Eastern Cape Province, remains the poorest, most underserved and historically neglected.[6,13] Xhosa-speaking people comprise the majority of the population of the Eastern Cape. The Xhosa people are a group of clans within the Nguni, Bantu-speaking people in southern Africa. The culture is patrilineal, with a strong hierarchical system of kin networks and chiefdoms. Ancestors play an important role in guiding traditions and cultural practices.[14] Mental

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disorders are bound up in complex belief systems, with culture bound syndromes and culture specific events closely linked to the understanding and treatment of mental disorders. There is widespread use of traditional healers in the management of mental disorders among Xhosa-speaking people.[15,16]

Influenced by Kleinman[17] we conceptualise patients and healers as key components of systems of health and illness. Kleinman describes the health care system as composed of three overlapping sectors: the popular, professional and folk sectors. The popular sector refers to the individual, family, social networks, community beliefs and activities. The professional sector is usually synonymous with modern scientific medicine (biomedicine). Lastly, the folk sector, referred to as non-professional and non-specialist, consists of healers and indigenous practices of various kinds.

It is only through rich and detailed understandings of local contexts and individual experiences that the challenges global mental health faces in making its best possible contribution can be fully appreciated. In this article, we use a single case study to elucidate core issues which, from our experience in rural mental health care in South Africa, we regard as key to further developments in the global mental health agenda. The data we present form part of a larger, multi-national research project studying access to health services for vulnerable populations. (For more information see www.equitableproject.org.)

Methodology

We utilised a qualitative, grounded theory approach, as it is best suited to explore cultural contexts and phenomena from the perspectives of the members of the cultural groups explored, and to build theory from data.[18] Data were collected from various sources that shed light on the questions under study,[18] such as people with mental disorders, their family members, members of the community, health workers from the professional and folk sectors, traditional leaders, management at hospital and clinics, relevant literature, policy documents, strategies and plans at international, national, provincial and local levels. Data collection techniques utilised in the project of which this case study is a part are observation, in-depth interviews (individual and group), informal conversations and desk study. In this article we focus on the case of a woman with mental disorder and her family; we add other contextual data from various health sectors and health users as required.

In grounded theory research, data collection and data analysis are concurrent processes, allowing for continuous alterations and additions to the data collection and analysis based on the research findings.[18–20] Grounded theory analysis has been used, generating categories and creating hypotheses from the data. The data were labelled through open coding, using conceptual categories to develop the codes.[20] The codes were derived from the literature, and from the actual data.[19]

Results

In the results section the data are presented in a purely descriptive manner, to best capture the complexities of the context and the experience of the patient and her family, in line with the methodological approach.

Madwaleni – the study setting

Madwaleni District Hospital catchment area is located in the Amathole District, in the Eastern Cape Province of South Africa. The Madwaleni area is characterized by rugged hills, deep valleys, rivers, forests, unpaved gravel roads, free running animals and round grass-thatched mud-huts. The settlement is spread out, placed on top of hills, with most people owning big pieces of land, where they grow vegetables and keep livestock. There is a scarcity of sewerage systems, running water and electricity to the general Madwaleni community.

Madwaleni health system – professional sector

Madwaleni Hospital, established in the mid 1950s, serves a population of about 120 000 in a 35 km radius. After the advent of democracy in 1994, eight clinics were built around Madwaleni Hospital as a result of the implementation of primary health care (PHC) policies. The clinics are nurse-driven, staffed primarily by nurses and community health workers (lay health workers). Most of the health providers are from the area, and are Xhosa-speaking. There is a severe shortage of health care providers both at the hospital and the clinics, and those who are there are extremely overworked, and work under difficult working conditions with shortage of equipment and medication, long working-hours, seeing many patients per day and hence have very little time with each patient. At the time of the data collection there were no social workers, no psychologist, no psychiatrist and no psychiatric nurses in the area. The health services have had short-term visits by psychologists in the past, but these usually do not stay long, and have very little sustainable impact. There are no dedicated professionals at the clinic or the hospital to diagnose mental disorders. The professional nurses and doctors have some basic mental health training, but none of them have practised it much, if at all. There is a rehabilitation department at the hospital, with physiotherapists and occupational therapists, but these are not involved in the acute care of people with mental disorders. The health providers explained that the most commonly seen mental disorder at the hospital and at the clinics is acute psychosis, often in young men, usually linked to alcohol and drug use. When asked about disorders such as depression, bipolar disorder and schizophrenia, they said that they rarely diagnose or treat people with these disorders. Those patients that are admitted to, or treated at the hospital, invariably are there because of violent or aggressive behaviour, and because they are viewed as a potential danger to themselves or to others. These patients will be referred from the clinic, which is the primary health care unit, to the Madwaleni hospital. At the hospital they will most likely be treated with sedatives or anti-psychotic medication. If they are not behaviourally more settled within 72 hours, they will be referred to the psychiatric wing at Mthatha General Hospital, which is a two hour drive away.

Madwaleni health system – folk sector

There are a number of traditional/faith/spiritual healers working in Madwaleni. Most of the health service users we spoke to were currently using or had at some point made use of these services, either instead of or in concurrence with professional health

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care. While there are several traditional healers in the area that provide treatment for mental disorders, in this article we will draw upon information gained through one interview with a spiritual healer. He reported that he treats severe cases of mental disorder. This treatment is in the form of special water which has been prayed over. He says that he heals more people than does the hospital. His patients drink the water, they bathe in the water, are sprayed with the water or they vomit the water. He explained that the people he treats have been exposed to witchcraft, and the water washes the witchcraft away or empties the body of it. He says that prayer is a key element in eradicating witchcraft, and that a lot, but not all disorders are caused by witchcraft.

The case of a Madwaleni health care user – popular sector

The case is a Xhosa-speaking woman of approximately 65 years. Pumla (pseudonym) is the oldest in her household of seven people, and the mother or grandmother of most of them. The household survives on three social grants. They have no livestock, but they have a garden where they grow vegetables for consumption. We interviewed Pumla together with several members of her family. Her oldest son answered most of the questions, but she, herself, answered when spoken to directly. The son told us that:

> *She was 'sick of the brain' about ten years ago, and she has never gotten well again. She went 'crazy'; shivering heavily, bleeding from the nose and mouth, running around aimlessly, running away, being violent and not knowing what she was doing. She was a danger to herself and others. At night she thought that she was being attacked by her small grandchild and by men in the community who were trying to kill her, but this was not real. The bleeding stopped after one day, but the rest of the symptoms lasted for about six months, on an everyday basis, before we the family took her to the hospital for treatment.*

The hospital is about 20 minutes by car from the house of the family, and several hours walk on narrow paths, up and down steep hills, across a river and on roads that flood during the rainy season. There is scarce public transport in the area, unaffordable to many, and unreliable at the best of times. Pumla and her family used public transport to get to the hospital. Of their experiences seeking health care her son told us:

> *At the hospital a nurse looked at my mother's head, and said that she did not know what was wrong with her, but she gave her some medicine. We were not told what it was, or what it was for, just how many and at what time to take the tablets. They also gave her painkillers for a bad headache she had, and told her to go to a traditional healer for help and medicine, and to combine these treatments. So we sought help from a spiritual healer just a few minutes' walk from our house. The healer gave my mother a bottle of something to drink. After this she got a bit better; she stopped hallucinating, and she shivered less. She took the treatment for six months, during which time she had to go to the hospital once a month for follow-up and medication. After six months a nurse told her to stop taking the treatment from the hospital. She has not been on any treatment since then, and she has not had hallucinations or been running around or away since then. After her illness, my mother has become very sad, she has lost her physical power, she can communicate, but she rarely does, she suffers from headaches, and she has stopped socializing. As a result, I have decided that she might as well do nothing. She now sits in the same spot every day, sleeping or just sitting there, she does not contribute to household chores, but she dresses and washes herself.*

The family says that no one ever told them what was wrong with Pumla or what had happened to make her ill. The health providers just asked the family to explain to them what had happened. Pumla herself says she does not know what happened to her. She says she now has pain in her head, and that before the disorder she was fine. The son says that she is now mostly a burden to the family. He wishes some doctor could help her get well, or that the family could get some help with the household chores that she used to do before she became ill.

Discussion

We shall use the case study to elucidate key challenges for mental health care in this context as they emerged throughout the data collection and data analysis process. We will then explore the implications of these for global mental health.

Key challenges

Mental health literacy

Care for physical or mental disorders most often start at popular sector level, where some basic health care can be carried out, or decisions about further health care steps are made.[17] When Pumla became ill, neither she, her family nor the community around her recognized that she was suffering from a mental disorder, and that there was health care available to help her. Due to the limited knowledge of the family and the community around her, help for her was sought only when she was presenting with behaviour that was potentially dangerous to herself and to others, and this was six months after she presented with the first symptoms of mental disorder. To this day the family have no idea what happened to her, and they struggle to talk about what kind of help they would want for her, mainly because they do not know what kind of help could exist. Mental health literacy—or the lack of it—is a clear challenge in the Madwaleni context.

Transport and lack of outreach

The next challenge for the family was getting to the hospital, which is where they decided to seek treatment. They decided to use public transport, which is expensive for them and even more so because someone had to accompany her to the hospital. Transport is a big problem for most people in the Madwaleni community, and while the health services do offer some outreach programmes and home based care, these are limited, and there is nothing for people with mental disorder.

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Limitations of professional health care

Arriving at the hospital they saw a nurse, and were given pills for Pumla to take. The most effective mental health interventions require access to proper diagnosis, medication and skilled health workers such as psychologists, psychiatrists, mental health nurses or social workers,[8,9] none of which is available in Madwaleni. As a result it is the general nurses and sometimes doctors who are left with the responsibility of diagnosing and caring for patients with mental disorders. Not only are these health professionals already overworked, they also only have very basic knowledge of diagnosis and treatment of mental disorder. The result can been seen in our case, where the family feel that they received very little information about what had happened to her, what medication she was given, and why. Furthermore, treatment of mental disorders is a problem in Madwaleni. Common mental disorders are rarely diagnosed and treated in the professional health sector, and it is likely that this is due to a lack of diagnostic capacity for these disorders, and not that they are less common in this particular community. The only treatment available is drugs, and even these are limited at both the hospital and the clinics. The family was advised by a professional health care provider to seek help also from a traditional healer, the rationale for which they do not know. This may be linked to the health worker's lack of skill, confidence and capacity to manage mental disorder. Or it may be because of the health worker's holistic attitude towards collaborative practice between the two sectors.

Challenges at the interface with the folk sector

As advised by a health worker at the hospital, Pumla also sought treatment from a traditional healer. The spiritual healer is only a short walk from her house, and he gave her a different treatment. Though there was referral from the professional sector, there was no mechanism to bridge the different health care contexts for Pumla and her family, and no follow-up. It appears that this is not a collaboration as such between the sectors, but the sending of a patient to traditional healing at least partly because of the health system challenges within the formal health sector.

Lack of follow-up and rehabilitation

While Pumla, at the time of the interview, had recovered from the most immediate and acute mental disorder, the aftermath of her mental disorder was still very much a defining factor in her life. Despite this, she has not received any form of mental health care in the past decade. The follow-up from both the professional and folk sectors ended when her acute symptoms were gone, and the family, part of the popular sector,[17] were left with the care responsibilities for a woman they describe as '*being able to do nothing*'. While the family see that she has never gotten back to her 'normal self', they do not know of any other places to seek help for her.

Implications

The experiences of this family are embedded in a complex web of different sectors of healing, together with practical challenges, including those of terrain, poverty and lack of resources. Issues of belief and paradigm are key: even professional health providers in Madwaleni, trained and working within the paradigm of biomedicine, are socially linked to and live within a more holistic health approach. An example of this is the health provider at Madwaleni hospital who told the family that they should seek help from a traditional healer alongside the treatment they received from the hospital. Regardless of the rationale for this advice, the challenges at the interplay between the two health sectors remain real. In contexts like Madwaleni, there are many challenges for cross-referral across health systems. From a professional mental health perspective, there is clearly a need for greater mental health literacy, for both community members and for professional and other health personnel. But it is also crucial, if limited resources are to be used optimally, that outcome evaluations of treatments within and across the full range of health care sectors are conducted.

It is unlikely that there will be an abundance of mental health specialists in Madwaleni or similar contexts any time in the near future. So while this may still, for many, be the ideal treatment option, this is not a likely solution to the problem in Madwaleni at this point. Within the global health and mental health literature, there is currently a great emphasis on what has been termed 'task-shifting', which is the deployment of lower-level health providers or lay health workers to provide basic prevention and treatment services, supervised by more skilled health workers at secondary or tertiary level.[3,4] This may well be an option in contexts like Madwaleni, however, in task-shifting one must be mindful of the already challenging conditions health workers work under. Given the strong link between physical and mental health conditions,[10,11] an interdisciplinary approach should be employed. For instance, there is already a rehabilitation team in Madwaleni, but these are currently not involved in the treatment or prevention of mental disorder. A more difficult question, but one that needs to be addressed, is how to integrate different forms of healing (including indigenous or spiritual healers) in evaluated innovations in task-shifting.

The global mental health literature emphasises shifting the focus of mental health care from cure to promotion and prevention. It also stresses the value of using an interdisciplinary team of lay and trained health workers from the professional, folk and popular sectors. This strategy needs to be complemented by other strategies, for example, integrating mental health into other projects focussing on sustainable livelihoods and development of infrastructure. The challenges are complex, as this small study shows, but it is only by looking closely at local conditions that it is possible to develop interventions which are contextually appropriate and make optimal use of local resources.

Authors' contributions: All authors participated in designing the protocol for the study. SHB, RV and GM contributed to the collection of the data. SHB, RV, GM and LS contributed to the analysis and interpretation of the data. All authors have contributed to the drafting of the article and approval of the final manuscript. SHB and LS are guarantors of the paper.

Acknowledgements: We would like to thank the following for their assistance: our brilliant interpreters for their assistance in interpretation both of the language and the Xhosa culture; traditional authorities in the area for allowing and assisting us in getting access to the field; and the

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staff at Madwaleni hospital and the satellite clinics for their participation as informants and helping us identify relevant informants outside the clinics. A special thank you to the Community Health Workers!

Funding: This research was funded by the European Commission Framework Programme 7; Project Title: Enabling Universal and Equitable Access to Healthcare for Vulnerable People in Resource Poor Settings in Africa; Grant Agreement No. 223501 and through the Department of Science and Technology, South Africa. The opinions expressed in this article are those of the authors alone.

Competing interests: None declared

Ethical approval: This project is part of a larger research project, which obtained ethical clearance from the Health Research Ethics Committee at Stellenbosch University. Furthermore, approval has been obtained from the Eastern Cape Department of Health to conduct research at the health facilities in the relevant study area

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