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METHODS AND MADNESS:
RESEARCHING COMMUNITY HEALTH WORKERS' PERCEPTIONS OF MENTAL ILLNESS IN KHAYELITSHA AND NYANGA

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ABSTRACT

This dissertation explores the use of qualitative methods to research community health workers' (CHWs) perceptions of mental health problems in Khayelitsha and Nyanga, two peri-urban Black townships in the Cape Town area.

Since the historic WHO-UNICEF meeting at Alma-Ata in 1978, there has been widespread interest in the concept of CHWs as the ideal work force for advancing the principles of the primary health care (PHC) approach. In seeking to transform the structure and delivery of mental health care in South Africa within the confines of limited financial and human resources, policy makers are shifting attention to the integration of mental health care within a PHC framework.

Fundamental to the PHC agenda, as conceptualised at Alma-Ata, is health care that is based on appropriate technologies and that encourages effective community participation in making decisions about health issues. In the past few decades, anthropological perspectives gained from cross-cultural research into health beliefs and practices have made valuable contributions to the planning and implementation of PHC programmes. In the field of medical anthropology, hermeneutically orientated approaches play an important role in advocacy, whereby the patient's perspective on illness and the meaning of illness is brought to the fore in an attempt to provide more patient-centred care.

In this research, CHWs were interviewed to gain insight into the scope of primary mental health care, as perceived by them, and prevailing beliefs and practices surrounding mental health problems. Unstructured individual interviews were conducted with 20 CHWs working in community-based PHC projects in Khayelitsha and Nyanga to elicit their personal accounts of mental health problems in their geographical communities. This material was used to construct five vignette descriptions of mental health problems in the CHWs' own words. Kleinman's explanatory model approach was used in structured individual interviews to access CHWs' understandings of mental illness. Questions related to naming the problem; theories of illness causation; coping with the problem; and decision-making as regards treatment options. Focus group interviews were held with the participants of two of the CHW projects to explore their feelings about involvement in mental health care.

This micro-level analysis was accompanied by the perspectives of critically-interpretive medical anthropology which shifts attention beyond the individual cultural construction of illness to the political and economic factors affecting the social organisation of health care. Within the PHC setting, the critical perspective entails challenging constraints to the attainment of health for all as a result of inequities in the distribution of power and wealth; barriers to achieving community participation in health issues; and inequitable access to basic primary health needs by the most disadvantaged.

CHWs' personal accounts of mental illness in their communities conveyed a narrow biomedical conceptualisation of mental health problems. Several explanations for their association of mental illness with violent and disruptive behaviour and their concomitant silence on quieter forms of psychological distress, notably depression, are explored. In terms of their role, CHWs are seen to be intervening at the level of maintaining a degree of social stability, rather than alleviating individual distress. I argue that they cope with feelings of impotence and disempowerment by aligning themselves with conventional power structures, specifically the law and biomedicine.

Of concern is the mismatch between CHWs' attributions of the causes of mental illness and their actual or suggested treatment. While CHWs predicate mental health problems on the distressing socio-economic and interpersonal context of people's lives, their predominant course of action, namely referral to doctors and hospitals, marginalises this context through its focus on subduing and sedating unruly bodies. I argue that social problems are medicalised and mental health care is professionalised. Furthermore, I explore difficulties in dealing with conflicts between CHWs' and biomedicine's explanatory models of epilepsy. I suggest that reaching a shared meaning is not always possible.

Finally, I examine the many contradictions in the CHW concept and the unrealistic expectations placed on them in fulfilling the social justice objectives of the PHC approach in the South African context.

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OUTLINE OF THE STUDY

The first part of Chapter 1 locates the discussion of CHWs and primary mental health care within the framework of the PHC approach and principles, as conceptualised at Alma-Ata in 1978. The promotion of CHWs as the ideal cadre of health worker for carrying out the objectives of PHC-inspired programmes is critically examined in terms of their actual performance. Hereafter, I discuss and problematise the application of PHC principles to the delivery of mental health care. The advantages and disadvantages of deprofessionalising mental health care to CHWs are considered. I then raise issues and principles in training CHWs, with particular emphasis on mental health care. I review selected examples of international primary mental health care programmes and the baseline research that informed their development.

In the second part of the chapter, the discussion is shifted to the South African context, where health care delivery in general, and mental health services in particular, are examined in the light of the government's commitment to the PHC approach. Finally, the advantages and disadvantages of extending mental health care through integrating it into PHC structures are considered.

In Chapter 2, I discuss the contributions of social science research to the provision of more appropriate, patient-centred health care. I trace developments in anthropological involvement in PHC settings and the changing conceptual bases which informed this research. The approach of hermeneutically orientated anthropology is examined as a means of democratising health care by highlighting the patient's experience of health and illness. I present Kleinman's explanatory model framework (1980) as a means of eliciting the patient's experience and understanding of illness. I argue that attention to this reality is important in providing health care that 'makes sense' to health care consumers. Insights gained from hermeneutically orientated medical anthropology are framed within the perspective of critically interpretive medical anthropology. This involves a shift in focus from the processes of clinical interactions to the macro-level social, political and economic factors that shape and distribute illness. This perspective has particular salience in this research context where poverty and political disempowerment are major determinants of health status.

Helman's (1984) taxonomy for classifying lay theories of illness causation and Kleinman's (1980) outline of the structural domains of health care are presented. Finally, I examine somatisation as a means of constructing illness meaning and outline some of the arguments on the cross-cultural experience of depression.

In Chapter 3, I set out issues and challenges in conducting qualitative research in cross-cultural settings and in popularising academic research. I begin with an outline of the philosophical tensions between qualitative and quantitative methodology. I then set out my research tools, namely, concepts and insights gained from critically interpretive qualitative methodology, grounded theory methodology, and Meulenberg-Busken's "relational mode". Challenges to redressing traditional researcher-subject roles in cross-cultural research are examined. Finally, I suggest that popularisation raises a number of additional requirements for doing 'methodologically-sound' research. These include questions of the political purpose of the work, accountability, and negotiating a research agenda.

Chapter 4 is an introduction to the research sites. I briefly outline the historical development of peri-urban townships in the Cape Town area and then provide community profiles of Nyanga and Khayelitsha. Lastly, I introduce the three CHW projects that are included in this study, namely, the St John Ambulance Community Health Project, the Cape Mental Health Nonceba Rehabilitation Project, and the Western Cape Regional Services Council CHW Project .

Chapter 5 sets out the research design, including sampling strategies; demographic details of the participants; the research procedure; the report back of the findings; and strategies for verifying conclusions.

In Chapter 6, I discuss the organisation of the research findings and analysis. I provide an overview of the findings in terms of the three research phases: the focus group interviews; CHWs' personal accounts of mental health problems in their communities; and details of their explanatory models of illness in response to vignette descriptions of mental health problems.

In Chapter 7, I talk about what is seen and what remains hidden in the field of mental health problems. I examine CHWs' construction of their role in terms of their functioning as extenders of the health system as opposed to empowerers.

Chapter 8 focuses on CHWs' understandings of mental illness within a matrix of explanatory models and health care resources. The complexities of dealing with conflicts in CHWs' and biomedicine's explanatory models are raised. Attributions of illness causation are examined as they relate to making decisions about treatment options. Alternative sources of health care are discussed in terms of Kleinman's (1980) structural domains of health care.

In Chapter 9, I talk about areas of concern to the CHWs and to me. These include substance abuse, violence and depression.

In the final chapter, I note limitations of the research and offer some concluding comments.

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CHAPTER I

MENTAL HEALTH CARE WITHIN A PRIMARY HEALTH CARE FRAMEWORK

This dissertation explores CHWs' perceptions of mental health problems in Khayelitsha and Nyanga, two peri-urban Black[1] townships in Cape Town.

This chapter begins by tracing the changing ideas about health and health care that led up to international endorsement of the primary health care (PHC) approach as the means of achieving equity and access in health care. I[2] examine the WHO-UNICEF's proposal of CHWs as the ideal work force for carrying out the social justice objectives of the PHC approach as well as the detection of a gap between their role in theory and their actual performance. The extent of mental health problems, particularly in PHC settings, is examined with reference to psychiatric epidemiological research. I then present potential advantages of the PHC approach as a framework for extending mental health care. Several PHC principles as they apply to mental health care are discussed. Advantages and disadvantages of CHW involvement in deprofessionalising mental health care are debated and issues in mental health training for CHWs are raised. International research informing the development of primary mental health care programmes and evidence for the successful deprofessionalisation of mental health care are examined.

The debate is then shifted to the South African context, beginning with an overview of health care policy and resource allocation and the status of mental health services. In the light of the scarcity of financial and human resources, I motivate that the burden that mental health problems present should be alleviated by optimising existing health care resources. One such resource is indigenous healers, who are CHWs of a kind, and current debates about their position *vis-à-vis* the formal health system are raised. Models for

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[1] I use the terms 'Black' and 'white' as they appear in the Population Registration Act of 1950, repealed in 1991. Further, I use the term 'black' to refer to all South Africans not classified as 'white'.

[2] In this dissertation, I dispense with the convention of using the third person narrator which is attached to positivist values of 'neutrality' and 'objectivity' in conducting 'scientific' research. In adopting a social constructionist stance, I assume responsibility for the production of knowledge in this research. By using the first person narrator, I am acknowledging and making explicit my authorship in telling this story.

mental health delivery that have been put forward in the South African context are presented, and the benefits and caveats of taking the PHC route are discussed.

The meaning of PHC in its original and narrowest sense is the first point of contact between health care providers and consumers (Walt & Vaughan,1981). As currently understood, the PHC approach involves much more than the provision of first-contact services. It is an essentially democratic concept which aims at a shift in health care resources to the economically and politically powerless in order that there might be a more equal distribution in society (Walt,1990). A discussion of the PHC approach generally embraces the concept of the CHW. In fact, CHWs have become so much a part of the PHC movement that they have been labelled the foundation of PHC, as defined at Alma-Ata.

The PHC approach and the CHW concept emerged as a consequence of changing ideas about health and resulted in a redirection of health care with emphases on basic health services, community participation, appropriate technology and home-based care.

From medical care to health care: the pathway to the PHC approach

By the 1950s, health planners and administrators realised that importing hospital-oriented health care into the developing world was of negligible benefit to the majority of the population, namely the poor (Mull,1990). In the following two decades, the World Health Organisation (WHO) and other international agencies attempted to redress this failure. In the 1950s and 1960s narrowly focused "vertical" programmes were implemented to target specific diseases (Mull,1990). These initiatives were vertical in that they were paid for and directed by people outside the target population and operated from the top down to the grassroots-level worker, as opposed to being integrated with other programmes. With a few exceptions, these efforts met with little success for a number of reasons (Mull,1990). There was a lack of institutional infrastructure and control of services by health care consumers to sustain programmes. Basic health problems were not addressed in that access to curative services was still denied the majority of people living in developing countries, especially those in rural areas. Furthermore, the impact of cultural, economic and environmental factors on even the simplest technologies, such as oral rehydration therapy, made their implementation across diverse contexts problematic. It was increasingly recognised that hospital-based technologies required modification when applied in other settings (Coreil,1990).

In the mid-1960s, the idea of basic health services developed as an alternative to hospital-based and -oriented services and paved the way for the PHC approach (Walt,1990). Recognition of the relationship between ill health and socio-economic factors led to disillusionment with the mechanistic, individualistic solutions of the dominant medical care model. The basic health services strategy was guided by the principles of accessible, acceptable, appropriate and affordable health care. There was a commitment to shift health care from professionals into the hands of health care consumers. The concept of 'medical care' was replaced by that of 'health care', acknowledging that people seek help from a variety of sources, not all of them medical. However, this approach also yielded disappointing results (Mull,1990). A key problem was that health care was still not in the hands of the consumers; it did not involve and 'belong' to the people it served.

The primary health care approach

In the wake of these failures, WHO-UNICEF held an international conference at Alma-Ata in 1978 to promote the PHC approach in service of the goal of "an acceptable level of health for all the people in the world by the year 2000" (Alma-Ata,1978:5). The goal of "Health for All" was linked to the broader concept of social development, the target being a level of health that would permit all people to lead socially and economically productive lives (Walt,1990). PHC, as outlined at Alma-Ata, is

> essential care based on scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost they can afford...it is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where the people live and work, and constitutes the first element in the continuing health care process (Alma-Ata,1978: Article VI).

The fundamental principles of the PHC approach are (i) equitable access to competent health services; (ii) active community involvement in health decisions; (iii) an emphasis on prevention and promotion rather than curative services; (iv) the use of acceptable and relevant methods and materials in health care delivery; and (v) recognition of the inextricable link between social and economic structures and health.

The main goals and objectives of the PHC approach related to social changes in the health system rather than medical interventions. It was recognised that health, broadly defined, cannot be attained through medical solutions alone. Because access to any of the primary health needs (food, clean drinking water, sanitation, etc.) is related to money and power, a health programme cannot be politically neutral but is part of a much larger struggle for equality and power. Several authors have concluded that the successful implementation of this model of health care is contingent on government commitment to a fundamental shift of wealth and power to those who previously had least (Sidel & Sidel in Bender & Pitkin,1987; Walt,1988). It is notable that countries that *have* achieved truly comprehensive PHC (such as Cuba, Nicaragua and Sri Lanka) have undergone a socialist or communist revolution with a subsequent re-allocation of resources to the poor and a commitment to political empowerment at the community level (Mull,1990).

Community health workers: the foundation of primary health care

The Declaration of Alma-Ata proposed CHWs as the most feasible way of bringing essential health care to more people.

> For many developing countries, the most realistic solution for attaining total population coverage with essential health care is to employ community health workers who can be trained in a short time to perform specific tasks. They may be required to carry out a wide range of health care activities, or, alternatively, their function may be restricted to certain aspects of health care...In many societies it is advantageous if these health workers come from the community in which they live and are chosen by it, so that they have its support (Alma-Ata,1978)[3].

The CHW concept exemplifies the PHC approach's focus on the use of existing community resources, not only medical, in the provision of health care - a principle that is reflected in the WHO's endorsement of the use of indigenous healers in the national health system in the same year as the Alma-Ata conference (Velimirovic,1990).

CHWs were recommended as the workforce most appropriate for carrying out the progressive ideals of the PHC approach. They were seen as having a political role by acting as agents-of-change, empowerers and community developers, awakening people not only to health issues but also to their rights (Werner,1980; Berman et al.,1987; Ennever et al.,1988). They were to address the socio-economic causes behind ill-health, rather than responding to symptoms. They were promoted as potentially increasing coverage and equity of health care at a lesser cost than extending existing health services into

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[3] This proposal is not accepted uncritically. Problems with the CHW concept in practice are noted, including their failure to achieve equity in health care by their neglect of the poorest of the poor (Binedell,1990); their being equipped with a restrictingly narrow range of skills (Kaseje,1987); negative implications of their living in their work environment (Binedell,1990); failure to achieve democratic selection procedures (Hammond & Buch,1984; Ramprasad,1988); and conflicts in their accountability to and support from the health system and the community (Walt et al.,1989; Bastien,1990).

underserved areas (Berman,1984; Berman et al.,1987). Moreover, they were to be catalysts in encouraging community participation in health care and, by virtue of their knowledge of and close contact with the community, they were to bridge the socio-cultural gap that has existed historically between health care providers and consumers (Coreil,1990) by providing appropriate and accessible health care (Berman et al.,1987; Ennever et al.,1988).

Following Alma-Ata, there was widespread support for the PHC approach and many CHW projects were set up as a demonstration of commitment to the PHC principles. Subsequently, however, there has been conflict and confusion regarding the meaning of PHC. The PHC approach was stated at a very general level and PHC concepts, such as 'community participation' and 'equity', have been noted to involve a complex set of issues and conflicts in practice (Mathews,1992). Not surprisingly, considering the ambitious goals of the Health-for-All movement, several critics have detected a gap between the inspirational recommendations in the CHW literature and their actual performance (Hammond & Buch,1984; Berman et al.,1987; Walt,1988; Matomora,1989).

A major criticism of CHW projects is the failure to consider the socio-economic and political context in setting up a CHW project and, in particular, the effects of an undemocratic society on CHWs' role as liberators, empowerers and catalysts in community participation (Walt,1988). Several authors have commented that the political role assigned to CHWs as agents-of-change in bringing about a more equitable distribution of wealth and power is more idealistic than realistic, the fact being that CHWs often function as extenders of the health system (Walt,1990). In addition, it has been noted that the level of community involvement and self-reliance in health care is affected by economic and political realities (Mathews,1992). Participation defined as "a process through which people gain greater control over the social, political, economic and environmental factors which determine their health" (Ramphele,1987:14) implies the devolution of power and control. This means that those conventionally controlling health interventions may have to surrender their dominant positions. Mathews comments that "in politically unstable countries where the central government has a rather tenuous control over the people, genuine community initiatives may be viewed as threatening and may not receive official encouragement" (1992:22).

Mental health problems in primary health care

Turning to mental health care, prevalence studies of mental illness in developed and developing countries yield comparable figures (WHO,1975; Beigel,1983; WHO,1984;

Holtzman et al.,1987; Freeman,1988). The standard of mental health care in developing countries is, however, lagging behind that of developed countries with an over-reliance on institutionalised care at the expense of PHC services (Abiodun,1991).

There is much literature that documents the high percentage of people presenting to PHC services with 'psychological' rather than 'physical' problems (Goldberg & Huxley,1980; Shepherd et al.,1986). A fairly conservative estimate of the prevalence of patients presenting at PHC facilities with psychological problems is 20% (Ben-Tovim,1987; Freeman,1988; WHO,1990). Other reports indicate that 50% of people entering medical care present with symptoms that do not correspond to accepted classifications of disease (Mechanic,1986) and approximately 60% of people presenting to PHC are troubled by 'psychosocial' rather than 'physical' distress (Katon et al. in Parsons & Wakely,1991:112). Reviewing South African psychiatric epidemiological research, Parry (1991) estimates the prevalence of conspicuous psychiatric morbidity[4] to be at least 10% among adults in general health clinic samples. Using the General Health Questionnaire, which is recommended as a general screening instrument for mental disorders in general practice, Miller & Swartz (1991a) identified minor psychiatric morbidity among 45% of a sample of adult PHC attenders in Mamre, a 'coloured' village 48 km outside of Cape Town.

Of concern is the large proportion of psychological problems in PHC settings that are undetected (Harding et al.,1980). A recent Zimbabwean study reported that up to 96% of 'true' cases were missed (Hall & Williams in Reeler,1991). Other reports give estimates of 'hidden' psychological morbidity of approximately 80% of true cases (Reeler,1991). A study of the prevalence of psychiatric disorder in attenders at a PHC clinic in Soweto concluded that 93% of the patients diagnosed by the researchers as having a psychiatric disorder were missed by the clinic staff (Zwi & Thom, 1992). The authors comment that PHC attenders, often presenting with multiple somatic complaints, are inappropriately investigated and treated, which results in their returning for treatment in an ever-recurring cycle. This so-called "revolving door syndrome" presents a costly drain on already scarce resources. The implications of this are serious. As Giel and Harding comment, "Unless health care workers are appropriately trained, such patients will be misdiagnosed and mismanaged; expensive (and sometimes dangerous) drugs will be used, unnecessary investigations will be carried out and frequent, unnecessary and wasteful attendances will result" (in Reeler, 1991:351).

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[4] The term used by researchers to estimate the number of people in need of mental health care, not all of whom are classifiable as psychiatric cases.

Primary mental health care

In theory, the PHC approach offers unique opportunities for the appropriate development of mental health care. It has a viable structure in that mental health care is integrated into existing health structures; it reverses the current tertiary care approach; it encourages community participation in mental health care[5]; it decentralises mental health care, with the aim of improving access and equity; it involves the transfer of 'specialised' skills and knowledge to grassroots health workers, thereby reducing the costs of care; it deals with mental health problems at or near the site of the aetiological circumstances, where people live and work; it involves intersectoral collaboration to address determinants of mental health in other sectors; and it has an integrated and holistic approach to health, aimed at physical, mental and social well-being rather than the absence of disease. Orley and Sartorius contend that

> the argument that the promotion of mental health care be included as a separate essential element in PHC rests on the premise that for every single patient under the care of a health worker, attention should be given to that patient's psychological and social well-being. For what ever reason a person is brought into the health care system, he/she should be treated as a "whole person", taking account of the psychological, and social, as well as the physical problems presented (1986:197).

Some of the PHC principles as they apply to mental health care will now be discussed in greater detail.

Decentralisation

The decentralisation plan involves a tiered structure of health care. Rather than perpetuating dependency on large, centralised psychiatric hospitals, mental health provision ideally occurs at provincial and district levels and in the hands of health workers in the community who are already trained in general health care (Freeman,1988). In this model, the more serious cases are treated by the more trained personnel at psychiatric hospitals; the less disturbed are treated in their homes by the less qualified. The emphasis is on treating people as close to their homes and work as possible, with institutionalisation being reserved for when absolutely necessary. Removing the mentally ill from their communities is considered disadvantageous in that it discourages community participation in the rehabilitation of the mentally ill as well as acceptance of them (Freeman,1988). The

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[5] At a minimum, community participation in mental health care involves acceptance of the mentally ill (as opposed to stigmatisation which results in pressure for institutionalisation).

success of the decentralisation model is contingent on close co-operation and referral between primary, secondary and tertiary levels (Freeman,1992a).

Community participation

Community participation in matters which affect people's health, including the identification of health problems and the design and evaluation of solutions, is a cornerstone of the PHC approach and has been labelled the *sine qua non* of effective mental health action (WHO,1984,1991). The emphasis placed on participation in health care in the PHC approach is related to the all-important process of empowerment, whereby people become actively involved in addressing the factors that determine their physical, social and mental well-being. In this way, health care is conceptualised in broader terms than the technicist interventions of medical professionals.

The process of developing meaningful community participation in PHC is, however, "fraught with hazards" and there is scant evidence of its achievement in the developing world (Mull,1990:42). Community participation in mental health care is particularly difficult to realise. For one, the level of community participation is determined by, among other factors, people's perception of need. While the issue of health care in general is likely to be valued by community members and therefore engender a degree of participation, the same, most likely, cannot be said for mental health care. This is especially true in contexts where there are other more pressing material needs to be met. On the basis of the experience of implementing a mental health programme in an impoverished *barrio* in Honduras, Eisenberg (1980) identifies the need for health education and promotion to raise the level of consciousness about mental health problems in deprived communities.*Peterson (1992) suggests that in such communities, mental health initiatives need to be undertaken within a broad development framework which allows for more pressing material priorities to be met, thereby creating "space" for mental health programmes. Another obstacle to community involvement in mental health care is that poverty and disempowerment have in some cases resulted in a sense of fatalism and apathy among the people (Ramphele & Ramalepe,1984; Mgoduso et al.,1992). Eisenberg asserts that "where anomie, despair, and disorganization are endemic, mental health for the individual is an unattainable goal except through the device of bringing people together into a social organisation" (1980:77). Therefore, mental health activities in Honduras were focused primarily on establishing a sense of "community" among the people as the foundation for co-operative activity.

Deprofessionalisation

Evidence suggests that priority mental health problems can be dealt with effectively by non-specialised health workers (WHO,1975; Harding et al.,1983; WHO,1984). Deprofessionalising mental health care necessitates extending the role of mental health professionals to involve training and supervision of non-professionals. Redefining the roles of mental health professionals and general health care workers needs to be co-ordinated if success is to be achieved (WHO,1984). Deprofessionalisation is not achieved simply, however, through additions to the role requirements of health personnel. As deprofessionalisation involves the decentralisation of power and control, it requires addressing resistances to this devolution of knowledge, skills and authority at both structural and interpersonal levels (Mgoduso & Butchart,1992; Seedat & Nell,1992). This issue will be examined further in exploring constraints to primary mental health care within the South African context.

Primary health care workers

The integration of mental health care into general health services requires that mental health components be incorporated into the work of the primary health worker and that he or she be appropriately skilled, equipped and supported (Freeman,1991a; Zwarenstein & Yach,1990). There is a need for grassroots workers who are generalists and who are able to provide a wide range of services, and to redress the view that specialists alone can deal with all cases of mental health problems (Freeman,1991a). Ben-Tovim (1987) notes that even in the West, only a small proportion of those who are psychologically distressed and who seek medical help are treated by specialist psychiatrists.

Deprofessionalisation is motivated as a means of utilising all existing health care resources to increase coverage of mental health care in a cost-effective way. It is also part of the trend to de-institutionalise mental health services (Guilmet & Whited,1988). As the treatment of mental illness often requires long-term medication, the closer the source of support and supervision, the greater the likelihood of acceptance and compliance with the treatment. Moreover, Guilmet and Whited (1988) contend that the use of community-based non-professionals should encourage greater community involvement in mental health care and the reintegration of "traditional" values, beliefs, and practices into mental health delivery. Nevertheless, the difficulties in initiating community involvement in mental health care and the reality of CHWs being trained to function as extensions of the formal health system suggest that these contentions are more ideal than real. Furthermore, research has indicated that where indigenous beliefs and practices conflict with biomedical ones, the health system's response may be to persuade people to abandon their lay conceptions in favour of biomedical ones (see Abiodun,1991 below).

Community mental health workers: pros and cons

On the one hand, the principle of decentralising mental health care through the training of CHWs would seem to be a good idea. CHWs have been successful in performing tasks that are usually part of the professional domain, they are accessible to the community in terms of locality, and are knowledgeable about social and cultural factors affecting people's health behaviour (Srinivasa Murthy & Wig,1983; Kuhn et al.,1990). CHWs are expected not only to live in the community in which they serve, but also preferably to share in people's beliefs, values and customs (Bastien,1990). Where the expectation that CHWs be truly representative of the communities in which they serve is met (Ramprasad,1988), CHWs may be 'key informants' in gaining an understanding of community members' beliefs and practices. By virtue of their generally living in their work environment, CHWs should be sensitive to the contextual factors which determine and shape psychological distress. These factors support the argument for CHW involvement in mental health care.

On the other hand, a consideration of the original intentions of the CHW concept, evidence of their actual achievements (Berman et al.,1987; Walt,1990) and the peculiarities of *mental* health care may present a counter-argument to their proposed involvement in mental health care. Also, it is questionable whether CHWs, who are often faced with more problems than they are able to deal with, as well as a lack of adequate support and supervision, are willing to assume further responsibility for mental health care.

Examining the context in which the CHW concept was developed, an important factor to note is that they were recruited and trained to deal with *specific* needs of communities. Their training generally includes an emphasis on education and prevention, treatment of common diseases and first aid. Walt (1990) suggests that one of the conundrums facing CHWs is that although many illnesses are preventable, they are not *easily* preventable, a fact which is seldom acknowledged by health professionals: "The rationale for training CHWs is based on the knowledge that much ill health is preventable, and on the assumption that most of the problems of ill health faced in a community are fairly common and can be relatively simply treated" (Walt,1990:37). Walt goes on to say that "from previous studies, there seems little likelihood of CHWs being able to affect changes in people's belief patterns or day-to-day activities" (1990:171). In short, CHWs' preventive successes seem to be more modest than their curative ones.

Difficulties of preventive mental health care

Preventing or curing mental illness is difficult both conceptually and practically. In terms of conceptual difficulties, varying definitions of mental health (in narrow biomedical terms or as a state of social, physical and mental well-being) result in different operationalisations of preventive mental health action.

There are also several practical problems in the prevention of mental illness. Firstly, not all mental illness is preventable. Even if all oppressive and unjust laws and practices were to be eradicated, a number of costly and socially disruptive forms of mental illness would still exist. These would require treatment and possibly tertiary prevention. Therefore the success and acceptance of primary preventive action presupposes the presence of adequate curative services. In South Africa, preventive programmes are marginalised by pressure to redress the inadequacy of curative services to meet the needs of people currently experiencing psychological difficulties (Vogelman,1990). Vogelman also notes that the absence of preventive care is less noticeable and has fewer political repercussions than that of curative services. In addition, the benefits of preventive care are appreciated only in the long-term.

Several authors have noted the tendency for CHWs to concentrate on curative care and function as extenders of the health sector, rather than performing the more difficult role of being community developers and agents of change (Berman et al.,1987; Kaseje,1991). This is partially a result of people's preference for being treated in *tangible* ways and hence for the more concrete treatment modalities of the medical system (Nell,1989). CHWs are expected to respond to the felt needs of the people in the community and there is evidence that mental health problems are often 'invisible' because they may be represented in terms of physical complaints and disorders (WHO,1984; Kirmayer,1986).

Nell (1989) argues that mental health care is unique among the health care modalities in that it cannot succeed with a 'passive' client. Rather, it requires people to mobilise their own resources and accept responsibility for healing themselves. This contention offers little optimism for effective mental health care delivery in disempowered communities (such as those often served by CHWs) where poverty may result in fatalism and passivity that makes the goals of self-help unrealistic (Ramphele & Ramalepe,1984). Moreover, proponents of the PHC approach, who note the inextricable link between health and socio-economic and political factors, would argue that mental health is also contingent on factors outside of the individual. In this view, mental ill health is not seen as an individualised problem. Rather, it is perceived as being brought about by a "stable, just and democratic political and economic environment in which basic human needs such as adequate housing, food and employment are provided for" (Freeman,1992a:2). Engaging an oppressed community in collective action aimed at redressing societal and political ills would seem to be an even more daunting task for CHWs. Also, as I have noted already, social justice will not rid society (or the CHWs!) of the problem of mental illness. This reiterates the importance of adequate and accessible curative services for the communities in which the CHWs work.

Both the CHW literature and my personal contact with CHW projects (Binedell,1990) reflect very little evidence for an explicit mental health focus in CHW projects. There is evidence that CHWs have generally negative attitudes towards dealing with mental illness, viewing mental health care as a specialised skill and stigmatising the mentally ill and regarding them as "dangerous" (personal communication with St John's CHWs; Freeman,1991a). Freeman (1989a,1989b) and Ignacio et al. (1989) suggest that these attitudes are a result of a lack of knowledge and skill in dealing with the mentally ill, and that, after training, more health workers advocate mental health work as part of general health concerns.

An important complement to providing training for CHWs in mental health care is the availability of mental health professionals in a supervisory and supportive role. There are, however, virtually no mental health professionals in community settings in South Africa outside state health and other bureaucratic structures (Freeman,1991b; Nell,1992). CHWs often work in areas that are isolated from other health care centres. As a result, they may be the only trained health workers in their community and may be expected to cope with a variety of problems in the absence of adequate support and supervision (Walt,1990).

Training of community health workers

Robinson and Larsen (1990) suggest that the support of the community, as the primary work environment and cultural reference group of the CHWs, carries more weight in sustaining CHW performance than that of the health system. Consequently, they argue that the health system needs to orientate its training of CHWs to promote the CHWs' status in the community by encouraging the community to respect their knowledge and yet not feel alienated from them. There is evidence, however, that training may be implicated in alienating CHWs from the communities they serve (Werner,1980; Kaseje,1987; Matomora,1989; Bastien,1990).

Basing their line of reasoning on the Freirian ideas of "conscientisation" and empowerment through education, as well as the experiences of non-formal education, some health planners have argued that CHWs are far more than health care deliverers (Walt,1990). They fulfil an important role as educators, conscientisers, liberators and agents of change, challenging the medical profession's monopoly interest in health care (Walt,1990). In cases where CHWs are extensions of controlling, paternalistic health systems, they are likely to become agents in "community oppressive" as opposed to "community supportive" programmes and evoke distrust and antagonism in those they serve (Werner,1980). Werner (1980) voices concern for not only the content of the training but also the method by which it is taught.

Freire proposes that education is about a *dialogue* that is set up in a horizontal relationship between teacher and learner in which knowledge is not a given but must be discovered anew in each learning context. Training that is modelled on this approach and is a flexible, dynamic, two-way process with both the trainer and CHW giving and receiving, not only provides the CHW with skills and knowledge, but also lends an example of how to engage people in the community in a supportive and facilitatory way: "A CHW who has discovered *her* own potential during training is surely more likely to help villagers discover *their* abilities once she starts work" (Hammond & Buch,1984:9).

Freire and Shor (1987) speak against imposing a curriculum that has been invented in isolation from the context in which it will be used. Similarly, Werner and Bower (1982) and the WHO's guidelines for training CHWs (1987) caution against planning training "backwards", where the course content is decided on before considering the special needs, resources, strengths and customs of the people involved. Such an approach results in a mismatch between what is taught, the community's needs and the health workers' abilities and concerns.

Turning to the issue of mental health training, it is generally agreed that the scope of CHWs' work is related directly to the training they receive (Kaseje,1987), participation in mental health care being linked to mental health training. Ignacio et al. (1989) note that, after mental health training, a broad range of health workers, including CHWs, in developing countries who had previously considered mental health care to be a specialised health concern were advocating some types of mental health care as integral to their work. After training, health workers became more capable of dealing with patients experiencing mental health problems and were more sensitive and willing to participate in psychosocial issues involving the families of their patients and their community.

In planning mental health training for CHWs, sensitivity should be paid to a number of factors. These include awareness of CHWs' potentially burdensome workload; their vulnerability in a clinical situation; and the need for CHWs to uphold realistic expectations about the changes their actions can affect.

Considering the existing workload of CHWs in meeting basic health needs in their communities, any addition to their job description needs to be judicious and guided by prioritised tasks (Srinivasa Murthy & Wig,1983). Time constraints apply not only to what a CHW can be expected to achieve, but also to time available for additional training in mental health care. In situations where CHWs' work and home environments overlap (as is frequently the case), they are not able to maintain a 'professional distance' from the people they serve, a factor which makes them particularly vulnerable to occupational stress (Pearlin & Schooler,1978). As a result, they need to be protected from over-involvement in the clinical situation. As it is, the nature of much of CHWs' activities does not result in an immediate and measureable impact in terms of the indices of health status (Berman et al.,1987). Therefore the health workers' expectations about the extent of improvement in psychiatric patients need to be realistic.

Freeman (1988) suggests that the emphasis in training should be on "doing" rather than on "knowing". In other words, it should be task- or problem-oriented. In addition, it should provide a specific approach to key problems, rather than providing general information about many different mental disorders. This was the approach adopted in the training of CHWs in Kenya (Kaseje,1987). The experiences of CHWs were elicited and shared in an attempt to identify, analyse and find solutions to specific local problems. Training occurred as close to where the CHWs lived as possible so that it was carried out in the context in which the problems occurred. The trainers were people who understood the problems, lived in the area and were known by the CHWs. In contrast to the stance adopted by Abiodun (cited below), Kaseje concludes that "the curriculum for CHWs must be adapted to the health problems and traditional health practices of the community and concentrate on specific tasks that the workers will be expected to perform. The 'target' community should be actively involved in assessing its own health needs" (1987:70). As Eisenberg (1980) noted, communities may not, however, perceive mental health to be a priority. In such cases, health promotive activities aimed at raising the level of consciousness about mental health problems may be required.

Primary mental health care programmes

The PHC approach has been implemented as a low-cost alternative for extending mental health care in developing countries (WHO,1975; 1984). Even in large cities with well-established institutions for the mentally ill, community-based models of care, involving the participation of health auxiliaries, relatives and neighbours in the rehabilitation of the mentally ill, have been achieved (WHO,1984).

Examples of programmes that have attempted to integrate mental health care into general health structures and the baseline research that informed their design will now be reviewed. It is noted that these studies, with few exceptions, involved decentralising *medical* care in the context of scarce resources where prioritisation of intervention needed to be confined within narrow limits.

The WHO Collaborative Study on Strategies for Extending Mental Health Care has initiated primary mental health care programmes in several developing countries, including Northern India, Sudan and the Philippines (Wig et al.,1980). In each of these three countries, baseline observations were made for the purposes of assessing the effectiveness of the intervention; gathering information for the prioritisation of tasks and the design of appropriate intervention, including training materials; and stimulating community involvement through education. A key aspect of this baseline research was a survey exploring community perceptions of and reactions to mental disorders, sources of help for people with mental illness (with emphasis on the role of indigenous healers) and the detection of cases of mental disorder in the community.

The study adopted a "key informant" approach, the sample comprising those "individuals whose social position made them influential and brought them into contact with a large number of people" (Wig et al.,1980:112). A structured questionnaire was used, including a series of vignettes that were designed to portray several mental disorders without using technical language and including local names, expressions and customs. The findings related to the perception of mental disorders and treatment choice. On the basis of the extent of community awareness and concern for the problems of alcoholism and drug dependence, these problems were included as priorities for intervention. In all areas, what the authors termed "modern" health services were the preferred source of help for physical rather than psychiatric health problems.

In Thailand in 1979, the government launched a pilot project at village level as part of a policy of incorporating mental health care into PHC structures (WHO,1984). Rural health workers were given a three-day training course in mental health care promotion and simple psychiatric treatment so as to be able to manage a number of specific mental health problems. The CHWs were supervised by staff working at a large psychiatric hospital. An evaluation after a year showed a dramatic reduction in mental health problems and a concomitant increase in the community's satisfaction with services. Specifically, the report showed an increase of almost 300% in the number of psychiatric patients attending out-patient health services, accompanied by a gradual decrease in hospital attendance.

Nigeria has adopted a National Mental Health Policy which seeks to integrate mental health care into PHC (Abiodun,1991). As a first step to involving PHC workers in mental health care and as a means of assessing training needs, an exploratory study was conducted to gain information about PHC workers' attitudes, knowledge and skills regarding mental health problems. A sample of 207 PHC workers, including CHWs, completed a structured questionnaire addressing (i) the nature of their work; (ii) perceptions of the aetiology of mental disorders; (iii) ability to recognise cases of mental disorder as described by a series of vignettes; (iv) attitudes to patients with mental disorders; and (v) knowledge of drugs commonly used to treat mental disorders.

The research findings indicated a marked underestimation of the prevalence of patients presenting with mental illness at PHC facilities. Eighty-two percent of the sample thought that mental illness accounted for less than 5% of all attendance at PHC facilities, a figure that is considerably lower than WHO's (1990) suggestion of a 20% prevalence of psychological problems seen in PHC settings. A difficulty in interpreting these results lies in determining what constitutes 'mental illness'. The diagnosis of people as having primarily psychological as opposed to physical disorders is subject to interpretation. Much literature documents the high percentage of people who 'somatise' their psychological distress (Kirmayer,1986). This issue will be explored further when considering the question of somatisation. While the majority of PHC workers (80%) believed that the problems of mental health care could be addressed by existing health facilities, there was an overwhelming preference (96%) for referring mentally ill patients to general hospital psychiatric units or mental hospitals as opposed to dealing with them personally.

The study indicated that the majority of PHC workers held what the authors termed "traditional beliefs" about the causation of mental disorder; that is, mental disorders were attributable to charms, evil spirits, witchcraft or being cursed by enemies. Holding traditional views on the aetiology of mental disorder was associated with no previous mental health training. Traditional understandings of the aetiology of mental illness were accompanied by a preference for "traditional" forms of treatment, with only 22% of the PHC workers favouring hospital treatment above traditional treatment for mental illness. The prevalence of traditional views on the aetiology of mental illness among these PHC workers led Abiodun to conclude that "since PHC workers are expected to play a frontline role in educating their communities on various aspects of health related issues...there is an urgent need to re-orientate these health workers on the nature and causes of mental disorders. These will in turn ensure the dissemination of accurate information to lay community members" (Abiodun,1991:117).

Abiodun may be accused of asserting the primacy of Western medicine as *the* unchallengeable framework for assessing any other system with the conclusion that people with differing explanations need to be educated into accepting this paradigm. Instead of using information on PHC workers' attitudes and knowledge of mental health to bridge the gap between "traditional" and "modern" medicine, Abiodun proposes that the research findings are to be used to 'convert' PHC workers to the biomedical approach. In this regard, Singer cautions against the danger of researchers.becoming "trapped in a restricted role as the translators of cultural knowledge to health care providers" (1989:1195) for coercive purposes (to get people to do and believe things that medical practitioners consider good and right) and in ways which reproduce power structures within the medical profession.

Guilmet and Whited (1988) criticise the ingrained ethnocentricism and scientism of modern medical and psychiatric professions that overlook the function and significance of indigenous health systems. They speak of the tendency for health professionals, when in contact with indigenous health care systems, to "restructure indigenous health care delivery by copying the idealized model of professional care prevalent in technologically advanced societies" (1988:301). Furthermore, this elevation of the role of professional practitioners does not match the actual situation, in which the majority of all health care occurs within the family context.

The issues raised by the above research are complex. Having access to biomedical knowledge places a researcher in a powerful position for which he or she needs to take responsibility. Research and intervention are inextricably linked and whether the effects of the research are empowering or disempowering for the participants is a key issue which the researcher has to face. If researchers believe they have 'better', more accurate knowledge, surely they are morally and ethically obliged to offer it? The way in which knowledge is offered may, however, be either "community supportive" or "community oppressive" (Werner,1980). These questions will be considered later in discussing the report back of findings in the current study.

The discussion will now be shifted to examine health care and mental health care within the South African context.

South Africa and the primary health care approach

After having been an active member of the WHO from its inception, South Africa was suspended in 1974, resulting in increasing academic isolation from global developments in the field of public health, the debates that led to the Declaration of Alma-Ata and subsequent public health policy (Yach et al.,1989). In 1980, the National Health Services Facilities Plan indicated governmental commitment to the PHC approach; little, however, has been done to put this into practice (Whittaker,1990). In 1990, the South African Minister of Health, Rina Venter, stated that "nothing has come of the high ideals of the National Health Services Facilities Plan...or its aims to make necessary services available to all" (in Greenblo,1990:9). Mathews affirmed that "despite the government's acceptance of the WHO's definition of PHC, the conception of primary care was characterised by fragmentary health care provision, little community involvement in controlling services and even less in challenging political, economic and social factors which affect health adversely" (1992:83).

In South Africa in the 1970s, impetus for establishing PHC projects on the basis of the principles of the PHC approach came from the non-governmental 'sector'. Innovative primary care projects and services were established by mission hospitals and non-governmental organisations (Mathews,1992). The National Progressive Primary Health Care Network (NPPHCN) was established in 1987 as a forum for collaboration among these initiatives and to develop national PHC strategy for an appropriate health care system. In the past few years, there has been increased interaction between the Department of National Health and Population Development, the NPPHCN and progressive PHC projects in a united attempt to develop appropriate PHC policy. Despite this, Chetty, on behalf of the Western Cape African National Congress Health Department, responded critically to Mr de Klerk and Dr Rina Venter's recent visit to Khayelitsha, which was purported to be a demonstration of the government's concern "to bring PHC to the people":

> While the present government claims to subscribe to the principles of PHC, the evidence to date indicates that there is no political will or commitment to effectively implement PHC...The government is directing substantial resources (nearly R13-million for 1992/3) into "special PHC projects"...But many people in rural areas, peri-urban and other disadvantaged areas do not have access to essential health services. While the government widely publicises its intention to build extra clinics...it appears not to be making adequate provision for the recurrent expenditure necessary to operate these clinics. In the absence of such financial guarantees, it is likely that these clinics will be built and then stand empty, as has recently been documented in the auditor general's report on government financial mismanagement.[6]

The present status of health care in South Africa, particularly mental health care, indicates that there is much ground to cover before the health care system approximates the tenets

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[6] Letter to the Cape Times from Dr K. Chetty - 8-3-1993

of the PHC approach. The standard of health care provision is compromised by fragmentation of both the control and delivery of health care; progressive privatisation; gross inequality of services for different racial, social and geographical groups; and an emphasis on secondary and tertiary health care at the cost of prevention and PHC (Jinabhai,1987; Freeman,1989a).

Many of the problems of fragmentation and mismanagement of existing resources are rooted in Apartheid ideology. As Nadelson observed, "South Africa is the only nation where the greatest differences in resource-allocation occur because of race" (cited in Dommisse,1987). Fragmentation to the ludicrous extent of fourteen different health departments in the public sector, with the resultant duplication of services and waste of resources was, until recently, rationalised on the basis of each 'ethnic' group having its own health service. Curative and preventive services are effectively separate, with curative care being under provincial administration and preventive care being provided by the state and local authorities. Swartz (1989) argues that just as the concepts of 'ethnicity' and 'culture' are abused for political purposes in the justification of separate health departments (with disparate health budgets), so the concept of 'community', in the context of "community-specific and community-sensitive" services, is similarly perverted as a "gloss for inequalities" (1989:59).

Mental health services

A general lack of health care resources has contributed to the marginalisation of mental health issues in health care provision (Heyman & Vandenbos,1989) with the result that mental health services are grossly inadequate (Vogelman,1986; Freeman,1989a,1992a; Allwood,1990). Disparities in mental health services reflect broader social and political conditions in South Africa. Racist ideology manifested itself institutionally in segregation and inequality in mental health services from as early as the turn of the century (Foster,1991). It was only in 1990 that the practice of segregation along racial lines in hospitals began to disappear on any large scale. Furthermore, in the case of services for children with mental handicaps, the policy of desegregation does not even apply since only services for whites existed up until very recently. In 1987, a government report on disability in South Africa admitted that there were virtually no services for Black mentally handicapped children (Foster,1991).

While the ratio of health workers to population in South Africa is reasonable by comparison with other developing countries (Pick,1992), the distribution of these personnel is cause for concern. A small proportion of mental health personnel (among others, 10% of clinical psychologists) serve the majority (80%) of the population in the public sector. Nearly half of the total health care expenditure is spent in the private sector and this caters for the needs of 20% of the population, just 6% of whom are Blacks (Freeman,1991b). The growing trend towards the privatisation of mental health care will disadvantage the poor (i.e. Blacks) even more (Freeman,1989a).

Apart from problems attributable to 'Apartheid health care', the adequate provision of mental health care is obstructed by the dominance of medical care. At present, mental health care is chiefly curative and reactive, occurring at the hands of the medical profession with its emphasis on the mentally ill (generally psychotic patients) and the mentally handicapped (Freeman,1992a). Although the significance of these services in alleviating the distress of the mentally ill within clinical settings is recognised, they have little impact on the mental well-being of the wider population (Mgoduso et al.,1992). A reliance on institutionalisation is clearly reflected by health and welfare expenditure which is channelled largely into psychiatric beds (double the amount recommended by the WHO for First World countries) and the funding and administering of disability grants (Binedell,1991; Freeman,1992a). This results in a neglect of community-based and preventive, promotive and rehabilitative aspects of mental health care. In 1988, 93% of the mental health budget was spent on hospital care with only 7% being allocated for community care, including prevention and promotion (Freeman,1991a). Given the meagre allocation of funds to community care, mental health structures within primary care hardly exist.

An over-reliance on institutionalisation is criticised on several grounds. It creates difficulties in social readjustment for the psychiatric patient and has been shown to discourage acceptance of the mentally ill and community participation in their rehabilitation (Freeman,1988). Furthermore, the removal of the mentally ill from their home environments often serves to mask the impact of socio-political and environmental conditions on illness. Institutionalisation is also seen as a reflection of the monopolisation of mental health care by medical professionals and this is criticised on several accounts. Firstly, it may reinforce the "individual blaming syndrome" in that the individual, as the target of intervention, is seen to be the location of the problem (Freeman,1988). Secondly, it is seen as dismissive of indigenous and popular approaches in the treatment of the mentally ill and discourages patients' participation in the construction of illness and its solutions. Thirdly, if, the biomedical perspective is presented as the only way of addressing mental health problems, lay dependency on professionals and the disempowerment of health care consumers is maintained (Petersen & Hansson,1987; Freeman,1991a; Seedat & Nell,1992).

Clearly, there is much evidence that points to the urgent need for the transformation of mental health care in this country. Many demands for improvements in other sectors (including housing, education, employment, etc.) are being made on limited human and financial resources. In the light of this, mental health care may arguably not be a high priority for the majority of South Africans and social planners (Vogelman,1990; Freeman,1992b). Despite the evident scarcity of resources, Freeman advocates that the mental health of South Africans *should* be a priority in this transitional phase "not only because of the welfare of the individual...but also because social and political reconstruction and development is to a greater or lesser extent dependent on the ability of citizens to participate and actively build the social order" (1992b:41).

It is suggested that the question is not *whether* resources should be given to the management of mental health problems, but *how* existing resources can be most usefully employed to assist distressed and disturbed individuals (Ben-Tovim,1987). One means of utilising existing resources to extend mental health care is the implementation of the primary health care (PHC) principle of deprofessionalisation through the training and equipping of grassroots health workers such as CHWs. Another existing health care resource that is receiving increasing attention from health planners and policy makers is indigenous healers.

Indigenous healers

One cannot talk about CHWs without talking about indigenous healers, who are already CHWs of a kind. In fact, in rural areas where community-based services are often non-existent, indigenous healers may be synonymous with PHC (Freeman & Motsei,1990). The term 'indigenous' is used here in preference to the value-laden term 'traditional', which is often applied in a derogatory way in the South African context to refer to people who are seen and portrayed as 'conservative', 'pre-rational' and 'primitive' (Spiegel & Boonzaier,1988). In this usage, a dualism is set up between indigenous and so-called 'modern' medicine, where the latter is seen as the preserve of 'modern', 'progressive' or 'developed' people.

While not being discrete categories, indigenous healers in South Africa may be classified into the traditional doctor or *inyanga*, the diviner or *isangoma*, and the faith healer (Swartz,1989; Freeman & Motsei,1990). The *inyanga* is usually a man who, after a period of apprenticeship to another *inyanga*, is qualified to use herbal and other medicinal preparations in the treatment of illness. The *isangoma,* who is usually a woman, is called to be a healer by her ancestors and enters a period of accepted spirit possession after which she trains to develop her clairvoyant powers. Healing is strongly emphasised within African Independent churches, where the faith healer, whose health care integrates Christian ritual and indigenous practices, uses divination and herbal medicines to diagnose and treat.

In South Africa, "dual treatment" by both indigenous healers and biomedical practitioners regularly takes place (Freeman & Motsei,1990), with approximately 80% of Blacks consulting an indigenous healer as their first source of help outside the popular sector (Freeman,1992c). Officially, the practice of indigenous healing in South Africa is illegal (Freeman,1992c). In terms of government legislation, any healer not registered with the South African Medical and Dental Council (later amended to include registration with the South African Associated Health Services Professions Board) is forbidden from practising or performing any act pertaining to the medical profession (Freeman,1992c). In reality, however, there are an estimated 200 000 indigenous healers in South Africa who continue to practice without legal consequences (Lansdowne,1991). In the minority of cases, co-operative relationships with biomedical practitioners have been established (Freeman,1992c). Nonetheless, there are many indigenous healers who perceive the current legislation, which essentially disregards them, to be discriminatory and a constraint to the development of indigenous healing (Freeman,1992c).

Ben-Tovim (1987) comments that, in recent years, progressive disillusionment with Western social and economic systems has led to a re-evaluation of indigenous care. In the spirit of Alma-Ata, widespread attempts are being made to harness indigenous healers in efforts to improve the health of communities. Local debates around indigenous healing are focused on the integration of indigenous healers into the formal health care system and the various forms this could take (Freeman & Motsei,1990; Freeman,1992c).

Freeman notes that biomedical and indigenous healers operate from quite different (perhaps intrinsically incompatible) paradigms, disparities that are reflected in "the reasons why a person becomes a healer/health worker; in the structure of the training; in the reasons why people are perceived to be ill; in the way diagnosis is done and in the way in which treatment is given" (1992c:67). As a result, negotiating a means of co-operation between the two models of health care is understandably difficult.

Arguments for the inclusion of indigenous healers into the health system are defended by reference to the scarcity of health resources; the benefits of indigenous healers' 'holistic' approach to health care; the inaccessibility of certain 'African illnesses' to Western medicine; and the view that colonial exploitation, embedded in Western health care, should not be allowed to extend to indigenous practices (Freeman & Motsei,1990). Counter-arguments come from three different quarters: biomedicine, indigenous healers themselves and proponents of the political economy of health perspective (Freeman & Motsei,1990). These will be discussed in turn.

While many biomedical health practitioners acknowledge indigenous healers' accessibility and acceptability to many health care consumers, some are dismissive of indigenous healing as 'primitive' and 'unscientific' or actually harmful (Freeman & Motsei,1990). Concerns voiced by indigenous healers include that the integration of indigenous healing into biomedicine is a move to 'colonise' the former and subvert it to the hegemony of Western medicine. As Ben-Tovim notes, "espousal of traditional medicine has become one way for a nation to assert that its own traditions still have power and relevance" (1987:173). Swartz (1989) contends that a central issue in any collaborative scheme between indigenous healing and biomedicine, particularly in the South African situation, is that of who holds the ultimate power. Other perceived threats of integration include a lowering of the status of indigenous healers in their communities as their client-base is undermined by biomedicine, and a decrease in their remuneration as a result of the regulation of rates. According to Zungu, the National President of the Southern African Traditional Healers Council, the individual way in which healers work (mostly in the form of one-to-one interactions with their clients) makes the integration of healers into the PHC system an extremely difficult issue (Lansdowne,1991). Proponents of the political economy of health perspective consider the unequal power relationship which perforce exists between indigenous healers and their clients to be disempowering for the latter. In addition, indigenous healing, in its conceptualisations of the aetiology of illness, is accused of masking socio-economic forces which determine health status.

In conclusion, it is noted that nowhere in the world has a comprehensive formal "dual" health system been achieved (Freeman & Motsei,1990). There are, nevertheless, examples of successful small-scale cooperative relationships between indigenous and biomedical health care systems, notably in the Ciskei[7], Swaziland and Zimbabwe (Freeman & Motsei,1990).

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[7] Personal communication with the community psychiatric nurse in Khayelitsha, G.N. Kuse, who previously worked at Celia Makewane Hospital in the Ciskei and reported regular meetings between the health team and indigenous healers and a pattern of mutual referral.

Extending mental health care

Two strategies for the reconstruction of mental health care that have been proposed are the primary mental health care (PMHC) approach and the community mental health centres (CMHC) approach. The CMHC approach involves the development of community health care structures independent of those already existing in a community. Given South Africa's financial constraints, this model has been argued to be less appropriate in that it necessitates the costly creation of a new health infrastructure as opposed to amending the existing one (Freeman,1992a). As Vogelman questions, "considering that a post-Apartheid government may need to concern itself with providing adequate housing and nutrition for the majority of South Africans, will South Africa be able to afford the building of...community mental health centres in what would have previously been known as the African townships?" (1990:504). Having delineated arguments for the integration of mental health care within a PHC framework, I will now present counter-arguments to PMHC, with particular reference to the South African context.

Obstacles to primary mental health care

While the existence of a viable structure for mental health care has been named an advantage of the PMHC approach, it is argued that the existing structure of health care in South Africa may frustrate the realisation of the PHC approach (Mgoduso & Butchart,1992; Seedat & Nell,1992). Seedat and Nell (1992) and Mgoduso and Butchart (1992) assert that in the context of an authoritarian, biomedically orientated health system, innovations within primary care structures, such as integrating psychological care into traditionally biomedical roles of primary care workers, can result in the perversion of a progressive and empowering concept such as the PHC approach.

By way of example, Seedat and Nell (1992) suggest that the training and accrediting of Black nurses in primary care clinics in Soweto, a Black township close to Johannesburg, may be interpreted as a political manoeuvre aimed at giving the appearance of "full participation" by the people in the health care system, while protecting and maintaining the credibility of state-controlled and biomedically monopolised health services. Alternatively, the authors suggest that this move may be construed as providing second-class care for oppressed communities. In this respect, the use of CHWs is open to perversion if they are viewed as a cheap substitute to governmental provision of adequate health services for the poor and politically powerless (Hammond & Buch,1984).

It is suggested that the organisation of health care in South Africa, which serves the interests and reflects the biomedical monopoly of health care, entrenches specific power relations and proscribes certain health care practices (Mgoduso & Butchart,1992). Change at the organisational level is viewed as prerequisite to changes in the micro-level processes of health workers' roles (for example, extending their role to include mental health care) and their interaction with the health team and patients. After interviewing PHC nurses working in Soweto who attempted to integrate psychological care with their traditional biomedical role, Mgoduso and Butchart conclude that "psychological skills and their application into patient care, although perceived as useful and desirable by nursing staff...cannot prosper in a context of power relationships and organizational structures dedicated to the promotion of biomedical remedies" (Mgoduso & Butchart,1992). Contrary to the democratising, demystifying goals of the PHC approach, the politics of professionalism may demand that PHC workers adopt the powerful language of disease and the curative, "quick-fix" mode of Western biomedicine. As a result, PHC workers may entrench the biomedical approach, marginalise lay conceptualisations of illness and healing, and disempower health care consumers from active participation in health care.

Furthermore, the principle of decentralising mental health care needs to be reflected in facilities, building programmes, community-based posts, and incentives for mental health workers within communities. The PHC approach requires addressing preventive and promotive aspects of mental health care, the difficulties of which have been discussed above. In addition, the lack of interest or negative attitudes towards mental health care noted among general health workers will have to be overcome (Binedell,1991).

Finally, without a re-allocation of resources (however scarce they may be) to the under-served, health care will continue to address the symptoms rather than the causes of disease and is unlikely to improve significantly the health status of the people who are most in need. In the absence of government commitment to a more equitable distribution of health resources, even seemingly progressive concepts, such as the PHC approach and CHWs, may be perverted to provide cheap and inferior health care for the masses.

Challenging biomedical ideology requires a re-conceptualisation of health, illness and healing that takes cognisance of the individual experience of illness and the broader socio-economic and political realities that shape the experience and distribution of illness. Anthropological theories that address these issues will be explored in the following chapter.

CHAPTER 2

ANTHROPOLOGY, ADVOCACY AND PRIMARY HEALTH CARE

In reviewing the literature that has informed this research, I note that the bulk of theory has been anthropological in nature. Within the field of medical anthropology, hermeneutically interpretive approaches have much to offer in service of humanising, demystifying and democratising health care. In particular, Kleinman's explanatory model framework (1980) is an important tool in tapping the individual's experience of distress and provides knowledge that will enable intervention to be orientated towards this subjective experience. Furthermore, it highlights the importance of negotiating conflicts between professional and lay explanatory models in an effort to provide health care that is acceptable and 'makes sense' to both health care deliverers and consumers. An examination of cultural constructions of illness does not imply that expressions of mental illness can be reduced to a discourse on culture. In this respect, critically interpretive medical anthropology contributes a valuable perspective in seeing illness as embedded in social and political structures.

I began the preceding chapter by tracing the changing ideas about health and health care that led up to international endorsement of the PHC approach. I introduce this chapter by noting developments in the nature of anthropological involvement in PHC settings over the past 50 years and the changing conceptual bases that informed this research.

Anthropological involvement in primary health care: an overview

The early phase (1945-1960) of anthropological involvement in health care in less developed countries corresponded with the large-scale introduction of biomedicine in many areas. Anthropologists assumed the role of "cultural brokers" and operated from a conceptual basis referred to as the "adversary model" (Foster in Coreil,1990). In this approach, acceptance of biomedical practices was seen as requiring people to abandon their existing health beliefs and practices. Anthropological research involved an "ethnography of health habits" to isolate the cultural barriers between indigenous and biomedical health care. Inherent to this approach was a dualistic conception of health service utilisation, with indigenous and biomedical health care seen as 'either-or' treatment systems with particular illness domains.

The middle period (1960-1975) was characterised by the movement of anthropologists from applied to academic settings, as the focus in the international health field moved from community development to hospital-based curative services, secondary and tertiary care, and highly sophisticated technological innovations. Anthropological research interests shifted from applied work to theoretical problems, as reflected in the emergence of cognitive anthropology and ethnosemantics. Some researchers adopted traditional epidemiological approaches and concepts from medical ecology, examining cultural practices as "risk factors" for disease or as beneficial for health.

In the late 1970s, two developments within the health field precipitated the re-entry and expanding involvement of anthropologists in PHC. These were the shift in attention to the rural poor with the need to develop appropriate technologies to meet the health needs of less developed countries, and increasing attention to the potential benefits of integrating indigenous healers into service delivery. These interests were marked by two important events in 1978: the WHO-UNICEF conference on PHC at Alma-Ata and the WHO Programme on Traditional Medicine, endorsing the use of indigenous healers in national health systems (Velimirovic,1990). Anthropological expertise became increasingly valued as social marketing principles and methodologies (notably the focus group interview) were adapted for the purposes of doing "social soundness analyses" in all development projects.

The anthropological approaches of the late1970s and the 1980s introduced more complex models to the domain of health beliefs and practices, focusing not only on concepts of disease but also on illness terminology; lay theories of illness causation; folk illness categories; diagnostic criteria for evaluating symptoms; and the language of distress used to describe illness experience. The dualistic conceptualisation of help-seeking has increasingly been replaced by a "multivariate decision process model" (Young in Coreil,1990:11). Choice of treatment is examined in the context of different illness episodes and multiple options within pluralistic health care systems. There has been increased interest in the household as a site of the production of health care and as the primary locus for decision-making about treatment options.

After a history of research focused on client populations, a critical perspective within anthropology has emerged. This addresses the social organisation of health care and its political and economic context as the locus of change. In the PHC setting, this approach is translated into an examination of inequities of power and wealth, barriers to effective community participation in decision-making, and the lack of equity in health services in meeting the needs of the most disadvantaged sectors of the population. The "adversary model" has been superseded by the "insight model" in which "knowledge and explanation of the cultural underpinnings of health-related phenomena are applied in a positive fashion to integrate new ideas and practices with what already exists and has meaning for populations being served" (Coreil,1990:12,13).

I will now examine the contribution of specifically medical anthropological approaches of the late 1970s and onwards in greater detail.

Medical anthropology and advocacy

Since the mid-1970s, the growing dialogue between social anthropology and the disciplines of psychiatry and medicine has alerted health care deliverers to the importance of sensitivity to and accommodation of cultural values in health care (Kleinman,1977,1980; Marsella,1982). In particular, medical anthropology has made an important contribution to cross-cultural psychiatry in its role of "advocacy" whereby the patient's perspective and values are brought to the fore in an attempt to move away from the ethnocentricism of Western psychiatry and its services (Littlewood,1990). In so doing, a more patient-centred practice, which represents the patient's perspective on illness and explores the meaning of illness, has been put forward as a challenge to a purely medical outlook on health problems. By accessing popular understandings of illness, anthropology addresses an important gap in health professionals' knowledge, as well as being valuable in terms of reaching decisions about effective treatment strategies and service provision in health care.

From disease to illness: principles of the 'new psychiatry'

The 'new psychiatry', an interdisciplinary field merging biomedical and anthropological approaches, provides an alternative theoretical and methodological paradigm to the 'old transcultural psychiatry' (Kleinman,1977; Littlewood,1990). The theoretical and methodological differences that distinguish the 'old' from the 'new' are as follows. Transcultural psychiatry undertakes comparative studies with the aim of establishing universal generalisations about illness. By contrast, the new psychiatry, operating from a perspective of cultural relativity, has a contextual approach that focuses on texts of distress in qualitative detail. A central focus is the influence of what Kleinman has termed "explanatory models" (EMs) on the communication of distress and the way it is managed. An attempt is made to move away from the ethnocentricism of transcultural psychiatry that asserts the primacy of Western psychiatric categories as the framework for assessing local 'psychiatric' systems. This claim is based on the biomedical assumption that "human universality must lie in the supposedly culture-free workings of the human body" (Swartz,1991).

Proponents of the new psychiatry see the transcultural psychiatric paradigm as problematic in terms of its scientific objectivism which reifies disease, seeing it as a reflection of what is 'real' and 'in nature'; a view of culture as something superficial, which masks the 'real' disease process and can be separated from it; and a technological interest in biological processes of disease at the cost of exploring the full context of local meanings and everyday knowledge of illness (Kleinman,1977; Fabrega, 1989; Littlewood,1990). The alternative perspective asserted by the new psychiatry is that biological knowledge and psychiatric categories are social constructions of Western culture, rather than direct representations of the natural world (Littlewood,1990). Therefore, the particular cultural construction of disease presented by Western medicine and psychiatry, albeit a powerful one, is not unchallengeable. Furthermore, using Western ethnopsychological categories for research in non-Western settings is considered problematic. Whereas transcultural psychiatry has, as its project, the removal of the layers of 'cultural camouflage' to reveal the biological core of the 'real' disease (Littlewood,1990), the new psychiatry sees the effects of culture as pervasive (Spiro,1991). Culture is less something which shapes already existing natural phenomena than the context in which any idea of illness is conceived (Kleinman,1977; Helman,1984).

Before going any further, the sense in which I understand and use the concept of culture and its potential misuse in the South African context are outlined. By way of a negative definition, culture is not viewed in a reified, essentialist sense as a defining feature or possession of a group (Thornton,1988). "Cultures are never static, homogeneous or isolated, nor are they the preserve only of the poor and the powerless" (Helman, 1991:107). Thornton (1988) suggests that culture is a resource that can be used in social relations, rather than a static entity that defines people from the outside. Swartz (1989) argues that to define people from the outside as belonging to a specific 'cultural group' is to engage in a political act. He criticises South African transcultural psychiatry for constructing and maintaining knowledge about 'other cultural groups' without a reflexive awareness of the process of construction itself. He contends that the concept of culture (and specifically cultural difference) has been and is used as an important ideological tool in the legitimation of oppressive practices, in particular Apartheid ideology, on the part of the South African state.

Negotiating health care: dialogue between lay people and professionals

Kleinman is a proponent of the merging of medical anthropology with the new cross-cultural psychiatry on the grounds of psychiatry's social interests with meaning and social relations and the interpretive nature of psychiatric assessment (Littlewood,1990). His EM of illness approach focuses on how the clinical encounter enables (or disables) people to translate disease and adverse circumstances into a meaningful illness and, through this process, to find ways to adapt to their circumstances.

The concepts of 'disease', 'illness', and 'sickness', central to Kleinman's work, are defined by him in the following way: Disease refers to a supposed fundamental biological disturbance and is situated firmly within the biomedical domain as "what the practitioner creates in the recasting of illness in terms of theories of disorder" (Kleinman,1988:5). In the biomedical model, disease is seen as being universal in form, content and treatment, irrespective of the socio-cultural context in which it occurs (Helman,1991). This is distinguished from the concept of illness, which Kleinman has defined as "how the sick person and members of the family or wider social network perceive, live with, and respond to symptoms and disability" (1988:3). It is possible to be ill without disease and vice versa. In most instances, however, disease and illness occur together and reciprocally influence each other (Kleinman,1977). It is the perception of illness, with or without the presence of disease, that motivates people to seek out medical treatment (Ben-Tovim,1987). While disease may respond to the technological cures of modern medicine, illness requires attention to the psycho-social issues involved in the healing process (Kleinman,1977). Sickness is a term used to label "the understanding of a disorder in its generic sense across a population in relation to macrosocial (economic, political, institutional) forces" (Kleinman,1988:5).

Kleinman addresses what he considers to be failings in conventional doctor-patient interactions, in which the doctor's gaze is focused away from the patient's experience of illness onto the task of translating the patient's symptoms into signs of the disease, a process which reduces the patient to "an object first of professional inquiry and then manipulation" (Kleinman,1988:130). Traditionally, practitioners ask questions about illness and then treat disease, a process which turns what is subjective into an objective reality. As disease is constructed according to the biomedical model, culture is implicit in any diagnosis.

Kleinman offers as an alternative goal of the clinical encounter a dialogue between lay people and professionals in which a treatment that is acceptable to both is negotiated. The aim is not to discover the 'true' explanation but rather to simultaneously present different perspectives and paradigms. He advocates that the practitioner elicit the patient's EM and negotiate this with his or her professional one in the process of reaching a shared meaning and therefore appropriate intervention.

Explanatory models

An illness experience is embedded in and constructed by a person's personal, social and cultural world and can only be understood through sensitivity to these contexts. The way to access an illness experience and to understand the way in which illness is patterned, interpreted and treated is through the EM, "the notions that patients, families, and practitioners have about a specific illness episode" (1988:121). EMs are constituted in response to particular illness episodes, rather than being general beliefs about sickness and health care. An EM is a set of beliefs that is elicited in response to questions of the aetiology; timing and mode of onset of symptoms; pathophysiology; course of sickness (including degree of severity and type of sick role); treatment issues; and fears and problems associated with the illness.

Kleinman attributes EMs to individuals rather than cultures, illness being viewed as an individualised process, and sees them as being heterogeneous and unstable, altering with an individual's experiences and clinical encounters. Therefore, exploration of an individual's EM will need to occur over time to probe what is a composite of changing beliefs. Professionals' EMs are, like those of their patients, infused by their cultural beliefs that colour their interpretations of the clinical encounter (Berger,1990; Reynolds & Swartz,1993). Practitioners listen to their patients' accounts of their illness and construct a clinical reality in the light of their own interests, therefore "the EM is an interpretation of what the practitioner *thinks* the patient thinks, not just a direct rendering of the patient's actual world" (Kleinman,1988:240).

Attending to a patient's EM is seen as crucial for the democratisation of health care and clinical interaction where patients, by virtue of their experience of illness, are able to make an 'expert' contribution to clinical judgement (Reynolds & Swartz,1993). According to Kleinman, "the real challenge is for the physician to engage in negotiation with the patient as colleagues involved in care as collaboration" (1988:242). Critics of Kleinman's approach argue that one cannot talk of collaboration between two equals in a clinical interaction and that such a suggestion obfuscates power issues in the clinical encounter. Biomedical knowledge and practice are historically and socially constructed according to who has power; political and economic factors are therefore implicated in the continued dominance of the biomedical approach.

Criticisms of hermeneutic medical anthropology

Hermeneutically orientated medical anthropologists have been criticised for failing to challenge the dominant organisation and practice of health care (Taussig,1980; Young,1982; Singer,1989). The "conservatising" features of conventional medical anthropology have been attributed to a gaze which is confined to the micro-level processes in clinical encounters between individuals (Singer,1989). The critique offered is that, while it asserts itself as offering an alternative to the conventional biomedical approach to clinical practice, hermeneutic medical anthropology does not take cognisance of the social relationships and power dynamics outside of the doctor-patient relationship that shape and distribute illness. In particular, the EM approach is criticised for "desocialising" and "dehistoricising" the nature of power which exists in macro-level relationships between social groups and classes, rather than in the micro-level processes of dyadic doctor-patient relationships (Taussig, 1980; Young,1982; Singer,1989).

In this instance, the clinician becomes "the agent of entrenched class interests, medicine becomes a means of social control, and the body is transformed into an instrument for ratifying socially engendered categories" (Young,1982:275). The hermeneutically orientated medical anthropologist is accused of being a translator of cultural knowledge to conventional health care providers "only to make the science of human management all the more powerful and coercive" (Taussig,1980:12). Taussig goes so far as to say that the EM approach subverts the goal of a socialised medicine. While the patient's story is given pre-eminence, the social relations of sickness are obscured behind discourse on illness and adaptation.

Critical medical anthropology

Critical medical anthropology attempts to redress these limitations by emphasising the social origins of disease and ill health and by examining the subjective experience of illness and healing within the context of macro-level structures, processes and relations. By so doing, it arguably retrieves illness from "the individualising domain of doctor-patient relations" to view it "in more collective and social terms as cultural narratives, as dramas and performance, and as rituals of bodily resistance and social reform" (Scheper-Hughes,1992a:6).

Young (1982) suggests that, as a single set of signs can designate more than one sickness, social forces are instrumental in deciding which people get what sicknesses. This is in part determined by people's access to different kinds of health care workers who have different "sickness domains". The availability and nature of health care facilities influence both the identification of mental illness and the way in which these illnesses are constructed. In terms of access to health services, Littlewood and Lipsedge note that where facilities for the mentally ill are scarce, admission is likely to be reserved for those who constitute a public threat: "If a community has few psychiatric facilities, they are likely to be allocated to those people whose emotional difficulties are the most conspicuously deviant and whose behaviour is the most disruptive" (1989:68). Therefore disease and illness are socialised through the arrangements that determine access to particular practitioners and interventions.

Frankenberg and Young, writers within the critical anthropology tradition, re-define sickness as the process by which signs, behavioural and biological, are made into socially recognisable symptoms and outcomes (in Young,1982). According to Young, sickness is "a process for socializing disease and illness" (1982:270). Every society has various cultural tools for understanding, experiencing and expressing emotions, distress and pain (Kirmayer,1989; Littlewood & Lipsedge,1989). The expression of illness is determined by social expectations as to what constitutes an accepted picture of illness, that is, each society is likely to give sanction to a characteristic pattern of illness.

People learn to communicate their illness in ways that are socially validated by, among others, highlighting what they think health care deliverers want to hear. Therefore, health care practices have implications for the form in which distress and pain are communicated. By way of example, one explanation for the much-debated phenomenon of 'somatisation', is the tendency to produce problems that are accessible to biomedicine. The question of somatisation will receive attention at a later stage.

Reflecting on the debate between conventional and critical medical anthropologists, Berger (1990) advocates a middle path, which neither ignores historical and material conditions nor views the patient as passively controlled by a biomedical system from above. Similarly, Kirmayer shows how, on the one hand, individualistic psychological theories obscure the social, economic and political underpinnings of disease and distress and, on the other, social theories "ignore the mediating processes of embodiment...that empower and constrain social knowledge and practice" (1989:332). It seems, then, that both the hermeneutic, micro-level and the critically interpretive, macro-level analyses have valuable contributions to make to the study of health, illness and health care.

Health care systems and help-seeking

Kleinman asserts that "in the context of culture, the study of patients and healers, illness and healing, must...start with an analysis of health care systems" (1980:250). Particular beliefs about illness are always translated into specific help-seeking patterns; therefore illness beliefs are simultaneously systems of knowledge and of action.

Critical approaches to medical anthropology have rescued the study of help-seeking behaviour from the 'either-or' dualism of indigenous versus biomedical healing practices and the "hierarchy of resort" model, whereby a sequence of choices are made once home treatment has failed. A more complex model is advocated in the examination of help-seeking in a context of diverse options within pluralistic health care systems. Treatment choices are seen to be governed by a "multivariate decision process" that involves recurrent decisions at multiple points, taking into consideration a wide range of factors, including situational variables and social and economic costs (Coreil,1990).

The relationship between the form and distribution of illness and the organisation of health care has been noted above (Young,1982). The health care system comprises the interconnections among individual experiences, responses to and beliefs about illness; the treatment of illness; and the particular arrangements of social institutions and interpersonal interactions relating to illness (Kleinman,1980).

Health care is described as a local cultural system composed of three overlapping domains: the popular, professional and folk sectors. The popular sector, consisting of the individual, the family, the social network and community beliefs and activities, is the "lay, non-professional, non-specialist, popular culture arena in which illness is first defined and health care activities initiated" (Kleinman,1980:50). Across many cultures, much health care, and in particular health maintenance, begins with self-help by the individual and family (Kleinman,1980). It is the lay person who activates health care by choosing to seek help; deciding among treatment options; choosing between compliance or non-compliance; and assessing the quality and efficacy of treatment (Kleinman,1986). The popular sector interacts with the other sectors, whereas the professional and folk sectors are often isolated from each other (although this is being challenged in recent debates about the integration of indigenous and biomedical healing practices - see Freeman & Motsei,1990). The professional sector comprises the organised healing professions and in most societies is essentially biomedicine. The folk sector, or non-professional, non-bureaucratic, specialist sector, generally differentiates between indigenous and religious healers.

An exploration of help-seeking within the context of the current research needs to avoid spuriously invoking the variable of *choice* that has limited applicability if treatment options are dictated by factors such as language, geographical accessibility and cost. For instance, consultation of indigenous healers among Black South Africans should not crudely be seen as a 'natural choice'. Such a view disregards the many 'non-cultural' determinants of choice mentioned above.

Lay theories of the aetiology of mental illness

Lay people's implicit, informal, 'non-scientific' explanations for behaviour are important in that they both shape and maintain various behavioural states (Furnham,1988). It is widely demonstrated that theories of illness causation and therapy are related to each other (Lutz,1985). Lay theories, as opposed to scientific theories, are frequently ambiguous, incoherent and inconsistent. Helman (1984) provides a model for categorising lay theories of illness causation based on the location of the origins of illness in one of four regions: (i) the patient; (ii) the natural world; (iii) the social world; and (iv) the supernatural world. He notes that most EMs see illness as multi-causal and therefore as an interaction of these four worlds.

(i) The patient

Here illness is seen as the responsibility of the individual, the cause being located within the body and predicated on bodily malfunctions and imbalances; changes in diet or behaviour; and notions of personal vulnerability.

(ii) The natural world

Here aspects of the physical environment, both living and inanimate, are seen to be the cause. This includes factors such as climate; astrological signs; infections caused by micro-organisms; and irritants such as pollen, poisons and other forms of pollution.

(iii) The social world

Predominantly in smaller-scale, non-industrialised societies, illness may be attributed to interpersonal malevolence in the form of witchcraft, sorcery and the 'evil eye'. The Western equivalent of ascribing illness to social phenomena invokes the notion of 'stress' as a result of occupational, familial and relational conflict.

(iv) The supernatural world

Here illness is seen as the result of intervention by supernatural beings, including gods, spirits or ancestral shades. Illness may be viewed as a form of 'divine retribution', punishment for the offence of ancestors or the unsolicited invasion of evil spirits. In the latter case, the victim of illness is considered blameless and therefore worthy of sympathetic help.

Young (1983) distinguishes between belief systems that are "externalising" or "internalising". Externalising beliefs locate the aetiology of the illness outside of the body and in the social world. They commonly involve illness narratives in which the meaning of the illness is expressed in the context of the individual's social, cultural and interpersonal life. By contrast, internalising belief systems, exemplified by the biomedical perspective, concentrate on intrasomatic processes as explanations for how and why people become ill.

An important distinction in classifying lay explanations of illness causation is perceptions of the internal versus the external locus of control of health and ill health. In cases where illness is attributed to agents which are external and random in whom they affect, sufferers of ill health are neither blameworthy nor morally accountable for their illness. Beliefs about the locus of control of health have been correlated with socio-economic variables (Helman,1984; Furnham,1988). Assuming responsibility for one's health (internal locus of control) is associated with having economic control over one's life and, by converse, economic and political powerlessness is correlated with ascribing illness causation to external forces over which one has no control. Health locus of control beliefs are powerful and motivating factors in determining health-related behaviours.

The meaning and purpose in illness

> Sickness is more than an unfortunate brush with nature. It is more than something that "just happens" to people. Sickness is something that humans *do* in uniquely original and creative ways (Scheper-Hughes, 1992a:6).

Medical anthropology has contributed the view of illness as both meaningful and purposeful: "Just as illness may be viewed as divine justice or an inexplicable intrusion into the order of our lives, so the expression of distress may be interpreted as meaningful communication or regarded as arbitrary" (Kirmayer,1989:336). Scheper-Hughes (1992a), in her work among marginalised sugarcane workers in Northeastern Brazil, focuses attention on the political nature of illness, as she examines illness as resistance and non-compliance, as a "weapon of the weak" or an act of "embodied refusal" in the face of political powerlessness and oppressive social roles and ideologies.

Somatisation

Somatisation is one method of constructing illness meaning. The expression of psychological states as somatic symptoms has been described as the commonest presentation of mental illness (especially depressive and anxiety disorders) in the non-Western world (Kleinman,1986).

The association of somatisation with marginalised, relatively powerless, psychologically unsophisticated and lower class non-Western societies has been disputed (Scheper-Hughes,1992a). Recent writings have rescued the concept of somatisation from the conventional psychiatric and psycho-somatic framework which sees it as the unconscious, "primitive" and generally mal-adaptive conversion of psychological and social distress into bodily symptoms (Leff,1981, cited in Lutz,1985). Implicit in this definition is the suggestion that the primary reality is psychological and internal, and that somatisation involves conversion into something other than the original, 'natural' form.

Instead, one may argue that the real anomaly is the value placed on introspection and the 'psychologisation' of distress in Western society, an investment that results in the labelling of somatisation as deviant. In this respect, Scheper-Hughes argues that "when personal and social distress is expressed 'psychologically' rather than through a bodily idiom, the 'natural' language of the body is suppressed, silenced and denied" (1992a:11). Scheper-Hughes (1992a) criticises the essential dualism of the somatisation model by asserting that "if mind and body are truly one...then *all* diseases...are and must be psycho-somatic - all are 'somatized' as well as 'mentalized' (1992a:9).

Kirmayer re-defines somatisation as:

> ...not simply the misdirected expression of psychosocial distress but an emphasis on one aspect of all distress. It is symmetrical to psychologization - the emphasis on personal and social dimensions of suffering. Somatization and psychologization must be understood as contrasting methods of constructing illness meaning that assimilate emotional experience to either the bodily or the social realm (1986:127).

Somatisation is a concept that is defined not by somatisers themselves but by practitioners who interpret illness within a psychosocial framework - an EM that is in conflict with the somatiser's view of the relationship between psyche, soma and affect (Kirmayer,1986; Parsons & Wakely,1991). Kirmayer examines somatisation in terms of "those processes that bias the experience and expression of distress toward an emphasis on somatic symptoms" (1986:128). Among these processes are the role of social networks, cultural determinants and the organisation of health care in prescribing the language of distress. These will be examined in greater detail.

A person's family and social network may proscribe the direct expression of psychological distress while accepting, legitimating and thus reinforcing the bodily expression of distress. In settings where there are hierarchical authority structures, "somatic symptoms offer a way to express dissatisfaction obliquely without a direct challenge to authority...and provide a strategy for the weak to redress the inequities of power in social life"

(Kirmayer,1986:125). Scheper-Hughes (1992a) speaks of the "somatic culture" among the marginalised, oppressed sugarcane workers of Northeastern Brazil. Here socio-economic and political conditions have their "natural" expression in nervous and sick bodies, which offer themselves as coded metaphors for covert and safe protest against unacceptable conditions. She argues that this communication should not be regarded as a "maladaptive amplification and exaggeration of psychological symptoms" and reduced to a discourse on somatisation (1992a:8). Too often the readily available weapon of bodily protest or assuming a sick role is blunted by an individualised and medicalised response that treats the disease and disregards its link to social and political conditions.

Culture determines the language in which distress is communicated and help obtained. In this respect, somatisation may be viewed as a culturally shaped idiom of distress for communicating personal and social suffering through the body as metaphor (Helman,1984). The extent to which the physical or psychological aspects of hardship are expressed may reflect socio-cultural norms for illness behaviour (Kirmayer,1989).

Finally, the social organisation of health care may compel people to express distress in somatic forms as "the most direct path to the ratification of the sick-role" (Kirmayer,1986:126). Recalling Scheper-Hughes's (1992a) argument of the "indissoluble unity of mind and body", Ben-Tovim comments that the view of somatisation as an epi-phenomenon of people's perceptions of the needs of Western health workers implies "a distinction between physical and psycho-social distress, and an assumption that the patient has the capacity (and the desire) to report distress in non-mechanical terms, but chooses not to do so because of his or her perception of the needs of the health care system" (1987:165). Health care deliverers may be implicated in somatising their patients' distress when they ignore psychosocial symptoms in favour of organic pathology.

Depression in cross-cultural research

The question of the universality of depression is a central polemic in cross-cultural psychiatric literature internationally. Much debate around depression has concerned itself with the widely held prejudice that depression is not experienced by Blacks. Historically, depression has been seen as the exclusive province of the white person, in that the experience of depression was said to require a degree of introspection and verbalisation attributed to a more mature and sophisticated society (Ben-Tovim,1987; Littlewood & Lipsedge,1989). Up until the 1960s, the subjective experience of depression among Blacks in America and Africa was still thought to be rare. Gradually, though, it has become clear that depressive disorders are common among Blacks, although they do not necessarily manifest themselves in ways that resemble their Western counterparts (Ben-Tovim,1987).

Discussions about the nature of depression often centre on whether or to what extent the illness may be seen as biologically or psychologically based. This issue is often resolved by invoking the concept of psychosomatic illness (Lutz,1985). Using the physical symptoms of depression as a measure, there seem to be approximately equal numbers of depressed people in different countries (Kleinman,1977; Littlewood & Lipsedge,1989). However, cross-cultural studies support marked variation in the way in which emotions are expressed and recognised, and hence in the phenomenology of depression (Kleinman,1977; Kirmayer,1989).

Cross-cultural studies report a high incidence of somatic symptoms in depressed and anxious patients in non-Western cultures (Helman,1984; Kirmayer,1986). As an example, Prince (1985) describes the syndrome of "brain fag", symptoms of a burning or crawling feeling in the head attributed to the exhausting effects of mental activity on the brain, as a common somatic presentation of depression and anxiety in Nigeria. In addition, Kleinman, in his early work on neurasthenic patients in China and among Chinese-American clinic patients, concluded that chronic somatisation masked the real underlying problem of depression (Kleinman,1986).

Kleinman (1977) and Lutz (1985) assert that the concept of depression as designated by the psychiatric classification of the DSM-III-R is not "culture-free". Rather, it is a reflection of largely American and European concepts of psychopathology based on implicit cultural conceptions of normality and abnormality, the nature of persons and emotion. As a Western cultural category, its application in cross-cultural settings results in what Kleinman has termed a "category fallacy", namely, the reification of a culturally constructed concept for use in cross-cultural research (Kleinman,1977).

The Western view of depression asserts the centrality of feelings and assumes that the ultimate psychosocial reality is internal. Therefore the judgement of depression is based primarily in terms of disturbances in affect, which are seen to be internal characteristics of individuals. As an alternative to the individualised, psychobiological conception of emotion, Lutz (1985) re-defines emotion as culturally constructed and socially negotiated judgements that people use to make sense of the situations in which they find themselves. Furthermore, as opposed to focusing on the culturally specific meaning contained within the concept of depression, she advocates that cross-cultural studies explore the universal aversion to loss through people's understandings and responses to a situation of loss or the blocking of goals. "The culturally narrow question of how loss "feels" then becomes transposed into the question of what loss means for people in the much fuller sense of its moral, political, and social implications" (Lutz,1985:92).

Having outlined the anthropological conceptual frameworks which guided my thinking about illness and health care in a cross-cultural context, I will now discuss the methodological issues that informed the research process.

CHAPTER 3

ISSUES IN QUALITATIVE RESEARCH

This chapter sets out the epistemological assumptions, methodological issues and questions, and specific approaches to data collection and analysis that informed this research. I begin by examining the philosophical tensions between quantitative/positivist and qualitative/interpretive approaches. This is followed by a discussion of the grounded theory approach to data collection and a strategy for addressing the potential weaknesses of much qualitative research. Power dynamics in the researcher-participant relationship, particularly in a cross-cultural setting, are examined, as they affect the research as a collaborative enterprise and the establishment of a relationship of trust. This is followed by a discussion of reflexivity in qualitative research. Finally, my commitment to popularising my academic research is discussed from the standpoints of (i) the political purpose of the research; (ii) lines of accountability; (iii) negotiating a research agenda; and (iv) popular education methodology.

Qualitative methods

Qualitative methods have been described as a strategy that combines "scientific rules and artistic imagination" (Nyamathi & Shuler,1990) in its systematic inquiry into human experience from the subjective perspective of the person. The qualitative researcher has to be both a 'good' scientist and a creative story-teller. He or she must not only produce valid and reliable data, but must also use imaginative skills in presenting the research situation and its associated data in stimulating and unconventional ways.

Having to defend and justify the use of qualitative methods is a thing of the past (Miles & Huberman,1984). Whereas qualitative researchers were once regarded as 'second-class citizens' by many hard-core quantitative researchers (Nyamathi & Shuler,1990), they are now contesting the "unquestioned, hegemonic dominance and universal appropriateness of quantitative research" (Scheper-Hughes,1992b:1). Qualitative methods are seen as a challenge to the biomedical model and the quantitative, empiricist methods it prioritises (Yach,1992).

Some areas of study lend themselves to the application of qualitative methods. Grounded in the experience of everyday life, qualitative methods are particularly useful in uncovering and interpreting the meaning and experience of a phenomenon such as illness (Strauss & Corbin,1990; Willms et al.,1990). Qualitative researchers have made significant contributions in social and behavioural sciences and in the arenas of public health and health policy (Preston-Whyte,1992; Yach,1992). The findings of qualitative researchers on health and illness in the developing world have been instrumental in focusing critical attention on ethical issues and human rights in health care and the cultural appropriateness of governmental interventions (Scheper-Hughes,1992b).

Philosophical tensions between quantitative and qualitative paradigms

The split between quantitative (empiricist, data-centred) and qualitative (interpretive, meaning-centred) research is so fundamental that it warrants reference to "two cultures" of research (Yach,1992). Scheper-Hughes suggests that the tension underlying these methodologies reflects their fundamentally opposed philosophies, positivist and interpretive:

> Positivist and interpretive frameworks constitute different convictions about what constitutes useful or respectable data, about research and funding priorities, about the forms that theories should take, about the kind of language researchers should use, how social scientists should go about their business, and how research findings should be used whether in terms of their applications to public policy or to the routines of everyday life (1992b:4).

As such, positivist and interpretive approaches represent two incommensurable paradigms with their own inner logic and concepts of thought, knowledge and power. A major division within social science methodology exists over the status of knowledge as "invention" or "imitation" of a 'ready-made' reality (Diesing,1971, in Strauss & Corbin,1990). The positivist position assumes that truthful, accurate and objective knowledge is uncovered or discovered by means of rigorous empirical research. By contrast, the interpretive viewpoint asserts that no 'facts' exist independent of the researcher (Helman,1991). Knowledge is constructed or created in the research process itself.

The critical interpretive approach

Lock and Scheper-Hughes (in Scheper-Hughes,1992b) argue for a particular qualitative methodology which they label the "critical interpretive approach". The emphasis in critically interpretive research is on the process by which knowledge is constructed (including the constitution of the unit of analysis; the kinds of questions asked and not asked; and the kinds of theories employed in the interpretation of findings); the meaning this knowledge has; and the relation between this knowledge and the maintenance of powerful ideologies and dominant political and biomedical practices. While the positivist/empiricist researcher is aligned to conventional knowledge, the critical/interpretive researcher is positioned "on the margins, a sceptic open to alternative truths and possibilities" (Scheper-Hughes,1992b).

Inductive and deductive qualitative research

Qualitative research typically stresses inductive, open-ended, intuitive approaches to data collection and analysis. Patton states that "the cardinal principle of qualitative analysis is that causal relationships and theoretical statements be clearly emergent from and grounded in the phenomena studied. The theory emerges from the data; it is not imposed on it" (1980:278). However, qualitative research does not imply a research process that is loosely structured, without an explicit conceptual framework, orientating constructs and research questions (Mathews,1992). In fact, it is argued that even inductive researchers, with their naturalistic discovery-orientated approach, operate from implicit pre-existing conceptual frameworks and research questions (Miles & Huberman,1984). Approaches to qualitative research may also be explicitly deductive if the research is directed by a clear conceptual framework, some orientating constructs and research questions and a pre-conceived research design.

The grounded theory approach

Rather than structuring data collection and analysis in terms of testing pre-existing theories, the grounded theorist derives theory from the data and shapes further data collection and analysis on the basis of these emerging theoretical categories (Charmaz,1990). Therefore grounded theory is constructed, developed and verified through systematic data collection and analysis. Data collection, analysis and theory reciprocally inform each other and as such are inseparable processes (Strauss & Corbin,1990). As interpretations are made from the data, the researcher is able to test and clarify them in further data collection. In other words, the process of data collection, coding, diary-keeping, developing conceptual categories and theoretical frameworks should all be shaped by and grounded in the data as much as possible.

The process and product of the research is shaped and structured by the researcher's epistemological assumptions, methodological strategies, experiences, values and interests (Antaki,1988). The researcher's perspective influences both what is seen and what remains hidden. After all, if the only tool you have is a hammer, you will tend to see everything as a nail!

Charmaz (1990) notes that the inductive process of analysis in the grounded theory approach does not mean that the codes and categories derive from the data just as a given reality to be passively observed. Instead, the researcher, in dialectical relationship to the data, is actively involved in the construction of meaning: "The researcher creates an explication, organization, and presentation *of* the data rather than discovering order *within* the data. The discovery process consists of determining the ideas the *researcher* has about the data after interacting with it" (Charmaz,1990:1169). Therefore the research is a social construction of the social constructions found and explicated in the data.

A caveat in qualitative methodology is not to impose preconceived theoretical frameworks onto the data or to prematurely arrive at conceptual categories (Charmaz,1990). The tendency to introduce personal constructs at an early stage in the analysis is a danger of much qualitative research. A limitation of this is that concepts emerging from the data are made sense of in terms of one's own concepts that are not debatable. As Meulenberg-Buskens[1] says, a good qualitative researcher must have a high "frustration-tolerance level" in being able to question everything, doubt everything, debate the undebatable and, echoing Levi-Strauss (1963), make the normal look anthropologically strange. This amounts to delaying making sense of the data for as long as possible. In the end, it is better to leave questions unanswered rather than force an interpretation.

The importance of context: the relational mode

Meulenberg-Buskens proposes a strategy for delaying imposing personal constructs on the data. She terms it the "relational mode". Fundamental to her approach is the importance of context: every theory has its context and without context there is no theory. The simplest theory consists of a relationship in a context and this is the building block for reconstructing the data. The relational mode is a response to the limitations of thematic approaches, such as content analysis. Meulenberg-Buskens argues that extracting themes not only introduces personal constructs from an early stage, but also often results in a loss of internal relationships with other trends and themes, both within a text and between texts.

In the relational mode, the first stage of the analysis is purely descriptive. With the information provided by detailed fieldnotes, personal and situational contextualisations are added to the transcripts. Each transcript is then read several times, giving special attention to those things that are counter to one's theories and to oneself. The focus at this stage is

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[1] Course on qualitative methods and data analysis by I. Meulenberg-Buskens, held at the Medical Research Council, Cape Town. 19 - 23 October,1992

on relationships, that is, relationships within a transcript, relationships between transcripts and relationships between the cumulative data and the total research context. One keeps close to the text and looks for relationships and the context, the frame of reference or meaning, in which they exist.

The relationships and their contexts are then used as building blocks to construct a model or framework for making sense of the data as a whole. Only at this stage does analysis begin. One's perspective influences the ordering of the building blocks and needs to be made explicit as context. In other words, responsibility needs to be taken for the construction of the data. Finally, the write-up traces the process of reconstruction of the deconstruction that occurred in the interview. (One will be able to achieve this only to the extent that deconstruction *has* occurred in the interview).

The researcher-participant relationship in cross-cultural, qualitative research

It is argued that qualitative research is participatory (Preston-Whyte,1992) in that both the researcher and participants are actively involved in the co-authorship of meaning. From this vantage point, the interview is a co-authored dialogue rather than a series of questions and answers. Consequently, the traditional role of research subject is re-framed, with the participant being a collaborator or co-actor in the research process and an 'owner' of the understandings that are constructed.

The participatory ideals of qualitative research present several challenges to the researcher, particularly when working in a cross-cultural setting. Preston-Whyte (1992) argues that to achieve success in qualitative research, researchers should actively try to narrow the distance between themselves and their participants, an aim quite antithetical to the positivist notion of maintaining an 'objective' distance from the research subject. Preston-Whyte suggests that qualitative research demands the development of a relationship of friendship and trust whereby both parties are involved in a collaborative process.

Preston-Whyte's conceptualisation of the researcher-participant relationship in qualitative research recalls Kleinman's goals for practitioner-patient interaction in which explanatory models are negotiated and treatment strategies are formulated in dialogue between two 'equals'. The same question may be applied to both situations, namely, to what extent does talk of collaboration obscure the power dynamics both inside and outside the interaction? In this research, I felt that the challenge was not so much to 'narrow the gap' between myself and the participants as to, in acknowledgement of its existence, find ways in which it could meaningfully be bridged. In my position as researcher, I was an 'outsider' in terms of race, education, language, and access to resources and information, factors which undoubtedly contributed to the power dynamics of the interaction. To suggest that the distancing factors between myself and the CHWs could be overcome through the building of 'rapport' and friendship seems to be a simplification of the situation.

I do feel, however, that establishing a relationship of trust is fundamentally important in doing 'good' qualitative research. Building trust with the research participants demanded that I show sensitivity to their issues and concerns and not just in a tokenistic way. The negotiation of conflicting agendas is, however, not an easy one. By being overly accommodating of others' agendas, one runs the risk of anti-intellectualism in which one's knowledge and skills (not to mention one's interests) are subordinated or denied. By way of illustration, uppermost on the RSC CHWs' agenda was the uncertainty of their jobs in the future. Clearly, it was not my place to lobby for their continued employment. Yet it was necessary to acknowledge their feelings about their work and to give them space in which to express their anger and frustration.

A relationship of trust is also dependent on leaving no room for participants to misconstrue the aims and processes of the research. This is particularly difficult to achieve in the absence of a 'research ethic' among the participants, as seemed to be the case with some of the CHWs. Having explained the purposes of the research, I was nevertheless asked by a respondent what I was going to use the information for. Another indication that the research process was mystifying to some of the participants, was a CHW's query when I requested a second individual interview with her: "Are these the questions you forgot to ask?"

In cases where research methodology and the research process is unfamiliar and the only negotiable is whether or not participants consent to being interviewed, I argue that it is unrealistic to talk of participants 'owning' the research. Clearly, participation in research exists on a continuum. At a minimum it can be participation in the construction of meaning around a unilaterally asserted subject. At a deeper level, it can be participation in articulating the research problem and in the research design and implementation.

Reflexivity

Yach suggests that the credibility of qualitative research is enhanced when "investigators describe and interpret their own behaviour and experiences as researchers in relation to the behaviour and experiences of subjects" (1992:605-6). The issue of reflexivity - the researcher's feelings about his or her position in relation to the participants and the effect of this on interpretations - is an important consideration in qualitative research.

Maso (1992) argues that qualitative researchers influence their results not only by their scientific and societal standpoints with respect to the participants, their appearance and behaviour, but also by their *character*. Some might argue that this influence conflicts with the aim of qualitative research to reconstruct the perspective and world-view of the participants. One strategy of qualitative researchers is to attempt to 'neutralise' their influence on the research: presuppositions are put to one side and appearance and behaviour are adjusted in an effort to be as inconspicuous as possible in the research setting. Maso (1992) argues that such researchers reduce themselves to being research instruments, rather than persons. He contends that if researchers behave naturally and present themselves as they happen to be, the research situation itself becomes natural and participants are more inclined to reveal aspects of themselves.

This approach necessitates a highly developed reflexivity on the part of the researcher in order that his or her effect on the research situation be used in the search for understanding. It demands an awareness of one's assumptions, prejudices and theories, how these are changed in interaction with the participants *and* the effect of all of this on the participants. Participants' responses are shaped by their perceptions of the demands of the interview situation and of what is relevant and appropriate information to give. Taking this into consideration, the researcher must construct an analysis that reflects the life-world of the participants more than the qualities of his or her character. The issue of reflexivity in qualitative research suggests that the precondition to good qualitative research is self-research. Because of the interactive nature of qualitative research, I kept a diary before and during the research process in which I recorded my expectations and assumptions, feelings and impressions, ideas, hunches and questions, as well as data-quality issues.

Popularising research

As a student of the Community Education Resources Project (CER) at the University of Cape Town[2], I was committed to popularising my research. This contributed a number of important considerations to the traditional requirements for doing methodologically sound

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[2] CER is an extension service project at U.C.T. with the goal of finding ways of making the resources and research of the University accessible to progressive organisations and oppressed communities. The CER masters' student programme was set up as a means of documenting the process of making academic research accessible to a community-based audience.

research. These included questions of the political purpose of the research, lines of accountability, and negotiating a research agenda. These issues will be addressed in turn.

The political purpose of the work

The popularisation of material is a political act. It is not only about the free-flow of information, nor is it a mere technicality (Walters,1987). Apart from its informative and educative function, popularisation aims "to counter the hegemonic domination of perspectives and perceptions in mainstream research. It aims also to change the established channels of knowledge production" (Schuster,1989:19). It provides an alternative to traditional, hierarchical knowledge production and to the exclusivity of research.

This research proceeded from the belief that knowledge is power (Foucault,1974) and that it should be shared with the relatively powerless. I therefore attempted to democratise knowledge and research. (While the popularised product does not appear in this dissertation, I discuss aspects of the process of popularising the research.) I was aware that the researcher-participant relationship involves power relations that need to be redressed in a way which reverses the traditional practice of conducting research solely as a means to acquiring knowledge that benefits the researcher and his or her community.

In attempting to make resources available to oppressed groups, a great challenge is to apply popularisation not only to the *content* but also to the *process* of research. Some of the difficulties in democratising the research process have been mentioned above in discussing the participatory ideals of qualitative methodology. Attempting to follow a democratic research approach is a long and difficult process, one which often conflicts with the pressure to produce an academically acceptable product within a given period of time.

Ideally, popularisation should be built into every stage of designing and conducting the research, rather than being an 'afterthought' once the research is completed. The convention of reviewing academic journals, identifying gaps in the research literature and basing conceptualisations of the research on this, arguably results in a research problem that is articulated through intellectuals and academics and may be confined to discussion in mainstream, established discourses. Alternatively, consultation with the research participants should ideally begin with the very definition of the research problem.

Accountability

The issue of accountability is an overtly political one in that, in a divided society, it involves serving the interests of one group above another. The lines of accountability are particularly complicated in community research in which there are often various interest groups with opposing agendas. The question of whom the research will benefit continually focused me on the need for the research to be an educative process for the research participants. Traditionally, it would seem that a researcher's ethical responsibility to participants has been fulfilled by the report-back of selective findings. (Problems raised by the research, but not resolved, seem often to be dealt with by relegating them to a list of 'recommendations for future research'.) It is doubtful whether such procedures amount to an empowering experience for the respondents.

Negotiating an agenda

A central concept of CER is that of the "user group", literally the people who will use the resource. Much discussion in the CER masters' students programme focused on negotiating agendas with the user group, the balance between recognising the role of academic knowledge and skills, acknowledging one's personal interests and yet not imposing an agenda.

Clearly, it is important that the research topic relates to a need. Less obvious is the basis on which the need for the research is decided. Research may in fact be creating a need rather than identifying one, a practice which may be implicated in creating a market for and dependency on one's professional skills. In situations where there are other more pressing, felt needs on peoples' agendas than those identified in academic literature or drawing on one's particular area of expertise or interest, the process of negotiating an agenda is complex. A possible solution to a potential impasse is a system of trade-offs. This may, however, be used manipulatively by paying tokenistic attention to people's needs in order to obtain a 'foot-in-the-door' for one's own interests.

Popular education methodology

The principles and practices informing popular resource production are those of popular education methodology. Key concepts include setting up a *dialogue* between teacher and learner, between the theoretical and experiential, to create a learning context in which knowledge is not a given but must be discovered anew. There is recognition of the knowledge that comes from life-learning and that knowledge is not the preserve of intellectuals. Popular educators start from a thorough understanding of the lifestyles, needs and concerns of their audience. In their handbook for community workers, Hope and Timmel proceed from the belief that "all education and development should start by identifying the issues which the local people speak about with excitement, hope, fear, anxiety and anger" and that "development comes from within a people's own understandings of their needs and rights. So they must decide the major issues and the basic needs and how to tackle them" (1984:8,16).

Before discussing the methodology for this research, I shall introduce the research sites (the townships and CHW projects) included in this study.

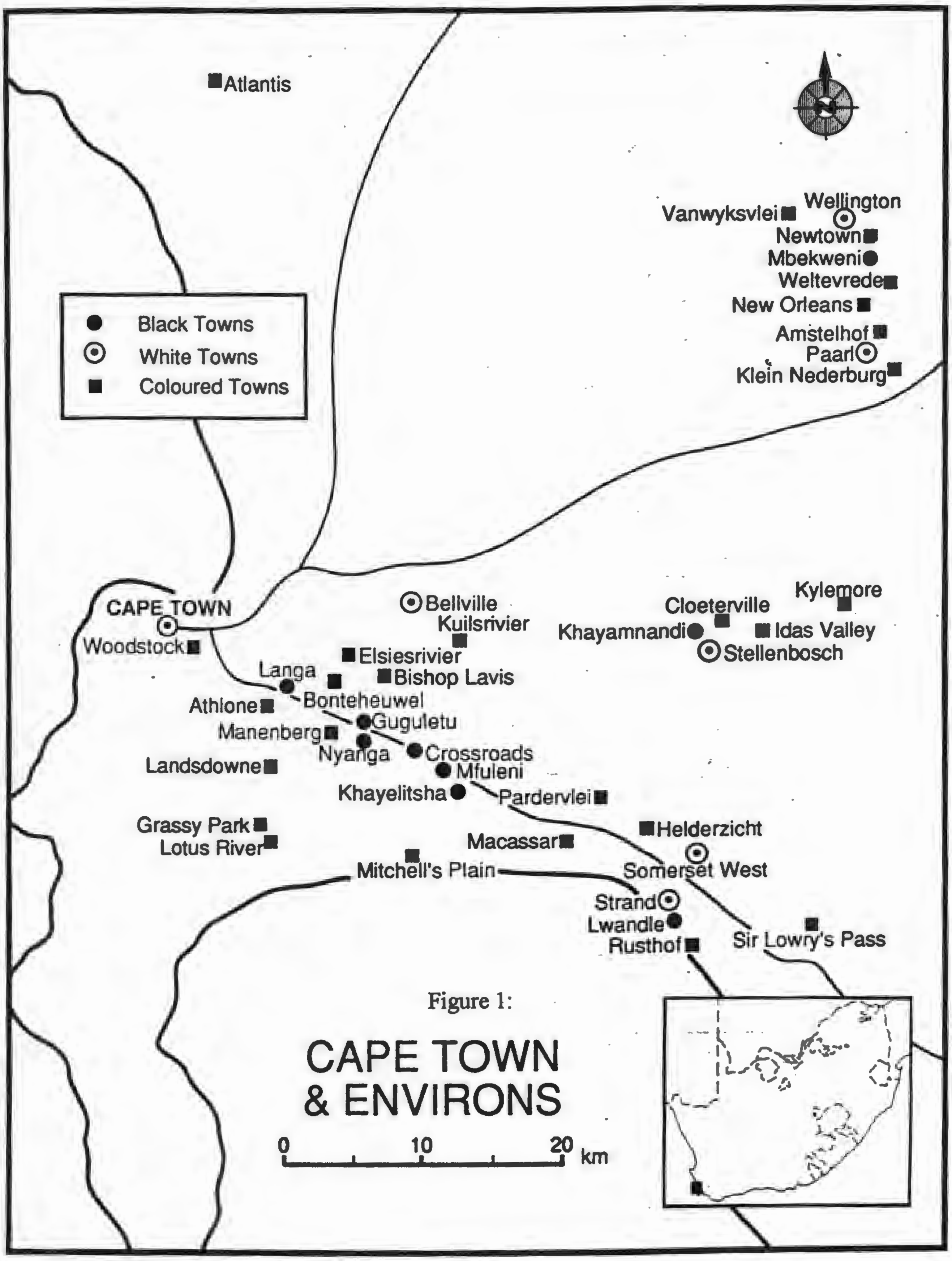

Figure 1:

CAPE TOWN & ENVIRONS

<u>The Two South Africas: a people's geography</u>. August 1992. Human Rights Commission.

HUMAN RIGHTS COMMISSION

CHAPTER 4

A BACKGROUND TO THE RESEARCH SITES

The research took place in Nyanga and Khayelitsha, two peri-urban Black townships approximately 20 and 32 kilometres respectively from the centre of Cape Town. What follows is a brief overview of the historical developments that led to the formation of such peri-urban townships. Thereafter, community profiles of Nyanga and Khayelitsha are given and the three CHW projects included in this study are introduced.

By prefacing the findings and analysis with a brief historical background of the research communities and by giving attention to health policy and practice in South Africa (chapter 1), I am asserting the importance of historical, social, economic and political macro-level factors in examining health and illness. Within this framework, cultural issues in health care provision can be explored with less risk of presenting a 'pseudo-relativistic' approach, which reifies contextual factors into cultural essences.

A brief history

In South Africa, the negative effects of urbanisation on health and the provision of health services are exacerbated by decades of active discouragement of the urbanisation of Black South Africans by legislative and other means (Pick et al.,1990). Until the turn of the century, racially mixed inner city and peri-urban settlements were permitted by city authorities. In 1923 the Native Urban Areas Act restricted the movement of Blacks in urban areas by means of influx control and empowered local authorities to set aside segregated areas (locations) for formal housing for Blacks (Harrison & McQueen,1992). Since the advent of the Nationalist government in 1948, Black people living in Cape Town have steadily been pushed further from the city (Cleminshaw,1985). Using the Group Areas Act (1950) and the Prevention of Illegal Squatting Act (1951) as instruments, the government embarked on a programme of 'ethnic spacial engineering' (Harrison & McQueen,1992). Pass laws and influx control led to the imposition of categories of 'legal' or 'illegal' onto Black people resident in the Western Cape. Those classified as 'illegal' residents were forced back to rural areas, while 'legal' residents were relocated to peri-urban townships such as Ndabeni and Langa (1923), Nyanga (1946) and Guguletu (1959) outside white areas (Cleminshaw,1985).

Despite an increasing emphasis on migrant labour for Black males in the Western Cape, the government froze all township development outside the bantustans[1] as part of the 'homeland policy' (Harrison & McQueen,1992). Furthermore, no houses were built in Black residential areas between 1972 and 1977 (Pick et al.,1990). However, legislation failed to stem the tide of Black urbanisation and there was a steady flow of workseekers from impoverished rural areas. In 1984 the official estimate of the maximum number of people that could be accommodated in the existing townships of Langa, Guguletu and Nyanga amounted to only half the 'legal' Blacks in the Western Cape (Cleminshaw,1985). Overcrowding soon resulted in the emergence of many squatter camps, the most well-known being Crossroads.

By 1979 there was growing realisation that current policies were economically and politically dysfunctional. In 1982 the government announced a new strategy for Black housing in which 'self-help' would be promoted. The principle on which it was based was that squatting "would not be accepted, but that where it is a reality it must be controlled and where practical upgraded" (Harrison & McQueen,1992:5). It was during this period that the 'satellite city' of Khayelitsha was first mooted.

On 10 January 1985 Prof. S.P. Cilliers called for the repeal of influx control and a "reconceptualisation" of separate development (Cleminshaw,1985). Urbanisation was eventually acknowledged as an inevitable process. Since 1990 there has been significant progress towards urban reconstruction throughout South Africa. Important developments include the 1991 White Paper on Land Reform, which dealt with the provision of land and services to forestall squatting, and the scrapping of the Group Areas Act and other restrictive legislation.

A profile of Nyanga

Nyanga lies between Guguletu and Old Crossroads. The first housing scheme, now referred to as the "Old Location", was completed in 1948. Subsequently Mau-Mau, Zwelitsha, Newlands and White City were built in 1952, 1957, 1968 and 1981 respectively (Sikwebu,1984). There has also been a continuous mushrooming of squatter camps over the years, KTC remaining despite several attempts by the government to remove it (Cleminshaw,1985). Living conditions are characterised by extreme overcrowding with the emergence of the squatter camps of Crossroads, Nyanga Bush and KTC indicative of

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[1] So-called independent states and self-governing territories

this problem. This situation was aggravated by the cessation of any new building in the area as a result of government plans to relocate residents to Khayelitsha.

The population of Nyanga was estimated to be 82 894 in 1991[2], the majority of whom live in overcrowded and poverty-stricken conditions: there are an estimated 52.88 housing units per hectare, with an average of 6.02 persons per household[3]. In 1988, a survey of households in Nyanga showed that none had a household income of more than R500 per month; and 64% had a monthly income of between R0 and R100[4]. Further indicators of the deprived conditions in which the residents of Nyanga live are the inadequate educational, recreational and social facilities.

In terms of state health services, there is one preventive health clinic, which deals with TB, child health and family planning. The nearest hospital is Guguletu Day Hospital. Many people, motivated by dissatisfaction with the crowded local facilities and the standard of health care provided, attend health services further afield, despite the transport costs involved.

A profile of Khayelitsha

Khayelitsha, situated on the Cape Flats, is translated as "new home". It is the largest black urban residential area in the Western Cape, with an official population of approximately 250 000 and an unofficial estimate of more than 500 000 (Cooper et al.,1990). The establishment of the township as an alternative to Crossroads was first suggested in 1978 and was officially announced in March 1983 (Pick et al.,1990). The original plan was to relocate the Black communities of Langa, Guguletu, Nyanga, Mfuleni (Blackheath) and Khaya Mandi (Stellenbosch), as well as squatter communities, to Khayelitsha. Dr G. Morrison, the then Deputy Minister of Co-operation and Development, motivated the government's decision as follows:

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[2] Dewar, D., Rosmarin, T., and Watson, V. Movement patterns of the African population in Cape Town: some policy implications. Project report of the Urban Problems Research Unit, University of Cape Town, Cape Town, 1991.

[3] Distribution of housing type by residential area. City Planner's Department, Surveys and Land Information, 2 February, 1989.

[4] Cape Utility Homes. Black housing need and demand, Cape metropolitan area, Cape Town, 1988.

Khayelitsha

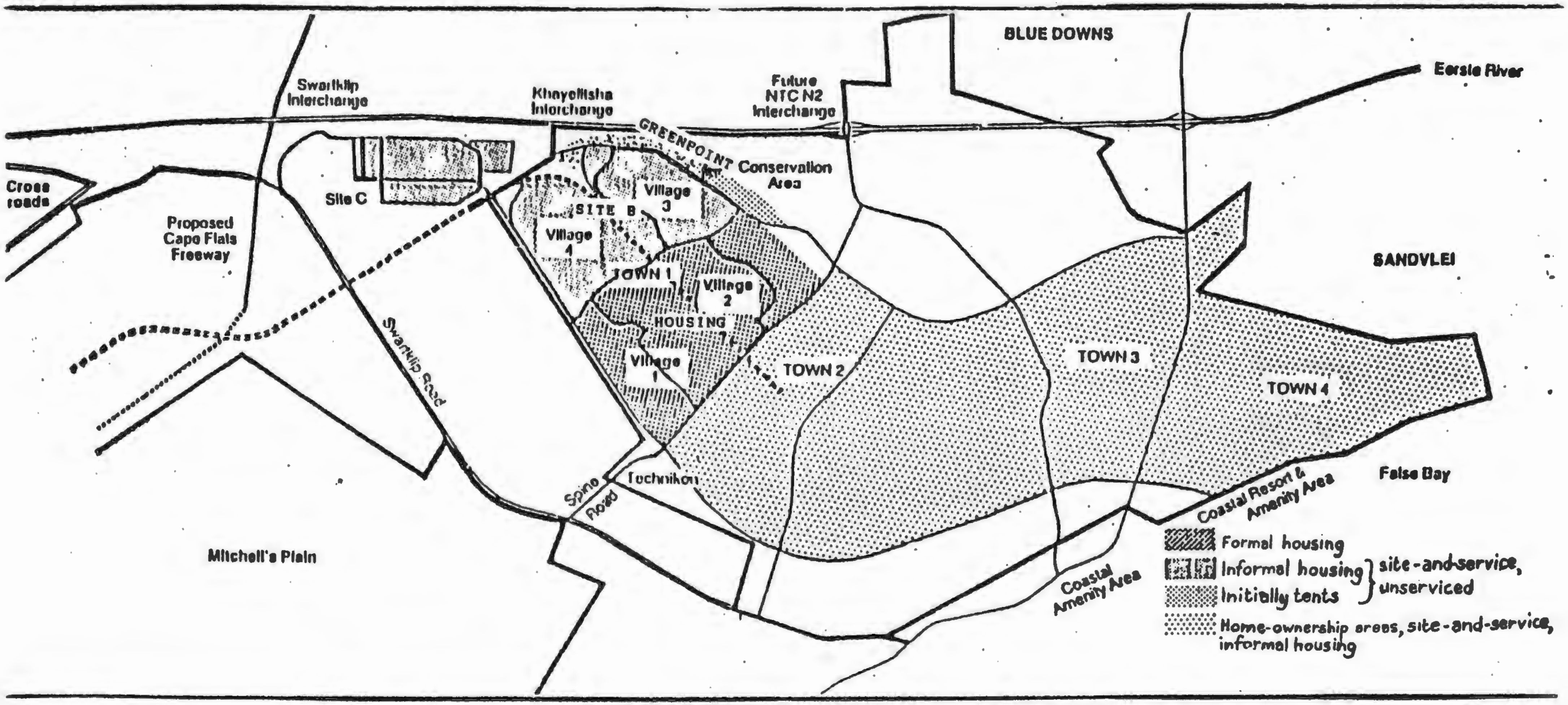

Figure 2: Adapted from Cooper et al, 1990

> Crossroads is a blot on the landscape. Today it is a symbol of defiance and anarchy. We are going to disperse them through the whole of Khayelitsha in an attempt to squash the spirit.[5]

Khayelitsha was conceived, planned and developed without consultation with the people whom the government intended should live there. Very soon the establishment of Khayelitsha was being met with popular resistance and international condemnation (Harrison & McQueen, 1992). After intense protest from the communities concerned and liberal organisations throughout the country, the government conceded that some of the townships should remain. Nevertheless, the development of Khayelitsha proceeded with the aim of accommodating some 280 000 people in houses and a further 30 000 migrant labourers in hostels.

The population of Khayelitsha is not homogeneous, consisting of people with a range of socio-economic backgrounds and in varying states of urbanisation. Some of the residents maintain strong links with the rural areas, other are second- or third-generation Capetonians.

Khayelitsha is divided into four towns, each consisting of four villages. Each village is supposed to have its own supporting facilities, including health, education and recreation facilities and commercial and community centres. To date, however, most of the areas are lacking in such services.

Town I of Khayelitsha:

1. Villages 1 and 2

These consist of 5 000 core houses, each a 30 m^2 unit made up of one room, one kitchen/room and one bathroom and toilet with running water. Originally intended to house people relocated from Crossroads, these units accommodate mostly an 'overflow' of people from other Black townships. Village 2 is commonly referred to as Harare.

2. Site C

This is an area of legalised squatting which has become a site-and-service area. It consists of 7 000 sites of 90 m^2 with bucket toilets and a tap between two plots. The original

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[5] Cape Times - 3-5-1984, cited in SHAWCO Community Health Worker Project (1990). Unpublished document compiled by the Clinic Working Group of the SHAWCO Health Management Committee.

residents of Site C were the 'Cathedral' squatters who left Crossroads and moved to Khayelitsha in 1985 on the basis of a government promise to legalise their urban status at the time when influx-control legislation was still in place.

3. Site B

This is a site-and-service shack area straddling Villages 3 and 4, which houses primarily refugees who fled Crossroads during the 1986 "Crossroads crisis"[6]. It is similar to Site C except that it has improved sanitation. The plots are 90 m^2. Each shack has its own outside flush toilet and shares a tap with another dwelling.

4. Greenpoint and Tent Town

On the edge of Town 1, these are refugee camps that house those who lost their shacks in the Crossroads crisis of 1986. The shacks are generally two-roomed due to the limited plot size which used to accommodate tents. Greenpoint has become a site-and-service area with two taps at the end of every row of shacks and bucket-type toilets that are shared by 2 to 4 families. Each tap serves an estimated 50 families, as they are also used by people in the squatting areas who have no services.

5. There is also the rapid growth of unauthorised squatting areas in Sites B and C and adjacent to Greenpoint. These areas are without sanitation and services and are greater in density than the serviced areas.

Town 2 is a relatively new development consisting of a mixture of private development schemes (such as Khulani Park) that cater for upper income residents, core housing and upgraded site-and-service areas. Conditions in Town 2 are a considerable improvement with tarred roads, bigger plots and therefore larger houses and a flush toilet and tap for each dwelling. Towns 3 and 4 are primarily home-ownership areas and are in the process of construction.

Environmental conditions in all but the home-ownership areas are strikingly poor, with a lack of electricity, poor roads, inadequate refuse removal, lack of social and recreational facilities and a high population density. Cooper et al. state that the environmental

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[6] This involved violent conflict between the Witdoeke, a vigilante grouping of mostly migrant workers, and community organisations affiliated to the United Democratic Front, a loose affiliation of community, youth and women's organisations which subscribed to the basic tenets of the Freedom Charter.

conditions in site-and-service areas are "sub-minimal and confirm the existence of peri-urban areas such as Khayelitsha as 'septic fringes' of the metropolitan areas" (1990:15).

Private health care services are generally experienced as being qualitatively better than public services according to a random sample of informants from all areas of Khayelitsha (Cooper et al.,1990). There are twelve general practitioners in Khayelitsha, not surprisingly concentrated in the formal housing and private development areas (Harrison & McQueen,1992). Only primary level health services are provided in Khayelitsha. These are administered by the Cape Provincial Administration (CPA), Western Cape Regional Services Council (WCRSC), and the University of Cape Town (UCT). Primary health services include three fixed clinics, several mobile clinics and a recently disbanded CHW project under the authority of the WCRSC; two day-hospitals (Khayelitsha Day Hospital in Site B and Nolungile Day Hospital in Site C) provided by the CPA; and a Midwife Obstetric Unit run jointly by UCT and the CPA. Valkenberg Psychiatric Hospital provides psychiatric services at both Sites B and C on a sessional basis. There is one community psychiatric nurse who is based at the Day Hospital in Site B. Commenting on the biggest obstacle to providing mental health care in Khayelitsha, the community psychiatric nurse said:

> Here we've got a shortage of staff - a big problem that...I think there are supposed to be four Sisters [community psychiatric nurses] here...because the area, it is a big area...I think there is no money...I think...community psychiatric services...don't have proper accommodation. If you go to Guguletu you can see the accommodation in which they are working - two small rooms and a small waitingroom. In Nyanga, the community of Nyanga needs a clinic every day. The [community psychiatric nurse] who is working in Nyanga, she sees maybe about 30 or 40 patients once a week because the accommodation is only once a week. She can't get other accommodation. I was lucky in Khayelitsha, very lucky, because Khayelitsha is a new place, you know, there are buildings.
>
> I go once a month to see patients in Site C because they are far away from where I work. They only go to my clinic in Site B when they have an appointment with a doctor...They allocated me the room for only the morning session in Site C. About 1 o' clock they need the room for another clinic...At least it's something.
>
> Harare, Macassar, for patients living there it is very far. But we are just looking at the Regional Services Council, maybe they are going to build some clinics there and then

> we ask for our accommodation from them...I ask them, they must not forget me please.[7]

The state health services provided within Khayelitsha are widely perceived as hopelessly inadequate (Cooper et al.,1990). In particular, people voiced dissatisfaction over the overcrowded facilities that result in people having to wait in long queues for short consultations; treatment by nurses rather than doctors; and problems of access due to transport difficulties. By contrast, health services provided by over 20 health-related non-governmental organisations are generally respected and utilised (Cooper et al.,1990). Transport to health services outside Khayelitsha is expensive and time-consuming. Despite this, if people can afford it, it is common to seek health care outside Khayelitsha.

An introduction to the community health worker projects

The three CHW projects included in this research were the St John Ambulance Community Health Project in Nyanga and the Cape Mental Health Nonceba Rehabilitation Project and the Western Cape Regional Services Community Health Worker Project in Khayelitsha,

The St John Ambulance Community Health Project (St John's)

The Nyanga branch of St John's, a non-profit, voluntary Christian organisation, was founded in 1980. Initially it functioned with just volunteers and still maintains a strong emphasis on voluntary work. In 1986 four posts for paid CHWs and one for a social worker were created. The project has curative, preventive and promotive aspects and focuses on first-aid, home-nursing and basic PHC. The CHWs' activities include running a nutrition clinic; sewing clubs and a lunch club, working in an old-age home, conducting home-visits, and crisis intervention. The CHWs are supervised by a community health sister.

Cape Mental Health's Nonceba Rehabilitation Project.

Nonceba Rehabilitation Project, an arm of the welfare organisation Cape Mental Health Society (CMH), targets people with mental or physical disabilities in the core housing area of Site B, Khayelitsha. Nonceba was started in 1990 in response to CMH's extensive 'register of need' - a waiting list of people in need of placement at training schools and workshops - of the disabled in the area. The six full-time rehabilitation workers employed are involved in a number of activities aimed at providing an alternative to institutionalised

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[7] Personal communication with G. N. Kuse - 5-15-92

care for the disabled, with a strong emphasis on building self-help skills among the disabled and their families. A selection criterion for the health workers was that only people with a disabled person in their family could apply.

Nonceba's projects include the facilitation of home-based care for the disabled; play groups or training groups for children; income-generating groups or recreation groups for adults; training of volunteers; and public education concerning disability. The CHWs are supervised by a nursing sister.

Western Cape Regional Services Council Community Health Worker Project

The Regional Services Council (RSC) CHW Project was established in 1988. The clinic is based in Site B, Khayelitsha. At the time of the research, there were eight full-time CHWs in temporary posts, supervised by a nursing sister. The CHWs initially worked in Site C, Khayelitsha, and when the residents were moved, the CHWs moved with them to Greenpoint and then to Harare. As a result of these moves, they had to commute from the RSC clinic to Harare each day. They were no longer living in their place of work and were not geographically accessible to the people they served.

The CHWs had an initial training period of seven weeks and continued to receive in-service training. They were involved in preventive and promotive work only. Their tasks included education around the GOBI-FFF[8] package; TB education; referral of suspected cases of STD and child abuse; peri-natal care; health education for the elderly; and facilitating community involvement and development around issues that affect people's health.

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[8] G=growth monitoring; O=oral rehydration; B=breast-feeding; I=immunisation; F=female education; F=fertility control; F=food supplementation

CHAPTER 5

METHODOLOGY FOR THIS RESEARCH

This research attempts to answer three broad questions:

1. What is the nature and scope of mental health problems as perceived by the CHWs?
2. What are the CHWs' attitudes towards their actual or potential involvement in mental health care?
3. What are the beliefs and practices of the CHWs with respect to mental health problems?

The study is deductive in that it has a pre-structured research proposal and uses a conceptual framework provided by Kleinman (1980). Yet it is also exploratory, as it attempts to discover the nature and scope of mental health problems from the perspectives and experiences of the CHWs themselves. To the extent that the research begins with the lived experiences of the CHWs, attends to how they construct mental illness and shapes further data collection on this basis, it makes use of principles of the grounded theory approach.

The epistemological assumption from which this research proceeds is that knowledge is produced as part of the research act, with concepts and theories being constructed as opposed to uncovered.

In using qualitative methods, one chooses "depth" of information as opposed to "breadth" (Mathews,1992). While quantitative methods allow for limited depth and detail of a greater number of variables with a large number of people, qualitative methods permit the in-depth study of selected issues among a smaller sample.

Sampling strategies

Qualitative research methods involve a different logic and therefore different criteria in sampling strategies from quantitative studies. The logic of in-depth qualitative research is to "show how complex structures of meaning and circumstances interrelate, and how a relatively small group of people understand their world" (Mathews,1992:52). In qualitative research, one does not use random sampling with the aim of generalising from the sample to the larger population. Consequently, conclusions need to be limited to the persons from whom the data was collected and the situations and contexts in which the research took place.

Sampling tends to be more purposive than random, purposive samples providing an understanding about limited cases without being generalisable to all such cases. Patton (1980) provides an outline of various purposive sampling strategies:
(i) Selecting the extreme or unusual cases, being those cases from which one can learn the most;
(ii) Selecting a few 'typical' examples, identified as such on the basis of experience and knowledge;
(iii) Maximising variation in case selection according to a dimension of interest in order to describe and understand the range of variations accurately;
(iv) Selecting critical cases, namely, those cases that can make a point dramatically and those that permit logical generalisation and maximum application because "if it's true of this one case, it's likely to be true of all other cases" (Patton,1980:105). Identification of a critical case depends on recognition of the key dimensions that make for a critical case.

The CHW projects considered for inclusion in this study were restricted to those in Nyanga and Khayelitsha and to those with a general health or disability focus. Within these parameters, the sampling process was guided by a number of factors. Cape Mental Health's Nonceba Rehabilitation Project was included as a "critical case", being a CHW project with an explicit mental health focus. A key dimension in designating this project a "critical case" was that these CHWs have received some mental health training. Mental health training has been implicated in more positive attitudes to mental health involvement, as well as increased identification of mental health problems (Freeman,1989a, 1989b; Ignacio et al.,1989). Other possibilities included the SACLA Health Project[1], the SHAWCO CHW Project[2] and the RSC CHW Project. A decision against the SACLA CHW Project was based on my perception of its being 'over-researched'. The deciding factor in choosing the RSC CHW Project was that it had been operating for four years, whereas SHAWCO CHWs were trained only at the beginning of 1992. I therefore thought that the greater experience of the RSC CHWs would allow for more learning.

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[1] The South African Christian Leadership Assembly Health Project is a non-governmental organisation that runs a CHW programme in four peri-urban townships of Cape Town.

[2] The Students' Health and Welfare Centres Organisation is a student body linked to the University of Cape Town. It runs a number of health and social services projects in townships on the Cape Flats. In 1992 a CHW Project, designed by University of Cape Town students, was set up in Town 2, Khayelitsha.

The process of consultation to gain access to a project is a lengthy and painstaking one. Therefore, in the case of the St John's CHW Project, where contact had already been made with the project co-ordinator and CHWs through previous research (Binedell,1990), the practical consideration of ease of access was a deciding factor. The value of this is aptly illustrated by the St John's project co-ordinator's response on my arrival: "Make yourself at home, you are part of the furniture here!"

Participants

Figure 3: Demographic data of participants

	RANGE	**MEAN**
Age	27 - 64	37
Years of service as a CHW	6 months - 10 years	3 ½ years
Highest level of education (std.)	5 - 10	8

	YES	**NO**
Paid Worker	16	4
Mental Health Training	6	14

With the exception of two St John's CHWs, both of whom were on leave at the time of the initial field-work, all of the full-time CHWs in the three projects were interviewed in the first phase of the research. In addition, four volunteers at St John's were included in the sample.

The final sample included:

1. All six of the Rehabilitation Workers of CMH's Nonceba Rehabilitation Project in Site B, Khayelitsha;
2. All of the eight CHWs of the RSC CHW Project in Site B, Khayelitsha; and
3. Two of the four paid CHWs and four volunteers of the St John's Community Health Project in Nyanga.

The volunteers were a convenience sample from a group of 15 volunteers currently being trained by St John's. Although convenience sampling is considered the least desirable strategy in qualitative research by some methodologists (Patton,1980), Scheper-Hughes (1992b) notes that it is commonly used (among other 'inappropriate' methods) by many skilled qualitative ethnographers.

Focus group interviews were conducted with CMH and RSC CHWs. Co-ordinating a time for the third focus group interview with St John's CHWs that was convenient to me, my research assistants, full-time and volunteer St John's CHWs, proved impossible. Also, there were a number of obstacles to completing the final phase of the research and fulfilling the requirements for 'appropriate sampling'.

The first phase of the field-work was delayed by a week as a result of problems in gaining access to the RSC CHW Project. During the course of the field-work, political activity in Khayelitsha stalled the process for a further week. The timing of the field-work was critical as both of the translators were university students and therefore available only at certain times. As many of the CHWs spend a large proportion of their time in the communities, co-ordinating times in which both they and the translators were free was not easy. (I regret not having recorded the number of telephone calls I made in setting up the field-work. This would have been a powerful quantitative measure of the methodological difficulties of this type of research!) A further difficulty was that appointments with volunteers had to be arranged through full-time CHWs or the project co-ordinator, as the volunteers were seldom at the St John's Centre and were not accessible by telephone. On three occasions in the final phase of the research, my translators and I spent several hours waiting for volunteers who did not arrive for their appointments.

As a result of these delays, the field-work extended into university 'swot leave' for the end-of-year examinations, which meant that my translators were no longer available. Time and budgetary constraints made it impossible to recruit and train further research assistants for the remaining six interviews (two CMH CHWs and four St John's CHWs) that still had to be conducted .

Several researchers in the field of PHC have noted the difficulties in following a methodologically water-tight research design (Pick et al.,1990). In some instances, the choice is between sacrifices of methodological precision or not doing the research at all. In this study, the research was considered important enough to justify the compromises which had to be made.

Procedure

Interviews were conducted with the co-ordinators of the three health projects to explain the aims of the study and request permission to include their CHWs in the research. Permission was also obtained from the Director of Cape Mental Health Society and the

Director of the RSC CHW Project. Two translators were employed, one being a third-year Psychology student at the University of Cape Town and the other being a second-year Social Work student at the University of the Western Cape who had assisted in research projects in Khayelitsha done under the auspices of the Medical Research Council. Prior to the field-work, a training session was held during which the research process was discussed, the purpose of each question and the types of responses it was expected to elicit were explained, and mock interviews were done.

The potential problems of translation are noted. Inasmuch as translators may bridge the distance of language and socio-cultural differences, they can consciously or unconsciously manipulate the outcome of an interaction through selective translation or partisan roles (Kuhn,1991). Particularly given the context of race-relations in South Africa, the researcher-translator relationship has the potential to become a site of conflictual power relations (Drennan, Levett & Swartz,1991). Kuhn notes that "the problem of maintaining rapport with the interpreter has even greater bearing on the quality of the interview than the time-honoured problem of maintaining respondent rapport" (1991:62). In mitigation of this, Triandis and Brislin (1984) suggest that translators should be afforded the autonomy of co-researchers, rather than being "hired help."

In this research, the translators were not only invaluable in gaining entrance to and establishing a rapport with the participants, but also made important contributions both during and after the interviews. Both translators had experience in interviewing, translating and transcribing. One of the translators had assisted in an evaluation of the RSC CHW Project earlier in the year and was therefore known to the RSC Project Manager and CHWs. The other translator lives in Site B, Khayelitsha and is known by many of the CMH CHWs. The translators' familiarity with some of the participants was important in building trust with the CHWs. In addition, their understanding of local expressions, customs and beliefs provided an invaluable source of information and insights.

The field-work took place over four months from July to October 1992. In the week before the field-work was to begin, I was informed by the Director of the RSC CHW Project that the project's future was in jeopardy. Both the Director and Project Manager advised that, given the uncertainty of the CHWs' jobs, it would be inappropriate to interview them. Due to the limited availability of the two translators, the timing of the field-work was critical and negotiating access to another CHW Project would have been a lengthy process. While realising the sensitivities of the situation, I persisted in gaining access and a week later was granted permission to begin interviewing. Unfortunately, all of the negotiations around access had been with the Director and Project Manager, with the result that the CHWs were removed from a decision-making process that affected them. I realise that in gaining access to the CHW projects, the CHWs themselves should have been approached early on as an ethical obligation. One of the RSC CHWs expressed her anger about this omission. She said that she had not consented to being interviewed and that she felt unprepared to answer questions. She also questioned the purpose of the demographic questions.

At each CHW Project, a meeting was held with all the CHWs for the purpose of introductions and to explain the aims and objectives of the research. An attempt was made to explain clearly the nature of the research, the research process and how the information would be used. At the beginning of each interview, the respondents were asked to answer the questions as fully as possible and to allow time for translation of my questions and their responses. The interviews were all tape-recorded, with the consent of the participants. I addressed the questions in English and they were translated, word for word, into Xhosa, even if the respondents had an understanding of English. The participants were encouraged to speak in Xhosa and their responses were translated, as precisely as possible, into English. As the aim of the interviews was to gather rich qualitative descriptions, it was considered important that the respondents speak in their own language.

Both translators were present at most of the interviews, one involved in translating, the other in observing and note-taking. They were given opportunities to contribute questions during the interviews. Having three researchers present at most of the interviews afforded the opportunity to triangulate impressions and interpretations. The recorded interviews were transcribed from Xhosa into English. The transcribers were instructed to provide an exact transcription of the respondents' words and were encouraged to include their interpretations and comments where they felt it appropriate.

Phase 1: personal accounts

The first phase of the study involved unstructured individual interviews with the CHWs to access their personal "accounts" (Harré in Furnham,1988) of people with mental illness or mental health problems in their community (see Appendix A). The CHWs were asked to talk about someone they knew or had met in Khayelitsha or Nyanga who had a mental illness or mental health problem. The aim was to elicit full and free descriptions of people with mental illness or mental health problems in the CHWs' language and drawing on local beliefs and cultural expressions. They were prompted along the parameters of a mini psychiatric-state examination. The interview schedule served as a framework for discussion, rather than being adhered to rigidly. Throughout the data collection process, questions were modified and added so as to include new interests and clarify emerging concepts. The interviews lasted on average half an hour.

Phase 2: attitudes to involvement in mental health care

The second phase of the research involved two focus group interviews with all the respondents in the CMH and RSC health projects to elicit their feelings about their actual or potential involvement in mental health care (see Appendix B). As I have mentioned, the logistics of co-ordinating volunteer and full-time CHWs with the availability of the translators made a focus group interview at St John's impossible. The focus group interviews were about an hour and a half in duration. They were introduced with the following explanation and question:

> I would like to know how you (would) feel about being involved in mental health care and dealing with people with mental health problems. Some people say that to be able to help someone with a mental health problem you need to be a mental health professional yourself. Other people say that *anyone* who is a health worker should help people with mental health problems. Some health workers say that people with mental health problems are often violent and that they don't want to work with such people. I would like to know, how do you feel about working with people with mental health problems in this community?

The focus group interview is a technique for gaining multiple perspectives on a single area of interest. When used by a skilful facilitator in a non-threatening environment, it generates detailed narrative data about participants' everyday experiences and is "critical for obtaining the insights, perceptions and attitudes of people in a dynamic group interaction atmosphere" (Nyamathi & Shuler,1990:1284). Because it recreates a social situation, the focus group elicits data of a different nature to that obtained in other forms of questioning. The hallmark of the focus group interview is its ability to elicit spontaneous and candid perceptions due to the security of being in a group (Nyamathi & Shuler,1990). A carefully considered question is essential in providing a focused environment in which the participants can advance their multiple perspectives. It is also critical that the purpose of the question is made explicit, to eliminate any suspicion of 'hidden agendas'.

Phase 3: explanatory models of mental illness

The aim of the third phase was to explore CHWs' understandings of mental health problems in their community using an EM approach (Kleinman,1980). The material from the individual interviews was used to construct five vignettes describing people with mental illness as perceived by the CHWs, using their own words and without having to label the conditions (see Appendix C). The vignettes were translated into Xhosa and then 'back-translated' (Brislin,1970) into English to ensure accuracy of meaning.

The vignettes were based on an analysis of the accounts given by CHWs in the first phase of the research and incorporated the most commonly mentioned features of mentally ill persons as described by the CHWs. A vignette describing a person with depressive features was included, even though this was scarcely referred to by the CHWs. Its inclusion was motivated by several factors: findings of a survey study among elderly residents in Khayelitsha which indicated an exceptionally high prevalence of depression (Gillis et al.,1991); international debates on the cross-cultural prevalence of depression; and as a means of assessing the efficacy of the research instruments in tapping the scope of mental health problems in the study communities.

The vignettes reflect the CHWs' actual words and expressions, rather than definitive or discrete diagnostic categories. They may be 'categorised' as follows:

1. A non-violent yet socially disruptive adult, showing loss of contact with reality;
2. A typical presentation of someone with spirit possession, or what is commonly termed *amafufunyana*;
3. A child from a broken home who abuses substances and is involved in acts of crime;
4. An adult who has uncontrolled epilepsy and can be violent;
5. An elderly widow with signs of depression.

Each participant was randomly assigned two vignettes and was given the following instructions:

> I am going to give you two stories about people with mental health problems. These stories are ones that CHWs talked about, so you may recognise them. I want to ask you some questions to find out more about these problems. This is not a test. There are no right or wrong answers. I want to know what *you* think about these problems.

I read the vignette in English and the translator repeated it in Xhosa. In addition, a written Xhosa translation of the vignette was given to the participant. These vignettes were used as the case material for exploring CHWs' EMs, the notions they have about specific illness episodes (see Appendix D). Questions for eliciting the details of an EM often use medicalised terms, such as 'illness' and 'treatment', which had to be modified for the purposes of this research.

The interview covered the following areas:

1. Identification of similar cases
2. Labels for the problem
3. Explanations for the problem
4. The course of the problem
5. Social effects of the problem
6. Intervention.

Report back of results

Sharing information is a minimum requirement for research that attempts to be accountable to and an educative process for the researched. Following the principles of popular education, the results had to be presented, not in terms of a one-way flow of information, but in a form with which the participants could actively engage. Owing to the small sample size, the data from different projects was not analysed separately (with the exception of the focus group material). Therefore the research findings were reported back as a whole. Unfortunately, by this stage, the RSC CHW Project had been disbanded.

Verifying interpretations

The report back of results was considered vital, not only in terms of ethical obligations and the aim of popularising the research, but also in terms of validating the results by obtaining feedback on interpretations. Unlike those in quantitative research, qualitative research has no standardised methods for assessing validity and reliability. Nyamathi and Shuler suggest that the validity of qualitative research is assessed by its credibility and that "credibility is strengthened when true to life descriptions or interpretations of the experience are recognized by the people who had the experience" (1990:1284). If the findings are a reflection of the perspectives and reality of the participants, it should follow that they are comprehensible and make sense to both the participants and to those practising in their area (Strauss & Corbin, 1990).

Miles and Huberman (1984) propose a number of strategies for testing and confirming findings, the following of which were used in this research:

(i) Triangulating:
This involves subjecting a finding to a series of "imperfect measures" to assess its validity. In this research, the presence of myself and two translators at most of the interviews allowed us to triangulate our impressions of the dynamics of the interviews and our initial interpretations of the data.

(ii) Checking for representativeness of data:
The grounded theory approach permits one to check emergent ideas in subsequent interviews with several informants. In this way, one can assess the extent to which findings are based on unrepresentative informants, events or processes.

(iii) Obtaining feedback from informants:
The report back of conclusions constituted the most important validity check. The form of the report back was designed to make space for dialogue around the information presented. This served as an invaluable strategy for correcting inaccuracies and adjusting perceptions.

In the following four chapters, I present the findings and analysis. I begin with an overview of the findings from the three research phases. Thereafter, I report selectively on findings in a narrative form.

CHAPTER 6

FINDINGS AND ANALYSIS: AN OVERVIEW

From the description of the process of qualitative analysis, it should be clear that analysis is not a discrete phase in the research process. On the contrary, the process of analysis is operative from the earliest conceptual phases of research, as questions are articulated. Analysis continues through the data collection process into the write-up, where ideas are sharpened, further insights gained and arguments developed. To reflect this process, I have chosen to present the results and analysis together.

I have suggested that qualitative research is about creative story-telling (chapter 4). Consequently, I have tried to present my findings in a narrative form, aimed at providing an alternative and imaginative perspective on the research situation and data. Therefore the material is not presented in terms of the different phases of the research; nor does it adhere rigidly to Kleinman's EM conceptual framework (1980). To have presented the data in this form would have been lengthy and repetitious, with the risk of the most interesting findings being 'lost' in the bulk of data. As an alternative, I have chosen to focus on those issues that struck me as most intriguing and thought-provoking. Due to the quantity of data the research generated, I have had to be selective in reporting my observations.

A problem in presenting the findings in this form was that of referencing the source of the data. To constantly interrupt the narrative to insert who said what and in response to which questions would, I feel, have detracted from the whole. An exception was made where these details were considered important to the reading of the findings.

A further problem of my narrative was noting percentages of respondents who spoke about issues in a certain way. Having amalgamated the findings from the three phases of the research, I was faced with an impossibly complicated task, especially as the sample sizes in each phase and for each vignette were not homogeneous.

To compensate for these difficulties, I have prefaced my story with an outline of the findings in terms of the three phases, namely, the focus group interviews, CHWs' personal accounts of mental health problems, and details of their EMs elicited in response to the five vignettes.

The substantial inclusion of quoted material is a deliberate attempt to document CHWs' voices. Quotations are verbatim presentations of the translations of CHWs' responses.

The material from the two focus group interviews with CMH and RSC CHWs is presented separately. As has been mentioned, the data obtained from this interviewing technique are qualitatively different from that of individual interviews. Having applied both a thematic approach and Meulenberg-Busken's "relational mode" of analysis to this material, I felt that the latter approach, while very time-consuming, yielded important insights. In particular, it was valuable in highlighting the salience of *context* in CHWs' responses, particularly significant in the interview with RSC CHWs. Another advantage of this approach was the close attention that it demanded to the raw data. Having not been involved in transcribing the interview material (a potentially distancing factor), I was able by means of this approach to re-familiarise myself with the content of the interviews in close detail.

Focus group interview with Cape Mental Health (CMH) CHWs

The CHWs were asked to talk about their feelings towards their being involved in mental health care. Despite my asking them leading questions and making 'space' for them to express negative feelings, they acknowledged very few problems in their work. When problems of violent people and resistance to intervention *were* acknowledged, they were spoken about in an atmosphere of laughter and camaraderie.

Positive feelings and commitment to their work

The CHWs all expressed high levels of commitment to and enjoyment of their work. There are a number of contexts in which these expressions may be understood. These include CHWs' perceptions of the demands of the interview situation and power dynamics in my relationship to them; the extrinsic reward of having a job, given their socio-economic context; intrinsic factors in their enjoyment of and motivation in their work; and CHWs' construction of themselves as people who cope. These contexts will be examined in turn, with the exception of CHWs' coping stance which will be discussed in the following chapter.

(i) Perceptions of the interview situation

The respondents' evaluation of the interview situation might have prompted them to present a positive attitude to their work in order to please both me, as researcher, and their employers. An indication of this was that a CHW asked that I show the transcription of the focus group interview to their employers "so that we can show the people in charge that we are proceeding". This request may also indicate the light in which the respondents saw me: as someone who had influence, by virtue of my contact with their employers.

(ii) Extrinsic rewards

The extrinsic rewards of having a job in the light of the socio-economic context in which these CHWs live are noted. A recent analysis of the employment status of women in Khayelitsha noted that 45% of the respondents had no employment in either the formal or informal sector (Cooper et al.,1991). Furthermore, income levels of most women employees fell well below the Household Subsistence Level of R582 for 1989, with 89% of the formal-sector employees and 80% of informal-sector employees earning less than R400 a month. In Khayelitsha, where unemployment and poverty are major determinants of the health status of the residents, a sense of privilege and satisfaction in having an above-average paying job, and one in which they are acquiring knowledge and skills, is hardly surprising.

(iii) Intrinsic rewards

The CHWs' positive and enthusiastic appraisal of their work was consistent with previous research among St John's CHWs in Nyanga, where high levels of motivation were ascribed to several intrinsic rewards, namely, religious values, being needed by the community, solidarity and significance, and work as a source of meaning (Binedell,1990).

A significant personal context in the CMH CHWs' feelings about their work is their having family members or relatives with disability. Consequently, the training they receive and their intervention relate to their own situations and needs as well those of the people they serve. The CHWs spoke of their training in terms of personal gain, a "gift" that they had received that could never be taken away from them. They expressed a sense of privilege at having acquired knowledge that helped them personally.

> Before we did not have any knowledge of how to help people with this kind of problem. We just had a feeling for their situation...But now, seeing that we are being helped, now we are also able to help them out of their problem.

The CHWs' response to having received training expressed a norm of reciprocity. Having acquired knowledge that helped them in dealing with their own problems, they felt obligated to share this with people in the community.

> I feel that this kind of job is very important to me because I am able to help other people who have not been trained for this kind of job by giving them advice...I would like to do good...to the public because I am trained, make the public aware that mentally sick people have a problem they are not aware of...and they need help. And help the parents of the children who are having the problem of being disabled.

There seemed to be a sense of solidarity and significance in these CHWs' efforts to help the mentally ill and their families in the community.

> We also feel good when we can give help to *our* people. [my emphasis]

Solidarity, a sense of belonging or togetherness, and significance, a sense of having a role to play as a community member, are closely linked as two fundamental elements of community (Clarke,1981). A sense of solidarity can be heightened in circumstances where a group is materially or physically in great need, such as those in which the CHWs work. What unifies these CHWs is their shared experience in coping with family members with mental illness and disability. A CHW made a link between having a mentally disabled child and being concerned for people with mental health problems:

> I wouldn't know whether it's because I've got a child who's got the problem of mental illness, a mentally handicapped child, that I [now] have that feeling towards those people. But what...I would add on is that if you are a person involved [with][1] these people...you must be able to understand these people.

In this respect, one may talk of a community of interest that has gathered around a common concern (Clarke,1981). The CHWs talked about their personal situations as the motivating force behind their intervention. In particular, they spoke of isolation, of feeling that you are alone with your problem and of the therapeutic value of being in contact with others with similar problems. Being part of a group was the solution for the CHWs personally and they are now implementing this strategy on a larger scale by encouraging the formation of psychiatric groups and groups for the disabled, both at Nonceba Rehabilitation Centre and in people's homes.

> What we were suggesting here at work is that we, as parents of people who have a mental problem,...we should get together and go out to the community and explain to them about people who have got a mental problem and...people who have got disabilities...Even though we have started grouping them at [Nonceba],...the majority of people are not aware of what we are doing here. That is why we are trying to go out to meetings and organisations [to] try to make the community aware of what is being done here so that [they will]...bring their people to us.

It seems as if the selection criterion for CMH CHWs has been very effective in motivating these CHWs in their work. CHWs also spoke of their own process of education as regards their perceptions and responses to mental illness. In particular, they had come to see mental health and illness as a continuum; they recognised their own susceptibility to

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[1]. The use of square brackets denotes my insertion.

mental health problems and were able to face people with mental illness, rather than running away:

> We ourselves can identify when [we] are...encountering problems...Now we are able to stand with a problem because before, when it was said there is someone who has got a mental problem or a person who has got a mental illness, we would run away, trying to protect [ourselves] from him injuring [us]. Now we have found out that...they don't just beat people without any reason. Even that we got to know...by having the training here.

It seems as if the training serves an important function in terms of the CHWs' feeling that they have something of value to give to the people they serve.

> [Our training] is very important to us because it is something that can never be taken away from you. It is a gift that you have that you can transfer to the community as [a] whole, teach the community how to handle problems.

In addition, the CHWs spoke of the positive impact of their work. In particular, they saw their intervention as having changed certain people's harsh treatment of those with mental health problems.

> Before there were CHWs, the people, when they [saw] someone who [had] a mental problem, they would just go and tie that person. But now, by talking to people they become aware that if there is such a problem, they can go to the doctor and talk to the doctor about the person who is mentally sick.

Violence and resistance to treatment

Two difficulties that CMH CHWs *did* acknowledge involved coping with mentally ill people who become violent and dealing with those who resist treatment. CHWs contrasted the way in which people in the community reacted to mentally ill people who were violent with the way in which they felt they should respond, given their training and position as health care workers. Family members of people who reacted violently were said to be fearful of them and derogatory and to provoke further violence.

> When he is violent you must...change [from] what the other people are saying about him...and move to something different. Try and praise him. Show him that those people are not saying the right thing and then...try [to] do all the means of praising him...It is only then, when you have got a grip of him [that] you start getting to the real thing that you are there for.

> You find that even the neighbours are scared to go there...People screamed at me saying she was going to hurt me but I went to her and I called her by name. That made her to calm down and I got closer to her...You see, this is not the first [violent] person

> that I've met. There is another one at Langa[2]. Even when that person became violent I went to her. I noticed that it seemed as if she became worse when people ran away from her.

There were circumstances where CHWs' intervention was met with resistance, notably where there were drinking problems.

> Some people say [that they don't want our help] because they are aware that what you are saying, they are doing. And now they would not part with what they are doing...You tell them about not drinking and yet it is what they are doing.
>
> We do encounter problems, for instance, in families where you meet parents who are so difficult to an extent that [they] do not want the problem to be exposed. It's a secret and they wouldn't give you any information about the problem. These are difficult times. And in families where...the children of the family...are mostly drinking and who have no time to listen to you whereby you could educate them about the problem. But then you do not know how to approach [them]. Then [the parents] just tell you that you can go and keep the person in your own home.

The generally positive feelings and experiences of these CHWs attest to the value of the "self-help" concept (Matzat,1987). The CMH CHWs are a group which embraces both the problems of its members as well as their capabilities and resources in dealing with these difficulties. The Nonceba Rehabilitation Project constitutes what may be termed a 'de-stigmatised' environment, where having a family member with a disability makes one an 'insider' rather than an 'outsider'.

Focus group interview with Regional Services Council (RSC) CHWs

The context in which the interviews with the RSC CHWs took place needs to be outlined from the outset. When I arrived at the Site B clinic, the CHWs and the project co-ordinator were engaged in heated discussion over the future of the RSC CHW Project. Nevertheless, the project co-ordinator greeted me enthusiastically, said I was a "God send" and suggested that I begin interviewing that morning. By contrast, after the focus group interview, one of the CHWs spoke angrily about not having consented to being interviewed and about feeling unprepared to answer my questions. Apologising for this CHW's outburst, another CHW explained that they were all "upset about their jobs". The CHWs seemed to view my presence in different lights. Some appeared to welcome being given the space to express their feelings about their work; others exhibited passive-resistance towards the interview process.

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[2] A Black township adjacent to Guguletu, approximately 20 km from Cape Town.

Qualitative data collection processes can be a means of acknowledging the concerns of the researched (Mathews et al., in press). Since listening, respectfully and sensitively, is at the heart of qualitative research, I felt that the interviews could be of therapeutic value in the CHWs' crisis situation. My strategy in dealing with the complex dynamics in this CHW project was to acknowledge and highlight this context at the start of interviews. In this way, I felt that the respondents' feelings could be used constructively in the research process, rather than remaining a hidden barrier to it. The complexities involved in this research site will be explored further in the discussion.

The RSC CHWs spoke more about indigenous beliefs regarding mental illness than the CMH CHWs. Echoing the responses of the CMH CHWs, stressful life circumstances, such as divorce and unemployment, were often implicated as causative factors in mental health problems. Issues of concern to these CHWs were the problems of violence, epilepsy, unemployment and substance abuse.

Dealing with violence and resistance

Dealing with people who are violent or "wild" was acknowledged to be one of the difficult aspects of mental health work. In general, CHWs, family members and people in the community felt unable to cope with people who were violent. CHWs, who do their home-visits alone, expressed fear at having to call on such people. The CHWs and community members' preferred intervention was to enlist the help of the police to take the violent person to a hospital, day clinic or doctor. Several CHWs commented on the absence of outside assistance, notably ambulance services. Another difficulty was that violent people were said to resist treatment. In the light of no alternatives, people often resorted to restraining violent people by tying them up. Several CHWs expressed dissatisfaction with this option.

Epilepsy

Apart from *amafufunyana,* epilepsy was the only other mental health problem that was given a specific label. "Madness" seemed to be a separate malady that was often associated with the condition of epilepsy. It appeared to be inferred from behavioural manifestations of epileptic seizures.

> People with epilepsy are also encountering the problem of madness because in my area where I am working there is a person with epilepsy. What is happening now is that he runs around becoming mad.

The problem of epilepsy was one which elicited a multiplicity of beliefs about causation and transmission and therefore varying ideas about treatment options. These will be discussed in Chapter 8.

Paradigms for understanding mental illness

The models that CHWs used to talk about people with mental illness differed from professional models, especially in that they were markedly context-bound. There was no reference to genetic or hereditary factors and minimal expression of physiological elements in mental health problems. The primary factor implicated in mental health problems was unemployment, particularly in the context of large families with many children. RSC CHWs' prioritisation of unemployment concurs with that of a survey conducted by SACLA CHWs in Site B to determine community-perceived problems. Unemployment was noted to be the greatest problem, while health problems received low priority (Mathews et al,1991).

The CHWs saw unemployment as giving rise to the attendant problems of substance abuse and "worrying". Substance abuse was discussed with reference to the selling of alcohol as a means of generating income; the growing number of taverns or "beer halls" in the community, and therefore increased access to cheap alcohol; substance abuse among young children whose parents could not afford their schooling; and substance abuse as a means of coping with the demoralisation and stress of being unemployed.

Attributions of causation and treatment preference

The CHWs spoke of treatment preferences in terms of the identification (or non-identification) of the cause of the problem. CHWs referred to Xhosa beliefs among their people in the supernatural causation of mental illness. These beliefs were articulated in terms of "bewitchment".

> Even long ago, not only here in Khayelitsha, it is our belief that a person is bewitched and must be taken to a traditional healer.

CHWs spoke of how a belief in supernatural causation was reinforced by the indigenous healers:

> The whole idea comes from where if you have the problem [of madness], your people do not [take] you to hospital but to a traditional healer who will say you are bewitched and now the people believe in that and that is common.

Amafufunyana was described by the CHWs as the territory of the indigenous healers:

> Who do you think can help someone with *amafufunyana*?

> No, I do not know except sending them to traditional healers to take the *mafufunyana* out.

Bewitchment was implicated not only in *amafufunyana,* but also in a variety of cases, including substance abuse and "worry problems".

Where the cause of an illness was unknown, people were more likely to consult indigenous healers. Interestingly, it was people who were quiet and did not exhibit violent or socially disruptive behaviour who posed diagnostic problems.

In comparison to the CMH CHWs, who have received mental health training, the RSC CHWs provided much information on indigenous health beliefs and practices. There seemed to be consensus among the CHWs in their beliefs about epilepsy that are in conflict with a biomedical understanding of the condition.

I will now present an outline of the findings from the unstructured and the structured individual interviews respectively. In these sections, there is a certain amount of repetition in the way the material is organised and discussed, that is, in terms of naming the problem; theories of illness causation; coping with the problem; and sources of health care.

Unstructured individual interviews: personal accounts of mental health problems

Twenty CHWs were asked to talk about a person they knew or had met in their communities who was mentally ill or had a mental health problem. They were prompted to describe the person in terms of the following: appearance and behaviour; comparison to someone who is well; activities and interpersonal relationships; illness history; prognosis; and the name of the problem.

Surprisingly, stories about men were reported four times more often than those about women. Not only is this contrary to the higher prevalence of psychiatric disorders among women in the general population (Kaplan & Sadock,1988), but it is also particularly unexpected given the results of a recent survey study on psychiatric morbidity in Khayelitsha in which almost twice as many women as men showed depressive symptoms (Gillis et al.,1991).

The CHWs' tendency to site examples of mental health problems among men rather than women may be due to the following factors. As many as 14 of the cases reported involved aggressive and oppositional behaviour, a more common concomitant of mental illness among men. Without a doubt, these cases are both more visible and problematic to people in the community and the CHWs. Secondly, depression may be a particularly invisible form of showing distress, not only because of its non-violent, non-disruptive signs, but also as it seems to be so common among sectors of the Khayelitsha population. Furthermore, it may be that it is more acceptable for women to adopt a sick role than men, an acceptability that leads to their neither being identified nor treated. Finally, the perception of deviant behaviour and distress is informed by the availability of labels and courses of action for certain conditions (Kirmayer,1989). Therefore, 'gaps' in CHWs' identification of mental health problems in their communities may reflect their lack of labels for mental health problems and/or gaps in service provision.

Naming the problem

There was no great profusion of names for mental disorder. Eleven of the 20 respondents used the broad labels "mentally ill" or "sick"; "mental problem" or "mentally disturbed" when asked to name the problem they were describing. In all but one case, these labels were used concurrently with the label of *phambene* or "mad". These respondents were unable to provide more definitive names for the problems, except in one case where a doctor had supplied the additional label of "pressure".

A few respondents felt that the label *ukuphambana* (the same category as *phambene*) was pejorative and therefore not appropriate for a person with mental illness. In most cases, it seemed to be reserved for people who were "wild" or violent:

> I wouldn't really call her a mad person because she was not wild and we normally regard wild people as mad. But because what she was talking [about] didn't make sense, we just call her mad as well...What [people who are mad] have in common is that they tend to say things that do not make sense to other people and as long as you are saying something that doesn't make sense to the next person, then you are mad whether you are violent or not."

In addition, CHWs gave three accounts of people labelled as having *amafufunyana* and single mentions of schizophrenia, epilepsy, depression and "nerves." As was to be expected, the CMH CHWs, who have received mental health training and whose work explicitly involves mental health care, generally used more definitive terms and technical language ("avoidant behaviour", "no contact with reality") to describe their cases.

Phenomenology of the illness

The CHWs' descriptions of the mentally ill people they knew revealed a cluster of behaviours that were commonly associated with mental illness. This included violent behaviour (n=14); taking off one's clothes (n=10); disordered speech (n=9); wandering around in the streets (n=7); collecting rubbish (n=6); smoking dagga/cannabis (n=6); and drinking alcohol (n=5). Edgerton's study (1977, in Helman,1984) about lay beliefs as to what constitutes madness in four East African tribes produced an almost identical set of signs, namely, violent behaviour, wandering around naked, "talking nonsense" and sleeping and hiding in the bush.

Disordered speech was described in terms of not responding to one's questions, not talking to others and not talking sense. The tendency for mentally ill people to wander was corroborated by the community psychiatric nurse in Khayelitsha. She commented on how difficult it is to follow-up on psychiatric patients, since they are often very itinerant:

> Psychiatric patients, they go from place to place...They move a lot. They go to an uncle, to sisters, mother and all that, they don't live in one place.[3]

A few CHWs suggested that this was because of rejection by family members and neighbours.

Prognosis

The likelihood of a person's condition improving was considered in terms of the individual's actions or the actions of care-givers. Actions on the part of the individual that would result in improvement of his or her condition included compliance with treatment, abstaining from alcohol and/or drugs, and keeping away from unhealthy peer influences.

> I think that if he could keep on with his treatment he would become normal. And also keep away from drugs.
>
> As far as I can see, what makes him become worse, when he comes home from Tygerberg [Hospital][4] he mixes with his friends. Then they smoke dagga and he goes back to his abnormal state.

As regards care-givers' responsibility in the person's recovery, people with mental health problems needed to be looked after, shown love and respect, be spoken to by close relatives, and be treated as if they were well.

> I think he can get better...if he could get close relatives that can speak to him concerning his drinking and smoking too much.
>
> If [the family members] can handle the person the way [they] used to, he will become right again.

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[3] Personal communication with G.N.Kuse - 15-5-92

[4] A large general hospital in Cape Town.

Causes of the problem

> There are so many things that cause [madness]. Some are depressed, they have no parents, they feel that they are lonely and have no one in this world and they just let it go with their lives...There are a lot of things that can make you to have mental illness, such as being bewitched...If you have an argument with someone and that person says "I'm going to show you" and then a child in your house gets ill, you [believe] that it is that person who cursed you or bewitched you.

In every case, CHWs could supply grounds for the person's problem. I have chosen to classify the CHWs' models for explaining how people become mentally ill in terms of the following paradigms:

1. The medical and organic:
The problem or illness is predicated on some inherent defect, genetics or inheritance or some physiological malfunctioning.
2. The social and interpersonal:
This category includes psychosocial factors concerning economic and environmental conditions and relational issues.
3. The supernatural:
This attributes problems to the intervention of gods, spirits or ancestors. It is commonly expressed in terms of being "cursed" or "bewitched" and results in a possession state such as *amafufunyana*.
4. The cultural:
Problems are ascribed to the neglect of certain rites of passage or the imposition of traditional role expectations.

This is an adaptation of the taxonomy for lay theories of illness causation proposed by Helman (1984). It addresses what I perceive to be an important gap in Helman's model, namely, the attribution of illness to economic and political causes. The economic and political factors that shape and distribute illness in the communities in which these CHWs work are a reality that cannot be overlooked.

1. The medical and organic

One fifth of the respondents attributed the problem to physiological factors. In two cases, mental illness was as a result of head injuries, one of these due to a forceps delivery at birth. Mental illness was also predicated on physical illnesses within the family and tuberculosis.

> The father was suffering from TB and the older sister was also suffering from TB and I think it's the physical illness that affects the mind.

> At first [the doctors at Brooklyn Hospital[5]] told me that she's got a bone disease. But then I asked if a bone disease makes a person say things that don't make sense to other people and then they told me that it's TB of the bones. They explained that it's the virus that affects the spine and then it affects the brain.

A single mention was made of hereditary factors, expressed in terms of "being born mentally ill".

2. The social and interpersonal

The majority of mental health problems (n=15) were seen to be rooted in the social, economic and interpersonal context in which people live. Social problems, namely, unemployment, divorce and poor living conditions, often gave rise to worries about the future, thinking too much and subsequently mental ill health. Unemployment was seen to be primary in the genesis of mental illness by three CHWs. It led to depression, thinking too much and poverty, which in turn resulted in mental illness.

> Firstly, he is unemployed and has no one to depend on and the place where he is staying is unhealthy [it is made of plastics and wood and is not warm] and then I found that his parents died [in a car] accident...Since he has fits he realises that he cannot be employed anywhere like that. So by thinking a lot he ended up looking like that...I think he worries about his life since he does not know where his future lies.

Substance abuse, including smoking dagga (n=6) and drinking alcohol (n=5), was the predominant secondary causative factor. Depression was named as the causative factor in two accounts. Separation from one's spouse (n=2) and of one's parents (n=1) was also implicated in mental illness. Living in impoverished and unhealthy conditions, without the "support" of food and clothing was seen as being a causative factor by three CHWs.

> What I think upset him most was the separation of his parents. He was very fond of his father...As far as I could see, he took [his parents' separation] serious[ly] and that damaged his brain because even at school he used to be bright. I can say that with confidence because after the parents were separated, the family lifestyle changed from what it was as the father used to accommodate everything. The mother on the other hand is not working...There is not enough support, even with food. Things are not as they used to be.

Two CHWs attributed mental health problems to "thinking too much" and one CHW felt

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[5] A hospital in Cape Town that deals with tuberculosis and respiratory diseases.

that studying too much contributed to the person's illness. In two other accounts, reference was made to the "brightness" and "giftedness" of the mentally ill person.

3. The supernatural

In cases where the problem was labelled *amafufunyana,* people were seen to be the victims of bewitchment.

> Since I come from the rural area, although his mother is under the Zionist religion, to me he seems like a person with *amafufunyana*. I have seen people with that doing such things.

Coping with the problem

Negative responses of community and family members to the mentally ill involved laughing and taunting them (n=4); forcing them out of the home (n=3); being scared of them (n=2); and not caring for the person (n=1). In four accounts where people *were* being looked after in their homes, women were notably the care-givers. It was striking how often cases of mental health problems were accompanied by the absence of a father or man in the house (n=4). A single mother seemed to engage the ready support of people in the community in dealing with a mental health problem.

Alternative sources of health care

Although the respondents were not asked specifically about the treatment of the cases they described, questions about the prognosis of the condition generally elicited this information. Four CHWs did not know if the people were being treated. In the case of an epileptic, no treatment was being received.

> There is one case of an eight-year-old child that I know who used to suffer a great deal from epilepsy...I advised the mother to take the child for treatment and when she started taking the treatment, she got much better. But then the mother got tired of collecting treatment now and again. She stopped taking treatment for the child and the child has gone back to the worst condition now.

Commenting on the aspects of her work that saddened her, an RSC CHW spoke about her unsuccessful attempts to find a placement for a mentally handicapped child:

> There is a child of eight years who is at school. At school she keeps quiet and say[s] nothing but laughs. I referred her to [Cape] Mental Health and they are still looking for a school for the child. The child was not admitted at Nolungile[6]. They could not speak to the child.

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[6] I presume that this is a reference to the Nolungile Day Hospital in Khayelitsha.

Treatment options will be examined within the framework of the structural domains of health care outlined by Kleinman (1980). Kleinman distinguishes between health care that takes place in the professional (organised healing professions, primarily conventional medicine); the folk (non-professional healers); and the popular (family, social network and community) sectors.

1. The professional sector

Treatment of the problems described by the CHWs occurred predominantly at the hands of professional health workers (n=12). In ten cases, people with mental illness had been or were being treated at a psychiatric hospital. Eight of these people were referred by Groote Schuur Hospital[7] to Valkenberg Psychiatric Hospital. In one case, a doctor advised that the help of a social worker be enlisted, the help being in the form of applying for a pension.

Four CHWs gave accounts of people resisting medical treatment:

> The family says that if he is told to take his treatment he goes away from home...he doesn't want to go to hospital to get treatment.
>
> While we were trying to organise a doctor for him he managed to pull away from the people who were holding him. He jumped out of the window and went to sit on top of the roof of the day hospital.

2. The folk/non-professional sector

The decision to consult an indigenous healer was expressed in terms of cultural and religious beliefs. In two cases, treatment of what was perceived to be *amafufunyana* was by spiritual healers or "religious praying people". *Amafufunyana* was seen to be a particular cultural category of distress that was outside of the realm of Western medicine. However, indigenous healers were consulted mostly in addition to conventional medical treatment (n=3). Two cases were mentioned where the indigenous healers were consulted first and, when this was seen to be ineffective, people deferred to hospital treatment.

3. The popular sector

Two CHWs felt that being given food was the help required by the mentally ill. Another CHW defined the care needed by a person labelled as schizophrenic as "love, assurance, recognition and safety". Three CHWs referred to financial support, in terms of disability grants and pensions, as the intervention required. Referral to CMH's Nonceba Rehabilitation Project was prescribed in two cases. One CHW spoke of the need for a 'halfway house' for a client, described as a violent substance-abuser:

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[7] A large general hospital in Cape Town.

> I don' t think that he will ever get better but what I suggested to his mother is that if we could get a place where he could stay instead of coming back home from the hospital but go and stay there, then the mother can visit him there.

In reporting the focus group interview with RSC CHWs, I noted that the CHWs' paradigms for understanding mental illness were markedly context-bound, with minimal reference to physiological factors implicated in mental illness. A similar pattern is observable in the CHWs' personal accounts of mental health problems. Only one fifth of the respondents attributed causation to medical or organic factors. While the majority of the problems were seen to be rooted in socio-economic and interpersonal factors, the CHWs' accounts of intervention suggested that these 'social' problems were being dealt with primarily by medical personnel.

Vignettes: explanatory models of mental illness

Fourteen CHWs (four CMH CHWs, eight RSC CHWs and two St John's CHWs) were randomly assigned two vignettes each. The final sample size for each vignette was as follows: vignette 1 (n=5); vignette 2 (n=5); vignette 3 (n=5); vignette 4 (n=7); and vignette 5 (n=6).

Responses to the five vignettes will be discussed in terms of key issues, as identified by Kleinman (1980), in exploring EMs of illness. These include naming and identifying the problem; causative factors in the problem; the social implications of the condition; and treatment options.

My decision not to preserve the separate identities of the vignettes was based on several factors. Firstly, the aim of the research was to explore CHWs' EMs of mental illness as defined by them, so their set of beliefs surrounding questions of the aetiology, course and treatment of the problem remains the primary focus in the analysis. Secondly, the vignettes were not constructed to represent discrete diagnostic categories of mental illness; rather they were a reflection of the cases that CHWs construed as mental health ones. Thirdly, there was great variation among the replies to individual vignettes with many idiosyncratic and irregular responses. This, in addition to the small sample size, would have made the noting of patterns or general trends within vignettes insignificant. Finally, reporting the findings in terms of themes gave the opportunity of noting responses according to the proportion of interviewees who spoke similarly about given issues.

Naming the problem

Questions pertaining to the naming and identification of the problem included the following:

Do you know of anyone who is like this person?
Are there people like this in Khayelitsha/Nyanga?
Do both men and women have this problem?
What name do you give to this problem?
Have you heard of any other names given to describe this problem?

In all five vignettes, at least one respondent had personally encountered a person with the problem being described. The vignette corresponding to a man with epilepsy (vignette 4) yielded the most personal experiences, with all seven of the respondents having met a person who fitted the description. It seems as if the very visible signs of epilepsy, manifest in epileptic seizures, make it an easily identifiable illness. Most striking were the negative responses to vignette 5 which was constructed around CHWs' statements about depression. Only one of the six respondents had encountered such a person and only two perceived it to be a problem in their community. The inclusion of this vignette and the respondents' unfamiliarity with it will be discussed in Chapters 7 and 9.

Vignette 1, describing a socially disruptive man showing loss of contact with reality, was recognised by four of the five respondents on the basis of personal encounters. All but one of the people the CHWs knew or had met who corresponded to this story were men. One CHW said that she did not know of anyone who fitted this description but thought that there were possibly people like this in Khayelitsha. All of the respondents labelled a person corresponding to this vignette as mentally ill. The problem was described as "damage to the brain", "retardation" or "sickness" in the mind.

Vignette 2, based on CHWs' accounts of *amafufunyana,* elicited a wide range of responses. Two of the five respondents knew both men and women who were like the vignette description and said that there were many such people in Khayelitsha. Three CHWs said that they did not personally know of such a person, although two of these had heard of such people in the community. The problem was labelled *amafufunyana* by two CHWs. Alternative labels given were an "infection in the brain" and mental illness. One CHW could not supply a name for the condition - it was just a "very difficult problem".

The scenario of a socially disruptive, substance-abusing boy (vignette 3) was not considered to fall within the category of mental health problems. The problem was labelled as "bad behaviour" and a problem that could lead to mental illness. Two CHWs did not know what to call this problem.

> I wouldn't say that a person like this is mentally ill because what he is now stems from the way he behaves and has nothing to do with mental illness.
>
> I can't say [that he is mentally ill] because he [does] that under the influence of dagga.

Nonetheless, all but one of the respondents felt it to be a significant problem in their communities.

> There are many parents complaining about boys who behave this way.
>
> It tends to start at a very young age, like nine.

Two CHWs did not know of anyone specific who corresponded to the vignette description. With one exception, all of the cases mentioned by CHWs concerned boys.

All of the CHWs knew of someone who matched the story of the epileptic man (vignette 4). The cases described included men, women and children. The problem was described as a "deterioration in the brain", "a temporary disturbance in the brain", epilepsy and *amafufunyana*. Two of the CHWs felt that epilepsy was not a mental illness.

> What makes me reluctant to say that this person is mentally ill is because I know that his brain is affected because of his illness and not because he is just mentally ill...I think it's got something to do with the damage of the nervous system which leads to this kind of problem...Sometimes it happens with people who have had TB and you find out later that they suffer from fits. Sometimes it happens that this person did have a disease but it was latent and then it just shows out.
>
> Some of them are [mentally ill], some are not. They are just confused at the time that they are getting fits, after that everything is normal.

Several responses indicated that epilepsy was perceived as a degenerative illness, with seizures resulting in progressive brain damage.

> When a person gets this sickness, you'll find that with the passage of time, it will tend to affect their brain as well.
>
> What I normally hear about people who suffer from fits is that everytime they get fits a little bit of their brain goes away and they become more and more like a child.

Four of the six CHWs responding to the scenario of the elderly depressive (vignette 5) said that they had never met or heard of anyone who matched this story. By contrast, a respondent said "there are many, many cases...I can remember three cases in my area only." Of those who had not encountered or heard of such a person, two of the CHWs said that they had met women who did not clean their houses, one CHW said that she thought there were such people in her community and the other could not comment on the prevalence of this problem. The problem was labelled a "social problem", a person who is "avoidant/anti-social because of depression", and "depression". One CHW could not supply a name for this problem and said "I would say that she's just causing problems for herself".

Causes of the problem

In the majority of cases, CHWs suggested a number of aetiological factors implicated in the problem, sometimes spanning a number of paradigms. Once again, the CHWs' models for explaining how people become mentally ill are classified in terms of the following paradigms: (1) the medical and organic; (2) the social and interpersonal; (3) the supernatural; and (4) the cultural.

1. The medical and organic

Medical and organic explanations were mostly applied in CHWs' understanding of what they termed epilepsy. People suffering from epilepsy were generally understood to have a brain disorder predicated on genetics or heredity, sustained by a head injury or as the result of some physical illness or disease.

> Some...get fits when they are young, some get fits when a person becomes involved in an accident. But the accident must be [the kind] where one sustain[s] head injuries...Some people are just born like that.
>
> It is said [that] some get fits when young but the parents don't know what caused that...Some people get injured or they hit against an object.

2. The social and interpersonal

The vast majority of aetiological explanations related to intractable social problems that people confront in their daily lives. The 'social' nature of many of the problems was confirmed by several suggestions that certain problems, notably those described in vignettes 3 and 5, were the domain of social workers. Eighty per cent of the respondents to the scenarios of the socially disruptive, substance-abusing boy and the 'depressed' woman suggested referral of the person to social workers.

3. The supernatural

In seven out of the 28 interviews, the condition under discussion was attributed to supernatural causes. In the majority of cases, the aetiological explanation of bewitchment or witchcraft was associated with the possession state *amafufunyana*. A CHW described the kind of situation that leads to such a condition:

> It's witchcraft, I think...There are people who buy [*mafufunyanas*]. It's a sort of medicine. They throw it on the sand and then, when you pass, it catches your body.

Three of the seven respondents who were given the story of the man suffering from fits (vignette 4) said that bewitchment was implicated in the illness. In one case, a CHW linked a belief in bewitchment to biomedicine's failure to provide an explanation of causality:

> We call it an epilepsy disease which is caused by witchcraft...Even if you take this person to the doctor he will just give you treatment and he will never tell you what caused this problem, that is why we believe it's witchcraft...People normally call [the epilepsy problem] evil spirits, like a baboon passed that child and the evil spirits remain with the child.

4. The cultural

In two cases, people's problems were predicated on their not having performed certain rituals.

> Let's say I was sick and there are certain customs that I should have done, but I did not, then these make me sick and affect me mentally.
>
> This man used to have visions that he should do some customs. He ignored that this happened continuously until he became blind. He went to a doctor and got glasses but they did not help. One day he accepted his feelings and beliefs and called the family and told [them] about his visions and did the custom and he could see again.

This example is interesting in respect of how clearly the physical ailment manifests the underlying cause, the man's blindness symbolising his failure to *see* the importance of his beliefs and customs.

Fulfilling certain rites of passage was considered to be part of the cure in the case of the young substance-abusing boy (vignette 3).

> There is a boy that I know who behaves like this and he is very naughty. His mother decided that [if] he should undergo circumcision, [then] maybe he would behave much better.

In response to the vignette description of an elderly woman with depressive symptoms (vignette 5), a CHW raised the traditional expectations of women during mourning. According to this CHW, this custom is a factor in the higher prevalence of depression among women. She spoke critically of the requirements of the enforced mourning period, labelling it as a "isolation".

Coping with the problem

I found that the EM approach has limitations when exploring an individual's understandings of *others'* illnesses. Sometimes the questions became rather abstract, especially in the few cases where a respondent did not identify with the vignette description in any way. In particular, the CHWs found it difficult to respond to questions relating to the personal and interpersonal consequences of the illness on others' behalf. These questions needed considerable reworking before I felt comfortable in asking them. In the end, I limited them to the following:

> What is it like for the family to live with a person like this?
> How do people in the community respond to a person like this?

In many cases, people in the community were said to respond in ways that exacerbated the ill person's situation. The accounts of reactions to people represented by vignette 1 illustrate this. The family either paid no attention to the person, laughed, or labelled him as "mad". Similarly, people in the community were dismissive of such a person, laughed at him, were scared, or blamed the family for not caring for the person. The lack of family and community support made such a case a problem in CHWs' eyes.

Alternative sources of health care

Beliefs about the causation of the illness or problem informed people's decisions about the appropriate treatment options. Treatment options will be examined once again within the framework of the structural domains of health care outlined by Kleinman (1980).

1. The professional sector

Twenty-nine of the treatment strategies for the problems under discussion fell within the professional sector. Most commonly mentioned was referral to the doctor (n=15). Three respondents specified that a psychiatrist or psychiatric hospital was the appropriate source of help. A notable observation was the number of times hospital and/or doctors' treatment was spoken of as a mechanism of control (n=4).

Referral to social workers (n=7) was the chief course of action for problems considered to be social rather than psychological in nature, namely, those described in vignettes 3 and 5.

Alternative responses to the problem of the substance-abuser (vignette 3) were referral to "special schools", "places of safety" or reformatories (n=3) or referral to NICRO[8] (n=1). One CHW recommended referral to "counselling groups" for the depressed woman.

2. The folk/non-professional sector

Consultation with non-professional healers, including indigenous healers (n=11) and spiritual or religious healers (n=1), was in 10 of the 12 cases advocated in addition to treatment by conventional medical practitioners. It is notable that five out of the seven respondents to the vignette description of a person with epileptic seizures supported referral to an indigenous healer. In two of these cases, bewitchment was seen as a causative factor in the problem. In cases where the problem was labelled *amafufunyana* or attributed to bewitchment (n=3), indigenous healers were seen to be the appropriate source of help.

3. The popular sector

There were 19 recommendations of intervention strategies relating to this domain. Two CHWs suggested that neighbours and other people in the community were an important source of advice about help-seeking.

> You must also listen to what other people are saying. For instance, your neighbours might say 'go to this person' and the other people will tell you about someone who has helped them. You must just try these people because they are all trying to help.
>
> [The family] listen to advice from other people. If I say they should go to this church, then they do. Or if someone tells them that he knows someone who can heal *amafufunyana,* then they take him to this person.

Three respondents advocated that the family approach members of the Civic Body. This was considered appropriate in the light of some problems being seen as the community's, rather than the individual's, responsibility.

> I think that the first thing that should be done is that the family or the people who are staying with this person should care for this person and should report the matter to the committee of that area [the civic members]. Then those are the people who should take the matter further and take the person to the hospital...When this person is sick, he does not...become a problem [only] to the family. He is also a problem to the community because he tends to hit the kids and that becomes an obvious problem for everyone.

CHWs ascribed much benefit to the sick person's not feeling alone in his or her situation through participation in support groups concerning particular problems. Intervention was

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[8]. National Institute for Crime Prevention and the Rehabilitation of Offenders

also seen in terms of being "cared for" and "supported", especially materially, by the family or concerned members of the community (n=6). An individual's prognosis was predicated on his or her being looked after and given food, guidance and work (n=3). One CHW spoke of the "spiritual relief" that could be found through the church and by speaking to the church minister.

Four respondents suggested that CHWs had a role to play in the problems under discussion, with the proviso in one case that the CHW was trained for such work.

CHWs' personal interventions

Apart from referral to other agencies, CHWs were questioned about their personal intervention, hypothetical or real, into the problems described by the vignettes. CHWs' strategies in the light of the scenarios presented to them were to talk to such people and let them know that there are others with similar problems; to ensure that people were compliant with their treatment and that their basic needs for food and shelter were met; and to keep them occupied at home where they could be taken care of.

> I don't think that they need a stable job as such, like going to work every day and get[ting] paid, [but] just a way of keeping them busy...Another thing is that they really get hungry because they are always wandering around, so if you take them to your home and ask them to assist you with something; thereafter you [can] give [them] food. You sit with [them] and talk...I think keeping them at home and seeing to it that they are always in places where there are people who can take care of them is a starting point in helping people who have this problem. I don't see any other way that they can get help.

A problem with giving work to such a person was that the family often viewed this as exploitive.

> One problem we normally experience is when you try to help the person...the family doesn't approve. Say you're asking this person to clean the grounds,...the family will say you are taking him for granted because he is mentally ill...In some cases [the family]...make comments that suggest that they don't want you to be involved in this case. For instance, if you go to this person's home and ask if you could get this guy to help you with something, they will make comments like 'You have found yourself a slave'.

Several of the CHWs (n=4) spoke of the therapeutic value of talking about a problem (Kleinman,1988). CHWs spoke of the requirements for being an effective counsellor: A counsellor should elicit the person's trust and confidence and should not be a stranger to the person but someone whom the person "favoured". A CHW felt that she would confide only in someone who was her elder. Furthermore, an RSC CHW suggested that counsellors should be trained people:

> It would be better if it is trained people who deal with the problem...because the neighbour may come and yet the neighbour want[s] to make a joke about the problem.

The CHWs' accounts of the mentally ill in their communities provided me with a baseline definition of mental health problems. By presenting the CHWs with vignettes constructed around these accounts, I was able to clarify and refine this definition. It was notable that the vignette descriptions of the substance-abusing boy and the woman with depressive symptoms were *not* considered to be mental health problems by the majority of the respondents. Alternatively, they were seen predominantly as social problems, requiring the intervention of social workers. In response to the scenario of the depressive woman, a CHW asserted "this is not our case, it is a social worker's case."

CHAPTER 7

MENTAL HEALTH PROBLEMS: DEFINITION AND RESPONSE

In this chapter, I address two main issues. Firstly, I offer explanations for CHWs' narrow definition of mental health problems in their communities. Thereafter, I examine their construction of their role in response to these problems. CHWs' delineation of the field of mental health care and their responses to mental health problems are discussed with reference to the ideals of the PHC approach and contradictions in the CHW concept.

Capturing an elusive concept

In the search for a beginning to my story, I realised that a primary finding related to the *method* rather than the *content* of the research - hence the title of this thesis "Methods and Madness". From the earliest formulations of the research, I struggled with the most appropriate way of getting to grips with the elusive concept of mental illness. I wanted to convey a conceptualisation of mental health, in line with the PHC approach, in the broadest possible terms. In particular, I was concerned to avoid framing mental health problems in a narrow biomedically orientated perspective. For example, I replaced medical words such as 'treatment' and 'illness' with the more neutral terms of 'help' and 'problem' in phrasing my questions. When examining CHWs' responses in the light of the motivation behind my questions, I was left wondering what it was I had uncovered.

The exploratory unstructured individual interviews, aimed at gathering CHWs' personal accounts of mental health problems in their communities, provided a baseline definition of 'mental illness' as perceived by the CHWs. With the notable exception of my deliberate inclusion of the depression vignette, I did not challenge this definition. Rather, the CHWs' definition of the mental health problems in their communities was accepted as the basis for the rest of the research, namely, in exploring attitudes towards involvement in mental health care, the construction of vignettes, and questions eliciting details of EMs.

While examining CHWs' stories of people they knew or had met who had mental health problems, I realised that their accounts were generally limited to a handful of the most visible and burdensome problems in their communities. As I have mentioned, stories about men were reported four times more often than those about women. Moreover, as many as 14 of the cases reported involved aggressive and oppositional behaviour. After the first phase of the research, CHWs' perceptions of the scope of mental health problems in their communities could be crudely summarised in two words - violent men!

At this stage, I suspected I was eliciting the proverbial 'tip of the iceberg' of mental health problems and constructed the depression vignette in order to explore this probability. What remained largely invisible were mental health problems that were articulated by means of physical symptomatology, problems requiring non-medicalised intervention, and 'quieter' expressions of psychological distress. Unfortunately, much of what seemed to be missing were those problems that would have been more accessible, in terms of meaningful intervention, to CHWs.

During the course of the research, several possible explanations for the 'invisibility' of certain mental health problems emerged. Some of these explanations related to the research methodology and the participants' perceptions of the demands of the research situation.

My use of the terms 'mental illness' and 'mental health problems' and my status as a student of psychology may have positioned me within a curative biomedical discourse into which the CHWs then entered when speaking of the kinds of problems that they saw as requiring primarily medical interventions. By focusing my questions on problems, I also excluded promotive and preventive aspects of mental health care from the dialogue. Researching CHWs' perceptions of mental health and well-being might have redressed this gap. On the basis of CHWs' responses in the current study, I suggest that CHWs might have defined mental health in socio-economic terms, such as having employment, adequate housing, food and other basic primary health care needs.

With the inevitable learning of hindsight, I would have framed the research question very differently. Rather than using the terms 'mental illness' and 'mental health problems', I would have had a more ethnographic approach in the research. A useful starting point might have been an exploration, by means of unstructured conversations, of CHWs' perceptions and feelings about life in their communities in general. (What is it like to live in Khayelitsha/Nyanga?) The aim of such a question would be to generate a number of themes, constituting the main preoccupations of the CHWs. Using Freirian methodology, select themes would be translated into problem-posing codes - concrete and contextualised presentations of a familiar problem about which the audience has strong feelings (Hope & Timmel,1987). These codes (in the form of diagrams, posters, a story, etc.) would be presented as stimuli for critical discussion in a process of describing and analysing the various situations that relate to health and illness.

As it is, however, the methodology employed in this research was time- and labour-intensive. An ethnographic approach may well have been prohibitively so.

While recognising possible shortcomings of my methodology, I feel that my questioning nonetheless yielded important and interesting findings. Both recurrent themes in CHWs' responses and what was not spoken of contributed to the observations I made and the insights I gained.

Constructing mental illness: "we don't go in-depth"

Having raised aspects of the research process that possibly delimited the type of problems that were reported by the CHWs, I will now explore personal and social factors that may influence what CHWs see (and do not see). I suggest that the kinds of problems that CHWs identify are related to their lack of 'distance' from the problems they deal with; their knowledge and capabilities; their living within the constraints of their environment; and the health care resources at their disposal. Furthermore, I suggest that available sources of help may inform the way in which psychological distress is communicated.

Dealing with trouble-makers

Kirmayer (1989) supplies four grounds for the recognition of psychological distress: evidence of a degree of pain, suffering or emotional distress that commands attention; behaviour that poses a threat or is troublesome to the public; behaviour that accords with a pre-existing category of distress; and behaviour that contravenes or challenges group norms. In this research context, my general impression was that problems are identified and responded to, not so much on the basis of alleviating individual distress or promoting the mental health or well-being of individuals, but rather in terms of maintaining a degree of social stability in the broader community.

It appears as if mental health problems that are socially disruptive or dangerous and highly conspicuous and that therefore *demand* intervention are those to be recognised. In contrast to the many accounts of people who are "wild" or violent, there was scant reference made to those whose distress is expressed in "quiet" ways. CHWs' assertion that there are *more* people who are violent than those who "just keep quiet and say nothing" may be indicative of the burden that the former present to their families, people in the community and the CHWs themselves. The burden placed on CHWs in coping with mental health problems is exacerbated by families' and community members' reported stigmatisation of the mentally ill. This will be discussed later.

Seeing soluble problems: a self-protective mechanism

In reasoning why she had not met anyone who corresponded to the vignette description suggesting a depressive woman, a respondent alluded to the possibility that only problems visible on the surface and those that commanded attention were being identified and acted upon.

> I think the reason why I haven't met someone like this is because *we don't go in-depth* to find out why a person is like this. It could be possible that you come to this house and maybe that is the situation. But when you find this...woman and the kids lying there hungry, what we normally concern ourselves with are the kids and not this...person so we really never know. [my emphasis]

Given that there are so many pressing material needs to be met, CHWs may deliberately, or unconsciously, not probe any further for problems as a self-protective mechanism. CHWs are expected to live in their work environment - among the people and problems that are the target of their interventions. By virtue of their requisite close contact with the people they serve, they are particularly vulnerable to problems encountered in their work. As I have mentioned in Chapter 1, CHWs are unable to maintain the 'professional distance' from their clients that is advocated as a survival mechanism for people in helping professions (Pearlin & Schooler,1978). Feeling powerless in the light of the problems that confront them is, in all probability, an inevitable part of working in a deprived context which frustrates the attainment of health. Therefore CHWs may selectively identify problems according to their capabilities.

Availability of health care resources

The identification of mental health problems may also be a reflection of the availability of health care resources. In their response to mental health problems, CHWs appeared to function primarily as referral agents. Given this, they may identify problems according to the avenues of referral at their disposal. In Khayelitsha and Nyanga, mental health resources are either absent or hopelessly inadequate. It is notable that mentally ill people who behave violently were perceived by the CHWs as requiring the assistance of more accessible resources, namely the police (to restrain and transport them) and ultimately medical personnel (to sedate them). By focusing on the violent and socially disruptive, CHWs may be operating within the confines of their context.

The form of psychological distress

Not only does the availability and nature of health care services affect the identification of mental illness, it also shapes the way in which illness is constructed (Young,1982; Kirmayer,1989; Littlewood & Lipsedge,1989). Given the scarcity of mental health resources, psychologically distressed people may have learned to communicate their distress in conspicuous ways, which are most likely to evoke a response. Therefore, in reporting predominantly on cases of oppositional and threatening behaviour, CHWs may be accurately reflecting the shape of mental illness in their communities.

A narrow definition of mental health care

Unfortunately, the CHWs' focus arguably misses those areas where they *could* possibly be equipped to play a valuable role in mental health care. Such areas might include counselling skills for intervention in family breakdowns; education about constructive parenting; dealing with child and women abuse; life-skills; recreation; and other areas requiring non-medical intervention (Freeman,1992a). As I have discussed, aspects of the research process possibly directed CHWs' focus onto biomedical mental health problems.

Community health workers' role: power and empowerment

Having focused on CHWs' constructions of mental health problems, I will now examine their construction of their role in response to these problems. I suggest that CHWs intervene on behalf of the stability of the community as opposed to individuals' needs. CHWs' personal interventions are discussed with reference to two CHW models, namely, CHWs as empowerers versus extenders of the health system. I argue that their practices are constrained by the "biomedical culture" that characterises health care in South Africa (Miller & Swartz,1991b). Thereafter, I examine CHWs' feelings of powerlessness when confronted by the "power" frequently attributed to people with mental illness. I see CHWs as resolving this dilemma by aligning themselves with conventional power structures. Finally, I explore the CHWs' construction of themselves as people who cope.

A social rather than individual role

CHWs do not appear to be responding to the mental health problems of individuals as such. Rather, I propose that they are engaged in 'damage control' of the eruptions that occur out of a socio-economically deprived and politically disempowered community. In their actions and recommendations, the CHWs seem to be fulfilling a controlling, containing, restraining and protecting function. In line with this role, CHWs utilise medical intervention as a mechanism of social control. Aggressive or deviant behaviour is subdued with tranquilisers and sedatives at the hands of the medically trained, the violent are tied up and policed (literally) and the socially disruptive are kept 'out of mischief' by being made to work. The medicalisation of psychosocial problems will be discussed further in considering alternative sources of health care.

Empowerers or mini-doctors?

A broad definition of PHC implies understanding and addressing the whole range of social, economic and environmental factors that determine the health status of individuals. This, in turn, implies that health and development are inseparable and that CHWs have a community development role, namely, to help people in the community understand about health and the factors affecting health and to mobilise people to change conditions. In addition, the idealism of the PHC approach proposes that CHWs deliver health care in a way that addresses, rather than obscures, the inextricable link between health and underlying socio-economic realities (Walt & Vaughan,1981).

Nevertheless, critical evaluation of CHW performance has tamed unrealistic and romanticised notions of what CHWs, especially those who work in undemocratic societies, can be expected to achieve (Hammond & Buch,1984; Walt,1988). There is acknowledgement that CHWs, in responding to people's felt needs, often function as 'mini-doctors' and deliver curative services (Berman et al.,1987), rather than fulfilling the more difficult role of community development and empowerment. Furthermore, it has been suggested that the authoritarianism that characterises South African health care proscribes health workers from fulfilling roles which conflict with the dominant "biomedical culture" (Miller & Swartz,1991b; Mgoduso & Butchart,1992). One such role is the delivery of health care that recognises and addresses the social nature of health problems.

In this research, there are a number of factors that seemed to proscribe the CHWs from fulfilling an empowering or development role, or from addressing psychosocial issues in mental health problems. Firstly, their interventions may be viewed as a logical extension of their training, supervision and the supportive structures available to them and these are generally biomedical in orientation. Secondly, several CHWs stressed the importance of being able to *do* things for people in their community. Berman et al. (1987) note that the nature of much of CHWs' activities does not allow for an immediate and measurable impact in terms of the indices of health status. Yet the measurable, short-term results seemed to be highly significant to CHWs. In a focus group interview, a CMH CHW spoke of wanting to "show the community what we can *do*, not just what we are saying, but they must *see* what we can do for them." [my emphasis] Research has also noted people's preference for the concrete treatment modalities of biomedicine (Nell,1989).

The level of intervention

In terms of CHWs' personal interventions into the problems under discussion, there appeared to be an incongruity between CHWs' ascriptions of the causes of mental health problems and their treatment recommendations. In the majority of cases, the root causes of the mental health problems described in the CHWs' personal accounts and the vignette descriptions were located at the door of the oppressive social and economic context in which the CHWs, and the people they serve, live. While CHWs reiterated the socio-economic realities underlying health problems, their interventions were, however, largely of the "band-aid" variety (Berman et al.,1987), such as meeting basic needs for food, money and shelter.

> I don't think there is much I can do...apart from [giving food] and talking to him.

Both the current study and previous research with St John's CHWs (Binedell,1990) indicated that CHWs gain much satisfaction from meeting people's immediate needs for food and money and that they find it extremely difficult to turn anyone with such requests away. Moreover, not meeting people's immediate needs is likely to affect adversely community members' acceptance of them as health care providers. It seems that to act only as referral agents in the context of mental health problems leaves CHWs with a sense of dissatisfaction and impotence.

Issues of power and powerlessness

There were indications that CHWs felt powerless in the light of some of the mental health problems they raised. This is ascribed to two factors: firstly, their vulnerability as women in coping with violent men and people who were perceived as possessing extraordinary "power"; and secondly, their marginalised status in the health system in terms of training, supportive services and access to symbols of authority. CHWs appear to redress their disempowerment by aligning themselves with powerful structures and by acquiring knowledge and skills through training.

Aggressive and socially disruptive sequelae of mental illness posed the greatest difficulties in coping with mental health problems and were spoken of in the focus group interview with RSC CHWs as one of the "tough" and "sad" aspects of mental health work. CHWs expressed their vulnerability in terms of the fact that they are all women, with the exception of a St John's volunteer who is now holding an office job at their headquarters in Cape Town, and that the incidences of violence, with few exceptions, were among men.

The CHWs, who do their home-visits alone, expressed fear at having to visit people who are violent:

> One of the violent people said to me, 'Look here, you are a *nomphilo* [CHW], I believe you can help me. Come here! See these tablets, they are for people who are mad and I am taking them.' I said to him I will come back when he is finish[ed] with the tablets. I knew that I was not going to him again. I was so scared and wanted to get away from him.

The vulnerability of CHWs is illustrated by several accounts in which their personal safety was threatened.

> I have a broken window from a violent person with *amafufunyana*. The person nearly hurt my mother who was sitting under the window. When I went out to see what was happening after he threw a [piece of] wood through the window, he threw a big brick [at] me and people came to pick me up.
>
> My problem is that I am also scared of them...When I meet this person while he is sick, I normally think that he will hit me.

The CHWs' feelings of powerlessness were contrasted by the extraordinary strength that was commonly ascribed to people with mental illness. In several cases mentally ill people were reported to possess "power".

> When a person is mentally ill, they become so strong it's impossible to control them. But if it's a woman, then maybe we could control her together with other women.
>
> [People in the community] say he's got a lot of power and he can overpower you and you mustn't make him angry. He can kill you.

A similar notion was expressed by a family member of a psychiatric patient in Mamre[1]:

> Hy was eenmal - so te sê hy was aggressive...Een maal het hy daar binne 'n vuur gemaak so te sê. So jy sien dat ons kan hom nie control nie, ne? As hulle so is, noem hulle dit mos domkrag, hy's uncontrollable.[2]
>
> [He was once - so to speak aggressive...Once he made a fire inside, so to speak...So you can see that we cannot control him, right? When they are like this, they call it *domkrag*, he's incontrollable.]

Here the "power" was literally referred to as "stupid power" or *domkrag*.

CHWs' powerlessness is exacerbated by the absence or inaccessibility of supportive structures. Several CHWs raised the problem of dealing with violent people in the absence of adequate outside assistance. A volunteer at St John's expressed his predicament as follows:

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[1] A 'coloured' village approximately 50 km from Cape Town

[2] Interview by T. de Ridder with a psychiatric patient in Mamre - 12-10-1989

> What can we do if we are far from the hospital and the person become[s] mad?...Sometimes even if you look for someone whom [the mad person] listens to, it's only for a minute that the mad person listens and start[s] wanting to wander at night again and you [can] see that he is out of his senses...Up country there are no ambulance[s]. The only alternative will be to tie him and take him to the doctor...[In] the rural areas [after-hours emergency units] may be far. We can only tie that person and take him to the doctor at the hospital to get medicine to calm him down. Because he will never listen to us."

Difficulty in organising ambulance transport for the mentally ill was expressed by CHWs from all three CHW projects. Among the RSC CHWs, ambulance services were never reported to be used for this purpose.

> It is difficult to call an ambulance for a violent person. We normally call a police van or get a bakkie and the sick person is not hand cuffed, he is only tied so that he can sit comfortably.

The community psychiatric nurse in Khayelitsha confirmed this. She related a situation of having to cope with a psychotic patient who refused to leave her consulting room:

> I phoned the ambulance, I think three hours elapsed before the ambulance came. *They don't see mental illness as being urgent.* [my emphasis][3]

CHWs' reliance on the support of others in responding to the problem of violent behaviour illustrates one of the conundrums facing CHWs. While they are on the lowest rung of the health system as regards training (Nichter,1986), they are also often the most isolated in terms of supportive services, supervision and channels of referral (Matomora,1989; Walt,1990). This is evidenced in the current study in CHWs' difficulty in organising ambulance transport to hospitals. Not only is this problematic in terms of the quality of health care that is provided to people in the community, but it also places a great burden on the CHWs. They have to either deal with problems beyond the scope of their training and abilities or jeopardise their status as health care providers in the eyes of the people they serve.

One way in which CHWs appear to deal with their disempowerment is by aligning themselves with conventional power structures, namely, the law and the medical system. The preferred treatment for a person who behaved violently was to enlist outside help to take the person to a hospital, day clinic or doctor.

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[3]. Personal communication with G.N. Kuse - 15-5-92

> When they become violent, they throw stones and you cannot come near them...When a person is at that stage, I do not know what to do because I feel that he just needs a doctor to give him an injection for that problem. The person I am talking about is now two weeks at Valkenberg [Hospital]...A car was hired and men had to tie him because he is powerful.

RSC CHWs' accounts of outside assistance were mostly in the form of the police who were called to transport the person to a hospital. In the absence of emergency primary health services, calling the police in cases of violent or destructive family members, was also reported to be the strategy employed by family members of psychiatric patients in Mamre (Miller & Swartz,1990) and the relatives of Black psychiatric patients attending Valkenberg Hospital (Spiro,1991).

Despite the fact that the St John's organisation includes an ambulance service, a similar strategy was reported by a St John's CHW:

> Those violent ones, when they start, people phone the police...That is the first approach we are being taught when dealing with such people because [the police] have all the power to take the person, put him in the van, and take the person to [the hospital]. Otherwise, if you call an ambulance he will just make a mess inside the ambulance. That is why it does not come...You see there are many first aid equipments inside, now if they can put a mad person [inside], he would make a mess of everything.

It is notable that the police are perceived as having "all the power" to control a violent person. By implication, the CHWs seem to feel powerless in the light of this problem. The CHWs are all members of the community which they serve and in many senses 'equals' without visible symbols of power or authority.

Training in mental health care seemed to be a key factor in CHWs' confidence in dealing with such situations. As an RSC CHW commented:

> I think that people who are trained for this job should pay regular visits to this family...they must be trained CHWs because we are CHWs and we are still scared of such people.

The issue of training seemed to be a crucial one for the RSC CHWs.

> I think it's important that we get training on mental illness because we do encounter such problems and if we cannot deal with them it appears as if our job is not really clear or complete. The people that we help usually ask us why, if we can help them with one aspect, we can't help them with the other. I understand that there are some areas of

> mental illness that we can't really deal with, but if we could be trained on some aspects and be informed about places of referral so that if we can't help them, we know where to refer them...If you tell people that you are unable to help them, they lose confidence in you. At least if you can't help them you should be able to refer them to someone who will. Another example is that of a young girl who was beaten by [her] father. Because I had some knowledge of first aid, I helped in that situation and that really helped in people recognising the role of CHWs.

The value placed on training by RSC CHWs needs to be seen in the context of the precariousness of their jobs (where their absence of formal qualifications was an important factor in terms of securing future employment), as well as in the more general context of the social status of CHWs in the health system.

The marginalised position of CHWs regarding their status within the health system has been raised (Nichter,1986; Bastien,1990). Nichter (1986) argues that the ideology of PHC, particularly its democratic and equity aims, needs to be considered from the vantage point of health centre staff and in relation to issues involving professional status and motivation. Professional status is determined by factors such as salary, specialised knowledge and access to sources of power and symbols of authority. CHWs, in terms of salary, training and qualifications, are positioned on the lowest rung of the health care system. Moreover, in service of their accessibility to the community, they are not granted the symbolic authority of a uniform that demarcates them as professionals and they are seldom equipped with the curative/palliative skills that have been shown to enhance status and credibility (Berman et al.,1987). Despite this, they are often expected to play an empowering, leadership role in the community, fulfilling the development goals of PHC-inspired programmes (Walt,1990). Nichter concludes that motivation is likely to flag unless provision is made to address PHC workers' social needs as professionals.

Maintaining a coping stance

In trying to elicit difficult aspects of mental health work in focus group interviews with the CMH and RSC CHWs, I found that CHWs felt it important to maintain a 'coping stance' in their work.

In their focus group interview, CMH CHWs acknowledged remarkably few problems in their work. In the case of these CHWs, potential difficulties in dealing with the mentally ill are not confined just to their work situation. According to the selection criteria for CMH CHWs, all of these CHWs have family members with disabilities. Therefore the challenges they face in their work are those that they have to confront in their personal lives as well. It may be that coping with others' problems is a buffer against the stress of dealing with their own.

CHWs expressed the importance of maintaining a coping stance in the eyes of the people they serve. In the context of the problem of mentally ill people who become violent, CHWs juxtaposed the way in which people in the community reacted with the way in which they themselves felt they should respond, given their training and position as health care workers. Parents or family members of people who reacted violently were reported to be fearful of them and to respond in ways which incited further violence. There were also accounts of their discouraging the CHWs from doing home-visits on account of perceived danger to them.

> Even the family doesn't want you to go into the home where he is...I don't really know [why], they just tell me that he's going to beat me...The parents are already old, they are scared that if you go to him...touch him, he can fight you and overpower you.

In contrast to this, the CHWs felt that they should not indicate that they were afraid as this would undermine people's confidence in them. There was an implicit acknowledgement that they *were* scared but were not allowed to show it. They spoke of facing a problem instead of running away and of being strong.

> As a CHW when you're facing this problem, you must not be a person who is scared. These people that you are dealing with must never see that you are scared of them, [they] must not know that...If you are [scared]...then they will lose hope in you. You must always try to show them that, no, you are strong. And then when you come back again they can accept you instead of saying, 'No, go away! We cannot confide in you anymore!'

Having discussed CHWs' responses to what they perceive to be the mental health problems in their communities, I suggest that several contradictions in the CHW concept have emerged. Firstly, it is considered essential that CHWs truly belong to the community in terms of subscribing to local beliefs and customs and of living in it (Bastien,1990). The requirement that CHWs live in their work environment seems, however, to have negative consequences for both the CHWs and the people they serve. I argue that CHWs' vulnerability to the difficulties they encounter in their work is exacerbated by their lack of distance from the problems and people that are the focus of their intervention. In the absence of being able to distance themselves from problems encountered in their work, CHWs seem to protect themselves by identifying and intervening selectively in those problems that are within their capabilities. They "don't go in-depth" and, by responding to the immediate (often symptomatic) problem, may be accused of delivering "band-aid" care (Berman et al.,1987).

A further contradiction in the CHW concept is that, while being the least trained member of the health system, CHWs are often the most isolated in terms of supportive structures. This is illustrated in the current research by the lack of ambulance services in dealing with people who became unmanageable within the home and community. In the absence of alternatives, CHWs had to resort to strategies with which they were not entirely comfortable (such as tying up the person).

In this research, the CHWs work in communities where basic primary health needs, such as access to clean drinking water, sanitation and food, are not met for many of those they serve. They face the unenviable task of delivering health care where unemployment and poverty are the major determinants of health status. They are the least-trained and -equipped cadre of health worker and they operate in communities that are grossly underserved in terms of health services. Nonetheless, the rhetoric of the PHC approach proposes that CHWs act as empowerers in facilitating a process whereby people become involved in effective decision-making about matters that concern their health. Given the context in which they work, I find it hardly surprising that CHWs appear to associate themselves with the health system, its knowledge and treatment modalities in order that they may enhance their marginalised status.

CHAPTER 8

POSITIONING CHWS' UNDERSTANDING WITHIN A MATRIX OF EXPLANATORY MODELS AND RESOURCES

The focus of this chapter is CHWs' EMs of what they construe as mental health problems. In the first part of the chapter, I examine complexities in negotiating differences in CHWs' and biomedicine's EMs of epilepsy. Thereafter, I explore the relationship between CHWs' understandings of causation and their treatment recommendations. Once again, I show how intervention into mental health problems is shaped by the nature and availability (or lack thereof) of health care resources.

Dealing with conflicts in lay and biomedical explanatory models

The "adversary model" that had currency in the early phases of anthropological research in PHC settings viewed indigenous beliefs and practices as barriers to the acceptance of biomedicine, with people having to be persuaded to abandon the former in order to embrace the latter (Coreil,1990). Since the mid-1970s, this conceptualisation has been superseded by the recognition of the need to attend to and integrate existing health beliefs and practices into health care in a positive way (Kleinman,1980; Marsella,1982). Consequently, researchers who function as 'cultural brokers' in eliciting cultural values surrounding health and illness, only to subvert this knowledge for the coercive purposes of making people do what biomedicine considers to be good and right for them, are criticised for not challenging the biomedical dominance of health care (Taussig,1980).

Before my experiences in this research, I looked askance at Abiodun's research among primary care workers in Nigeria, where the presence of what the author termed "traditional" beliefs about mental illness causation led him to conclude that there was an "urgent need to re-orientate these health workers on the nature and causes of mental disorders...[to] ensure the dissemination of accurate information to lay community members" (1991:117). After all, the reintegration of indigenous beliefs and practices into mental health delivery was named as an advantage of the use of community-based non-professionals in mental health care (Guilmet & Whited,1988). On the basis of this study, however, I suggest that the role of the researcher in cross-cultural research on health and illness, in which conflicts in indigenous and biomedical beliefs and practices emerge, is a complex one.

The case of epilepsy

In the current study, such conflicts primarily involved beliefs and practices regarding epilepsy. In their focus group interview, the RSC CHWs reported the belief that epilepsy is infectious and that one can get epilepsy from being in contact with someone having a fit.

> Some [people in the community] run away because they are scared, because at some stage during this attack [epileptics] release wind and people believe they can be infected.
>
> You're always conscious or aware that you shouldn't be next to this person when he is releasing this wind...[The family] are under the strain that they shouldn't get infected by this disease although they should help this person.

There was consensus among the RSC CHWs that epilepsy is incurable. But sometimes this belief was accompanied by the idea that it is also untreatable.

> [The family] believe that they can never get help and they learn to live with it.
>
> There are many people that we meet with epilepsy but not a single person has become cured, even though they take their tablets regularly.
>
> No, it doesn't happen. You'll find that even if he is taking treatment, he still gets epilepsy.
>
> Sometimes [people with epilepsy] run away...because they believe that if they are taken to a doctor, it just makes them worse; then they refuse to go to the doctor.

With Western medicine being unable to provide a cure for the problem, the only possibility of cure was predicated on the indigenous healers.

> This person can never be cured, even when using the tablets. He then lack[s] confidence in the tablets. Even when you ask the person to use the tablets, he will tell you that he does not think they help him. He then tell[s] you that...what made him...feel better is a bottle of medicine from the traditional healer who also told [him] to stop using the tablets.
>
> There are many people that we meet with epilepsy but not a single person has become cured, even though they take their tablets regularly, to an extent that some people believe in using traditional medicine.
>
> The family believe that one day the illness will be cured. That is by the traditional healers, not from using the medication of the doctors (Several CHWs made this comment).

Another unanimous belief among these CHWs was that epileptics who burned themselves accidentally would never be cured, not even at the hands of indigenous healers.

> If that person with fits become[s] burnt, forget! He will never be cured. We have that belief.

According to RSC CHWs, this conception placed a great burden on care-givers "to the extent that the major thing the family takes care of is that such a person must never be left alone in the house."

It is interesting that Ben-Tovim (1987), in his work among the BaTswana in Botswana[1], noted striking similarities in beliefs about and help-seeking patterns for epilepsy. He observed that people with epilepsy did not readily seek medical treatment, a disinclination that Ben-Tovim ascribed to the widespread belief that indigenous healing was the first choice of treatment for epilepsy. A study on treatment preferences for various disorders showed that, in the case of epilepsy, over 30% of hospital nursing staff and over 60% of the villagers opted for indigenous healing over and above biomedical services (Dale & Ben-Tovim in Ben-Tovim,1987).

A fairly common belief was that epilepsy was contagious, the infectious agent being the froth that results from the clonic tongue and mouth movements during an epileptic seizure. In terms of the responsibility that epileptics posed to their care-givers, the open fires for cooking and heating purposes were a substantial hazard. In a sample of 80 patients diagnosed with generalised grand-mal epilepsy, 23 had been burnt as a result of falling into a fire while having an attack. Of these, half were severely disfigured or disabled as a result of their burns. Adding to the damage of the burns was the widespread belief that once an epileptic has been burnt, the epilepsy is incurable. This belief was confirmed by indigenous healers.

Ben-Tovim comments that these beliefs and practices had to be taken into account when formulating an approach to the organisation of services for people with epilepsy. He asserts that

> understanding culture is a necessary, but not sufficient, prerequisite for the effective provision of psychiatric care. Developing countries cannot solely be looked at as

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[1] A landlocked African independent state bordering Namibia, South Africa, Zimbabwe, and Zambia.

> laboratories for the study of the primitive, and the emphasis of psychiatrists working within them must tend towards problems of service delivery, rather than an emphasis on cultural explanation alone (1987:210).

An issue of power

Having gained insight into the EMs held by CHWs, a caveat for me was neither to dismiss their understandings and strategies as 'primitive' nor to 'romanticise' them and see them as necessarily beneficial. In this study, I viewed local understandings of epilepsy as damaging to the welfare of epileptics. Judging by several of the CHWs' accounts, there appeared to be many cases of uncontrolled epilepsy where the condition was fatalistically accepted by the family. Furthermore, beliefs about transmission seemed to result in avoidance and fear of epileptics.

Given CHWs' perceptions of me as someone who was powerful and aligned to the biomedical system, my keeping silent on these issues may have been construed as tacit legitimation of what I knew to be inaccurate knowledge. I felt that not to correct these misconceptions according to my biomedical knowledge would have been unethical. The new knowledge needed to be framed in an empowering way, however, that did not undermine the confidence and status of the CHWs or ignore the function and significance of their existing beliefs and practices. A process needed to be facilitated whereby the CHWs looked critically at both their old knowledge and the new knowledge in order to avoid what was harmful and extract what was useful (Werner & Bower,1982).

While this process is not dealt with in this dissertation, some of the complexities that emerged in the planning thereof will be discussed.

Facilitating critical consciousness

Initially, I planned to produce a popular resource in the form of a booklet for CHWs that would reflect their experiences, understandings, problems and strategies in dealing with mental health problems in their work. This resource was intended to be more than a summary of their collective voices. It aimed to present the research material in a problem-posing way in order to facilitate critical reflection on mental health beliefs and practices with the aim of affirming what was valuable and transforming what was not. Yet there were several factors, relating to problems of both the format and the content, that made this project inadvisable.

Firstly, although all the CHWs interviewed were literate, it was questionable whether they would truly engage with something in a written form. Secondly, it was also difficult to produce an 'open text' that encouraged dialogue around the issues involved rather than asserting a number of consolidated viewpoints. Finally, a major obstacle was how to address what I regarded as misconceptions held by some of the CHWs. To present beliefs and practices, which I perceived to be harmful, in an uncritical way would have been unethical. Also, to juxtapose CHWs' understandings with my conflicting biomedically orientated ones may have undermined both their confidence in themselves and their status in the eyes of people in the community. Taking these factors into consideration, I decided that the more appropriate course of action would be to provide verbal feedback and to facilitate discussion around contentious issues.

Apart from the considerations of the format and content of the feedback, another concern was my approach to presenting my findings. This was important in terms of providing CHWs with a positive example for engaging with people in the community in a supportive and facilitatory way.

Werner and Bower (1982) comment that one of the most delicate tasks of a CHW is to challenge people about health habits or practices that are harmful without offending them or showing disrespect. I would add that one of the more complex tasks of a researcher is taking responsibility for his or her power in challenging participants about understandings that are considered to be harmful.

Causation and intervention: medicalising 'social' problems

In this section, I examine the relationship between CHWs' theories of illness causation and their recommendations for the appropriate sources of help and health care. I begin by arguing for the inappropriateness of a dualistic conception of health service utilisation and suggest that, in this research context, one cannot truly talk about *choices* among *alternatives*. I examine trends among the CHWs to assign certain problems, namely *amafufunyana*, epilepsy, violent behaviour and "quiet" manifestations of mental illness, to specific health care domains. I then raise the paradox of CHWs' attributing causation to predominantly socio-economic and interpersonal factors and subsequently advocating medical intervention in the majority of cases.

Decision-making models

It is widely noted that the majority of South Africans make use of a variety of healing systems (Freeman & Motsei,1990). Therefore, in the health care consumer's perspective, biomedical and indigenous healing systems do not seem to present the either-or alternatives that dualistic conceptualisations of decision-making propose (Coreil,1990). In the present study, multicausal explanations of illness were accompanied by a variety of treatment options, spanning the popular, folk and professional health systems (Kleinman,1980). In cases where indigenous healers were reported to be consulted, it was mostly in addition to medical practitioners.

Young (1980, in Coreil,1990) replaces the dualistic model of health care utilisation with a "multivariate decision-making model", which examines treatment choices in the context of different illness episodes and multiple options within pluralistic health care systems. In this research context, it is debatable whether one can speak of choice between "multiple options". This is because access to mental health care is restricted by a number of 'non-cultural' factors, such as geographical distance, language and affordability. By way of example, the community psychiatric nurse in Khayelitsha[2] noted that Avalon, an alcoholic treatment centre, was inaccessible to many of her patients in terms of language. She suggested that Avalon needed to employ Black sisters in order to redress this problem.

CHWs' theories of illness causation

Nowhere was the "vagueness, multiplicity of meaning...and lack of sharp boundaries" (Kleinman,1980:107) characteristic of lay EMs more evident than in CHWs' ascriptions of the aetiology of mental health problems. In the majority of cases, CHWs suggested a number of causative factors implicated in each problem, sometimes spanning a number of paradigms. As an RSC CHW stated,

> There are many reasons [for mental illness]. Some of them are disturbed in the brain, some of them it's because of drugs and some it's *amafufunyana* and the others it's worrying too much.

Explanations of illness sometimes involved a combination of indigenous and biomedical understandings. For instance, epilepsy was recognised by a CHW as both an abnormality of the brain and a "disease which is caused by witchcraft". It may be that scientific explanations satisfy questions as to *how* the illness affects the biological system but *why* a particular person is afflicted with this illness may be accounted for by explanations involving witchcraft and supernatural reasons.

The sometimes contradictory ideas that CHWs' EMs reflect are possibly due to their straddling folk and professional health care systems. One of the strengths of CHWs is that they are viewed as "cross-cultural communicators" to bridge the gap between modern and indigenous medicine (Bastien,1990). Through the often medical orientation of CHW

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[2] Personal communication with G.N. Kuse - 15-5-92

training, they are partially socialised into the professional health care system that presents an understanding of health and disease frequently at odds with a lay understanding. At the same time, CHWs are expected not only to live in the community they serve, but preferably also to participate in its customs, values and beliefs (Bastien,1990), including the holistic and folk practices in health issues that may prevail.

Attributions of illness causation and decision-making about treatment options

In this study, there were several instances in which treatment choice was articulated in terms of ascriptions of causation - a relationship that has been widely documented (Lutz,1985).

In cases where the cause of problems was unknown, people were reportedly more likely to consult an indigenous healer. This applied to "quiet" manifestations of mental illness and to cases of epilepsy. By contrast, where an illness was readily recognised and understood, as in the case of violent behaviour, medical intervention was generally prescribed.

> If the person from the very first onset became violent, [people in Khayelitsha] will take that person to the physician. But if they cannot identify the problem because the person is calm, they would take the person to a traditional healer.

Part of the 'cure' of indigenous healing was explicitly stated to be the identification of causative factors. This finding possibly confirms the assertion that indigenous healing, by attending to issues of meaning, fulfils an existential need that biomedicine, with its focus on treatment, fails to address (Ben-Tovim,1987).

There were indications that the CHWs respect and accommodate people's beliefs about ill-health and their preferences regarding treatment. Commenting on a family's decision to take their epileptic son to an indigenous healer, a CHW said: "You cannot tell someone to get away from his belief." Two CHWs said that they would not discourage a family from consulting an indigenous healer, so long as they also sought the advice of a doctor.

> [Referral] depends on the family of the client. We are not against the healers because the people believe in healers. But we tell them that ...[when] you take a person to the healer, at the same time you must take the person to the doctor.

The medicalisation of 'social' problems

A contradiction between CHWs' attributions of the causes of mental illness and their personal, "band-aid" intervention has already been mentioned. A further contradiction relates to their medicalisation of what they see as 'social' problems.

The vast majority of aetiological explanations of the problems under discussion related to social and interpersonal factors. The CHWs' view of poverty and unemployment as primary in the genesis of mental health problems was a common thread throughout all the phases of the research. Interpersonal problems, such as loss or separation from a loved one, were another common denominator in many mental health problems. The mechanism for illness was often described in terms of the stressor (hunger, poverty, joblessness, bereavement, and divorce) leading to worrying about the future, thinking too much or "nerves"; the adoption of unhealthy coping mechanisms (the abuse of alcohol and drugs); and the resultant physical and/or mental illness.

> I think the main problem is a case where a person has a certain problem or is worried about something and doesn't solve this problem which then turns into this kind of illness...Say a married man with a family is unemployed. Now this tends to worry him and he resorts to drinking. Obviously drinking won't solve his problem but it's making the present situation worse. The wife is not working and he is busy drinking and he can get sick.

> Some people have this problem because they have problems at home. Some it's because of drug abuse...I could say it's because [in the rural areas] they are normally very poor so they've got lots of problems in the household...The same thing almost happened to me because I was poor...I was married in the homelands and I was in serious financial problems and I was nearly like this woman.

Despite their recognition of the socio-economic and interpersonal realities underlying mental health problems, CHWs advocated seeking the help of health care professionals in the majority of cases. Most commonly mentioned was referral to the doctor. A notable observation was the number of times hospital and/or doctors' treatment was spoken of as a mechanism of control. (Four CHWs spoke of this in their responses to the vignettes.)

> They get tablets [from the hospital] to control their temper and make them sleep for a while.

> It's not difficult for a doctor because they've got these tablets that can make a person sleep and then they deal with a person.

> The first thing [to do] is to take the person to the doctor and be given sleeping pills.

> If he does not calm down, we then take him to the doctor for an injection which calms him. You can hear from his speech that he does not have the power and talk too much.

Zola (in Kleinman,1980) suggests that modernisation carries with it the tendency to include within the health care system more and more problems traditionally located in other cultural systems. He terms this the progressive "medicalisation" of modern society, which results in the increasing use of medicine and psychiatry for purposes of social control. Ben-Tovim (1987), speaking of his experience of Botswana's programme to integrate psychiatric care with PHC, alludes to the dangers of over-medicalising distress. He comments that much of the community-based care was based on "the *judicious* use of western-style remedies, usually in the shape of psychotropic medication" (1987:103). [my emphasis]

In the current study, the frequent recourse to sedative treatment is a reflection of CHWs' common association of mental illness with violent behaviour. If distress is communicated by means of oppositional and disruptive behaviour, it is promptly subdued by tranquilisers, injections and sleeping pills. Such practices arguably mask "the secret indignation of the sick and...transform the fluid symptoms of bodily protest into passive, reified, individualised and contained forms of breakdown: into disease alone" (Scheper-Hughes,1992:14).

It would seem that mental health issues are medicalised and commodified and then matched with medical solutions. Contrary to the ideals of the PHC approach, CHWs may obscure social and political issues in illness by individualising and pathologising them. In their recommendations of the appropriate source of help for these problems, namely specialist intervention, CHWs' also distance themselves from any role they might play in the delivery of mental health care. Given the specialist treatment they advocate, their role in the arena of mental health care is reduced primarily to that of referral agents.

Alternative sources of health care

I will now examine the help offered to the mentally ill in terms of Kleinman's (1980) model of the structural domains of health care: the professional, folk and popular sectors. It must be noted that these are not discrete categories. Boundaries between them are fluid and are constantly being negotiated. By way of example, the status of indigenous healers in South Africa *vis -a -vis* the formal health care system is the subject of much debate at present (see Freeman & Motsei,1990). Furthermore, some categories of health worker do not fit neatly within this model, notably the CHW who, while being part of the health system, has no formal qualification or professional status. Finally, this model does not make provision for those sectors outside health and welfare that are involved in health care.

The professional sector

CHWs' intervention strategies and recommendations are suggestive of the professionalisation of mental health care. In their personal accounts of mental health problems, the CHWs reported ten cases which were being treated at psychiatric hospitals. Furthermore, in their responses to the vignettes, the CHWs predominantly advocated treatment strategies that fell within the professional sector. Half of these recommendations involved referral to a doctor.

The professionalisation of mental health care may be linked to CHWs' biomedical focus in largely identifying psychiatric problems as constituting the scope of mental health problems in their communities. Moreover, it is indicative of the curative, reactive nature of CHWs' interventions. Intervention in a problem often appeared to be precipitated by a crisis that made the person unmanageable at home. A psychiatric sister[3] who worked in a psychiatric ward at Groote Schuur Hospital for 12 years, observed that Black patients admitted to the ward were generally far more disordered and distressed than white patients. She concluded that Black communities are less inclined to seek professional help for psychiatric problems immediately (possibly due to problems of access). Rather, the mentally ill are coped with in their homes and communities until such time as they become uncontrollable. In this respect, Ben-Tovim (1987) comments on hospital care being the "court of last resort" among the BaTswana, reserved for the most violent, disruptive and crazy of the mentally ill once more local indigenous care had failed.

An interesting motivation for seeking professional help was as a pathway to securing a disability grant or pension. Two CHWs spoke of the benefits of admission to a psychiatric hospital and consultation with a doctor (and the legitimation of the sick role this afforded) in terms of receiving a disability grant.

> I think as he is now, he need[s] treatment from Valkenberg [Hospital]...so that when he is discharged he can be entitled to a disability grant.

Only a registered practitioner is empowered to provide the certification necessary for applying for such a grant.

In responses to the vignettes, referral to social workers (n=7) was the chief course of action for problems considered to be social rather than psychological in nature, namely, the

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[3]. Personal communication with L. Robertson - 3-2-93

substance-abusing boy (vignette 3) and the elderly woman with depressive symptoms (vignette 5).

The folk/non-professional sector

Several CHWs articulated the decision to consult indigenous healers in terms of cultural and religious beliefs, namely, whether witchcraft was part of one's belief system and, by implication, whether indigenous healers were legitimate.

> Seeing that we are Xhosas, we do go to traditional healers.

> I was not brought up to believe in witchcraft that is why I'm not interested in believing such things.

Three CHWs stated that acceptance of witchcraft and indigenous healers was counter to their religious convictions.

> I do not believe in [bewitchment]...I only believe in God...You see all these things come from the traditional healers.

Concurring with Ben-Tovim's observations among the BaTswana (1987), non-believers in indigenous healers were mainly church attenders. With few exceptions, *amafufunyana* was seen as a particular category of distress that was outside of the realm of biomedicine and the territory of the indigenous healers.

> I usually encourage [people with *amafufunyana*] that even if they go to the doctors, there is a need for them to use the [African] *muti* too. Because we believe, we as Black people, that the *amafufunyana* you get through witchcraft, so doctors cannot take it out. It has to be taken out by another witchcraft.

Furthermore, five out of the seven respondents to the vignette description of a person with epileptic seizures advocated referral to an indigenous healer. In two of these cases, bewitchment was seen as the causative factor in the epileptic's condition.

According to the CHWs, dual treatment by both indigenous healers and conventional medical practitioners is common practice. Consultation of an indigenous healer was also linked to dissatisfaction with medical treatment, in cases where the condition worsened or where no cure or explanation of causation was provided.

> If you take this person to the doctors and they cannot help this person, they cannot find what the cause of the problem is, the witchdoctors will tell you what the cause of the problem is. They will tell you that the person is bewitched.

> If my child...suddenly becomes ill without any prior warning that he was going to be ill, what I would do is...take this child to a doctor. But if he is becoming worse then I would take him to traditional healers.

By converse, two CHWs stated that where indigenous healing proved ineffective, they would defer to hospital treatment.

> We do go to traditional healers but if the person does not become better, we will take that person to Valkenberg [Hospital] for medical treatment.

Freeman and Motsei (1990) comment that indigenous healing is often family- and community-, rather than individually, orientated, with the aim of integrating the individual within his or her natural environment. It seems as if this quality of indigenous care is sometimes experienced as burdensome by the care-givers, in that it may make greater demands on them. In this regard, a St John's CHW commented on a family's preference for hospital treatment above that of the indigenous healers:

> In hospital these people are looked [after] in the wards but with the traditional healers the person can get lost at night and the family will have to look for the person.

The popular sector

Kleinman (1980) observes that the family, people in the community and social networks that make up the popular sector are the major site of health care. The CHWs' descriptions of community members' and families' responses to the mentally ill suggested, however, a stigmatising rather than a supportive environment.

The general impression gained from CHWs' accounts was that the lack of care for the mentally ill within their own homes made them a burden for people in the community and the health workers. In their focus group interview, CMH CHWs spoke of a lack of awareness and understanding of mental health problems among people in the community, which resulted in uncaring and inappropriate responses to the mentally ill. Such responses included denigration and rejection; forceful or violent reactions; exploitation and abuse; passivity and fatalistic acceptance; and abdication of responsibility. These will be examined in turn.

In many cases, people in the community were said to respond in ways that aggravated the ill person's situation. An account of people's reactions to a person who resembled the vignette description of a socially disruptive man showing loss of contact with reality (vignette 1), illustrates this:

> Some [people] understand, some don't understand. They call him mad and they make him worse...The children are running after this person and they are screaming at him...and he wouldn't stay in one place. He wouldn't even like the people of that area. He will prefer to go away.

There were a few reports of brutal treatment of the mentally ill. In the focus group interview, an RSC CHW related the following account:

> [A] woman was so sick that she took off her clothes...They hacked her to death saying that she is a witch because she took off her clothes. They did not call the police. They set her on fire and I don't know what happened to her.

Such violent reactions to the mentally ill will be considered further in the discussion of the issue of violence.

From CHWs' comments, it seems that the tendency of people taking advantage of and abusing the mentally ill is a problem in their communities. Several CHWs gave accounts of people with mental health problems being sent on endless errands and made to work slavishly.

> They misuse them. They send them up and down, maybe to collect drink. Those people who sell drink send him to the shop because he can't say, 'No, I'm tired now'.

> [The family] treat her very well except for one thing that I didn't like. I noticed that they gave her a lot of work at home. They are...unreasonable and they give her these loads and loads of washing and she's always the one who is carrying water from the taps into the house.

> With woman they normally get raped, with the elderly ones, when they go to get their pension, by the time she gets home she doesn't have money. They just keep on borrowing and borrowing and they never return it.

CHWs spoke of the difficulty of intervening where there is a fatalistic acceptance of the problem, as in the case of a person suffering from fits.

> [The family] tend to accept this person and justify the situation by saying that this illness has always been there; it's not something new. They believe that this person can never get help and they learn to live with it...That's usually the case. But now that we as CHWs are involved in such things, we tend to give them health education and explain to them that these people can get help. And it's a very difficult task.

There were also cases where the family was seen to have abdicated responsibility for the problem. Families' inability to cope with problems, especially when the male members of the household were absent, resulted in their exerting pressure for institutionalisation. It is notable, however, that in cases where the mentally ill *were* being looked after in their homes, women were the care-givers.

A CMH CHW gave the example of a mother's inability to cope with her son who "smoke[s] dagga [cannabis] when out of hospital and goes back to his abnormal state."

> The mother phoned me and talked to me about the condition. She told me that she is very tired of him. She would prefer that he doesn't come home [from Valkenberg Hospital] at weekends.

Families' preference for institutionalisation, or incarceration, was notable in the scenario of the substance-abusing boy (vignette 3).

> Some parents just let go, they don't want to be involved with their children anymore because they are tired of the situation. They even say "It's best if he is in jail because, if he dies, I'll be the one who is worried. When he is in jail, I know at least that he is safe there, he is being taken care of by other people."
>
> In Khayelitsha ...there is a boy whose parents thought he was going to school since the age of seven. They only discover now when he is twelve that he doesn't go to school and he smokes dagga and sells it... The police asked his mother to come and fetch him. She refused and said she doesn't want to fetch him because if he is at home he just disappears and she won't know where to find him.

Some parents said that having their children in jail was preferable to the unhealthy influence of the township environment. According to a CHW, however, people at NICRO expressed a different opinion:

> NICRO helps in preventing these kids from going to jail because they believe that if they go to jail, they come out worse than they were before.

Parents' apparent eagerness to have their 'problem children' institutionalised may be a result of social pressure. People in the community, as well as some of the CHWs, seemed to attribute blame for such problems to the parents. Such children were always on the streets "because of problems in the home among the parents."

> [People in the community] are not happy at all with this situation because you'll find that these boys break into people's houses and steal TVs and radios and leave people with nothing. And [in] the end it's the parents who take the blame for this.

'Policing' people who are violent seems to be the main assistance offered by people in the community.

> The people in the community assist when this person is sick. Because when he is running away, he tends to be very strong and they help in controlling this person and getting him to be normal again.

Research on support has focused primarily on receivers of support rather than on the determinants of providing it (Kessler et al.,1985). Wortman and Lehman (in Jacobson,1987), examining the motivation behind providing support, suggest that people's beliefs about the victims of misfortune and life crises play a decisive role in dictating whether support should be given and to whom. Determinants of the giving of support are whether a person is considered to be responsible or unaccountable for both/either their problems and/or their solutions. If people are assumed to be responsible for both their problems and the solutions, they are less likely to receive support than if responsibility for the problem and/or its solution is seen to reside elsewhere.

There were two notable exceptions in which responsibility for the problem was apportioned elsewhere and problems appeared to elicit supportive responses. These were in cases of what was perceived to be *amafufunyana* and where a single mother was burdened with the child care.

> [People in the community] try hard to give [a] person [with *amafufunyana*] help by taking the person to places where he can be helped as soon as they get to know that he has got *amafufunyana*.
>
> Some people...come and assist. For instance, if it is a family with no father figure, the men from the community come and try to help this mother who's got a problem with [her] son...Some mothers...go to the Civic [Body] to ask for help. They explain to the Civic that they are only mothers and that they can't deal with their sons. Then they get help from the Civic.

Despite CHWs' perceptions of family and community members' lack of coping with the mentally ill, they made 19 recommendations of intervention strategies relating to this domain in response to the vignette descriptions.

Three CHWs advocated intersectoral collaboration by involving members of the Civic Body in mental health problems. This was considered appropriate in view of some problems being viewed as the community's, rather than the individual's, responsibility. Kirmayer notes that

> where the person is conceived of in terms of the family or a larger social unit, rather than an isolated individual, the stigma of illness affects the entire unit and demands a collective response to re-integrate or expel the deviant member (1989:334).

CHWs ascribed much benefit to not feeling alone in one's situation. Loneliness could be remedied through participation in support groups around particular problems.

> The first thing you try [to] do is to advise a person who has this problem and explain to her that she is not the only person who has this problem, that there are many other people who have this problem.

The self-help philosophy seemed to be promoted by many of the CHWs, particularly the CMH CHWs who worked at the Nonceba Rehabilitation Project with its emphasis on self-help and support groups. CHWs also stressed the therapeutic value of being able to talk about one's problems. By converse, a person who contained her problems was thought to be "just causing problems for herself."

> [Some] people when they have a problem they do talk about it and they get help. But others decide not to talk about their problem to anyone else and try to solve their problems on their own. That's how they get into problems.

Suitable 'counsellors' were people who were trained for such work, people who were "favoured" or senior to the person and "women of the community" who commanded respect. CHWs felt that their category of health worker was particularly accessible to people in the community and invited their confidence.

> A CHW can be easily reached by everybody. She does not wear a uniform but is known to be a CHW. A person can easily talk about her problems but that does not happen easily during the first visit...Because during your first visit, the person takes you as a stranger. When you go the second time, you find the person busy cleaning. We CHWs give her or him a hand so that the person feels comfortable. Meanwhile we know what we are up to.

In the first chapter of this thesis, I outlined several arguments for the deprofessionalisation of mental health care to community-based non-professionals. These included the suggestions that non-professionals may encourage the integration of indigenous beliefs and practices into mental health delivery and that they may facilitate community involvement in mental health care. On the basis of this research, however, I argue that *integrating* indigenous and biomedical understanding and approaches to mental illness is not always possible. Furthermore, in their frequent recourse to biomedical treatment for the problems under discussion, the CHWs in this study appeared to perpetuate rather than challenge the professionalisation of mental health care.

CHAPTER 9

THE VISIBLE AND INVISIBLE: AREAS OF CONCERN TO CHWS AND TO ME

To conclude, I will examine the specific areas of concern that emerged as significant to the CHWs and to me in talking about mental health problems. These include substance abuse, violence and depression.

Substance abuse

Throughout all the phases of the research, CHWs noted a high level of involvement of substance abuse in the mental health problems in their communities. In their personal accounts of mental illness, smoking cannabis was linked to six of the cases, with alcohol abuse being implicated in five cases. In most of these cases, substance abuse was named as the causative factor in people's illness.

> This madness go[es] hand in hand with drinking.
>
> Most of [the problems] are caused by alcohol because I haven't seen a normal person drinking. All those who are abnormal drink...The taverns are always at hand [and] you do see that drinking has increased.

There were also descriptions of what appeared to be toxic psychosis.

> Some of them when they are deeply involved in alcohol and smoking dagga, they become ill. They hear sounds in their ears and they start to run around.

According to the community psychiatric nurse in Khayelitsha[1], toxic psychosis constitutes one of the main psychiatric problems in this township.

Coping with stressful life events

Drinking alcohol and smoking dagga were seen as unhealthy coping mechanisms in response to stressful life events such as unemployment, divorce and financial difficulties.

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[1] Personal communication with G. N. Kuse - 15-5-92

> People are not working so they think to drink and smoke is the best thing to bring down stress...The person says, "I have a problem now and I am going to drink alcohol." Now the drunkenness is going away but the problem is still there.

An RSC CHW described the typical chain of events as follows:

> At first you have a problem, then you start drinking and then alcohol results in mental problems which could turn to mental illness.

In addition, substance abuse was linked to a person who had "given himself up".

> Some people find themselves in the chronic stage and they cannot go back to uplift their standard of living. Such a person we refer to SANCA[2].

The dilemma of the taverns

In the focus group interview with RSC CHWs, the relationship between unemployment and substance abuse was spoken of in the context of the accessibility of cannabis and alcohol in the community. CHWs linked the increase in alcohol abuse to the increase in taverns, "Jabulani and Jikeleza" beer halls, in Khayelitsha.

> The major problem is that in our community we have these taverns. [Whereas] a child who is under 16 years could not go into a bottle store and buy alcohol...now [bottle stores] have been moved right into our community and that is the cause of the increasing of the problem.

> In the community there is a lot of dagga and alcohol to an extent that for the people to get hold of these things is not a problem because they can get them anytime.

> People who cannot afford to buy expensive alcohol make a collection of 50 cents as a group and buy the jikeleza/jabulani beer. That jikeleza is not like the old traditional beer whereby you never got drunk from drinking it. Today when you buy the jikeleza, you get a tablet that you put in. And you shake the jikeleza and the tablet and that makes you drunk. Your health also deteriorates quickly...You'll be surprised to see well-dressed people going to that jikeleza/jabulani beer hall.

A dilemma of the taverns, with their cheap and easily available alcohol, was that selling alcohol was a matter of survival for many people who were unemployed.

> As far as alcohol is concerned, it is a problem because some people will tell you that they have to sell alcohol to survive because they are unemployed.

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[2] South African National Council on Alcoholism

A similar pattern of alcohol abuse has been noted in Botswana, where alcohol appeared to play a major part in acute and chronic psychiatric disorders (Ben-Tovim,1987). The perceived increase in consumption of alcohol in recent years is related to the growing number of "shebeens", unlicensed drinking spots, in the villages. Brewing for profit has become a major source of income for the most disadvantaged groups in rural society. Alcohol, most often home-brewed and cheap, is available day and night and has resulted in a new pattern of regular heavy consumption.

High-risk groups

In the current study, drinking and smoking cannabis were perceived to be a problem among children who did not go to school and unemployed adults. School absenteeism was attributed to parents not being able to afford their children's schooling and a lack of parental supervision in cases where parents spent too much time in the taverns themselves or, ironically, where parents were working all day. Children who did not go to school were often reported to be substance abusers.[3]

Management of alcoholism

Several CHWs commented on the difficulty in dealing with alcoholism.

> You see it depend[s] on the person to say that he is going to stop drinking. Even if you offer that person something, if he is not ready then it is difficult to stop.
>
> We tell people that by drinking you are damaging you life physically and by smoking dagga, your brain is getting damaged. It is not easy to get away from these things when you have started.

The management of alcoholism is notoriously difficult. The efficacy of even the most intensive alcohol treatment programmes available in developed countries is uncertain (Ben-Tovim,1987). Commenting on PHC workers management of the recurrent alcohol-related problems in Botswana, Ben-Tovim suggests that "it could be legitimately argued that all any health worker was doing by treating an alcohol-related disorder was to ameliorate a problem that had been caused by social and economic upheaval, and that health workers

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[3]. Based on a population estimate of 300 000, just under half of the children of primary school age living in Khayelitsha are enrolled in primary schools (Harrison & McQueen,1992). While this figure may be inflated by denominator inaccuracy and attendance at schools outside of Khayelitsha, it still reflects a low school enrolment.

should concentrate their efforts on prevention rather than cure" (1987:113). However, CHWs' limited success in carrying out preventive activities and in affecting behavioural change, as well as practical problems in the prevention of mental health problems, have been noted (Vogelman,1990; Walt,1990).

A culture of violence

Helman (1984) notes that culture determines the language in which distress is communicated. In her work among the marginalised sugarcane workers in Northeastern Brazil, Scheper-Hughes (1992a) speaks of a "somatic culture", which is revealed in nervous and sick bodies. In the context of my research, I suggest that one may speak of a "culture of violence" in which violence is a readily available and culturally shaped means of expressing distress.

Unfortunately, this communication seems to have few, if any, positive repercussions for all concerned. In CHWs' accounts, violent people are presented as being a burden to their families, people in the community and the health workers themselves. Furthermore, their protest appears to be silenced either by forceful or brutal treatment at the hands of family and community members or by medical intervention that they often violently resist. In terms of CHWs' (generally positive) attitudes to mental health involvement, violent concomitants of mental illness are among those problems that are experienced as "tough" and "sad". I question whether CHWs, given their lack of support and their vulnerability as women, *should* be 'empowered' to deal with these problems.

Family members of violent patients were reported to experience difficulties in coping with them. The wife of a mentally ill person said to a St John's CHW:

> You know, Mama, if he take[s] the first plate and throw[s] it on the wall, then all the others are also going to follow.

Violence on violence

There were many accounts of inappropriate responses to violent people with mental illness. In their focus group interview, CMH CHWs suggested that this was due to a lack of understanding of mental illness among people in their communities. On a number of occasions, aggressive and oppositional behaviour was reported to be exacerbated by a tendency to respond to violence with violence.

> What other men normally do is...if he is becoming impossible they threaten that they will hit him.

> The other person...stabbed a girl and when the people intervened, he hit those people. These people hacked him and they called the police for him. They did not know that he had a mental problem. He was then to be sent to the hospital for treating the cuts. The sick man then became so wild and overpowered the police. He then went out of the hospital yard, took off his clothes and walked naked to the station.

Silencing the protest and protesting the silencing

The account of the violent man who was "sent to the hospital for treating cuts" exemplifies the way in which the communicative and political nature of illness may be reified and medicalised. As Scheper-Hughes notes, "whatever else illness is...it is also at times, an act of refusal. This refusal can express itself in various ways: a refusal to work, a refusal to struggle under self-defeating conditions, a refusal to endure, a refusal to 'cope' " (1992:14). In the above narrative, an attempt is made to reduce a person's distress to "treating the cuts", an intervention which he ultimately resists.

> He is still not right in his mind because he does not want to take the tablets.

As I have discussed, CHWs' and community members' impotence in the face of violent behaviour was addressed by invoking the authority of the police and medical professionals, intervention being mostly in the form of curbing, subduing or sedating the violent person. These strategies were often met with resistance.

> People who are violent give problems. They don't want to attend clinic. The other person went on top of the roof here at the day hospital because he did not want to be given [an] injection.

'Policing' the violent

In general, CHWs, family members and people in the community felt unable to cope with people who were violent, except for restraining them by tying them up. There were indications that CHWs considered tying people to be an unsatisfactory option that was used in the light of no alternatives.

> I think it is right as far as the neighbours are concerned but to me it is not right.
>
> So what would you do if you came to him and he was violent?
>
> Hayi! That confuses me because I also depend on the people to help me.

The co-ordinator of the RSC CHW Project commented that "people are violent because they are treated as if they were violent".[4] This sentiment was repeated by several of the CHWs, who felt that one must not respond to the violent behaviour with force or fear, but approach the person with respect and understanding.

CHWs' responses

CHWs had differing responses to dealing with a violent person. Some avoided any confrontation with a person in a violent state; some called the police; some suggested tying the person as the only solution; and others felt able to deal with the situation without exercising any force. The latter were notably some of the CMH CHWs, who appeared to feel empowered by their training. A CHW raised the issue of their vulnerability as women in dealing with cases of violence predominantly among men:

> When a person is mentally ill, they become so strong it's impossible to control them. But if it's a woman then maybe we could control her together with other women.

Empowering CHWs?

CHWs' dilemma in coping with violent people while maintaining their status as health workers was evident. A St John's CHW challenged me with what strategy I would recommend, given their situation. A psychiatric sister whom I consulted concerning the problem of dealing with violent, mentally ill people in the CHWs' context, advised that the CHWs approach a violent person in a group of preferably five people.[5] As the CHWs are already so thinly spread in meeting the needs of their communities, to do home-visits in large groups is, however, unfeasible. My conclusion was that CHWs should not be 'empowered' to deal with situations that are threatening even to highly-trained professionals, armed with psychotropic medicine and the support of a team of health workers. Rather, they should be affirmed in the strategies that they employ, namely, in mustering the help of people in the community and calling the police. Whereas it may be argued that police involvement in such cases stigmatises the mentally ill, in this context it appears to be an important source of help that, I feel, should be encouraged.

Depression

As I have already observed, "quiet" manifestations of psychological distress were conspicuous by their absence in CHWs' accounts of mental health problems in their

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[4] Personal communication with E. Mtyala - 23-3-92

[5] Personal communication with L. Robertson - 3-2-93

communities. There were indications that people who were quiet posed diagnostic problems.

> I met a young man who has got a mental illness but he is quiet. I asked these people what is the problem...*To me he did not seem to have a problem* [my emphasis].
>
> By and large there is no difference between a depressed and a not depressed person when you look at them...especially when you do not know the person.
>
> If [people] cannot identify the problem because the person is calm, they would take the person to a traditional healer.

The 'invisibility' of "quiet" expressions of mental illness may be a function of a lack of understanding of the causes of such problems. As an RSC CHW commented:

> [The people] do not see the madness [because] they don't know the reason for the madness.

I have already noted CHWs' generally negative responses to the scenario of depression (vignette 5), which was constructed around their limited references to this category of distress. Eighty per cent of the respondents had never met or heard of anyone who corresponded to the vignette description.

A St John's CHW ascribed the problem of depression to negative effects of urbanisation, particularly the erosion of a sense of 'community':

> What I noticed is that the community that we live in, the township community, they are not people who really care for one another. Unlike the rural communities where we used to look after one another and know about each other's welfare. But it's just not the case here. You see in the rural areas it would be easy to notice if this person is mentally ill because there are always people coming in and out if something has happened to you, for example, if you have lost a husband. So it's easy to detect whether a person is worried or is mentally ill.
>
> You'll never find a person like this [in the rural areas] because a person doesn't have a chance to be alone in the house. There are always people coming in and out to find out how she is...If you visit a person everyday to find out how she is, then she gets an opportunity to say if there is something really wrong.

A CMH CHW contributed the perspective that the problem described in the vignette was due to traditional expectations of women in mourning. She spoke critically of the enforced mourning period of detachment from social life, which lasts for as long as the family decides. She suggested that this period of "isolation" was responsible for the higher prevalence of depression among women.

> For a man it's easy to remarry tomorrow after the funeral or even before the funeral...For a woman it's difficult...In our culture you have to wait, both men and women. But nowadays it doesn't happen. It's only women who wait...You can't lose your husband two weeks from now and then two weeks later, you've got another man. Especially when you have children. It's not easy, it takes time. You might never be the same person...[The woman] must just wait. You also wear black to show the public that you've lost your husband...It's difficult for men to go and speak to a woman who's got [a] black uniform. As a result, when we've got that uniform, you look very bad, even if you stand in the queue [at the shops], you'll get the privilege of being moved to the front so you can be served first and go home...You feel isolated from other people, especially if you are wearing that black uniform.
>
> I'm sure that is why the women suffer from depression because she's thinking that she's got to wear [a] black uniform and she is going to be isolated from other people.
>
> You are not to be seen by a lot of people. The public should see you maybe if you are going for your pay or when you go to work but you can't call this woman loudly or wait for her if you see her in the street...You may...visit a house where someone has passed away but you can't go to fun places like weddings, twenty-firsts, anything that is associated with fun. That is why I say it is isolation. In fact the women should stand and look at it when talking about women's issues.

The negative responses to this vignette can be interpreted on many levels. One interpretation may be that depression among sectors of the population, notably elderly women, is so common that it has become normalised. It may be that the scenario presented was viewed as a culturally appropriate response to bereavement, rather than a problem requiring intervention. Within the context of this research, such withdrawal may have been given positive social value.

Alternatively, despite having constructed the depression vignette around CHWs' words and phrases, I may have presented a Western cultural construction of depression, committing what Kleinman (1977) terms a "category fallacy". Following Lutz's (1985) recommendations, it may have been more appropriate to explore people's understandings of and responses to loss.

In spite of their generally negative responses to the depression vignette, CHWs did offer important insights into the nature of such problems. Particularly noteworthy was a CHW's perception of the unhealthy effects of traditional expectations of women. Her recommendation that "the women should stand and look at it when talking about women's issues" suggests the role that CHWs may play in awakening people to the causes of problems and facilitating a process of critical reflection as a means to transformative action.

In this chapter, I have focused on problems that were of great significance to CHWs, namely, substance abuse and violence, and what I consider to be a gap in their discussion of mental health problems in their communities, namely depression. It is ironic that CHWs focus their attention on those areas of mental ill health that are rooted in intractable social problems and are therefore relatively inaccessible to them. By contrast, they appear to miss cases, such as depression, that are relatively easy to treat.

CHAPTER 10

DISCUSSION AND CONCLUSIONS

This research has looked at CHWs' perceptions of mental health problems and mental health care in two peri-urban Black townships. In examining mental illness within a PHC setting, I have chosen to focus on CHWs (rather than primary care nurses or doctors), because they have been proposed as the ideal work force for advancing the objectives of the PHC approach. No doubt the views and experiences of other PHC workers would contribute important insights to current debates about the means of extending mental health care to all South Africans. Nonetheless, documenting CHWs' perceptions and experiences has raised important issues in negotiating a place for mental health care within the context of the transformation of the structure and delivery of health care in South Africa.

I have used theories from hermeneutically orientated and critically interpretive medical anthropology to explore aspects of mental health culture in Khayelitsha and Nyanga. In particular, Kleinman's EM conceptual framework (1980) was used to elicit CHWs' EMs of mental illness in their communities. I argue that knowledge of how individuals think about illness, make decisions affecting their health and evaluate outcomes is important in terms of decreasing the historical communication gap between health care providers and consumers and in planning appropriate health care intervention.

Critically interpretive approaches contribute the view that illness is shaped by the social organisation of health care and the political-economic context. Therefore any examination of illness beliefs and practices must be contextualised within macro-level analyses. Coreil notes that one of the hazards facing social scientists in PHC settings is that the socio-cultural knowledge they provide will be used as a "quick-fix" to address health problems in the same way as technological innovations in the biomedical approach have been implemented: "The search for simple 'human factors' solutions that do not entail the reorganization of the health care system or change in the socio-political structure of the society underlies much of the current utilization of social science in international health" (Coreil,1990:17). I assert that the oppressive conditions in which the CHWs, and the people they serve, live, cannot be ignored or seen as a modifying factor in the occurrence of mental illness.

I have also looked at the application of qualitative methods to cross-cultural research and have noted the difficulties in democratising the research product and process.

By entitling this thesis "Methods and Madness", I suggest that, in the final analysis, the research process and findings have been of equal value. Both have afforded me powerful learning experiences. Before examining the research findings, I will comment on aspects of the research process.

The research process

The field-work was sometimes arduous, particularly as this part of the research was influenced by a number of factors (mainly human!) that were beyond my control. I was dependent on people whose investment in the research, quite understandably, did not equal mine.

My attempts to popularise this research alerted me to a number of the challenges (and frustrations) in trying to engage in democratic, participatory research. My position as a white, non-Xhosa-speaking researcher in Black townships undoubtedly contributed to the difficulties I experienced in trying to redress the power dynamics in the traditional researcher-subject role. CHWs' often-repeated phrase "We as Black people..." was an indication that they continued to perceive me as an 'outsider'. An obstacle to achieving participation in the research process was certain participants' apparent mistrust of the research enterprise. This seemed to be due to some of the CHWs' negative perceptions of the outcome of past research. I learned that several RSC CHWs felt that the results of an evaluation on their CHW project earlier in the year had been used to lever them out of their jobs. (Despite the fact that the evaluation had concluded positively that this project *could* provide a model for other government CHW projects to emulate (Mathews & Van der Walt,1992).) My experiences with the RSC CHW Project illustrate how awareness of and sensitivity to the internal dynamics of an organisation are important as they can affect one's relationship to individuals.

Another difficulty was the lack of 'research ethic' among some of the respondents, which alienated them from the research process in a number of ways. In some cases, participants seemed unfamiliar with the interview process, particularly the open-ended questions, and they required a great deal of prompting to elicit full answers. This forced me to be more directive in the unstructured interviews, which could have cut off interesting leads and compromised the richness of the data. Some respondents could not understand the need for a second interview and wanted to know if these were the questions I forgot to ask the first time! One of the CHWs was reluctant to provide me with demographic details and, even after I motivated my need for this information, still offered resistance. This CHW showed a great deal of passive resistance to involvement in the research. The research probably represented one more instance in which she felt disempowered, because real decision-making power and participation were denied her. Interestingly, several of the CHWs took a measure of control over the research process by dictating when they were prepared to be interviewed.

In retrospect, I realise that I should have been spent more time in ensuring that the participants were fully informed as to the process and purposes of the research. I was too ready to interpret a lack of questions and nodding of heads as complete understanding. Often questions concerning the nature of the research would emerge only during individual interviews. Furthermore, in line with the aim of empowerment in democratic, participatory research, time should have been spent in familiarising participants with aspects of the research process, including sampling, drawing up an interview schedule, the need for demographic information, and the analysis of results. Applying popularisation to the *process* as well as to the *product* of research is a challenging task and one that I consider merits greater attention.

Before discussing key aspects of the research findings, several limitations to the validity and generalisability of the findings are noted:

Limitations

Firstly, the non-random sampling technique does not allow generalisation of the findings to other settings. Therefore the conclusions need to be limited to the contexts in which, and the persons from whom, the data was obtained. The incomplete sample in the final phase of the research may have biased the research findings, particularly as those CHWs who failed to arrive for their interviews were all St John's CHWs. While the explanation given for their non-attendance was a clash with other activities, their absence is nonetheless problematic.

I recognise that the complex dynamics at play in the RSC CHW Project at the time of the field-work undoubtedly affected these CHWs' participation in the research. Their responses were analysed with reference to this context. It was difficult, however, to apply different weighting to their responses in the *presentation* of material, in that the individual identities of the participants were not preserved. Unfortunately, this CHW Project was no longer in existence at the time of the report-back of the findings. Consequently, I was unable to check the accuracy of my information and interpretations with these CHWs.

Explanatory models are subject to incoherencies, contradictions, vagueness and change.

As such, I recognise that a single interview is inadequate to tap the entirety of this complex, shifting belief system.

The findings

Defining mental illness

The motivation behind the unstructured individual interviews was to elicit CHWs' conceptions of mental health problems. Despite my intentions to avoid a medical model framework, CHWs' responses were largely in terms of a narrow set of mental health problems that they saw as requiring predominantly medical intervention. As informative as the problems they spoke about, were those on which they were silent. Most commonly mentioned were violent and oppositional concomitants of mental illness. This was contrasted by CHWs' relative silence on quiet forms of distress, notably depression.

I have put forward several explanations for what CHWs see and do not see in the arena of mental health problems. I have examined the role of my methodology in positioning the concept of mental health problems within a biomedical framework. I suggest that CHWs' generally limited range of labels for mental health problems may proscribe them from recognising certain forms of psychological distress. In cases where their gaze is focused on the 'mad' or *phambene*, CHWs may continue to identify violent men as constituting the bulk of their largely reactive, palliative interventions. Moreover, in the presence of so many basic unmet needs and in the absence of adequate mental health facilities, CHWs may selectively identify and intervene in those problems for which they are equipped (and empowered) to offer solutions. This may be a self-protective mechanism, given the fact that these CHWs live among the people, and share in the problems, that are the focus of their intervention. In this respect, it is notable that several CHWs personally identified with the problems under discussion. Finally, the many accounts of aggressive and oppositional behaviour may reflect the way in which psychological distress *is* communicated. In a context of minimal mental health care services, afflicted people in Khayelitsha and Nyanga may have learned to communicate their distress in ways that command attention and intervention. I propose that one may speak of a 'culture of violence' in which violent expressions are a readily available and legitimated means of communicating discontent with and opposition to prevailing conditions.

Attributing causation

CHWs' aetiological explanations of mental health problems were strikingly context-bound, with scant reference to physiological factors in mental illness. In the majority of cases, mental illness was attributed to the distressing conditions of peoples' everyday lives, a context characterised by unemployment, poor living conditions, divorce and the erosion of a sense of 'community'. By emphasising external factors (social, economic and environmental problems) in illness causation, CHWs may be seen as presenting an alternative perspective to the individualising, pathologising approach of biomedicine. In this respect, the CHWs are challenging biomedical conceptualisations of illness and upholding a tenet of the PHC approach, namely its recognition of the 'social' nature of illness. This positive impression is, however, tempered by the nature of CHWs' responses to mental health problems.

Community responses to the mentally ill: expelling the deviants

The nature of CHWs' interventions into mental health problems may be partly a consequence of the stigmatising rather than supportive environment in which they work. Living with a mentally ill person seemed to be burdensome for many families. As a result, institutionalisation, and even incarceration, of troublesome relatives was often welcomed. There were cases where people were said to reject indigenous healing practices in favour of medical solutions, because the former placed too great a responsibility on the family as care-givers.

CHWs' role in mental health care

Given their definition of the field of mental health problems, their attributions of causation and the lack of community involvement in caring for the mentally ill, how do CHWs construe their role in mental health care? In general, I argue that CHWs intervene at a social rather than an individual level. Their actions seem to be aimed at subduing the deviants and trouble-makers in order to maintain a degree of social stability. To this end, medical treatment is used as a mechanism of social control.

Of concern is the mismatch between the CHWs' understandings of the causes of mental illness and their actual and recommended interventions. Having recognised the link between socio-economic factors and illness, the CHWs recommended the biomedical treatment (often sedation) of troubled bodies in the majority of cases. The CHWs' many accounts of people's resistance to such treatment may indicate people's opposition to being successfully 'managed', as well as dissatisfaction with health care that does not attend to their communication of distress or address their experience of illness.

In their responses to the mental health problems they raise, the CHWs appear to be functioning as extenders of the health system. Their reliance on the professional sector, predominantly medical treatment, places them in the position of referral agents and distances them, and community members, from active participation in and control of mental health care. I conclude that the involvement of non-professionals in mental health delivery should not be seen as inevitably leading to the deprofessionalisation and democratisation of mental health care.

Nonetheless, several of the CHWs emphasised the importance of being able to do things for people and adopted an active stance in terms of meeting people's felt needs for food and money. Apart from what may be termed their 'band-aid' care, the CHWs also spoke of their role as educators in the light of unsupportive and inappropriate responses to the mentally ill.

Feelings of impotence and vulnerability

CHWs' examples of the "tough" and "sad" aspects of mental health work included dealing with mentally ill men who exhibited violent or socially-disruptive behaviour and failure to find a placement for a mentally-handicapped child. It is notable that these cases were associated with the absence or inadequacy of outside assistance, supportive structures and mental health facilities in the CHWs' communities. The CHWs also ascribed feelings of vulnerability and impotence to their being women and to a lack of training.

Integrating indigenous and biomedical EMs

Recent anthropological work stresses the importance of integrating the ideas and practices relating to health and illness that have meaning for health care consumers into health care practices (Coreil,1990). This requires the negotiation of conflicts in professional and lay EMs in order to reach a shared meaning that is acceptable to both health care providers and the people they serve. It has been suggested that CHWs, as intermediaries between people in the community and the health system, serve as "cross-cultural communicators" in bridging the gap between indigenous healers and health care deliverers subscribing to biomedicine (Bastien,1990). It may be, however, that indigenous and biomedical healers operate from intrinsically incommensurable paradigms (Freeman,1992c) and that the CHWs' role in bridging this gap is an unrealistic one. On the basis of this research, I argue that the *integration* of lay and biomedical EMs is a complex issue and is not always possible.

Some CHWs' and community members' EMs of epilepsy were greatly at variance with biomedical EMs. CHWs reported the belief that epilepsy is infectious, that it is caused by witchcraft and that it is both incurable and untreatable. It is notable that CHWs gave several accounts of patients' and families' dissatisfaction with the biomedical treatment of epilepsy. A particular shortcoming appeared to be biomedicine's failure to provide an explanation of causality. By contrast, part of the "cure" of indigenous healers was their diagnosis of the causative factor in this condition.

The belief that epilepsy is infectious and the apparent number of uncontrolled cases of epilepsy are causes for concern. Given the fact that many CHWs knew of people in their communities who suffer from fits, it would follow that they could play an important educative role in this area. However, the CHWs seemed to be extremely culturally sensitive in their dealings with people in the community and several CHWs spoke of not overriding people's conceptions of illness and their treatment preferences. When asked whether she agreed with a family's diagnosis of a problem, a CHW responded "you cannot say to someone else's child, 'I think that you have this.' No, you must side with the people, the parents." In the context of beliefs about the supernatural causation of epilepsy, another CHW asserted that "you cannot tell someone to get away from his beliefs." This CHW's strategy was to encourage the person with epilepsy to consult a medical doctor in addition to indigenous healers. Walt (1990) comments that on the basis of CHW performance, it is unlikely that CHWs will affect changes in people's belief patterns.

CHWs and the ideals of the PHC approach: rhetoric or reality?

In listening to CHWs' stories, I was struck by the many contradictions in the CHW concept. I suggest that the ideals of the PHC approach need to be considered from the perspective of the daily realities within which CHWs such as these attempt, against all odds, to fulfil the many expectations placed on them.

Werner (1980) suggests that the CHW's primary task is to help people gain greater control over their health and their lives, that is, empowering people to make decisions that affect their health. Several people have commented, however, that the political role assigned to CHWs is unrealistic where CHW programmes are implemented in undemocratic societies (Hammond & Buch,1984; Walt,1988). The success of the CHW model has been predicated on government commitment to a redistribution of health care resources in favour of the poor and politically powerless. The CHW concept should not be viewed as a cheap substitute for a comprehensive policy on PHC. For example, CHWs cannot be expected to play an empowering role in the absence of adequate and accessible curative health services.

It has also been suggested that the organisation of health care in South Africa, which serves the interests of biomedicine, proscribes certain health care practices. These include extending health workers' traditional biomedical roles to include psychological care

(Mgoduso & Butchart,1992) and addressing psychosocial issues in illness (Miller & Swartz,1991b). These CHWs appeared to align themselves with the health system, adopting the curative, palliative treatment modalities of biomedicine.

I have noted the contradiction in the expectation that CHWs, who are often disempowered themselves, should act as empowerers. I suggest that one way in which CHWs deal with feelings of impotence is to align themselves with powerful structures such as the health system and the law. Acquiring knowledge may be another means of CHWs' redressing their marginalised status. Mental health care training seemed to be important to many CHWs in several respects. First and foremost, it increased CHWs' confidence in their ability to cope with mentally ill people. As a CMH CHW stated, mental health training made the difference between being "able to stand" as opposed to "run[ning] away" when confronted by mental illness. Training seemed to be significant in motivating CMH CHWs to educate people in the community about more appropriate responses to the mentally ill. Finally, gaining knowledge was seen as an asset in itself - a "gift" that could not be taken away. It was notable how often RSC CHWs, who were faced with the possibility of unemployment and no formal qualifications, stressed the importance of training. In the absence of an accredited status as health workers or visible signs and symbols of authority, CHWs may feel too 'equal' to the people they serve. This is especially so when they are confronted by problems that are beyond the control of community members.

In certain respects, the question of whether CHWs *should* be involved in mental health care is an irrelevant one. Given the prevalence of people with psychological difficulties presenting in PHC settings, CHWs unavoidably deal with mental health problems in their work. In this research, all of the CHWs volunteered stories of their personal intervention into cases of what they construed as mental illness. In South Africa, the CHW model is often implemented in deprived communities characterised by a scarcity of health resources. As a result, CHWs may constitute both the first *and* last point of contact with the formal health system for many health care consumers. This applies even more so in the case of access to mental health services.

In conclusion, this research has documented CHWs' perspectives of mental illness in their communities. While their aetiological explanations of mental illness focus attention on the distressing lives behind distressed minds and bodies, the CHWs deal with mental health problems by using strategies which deflect attention away from this reality. The professionalisation of mental health care is ascribed to CHWs' attempts to deal with their disempowerment. I argue that, in their attempts to cope with mental illness, CHWs reveal the many contradictions in the role they are expected to play as well as the constraints to achieving the democratic ideals of the PHC approach in the South African context.

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APPENDIX A

INDIVIDUAL UNSTRUCTURED INTERVIEW

The aim is to elicit CHWs' experiences and personal accounts of people with mental health problems in their communities. Their personal accounts, full and free descriptions of social episodes, will provide the material for the construction of vignettes.

Date: Health project:

Demographic data:
Name:
Date of birth:
Marital status:
Place of residence:
Highest level of education:
Employment history:
Number of years as a health worker:
Details of training (how long? in what areas?):

Q: Tell me about someone you know or have met who has a mental health problem.

Prompts:

Tell me about the way he/she looks (dress; appearance; cleanliness; unusual physical characteristics).

Tell me about the way he/she behaves (general body movements; mood; speech; perception; thoughts; attitudes; actions).

What is he/she like compared to other people of his/her age (developmental milestones; ability to learn; social skills; independence)?

In what other ways is he/she different from someone who is healthy?

What does he/she do during the day (work; leisure activities)?

Tell me about his/her relationships with others (amount of contact; closeness).

For how long has he/she had this problem?

What will he/she be like in the future? (Better or worse?)

What do you call this problem?

APPENDIX B

FOCUS GROUP INTERVIEW

The aim of these interviews is to elicit CHWs' fears, hopes, needs and questions around their actual and/or potential involvement in mental health care.

What are your feelings about being involved in mental health care?

Anticipated areas of response:

- negative attitudes towards mental illness and the mentally ill
- fear of people with mental illness who are seen as being violent
- mental health care as the responsibility of mental health professionals
- lack of training, skills, knowledge and experience in the area
- overloaded with work, therefore no time
- mental health not a priority
- mental health care as an essential, integral part of health care
- willingness if adequate training, support and supervision
- collaboration with PHC workers; traditional healers
- personal experiences of coping with mental health problems; resources and abilities
- needs and questions with regard to involvement in mental health care.

APPENDIX C

VIGNETTES

Vignette 1

A is a 35-year-old man. He looks ragged and dirty and has a bad smell. His head is never upright and he always talks to himself. He doesn't answer questions or talk to anybody. He doesn't stay at home but collects rubbish, takes off his clothes and walks naked in the streets. Sometimes he marches, imitating a soldier.

Vignette 2

M is an 18-year-old woman. She was sent home from up country because she was not well. She doesn't talk sense and sings her own songs. She often wants to be alone and will stay in the forest on her own. If she wants to sleep, she will sleep for the whole day. Sometimes she throws herself on the ground and screams. She can be violent and overpower you.

Vignette 3

V is a 17-year-old boy. His parents separated and now he lives with cousins. He suddenly became naughty at school and eventually left. He smokes dagga, drinks a lot and spends a lot of time on the streets. He breaks into houses and steals things. He gets wild and beats everybody. When you talk to him, he just laughs at you.

Vignette 4

T is an 18-year-old man. He has had fits from childhood and cannot get a job. He shuts himself in his house. When he is becoming ill he turns up his eyes so that only the white part is visible. He sometimes becomes violent and tries to hit you. When he comes to his senses he doesn't remember what he has said or done.

Vignette 5

L is a 60-year-old woman. She lost her husband a few years ago. She is quiet and stays in her room. She does not eat well and does not clean her house. She thinks a lot and worries about her future.

APPENDIX D

INDIVIDUAL STRUCTURED INTERVIEW

The aim of these interviews is to explore CHWs' understandings of mental health problems in their community using an explanatory model approach. Each CHW will be randomly assigned two vignette descriptions of people with mental health problems. They will then be asked the following:

Naming the problem

What is this problem called?
Have you heard of any other names given to describe this problem?
What is the difference, if any, between these names?
How many people do you know who have this problem?
Do both men and women have this problem?

Severity

How serious is the problem?
Is it always the same, i.e. equally bad?
How is someone who has this problem different from someone who is healthy?

Aetiology

What do you think caused this problem?
Have you heard of any other explanations? What are they?
Why do you think it started when it did?

Course

How long do you think this problem will last?
Do you think it will go away or get worse?

Social consequences

What will the effects of this problem be on the person's
a) interpersonal relations?
b) family?
c) community?
d) work?
e) extramural activities?

Intervention

Is it possible to help someone with this problem?
If so, where and to whom should someone with this problem go for help?
What kind of help is needed?
What, if any, are the particular difficulties in helping someone with this problem?