Mental Health Facilitator (MHF) Service Implementation in Schools in Malawi, Africa: A Strategy for Increasing Community Human Resources

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The Mental Health Facilitator (MHF) program utilizes a population-based curriculum and has been implemented in Malawi for the past seven years. This article reports findings from an ethnographic study that explored how 40 MHF stakeholders have experienced the MHF program. This transdisciplinary program is a 30-hour training in community mental health that focuses on fundamental helping skills; identification of stress, distress and mental disorders; and appropriate community referral and follow-up. Results indicated four interrelated themes representing participants' beliefs about their experiences with the training, including the curriculum's responsiveness to the Malawian context, the availability and limitations of resources, the processes involved, and a variety of identified outcomes. Implications for community implementation and future directions are identified.

Keywords: **Mental Health Facilitator, MHF, mental disorders, Malawi, ethnographic study**

Mental health research supports the notion that better care management is achieved when people receive education, training and support to carry out the role of informal caregivers (World Fellowship for Schizophrenia and Allied Disorders, 2006). Although the prevalence of mental disorders in Africa is a significant health problem (Jenkins et al., 2010), treatment remains a low priority (Bird et al., 2011; Jacob et al., 2007), placed at the bottom of the public health care agenda. Mental health patients of all ages and their families are too often invisible, voiceless and living at the margins of society, and they are rarely mobilized to advocate for themselves (Saraceno et al., 2007). In Africa, mental health receives less attention due to a plethora of problems with communicable diseases and malnutrition (Gureje & Alem, 2000). Moreover, the contribution of mental distress to morbidity, as well as mortality, largely goes underappreciated (Jenkins et al., 2010).

Skeen, Lund, Kleintjes, Flisher, and the MHaPP Research Programme Consortium (2010) have reported: "Mental health is a crucial public health and development issue in sub-Saharan Africa" (p. 624). At least half of all African countries have no community-based mental health services, and almost as many have no integration of mental health into primary care or training facilities for primary care staff in the treatment of mental health (World Health Organization [WHO], 2005). In low-income countries like Malawi, essential psychotropic medications are not available, and resources for mental health training and care are largely lacking (Becker & Kleinman, 2013; WHO, 2004). Challenging the negative perception of mental disorders, reducing their prevalence

and providing adequate care are essential policy goals for most of Africa (Gureje & Alem, 2000), a continent where widespread stigma and discrimination, human rights abuses and poverty are the hallmarks of mental health care (Lund, 2010).

In Africa, alternative explanations for mental distress, such as bewitchment, taboos and the belief that *it runs in families*, reduce the chances of access to mental health care (Bird et al., 2011; Wright, Common, Kauye, & Chiwandira, 2014). Moreover, attitudes about mental illness are strongly influenced by traditional beliefs (e.g., supernatural causes) and remedies. Public education that dispels notions that mental disorders are incurable and nonresponsive to typical care is needed (Gureje & Alem, 2000) as well as an effective strategy to decrease stigma (Bird et al., 2011). To accomplish these goals, governments, as well as nongovernmental organizations, need to bring community mental health services to scale (Hinkle, 2014; Patel, 2013; Patel et al., 2007). In 2006, Murthy reported that a global community mental health blueprint does not exist in order to achieve mental health access, and that national community workforce strategies need to be linked to each country's unique situation. Relatedly, Hinkle (2012a, 2014), among others, has advocated for a radical shift in the way mental disorders are managed, including increasing the numbers of trained community-based workers who can be effectively utilized via informal non-health care sectors, as well as formal health care systems (Bradshaw, Mairs, & Richards, 2006; Gulbenkian Global Mental Health Platform, 2013; Petersen et al., 2009; Saraceno et al., 2007).

About 70% of African countries spend less than 1% of their budgets on mental health, with most of these monies going toward large psychiatric hospitals rather than cost-effective, community-based care (WHO, 2005). Mental health services are basically focused on emergency management (Petersen et al., 2009), with minimum long-term planning within the community. Resources for assisting people with mental stress, distress and disorders are insufficient, constrained, fragmented, inequitably distributed and ineffectively implemented (Becker & Kleinman, 2013; Chen et al., 2004; Gulbenkian Global Mental Health Platform, 2013; Hinkle, 2014; Hinkle & Saxena, 2006; Jenkins et al., 2010; Saraceno et al., 2007), especially in low-income African countries like Malawi, where there is a clear link between the lack of human resources and population ill health (Hinkle, 2014). Unfortunately, mental health services continue to be inequitably distributed, with lower-income countries having fewer mental health resources than higher-income countries (Coups, Gaba, & Orleans, 2004; Demyttenaere et al., 2004; Hinkle, 2014; WHO, 2005), as well as inefficient use of and decentralization of existing resources (Petersen et al., 2009). In summary, one of the major barriers to increased mental health care is the lack of people trained to provide care (Saraceno et al., 2007).

Historically, developing and promoting population-based mental health services at the grassroots level has been a difficult task (Hinkle, 2014). In less-developed countries like Malawi, 75–85% of people with mental disorders have received no treatment in the 12 months preceding a clinical interview, and this statistic does not account for the countless subthreshold cases (Demyttenaere et al., 2004; WHO, 2010a, 2010b). Furthermore, when people with mental disorders *are* identified, there is often no adequate resource to refer them to (Petersen et al., 2009).

Hinkle (2014) has reported the following:

> Most mental disorders are highly prevalent in all societies, remain largely undetected and untreated, and result in a substantial burden to families and communities. Although many mental disorders can be mitigated or are avoidable, they continue to be overlooked by the international community and produce significant economic and social hardship. (p. 2)

Existing mental health care in Africa is under-resourced and overburdened (Bradshaw et al., 2006), with enormous gaps between the degree of mental suffering and the number of people receiving care (Becker & Kleinman, 2013; Hinkle, 2014; Saraceno et al., 2007; Weissman et al., 1997; Weissman et al., 1994; Weissman et al., 1996; WHO, 2010a, 2010b).

Chorwe-Sungani, Shangase, and Chilinda (2014), as well as Pence (2009), have indicated that mental health problems in Malawi "are often not identified and treated, because health professionals do not believe they are sufficiently competent to provide mental health care" (Chorwe-Sungani et al., 2014, p. 35). Unfortunately, mental health professionals might not have the "requisite public health skills for effective national advocacy" regarding mental health (Jenkins et al., 2010, p. 232). The numbers of primary care and specialist mental health workers are in general decline because of training costs and migration from frontier or rural settings to urban areas, and from low-income countries like Malawi to higher-income countries (Jenkins et al., 2010). In general, collaborations between mental health organizations and health agencies are weak (Gureje & Alem, 2000).

Low salaries and poor working conditions, as well as lack of training and recognition, are major demotivating factors for existing health workers' involvement in mental health care (Bach, 2004; Manafa et al., 2009). Higher salaries in the private sector have resulted in few incentives for health care workers to work in rural areas where most people live in low-income countries (Saraceno et al., 2007). Overreliance on medical solutions to address psychosocial issues has a disempowering impact on communities (Jain & Jadhav, 2009), including their schools.

Furthermore, primary health care providers cannot adequately intervene with the numbers of mental health cases confronting communities, and medicine has not yet developed sufficient answers for chronic mental health and lifestyle problems (Swartz, 1998). Depending exclusively on medicine to deliver mental health care services risks an overreliance on a medical model and its medications, and less reliance on psychosocial interventions and influences, such as talking with people and problem solving (Patel, 2002; Petersen, 1999), especially for school children. Ten percent of children are considered to have mental health problems, but pediatricians are not generally equipped to provide effective treatment (Chisholm et al., 2000; Craft, 2005). The evidence reveals significant psychopathology among sub-Saharan children, with one in seven children and adolescents experiencing significant difficulties. The most common mental health problems among this age group include depression, anxiety, post-traumatic stress disorder and behavior issues.

In addition to a general lack of mental health workers (Chorwe-Sungani et al., 2014), one psychiatrist served the entire country of Malawi (Chorwe-Sungani et al., 2014), only 2.5 psychiatric nurses were available for every 100,000 people (WHO, 2005), and only one psychiatric unit was available, but not always open or at full capacity. A variety of settings must be used in Malawi, and not all of them are within formal health care. For far too long, the concentration has been on an overburdened medical system and not on the development of local community mental health care (Becker & Kleinman, 2013; Hinkle, 2014; Patel, 2013). For a review of the global impact of untreated mental health problems, see Hinkle (2014).

Recognizing the importance of community and family support and using general lay workers equipped with fundamental mental health skills can have positive outcomes (Gureje & Alem, 2000; Saraceno et al., 2007; Swartz, 1998). Saraceno et al. (2007) have reported, "Non-formal community resources will need to be recognized and mobilized to ensure access to care" (p. 1172). Likewise, in low- to middle-income countries, community workers are often the first line of contact with the health care system (Anand & Bärnighausen, 2004; Hinkle, 2014; Hongoro & McPake, 2004).

Communities in developing countries have historically lacked opportunities for mental health training, skill development and capacity building (Abarquez & Murshed, 2004). However, Hinkle (2014) also has indicated that "long years of training are not necessary for learning how to provide fundamental help for people who are emotionally distressed" (p. 4). International health care organizations have demonstrated a need to develop innovative uses of informal mental health assistants and facilitators to establish community mental health services (Hinkle, 2014; Warne & McAndrew, 2004). Hinkle (2006, 2009, 2014) and Eaton and colleagues (Eaton, 2013; Eaton et al., 2011) have indicated that if the gap in mental health services is to be closed, it must include the use of non-specialists to deliver care. Such non-specialized workers should receive Mental Health Facilitator training in order to identify mental stress, distress and disorders; provide fundamental care; monitor helping strategies; and make appropriate referrals (Becker & Kleinman, 2013; Hinkle, 2014; Hinkle, Kutcher, & Chehil, 2006; Hinkle & Schweiger, 2012; Jorm, 2012; Saraceno et al., 2007). According to Hinkle (2014), the "data speaks loudly to the need for accessible, effective and equitable global mental health care. However, a common barrier to mental health care is a lack of providers who have the necessary competencies to address basic community psychosocial needs" (p. 5).

Informal community mental health care is characterized by community members without formal education or training in mental health providing much-needed services. MHF training has been used to bridge the gap between formal and informal mental health care (Hinkle et al., 2006). Murthy (2006) has indicated that informal community care, including self-care, is critical. Moreover, promotion of community mental health increases understanding of mental health problems and decreases mistrust of people suffering from mental health concerns (Kabir, Iliyasu, Abubakar, & Aliyu, 2004; Wright et al., 2014).

Simply put, community workers are a large untapped volunteer resource for people suffering from problems associated with poor mental health (Hinkle, 2014; Hoff, Hallisey, & Hoff, 2009), and data have shown that the delivery of psychosocial-type interventions in non-specialized care settings is feasible (WHO, 2010a, 2010b). Hinkle (2014) has reported that "enhancing basic community mental health services, both informally and formally, is a viable way to assist the *never-served*" (p. 4). He elaborated that the "MHF program is part of a grassroots implementation trend that has already begun in communities around the globe" (p. 4). In straightforward terms, the demand for the strategic increasing of community mental health services in low-resource settings (Wright et al., 2014) needs to be simplified, locally contextualized, available where people live, affordable and sustainable (Patel, 2013). This plan includes offering services to school children and their families. Wright et al. (2014) have reported that "brief structured psychotherapies, delivered by non-specialist health workers, have been successfully trialed" (p. 156), but the benefits have not necessarily translated into everyday practice. However, this paper reports on one such translation.

Overview of the Mental Health Facilitator Curriculum and Training

The National Board for Certified Counselors (NBCC) International developed the MHF curriculum as well as an implementation method that is making a global impact (Hinkle, 2006, 2007, 2009, 2010a, 2010b, 2012a, 2012b, 2012c, 2013a, 2013b, 2014; Hinkle & Henderson, 2007; Hinkle & Schweiger, 2012). The MHF training program addresses the need for population-based mental health training that can be adapted to reflect the social, cultural, economic and political realities of any country (Hinkle, 2014). Hinkle (2014) described the MHF program as follows:

The MHF training program draws on a variety of competencies derived from related disciplines, including but not limited to psychiatry, psychology, social work, psychiatric nursing, and counseling. Because MHF training is transdisciplinary, traditional professional helping silos are not reinforced; skills and competencies are linked instead to population-based mental health needs rather than professional ideologies. Thus, individuals with MHF training (MHFs) can effectively identify and meet community mental health needs in a standardized manner, regardless of where these needs are manifested and how they are interpreted. Mental health and the process of facilitating it is based on developing community relationships that promote a state of well-being, enabling individuals to realize their abilities, cope with the normal and less-than-normal stresses of life, work productively, and make a contribution to their communities. (p. 6)

The MHF training program has been taught in 25 countries and augments specialized mental health services, where they exist, by functioning within the community to provide targeted assistance, referral and follow-up monitoring (Paredes, Schweiger, Hinkle, Kutcher, & Chehil, 2008). The MHF curriculum consists of information ranging from basic mental health knowledge to specific, local, culturally relevant, first-contact approaches to helping, including mental health advocacy, monitoring, and referral, all of which meet local population needs and respect human dignity (Hinkle, 2014). Nonclinical forms of mental health care such as emotional support or strategic problem solving utilized within the community and schools are emphasized.

Mental health training programs must have a practical component in order to become successful (Saraceno et al., 2007). Accordingly, Hinkle (2014) has stated, "the MHF program is designed to be flexible so local experts can modify components of the training to reflect the realities of their situation; so consumers and policymakers ensure that MHF trainings provide culturally relevant services to the local population" (p. 6). Such a contextual approach connects the MHF program to the principle that mental health care is a combination of universally applicable and context-specific knowledge and skills (Furtos, 2013; Hinkle, 2012a; Paredes et al., 2008; Swartz, 1998).

The diverse backgrounds of MHF trainees enhance the possibilities of addressing gaps in local mental health care. This factor in turn assists local educators, policymakers, service providers and volunteers to meet mental health needs without costly infrastructural investments. Local, contextualized MHF training further facilitates the development and delivery of school- and community-based care consistent with WHO recommendations for addressing the gap in mental health services (Hinkle, 2014), especially among school children.

More specifically, the fundamental features of the MHF curriculum include first-responder forms of community mental health care such as basic assessment, social support and referral. The standard training consists of approximately 30 hours, and a brief one-day version is available (Hinkle & Henderson, 2007). The curriculum includes a focus on the universality of mental stress and distress, as well as mental disorders (Desjarlais, Eisenberg, Good, & Kleinman, 1995; Hinkle & Henderson, 2007), basic helping skills, community mental health services, and advocacy, in addition to specified interventions such as suicide mitigation and responses to child maltreatment. Hinkle (2014) has indicated: "In general, MHFs are taught that negative and unhealthy assumptions about life and living contribute to additional mental and emotional stress" (p. 9). Investing in mental health, cost-effective interventions, the impact of mental disorders on families, and barriers to mental health care also are included. Hinkle and Henderson's (2007) curriculum also encompasses understanding perspectives regarding feelings, effective communication (e.g., *listen, listen, listen*) and using questions

effectively in the helping process, as well as how to assess problems, identify mental health issues and provide support (e.g., *assess, identify, support, refer*).

Hinkle (2014) has reported that MHF "trainees concentrate on the abilities, needs and preferences that all people possess and how these are integrated in various cultures," as well as "how to solve problems and set goals with people experiencing difficulty coping with life" (p. 11). Similarly, trainees learn specific information about basic mental disorders (e.g., anxiety, posttraumatic stress disorder, depression and mania, psychosis and schizophrenia, substance abuse and dependence, intellectual disability, autism, epilepsy).

In view of the vast burden of mental disorders in low- and middle-income countries, as well as the lack of resources for such care in these countries, more research and services are desperately needed (MacLachlan, Nyirenda, & Nyando, 1995; Saxena, Maulik, Sharan, Levav, & Saraceno, 2004). The MHF curriculum has been applied in public schools in Malawi, prompting an initial investigation of its effectiveness.

Method

Design

An applied ethnographic research design (Pelto, 2013) was selected to explore how MHF stakeholders in the schools experienced the program in Malawi. As a constructivist research tradition, ethnography explores cultural patterns within a group (Hays & Wood, 2011). Accordingly, it has been argued that ethnographic methods can enhance education-related research conducted within multicultural communities, as well as provide a contextual understanding of diversity; consequently, ethnography has been purported as effective in giving a voice to those who have been underrepresented in research (Quimby, 2006).

Several steps were taken to strengthen the methodological rigor of this study, specifically efforts to increase trustworthiness through establishing credibility, dependability, transferability and confirmability (Lincoln & Guba, 1985). To demonstrate the credibility or believability of the current findings, we used prolonged community engagement and triangulation (Hays & Singh, 2012). Two of the four researchers were involved in data collection through interviews and focus groups over a five-day period, and a three-person coding team (one author and two advanced doctoral students) were employed for the analysis. As another form of triangulation, and consistent with past research, those involved in data collection and analysis intentionally maintained different degrees of familiarity with the MHF program itself, the research methodology and the related literature (Goodrich, Hrovat, & Luke, 2014). To demonstrate dependability, or consistency of study results, researchers kept detailed accounts of the data collection and analysis processes undertaken, including the steps used to collapse codes, reduce data and represent relationships between themes. To address transferability, or how well findings apply to other students and educators, the researchers used purposeful maximum variance sampling to solicit participants across differing MHF stakeholder groups and used persistent observation while collecting data until saturation was reached (Hays & Singh, 2012). Lastly, to address confirmability or assurance that findings reflect the participants in the study, the researchers utilized prolonged engagement with research participants, bracketing and participant member checking as part of data analysis. Finally, thick description was used when reporting the findings (Lincoln & Guba, 1985).

Participants

Participants in this study were working and living in three different regions of Malawi (i.e., Lilongwe, Michinji and Salima) and included various stakeholders—five MHF master trainers, twelve MHF trainers, seven MHFs, seven MHF beneficiaries and nine MHF community member stakeholders, who included parents, school personnel and government officials. Twenty-four participants were males and sixteen were females; seven of the participants were children or adolescents. Researchers did not ask participants to identify their ages in order to be culturally responsive to customs in Malawi.

Master trainers are the highest level of trainers in the MHF program. They are required to have a minimum of a master's degree in a mental health field and significant teaching experience, or they can be included in the Malawi program if they have significant experience with the MHF program. Master trainers are required to take part in additional training, which includes a teaching demonstration and receiving feedback on their subject matter knowledge and interactive skills. In addition, in order to be fully vested in the MHF program, they are required to take part in a co-training exercise. All master trainers were highly placed administrators in the Malawian Ministry of Education or were upper-level staff at an institution dedicated to working with youth and the school system.

MHF trainers have a bachelor's degree or its equivalent in a mental health-related field, experience as trainers, and are required to attend additional instruction that includes a teaching skills demon-stration. MHF trainers in the current study were teachers, guidance teachers and head teachers (Malawian reference to school principals) who worked in schools participating in the MHF program.

Lastly, MHFs have been instructed in the full MHF curriculum and completed all curriculum requirements. MHF beneficiaries in this study were learners (Malawian reference to students) in schools that incorporated the MHF program. MHF community stakeholders were parents or village leaders who were familiar with the MHF program and able to discuss its effects on their children and communities.

Researcher Stance

In presenting ethnographic results, it is imperative to discuss the researchers' characteristics due to their potential to influence data collection and analysis. One *outside researcher* had no prior experience with the MHF curriculum and was intentionally included in an effort to reduce researcher bias. All four researchers identified as Caucasian doctoral-level counseling professionals from the United States. Two female researchers identified as doctoral-level school counselor educators with previous experience working as school counselors, and two researchers (one male and one female) identified as employees of NBCC International (a division of NBCC). All four researchers had professional experiences focused on the development of counseling within an international context and shared an interest in better understanding how the MHF program impacted stakeholders in Malawi. Two of the researchers had previous professional relationships with the partnering organization in Malawi where the MHF training took place.

As part of the research development, all four researchers met to discuss their respective positions and how their experiences might impact beliefs and perceptions related to the study. Intentional efforts were made to bracket and triangulate perspectives throughout the research process for the purpose of identifying and mitigating biases that could interfere with the project (Hays & Singh, 2012).

Sampling and Data Collection

The sole inclusion criterion for the project was for participants to be MHF stakeholders in Malawi since each stakeholder group could provide a unique perspective. The researchers used purposeful sampling to identify potential participants in two different ways. Prior to leaving the United States, the research team contacted the partnering MHF organization in Malawi to discuss the project and make arrangements for the research visit. During these contacts, the partnering organization agreed to review their records of the MHF master trainers, MHF trainers and MHFs to identify potential participants. Additionally, the partnering organization worked with collaborating schools to solicit potential MHF beneficiary and MHF community member stakeholder participants. Convenience sampling was used based on participant availability at schools (both parents and children) and related organizations. One quarter of the participants ($n = 10$) were interviewed individually to encourage open dialogue. Three quarters of the participants ($n = 30$) took part in both individual interviews and focus groups. As noted above, the partnering MHF organization solicited participants for this project and scheduled potential participants during the five-day research visit. Potential participants were provided with information about the research and an informed consent or assent and asked if they would participate in an audiotaped interview about their experiences with the MHF program. As part of the signed consent, all participants were informed of the voluntary nature of this research and their right to withdraw from participation at any time.

All interviews and focus groups were conducted in person by one or two of the researchers using a semi-structured research protocol. Interviewees were selected by their availability and convenience. Focus groups were conducted at either a convenient administrative building or classrooms at MHF-participating schools. Each of the 10 interviews began with one of the researchers asking the following open, general question: "Can you please describe what it was like to train/provide/receive MHF services?" After this question, the researchers followed up with probes from the semi-structured research guide that consisted of five areas, including the first question, with follow-up questions (probes) for each area. Another example of a question later in the interview was the following: "What has surprised you about MHF services?" If time permitted, the researchers ended the interview with a question that allowed individual interviewees or focus groups to address anything not discussed in the five areas; for example: "Is there anything additional that you thought we would ask that we did not?" There were between six and nine potential probes that could follow each of the five areas. The following is an example of a probe following the initial question: "On a scale of 1 to 10, how satisfied were you with your MHF experience?" Probes also were open-ended, such as, "What might have made your experience with MHF implementation better?" Consistent with the institutional review board-approved research protocol, researchers tried to use probes from all five areas outlined, but consistent with qualitative research design, not all questions were asked of all participants in the same order. This flexible interview style has been used in past research, permitting researchers to probe and follow topics introduced by participants (see Goodrich et al., 2014).

Focus groups were used as a culturally responsive strategy to facilitate the sharing of multiple perspectives and to promote conversations about a topic which, given customs and cultural practices, might be more challenging to discuss in an individual interview (Bogdan & Biklen, 2006). Focus groups were scheduled based on the participants' availability and generally delineated by stakeholder group (i.e., other MHF trainers, MHFs, MHF beneficiaries, and community stakeholders). The number of participants in each of 10 focus groups ranged from three to 12 participants, with an average of five per focus group. The total number of focus groups was dependent on the combined schedules of participants and the need to balance the overall schedule with the necessity of researcher travel to conduct interviews in locations most convenient and appropriate for the participants. The

use of a semi-structured focus group research guide also allowed researchers to ask specific questions that focused on predetermined key topics related to the study, while also maintaining flexibility to follow up on topics that emerged from participants. Similarly, the 10 focus groups all began with the question, "As you reflect on your own experiences as MHF stakeholders, what is significant?" and then proceeded with probes based on the semi-structured research guide. Both interviews and focus groups were audiotaped in their entirety and conducted in English. Individual interviews averaged 35 minutes, ranging from approximately 20–60 minutes in length. Focus groups averaged 50 minutes, with a range of approximately 30–75 minutes. All individual interviews and focus groups were transcribed verbatim by a team of transcriptionists associated with the study.

Data Analysis

Data analysis began on site in Malawi during the data collection process, with the on-site researchers debriefing about patterns and themes as well as their reflections at the end of each day of data collection. After interviews and focus groups were transcribed, the outside researcher created a consensus coding procedure (Hays & Singh, 2012) similar to that used in past studies (Goodrich et al., 2014; Luke & Goodrich, 2013) in which she and two advanced doctoral students trained in ethnographic research each performed the initial coding independently. The process began with each coding team member reading and rereading the data to become familiar with the content and then conducting initial coding using constant comparative methods (Bogdan & Biklen, 2006). Therefore, throughout the initial stage of the analysis, all three coders used line-by-line open coding (e.g., Fassinger, 2005) and compared codes within and across transcripts. This process ensured triangulation, as three different individuals viewed all data.

Although the coding team moved back and forth between the coding stages, the second stage of coding involved the coding team meeting weekly during the coding process. Consensus meetings were conducted using a modified Miles and Huberman (1994) approach to discuss the emergent codes, clarify questions and identify key quotes and reflections on the data, as well as refine the next steps in the research process. Once all transcripts were coded and discussed, the third coding stage began. During the third stage, axial coding was utilized to group and collapse the initial codes, and to form larger categories or themes (Bogdan & Biklen, 2006). The final step of analysis involved developing operational definitions for each theme (Hays & Singh, 2012) and soliciting feedback through peer debriefing and member checking. The feedback received through both peer debriefing and member checking was considered and incorporated into the findings.

Results

In general, the results revealed that the 40 MHF participants in Malawi all agreed that the MHF program was valuable. Participants unanimously noted appreciation for the MHF program and the vital educational role it served in their communities. For example, one adult participant noted, "I am very satisfied with [the] MHF program: It's a 10 [on a scale of 1–10, with 10 being the best]." Participants also described what made the MHF program implementation successful, with one adult participant stating, "MHF is contributing positively, not only to the access of education, but [to] the quality of education." Additionally, participants reported that there would be negative consequences should the MHF program discontinue. Illustrating the significance of the MHF program and his appreciation for it, another adult participant stated, "It is our prayer that this program should continue. I know sometimes resources are limited, but I know God is going to help us."

More specifically, four interrelated themes emerged to illustrate the MHF participants' appreciative beliefs about and experiences with the MHF program. The first theme, *Malawian cultural history and context*, served as grounding for three additional themes: *resources and needs*, *processes* and *outcomes*. Participants explained how these themes interacted with and influenced each other.

MHF Themes

Malawian cultural history and context. One adult participant described how the MHF program was culturally congruent as follows:

> There is a culture of working together. . . . This program . . . has some of the components such as stress, distress, disorders . . . it helps people to identify the signs and symptoms which show that this person is stressed [or] distressed. . . . African culture says, "We are because you are," meaning that we belong to each other . . . meaning that if you see a person showing signs of sadness, you must quickly go in and help.

Another adult participant echoed the idea that the MHF program was interacting within the unique Malawian educational context by saying, "We have packed classes. . . . It's very difficult for a teacher to reach out. . . . Together with the MHF program and the training of teachers . . . they can respond." Still another adult participant explained that before the MHF trainings,

> they [teachers] didn't know that a learner goes through a lot of experiences, right from their homes and on their way to school. . . . They have experiences that need MHF. So the teacher is now aware of handling the learner as a human being, as somebody . . . that is available for their assistance.

Participants also described how the MHF program was adapted to contextual needs in Malawi. One adult participant noted the realism in the MHF training, saying, "Everything that we do and say in trainings, or everything around [the] MHF program, is based on real-life issues." One of the strongest features of the MHF program is its adaptability to cultural contexts. MHF clubs were created in Malawian schools by guidance teachers, teachers, and administrators who had completed MHF training. The clubs are a place where MHFs teach mental health skills to learners and provide a safe place for learners to talk about school and family concerns. Several of the clubs have organized performances for other students and the community using song and dance, an important contextual part of Malawian culture, to illustrate common concerns and the use of MHF skills in addressing these matters.

Participants also discussed specific cultural meanings and social practices as well as context-specific activities within the schools and communities where MHF was implemented. A focus group of learners described the activities they did in their MHF club, and one learner began by saying:

> My poem is based on [a] true story of my friend who [was] . . . always stressed when we had class, wasn't concentrating, always feeling down . . . so, I tried to ask him what his problem was and then I went to a teacher. . . . The patron helped him . . . and now he is doing pretty well. . . . I tried to give him . . . some tips how he could manage stress on his own, like telling him to sometimes listen to some music, do some physical exercises . . . and then after that . . . I referred him to the teacher.

Another learner described a story he developed based on MHF content. He explained that he had a friend who had failed a test and who was worried about going home and telling his father, whom he

believed would be angry. The learner stated that he referred his friend to a teacher who successfully met with the parents and his friend about the test score.

Resources and needs. Bird et al. (2011) have shared that African health workers believe that mental health resources are desperately lacking. Participants discussed examples of invested individuals and MHF programming, and articulated specific ideas about the materials and adaptations desired for the MHF program in the future. One adult participant spoke about MHFs as an asset, saying, "MHFs are creative, [and] like [using a] curriculum that is more simplified [the MHF curriculum is now offered in 1-day formats for communities and schools]." Participants also described the receptivity of people and educational communities as a significant resource. For example, one adult participant said, "The schools are very interested and communities are eager to be involved. They are open to . . . MHF." Another adult participant described something similar within the community, saying, "So far, we engaged the traditional leaders in communities to say there's this program. . . . We have talked to them and I think they would be interested in the training . . . because this time we talked to the chiefs." Expanding on this idea, another adult participant noted,

> I am sure this program is even extending [beyond] the learners. Even the parents also benefit from the program. Because we can tell the learner, and the learner goes to their parent. But if the parent has no idea about it, it would be so difficult. So, also looking at even the parent and community should be synthesized . . . so they know actually what we mean when we talk about mental health. . . . The teachers, the learners and the parents . . . join together [and] they will be able to assist the learner.

Participants also described how their experience of the MHF program was influenced by the need for more tangible resources (e.g., materials, personnel, transportation). One adult participant reported,

> Because the whole program is . . . 19 modules, we ask the office to at least produce one for the school so that we can have it in the building. . . . We have loaded them all on our computers, but access isn't possible by every teacher.

In addition, many participants expressed a desire for the MHF program to incorporate transportation as one of the provided services, to improve communication between MHFs, and to increase dissemination of MHF information. For example, an adult participant suggested, "If other zones [regions or geographic districts] also [had] mental health facilitation, that could assist [with] ideas." Another adult participant commented similarly, "More and more teachers are getting [MHF] and it's very helpful. Maybe to travel to see one another or meet, to talk about what we are each doing—that would be good." Adult participants explained the purpose of travel for MHF collaboration, stating that it would be helpful if the schools involved with MHF could meet at both the district and regional levels to share ideas and that this would benefit not only those involved, but also those outside of the program's current involvement.

Additionally, even though all MHF participants expressed a desire for more MHF programming, participants described how less tangible resources and needs (e.g., mental health and education status, service demands and credentials) influenced their experience of MHF. For example, an adult participant noted that language fluency was one such resource that could expand access to the MHF trainings, commenting, "The other thing that I think you should know in order for your project to benefit . . . you [MHF program] should learn our language . . . so that you can communicate with

those village headmen because most of them do not speak English." (The MHF curriculum has been translated into 11 languages, including Swahili.)

Several participants also explained the importance of religious institutions in Malawi, offering recommendations for their involvement in MHF service delivery. One adult participant said, "You should take it [to] religious institutions because they understand there [are] some religious beliefs which prohibit children from going to school. So, by targeting these religious institutions you can easily reach the minds of the young ones."

Processes. Participants distinguished various MHF-related processes as those consisting of psychoeducational helping, those linked to larger community development efforts, and those focused on specific strategies for spreading the MHF message more broadly. One child participant said, "In the MHF club we learn about how we can . . . advise our friends or how we can . . . [have] good behavior." A second child participant added, "We are supposed to talk, to show people who are drinking or smoking to stop this bad behavior." A third child participant offered, "We learn more about having good friends who have good behavior."

Participants also noted additional educational processes related to MHF. One adult participant stated, "So, the program is developing leadership. It is helping people to grow as individuals and helping society to grow, and when it comes to the learners the program has . . . increased . . . access to education." Another adult participant described the processes of MHF service delivery as follows: "They [beneficiaries] feel as if they are in control because they are decision makers. We just listen, we just guide and they come up with the decision . . . because we cannot make decision[s] for them." Yet another adult participant described MHF activities, including the ability to make referrals, in the following way: ". . . helping people individually [and] referring people to other sources of assistance. I can do that, because I know . . . many systems that can offer assistance."

Relatedly, participants also discussed MHF efforts that were incorporated into educational communities. One child participant described the community process of singing and sharing MHF messages as follows: "I feel good . . . when . . . we sing songs. Songs are more about what MHF [is], so people can remember what we sing and if people drink or smoke they can stop because of the song." Other child participants demonstrated something similar, singing an MHF song they had created and performed. One child participant described how social role modeling was an important process in MHF service delivery, saying, "You become a model to other people and because of that, even those people that we talk to, those people that we teach . . . become recognized in the communities." Other adult participants described how the MHF program used relational implementation processes, stating, "The MHF program addresses critical thinking, good planning . . . in addition to mental health because now we are looking at the whole person."

Lastly, participants described the importance of the use of technology when it came to marketing strategies for the MHF program. One adult participant described how "t-shirts with anti-suicide messages" could be produced to serve two aims, indicating that "learners would feel a sense of belonging" and they could "spread the MHF messages to others." Another adult participant described how communication of the MHF message was important by saying, "We share information about the availability of MHF now by word of mouth, but it could be broken down by different media, like using radio or TV programs." Another adult participant offered the following perspective on MHF results:

[People] are able to discuss . . . mental health whereas before they could not. Some topics weren't discussed, now they air [them] out. . . . This [is a] very important topic, because once you air [it] out on the radio and in the media or in the newspaper, the ability to discuss [mental health] spreads.

   Outcomes. It is of note that participants only identified positive outcomes of the MHF program, without any negative impacts. Participants described the positive global impact by saying, "Every time, every year the MHF training comes and goes, it leaves [the] facilitator, it leaves the community, it leaves the learner, and even the teachers better off than they were before." Another adult participant described the change of perspective provided through the MHF program as follows: "It's an eye opener. . . . It's really a new way of thinking."

   Participants also identified manifestation of MHF-related growth and development as personal change, community welfare and larger systemic influences. One child participant described the personal impact as follows: "Personally I have benefitted a lot, because [MHF] touches what I go through on a daily basis." In addition, an adult participant reported, "In my family there is a big improvement. I do respect other people's views and even have to promote my decision-making skills." Another adult participant described a similar change:

   I've got two children who are in the [MHF] club. . . . Previously, the boy was very, very, very troublesome. But I've . . . noticed some changes in . . . him and I've never heard about any fight against his friends up to now, so I was wondering what is happening to this child now that he has changed. . . . I came to understand that . . . it is because of this program, the Mental Health Facilitator.

Likewise, a participant described the community benefit when he offered, "The whole school is changing because they are . . . teaching [MHF]. . . . Children as a group . . . are changing. . . . There's no violence . . . as it was before." Still another adult participant described the community outcomes in the following way: "One of the teachers was telling me [that] now [learners] trust him even more than their own parents." Participants identified how the MHF program has been able to shift some community inequities as well. For example, one adult participant indicated the following:

   They [MHFs] are able to identify people's problems at the early stage and they are able to give them personal data and some assistance [so] that these people might be healthy. . . . What happens [when people drop out of school] you find out . . . in fact there are more girls [dropping out] than boys . . . because of stressful situations that they have at home or . . . in the schools. So [MHF] programs have [provided] assistance [in] ways [so] teachers can give some guidance.

At times, participants distinguished direct from indirect outcomes. One adult participant offered the following example of direct impact: "The teachers [and] the learners are directly able to understand and know how to handle . . . life challenges."

Discussion

   Participants in this study expressed engagement in and appreciation for the MHF program in Malawi schools. Interview responses indicated similarities between the interconnectedness encouraged in the training and the strong interpersonal relationships within the local culture.

Participants also recognized the adaptability of the curriculum and credited the MHF program with dealing with *real issues*. Indeed, they discussed the ways that the MHF training transformed them and provided examples of the influence that the school MHF clubs had on teachers and students. One goal of the MHF program involves culturally appropriate, grassroots efforts to address mental health concerns in resource-poor countries. Based on the comments delivered by the participants, we have initial evidence of meeting that goal in Malawi.

The appropriateness of the research method used in this study provides an important implication. The focus groups allowed researchers to uncover a depth of description about the impact of the MHF project. Had the investigation proceeded with a survey instrument or a more structured interview, the results likely would have been limited. With an ethnographic design, more was uncovered about not only the similarities of the MHF participants' experiences, but also their particular voices and variations on these similarities. Thus, the applied research design (Pelto, 2013) allowed for a constructivist investigation that provided a contextual understanding of the participants in Malawi and their experiences with MHF.

A further implication involves an unforeseen benefit of the MHF curriculum. Participants in this study reported a community of helpers. They credited the MHF training with providing a platform for a shared language and a common desire to support students, families and communities. Furthermore, they discussed how that language and mission have a ripple or multiplier effect that extends the benefits of the MHF curriculum to strengthen various groups.

Participants in this study confirmed that the mission of the MHF training in Malawi's schools was fulfilled—members of a community can learn to help each other. The findings of this study suggest positive results from a compressed training period designed to prepare participants to adapt basic mental health responding skills and knowledge to their community. Current responses to the lack of mental health resources would be augmented significantly by supporting this type of community and school peer assistance preparation, an economical answer to a persistent need for mental health care.

Participants learned the MHF concepts and integrated the information into their daily living. Their explanations incorporated the terms (e.g., "stress, distress, disorder") and the phrases (e.g., "We just listen, we just guide"). The limits of what an MHF can do also were reported as follows: ". . . helping people individually, referring people to other resources of assistance. I can do that." Participants have written songs about mental health and have become role models and leaders in schools and the community since the completion of the MHF training. They demonstrated improvements in their confidence levels and competence in the information they shared; it seems reasonable to acknowledge these improvements as evidence of the positive impact the project has had on their knowledge and skills, as well as their influence on the people they encounter. This study outcome reflects a multiplier effect with which the project was designed. Therefore, based on these interviews and the resultant themes, we conclude that the participants in the MHF program in Malawi exemplify the ideals of the project.

The Study and General Limitations

Although this study used maximum variation sampling to identify a diverse group of MHF stakeholders, all participants were ultimately self-selected. Therefore, it is possible that the experiences of participants agreeing to be part of the study might reflect something outside the scope of this study and as of yet not identified (Bogdan & Biklen, 2006). Additionally, as all interviews were conducted in English, the design may have privileged participants with more formal education.

Accordingly, the convenience sample may not be representative of the perspectives of all MHF stakeholders in Malawi. Also, cross-cultural research can present unique challenges (Goodrich et al., 2014); therefore, it is conceivable that the level of comfort and openness of participants, as well as decisions about the content shared, may have been different had the two researchers who collected data not been Caucasian American women. Although the research team included an independent member not affiliated with NBCC-I or the MHF program in Malawi, it is possible that the positionality of the research team influenced the participants' reported experiences. That said, as noted elsewhere, intentional efforts were undertaken to strengthen the trustworthiness of the study; however, as with results of any single qualitative study, findings should be interpreted with caution (Kline, 2008).

Participants were proud of the designation of being an MHF and saw themselves as assets to their communities, schools and families. But they also pointed out barriers to expansion of the MHF program and shared solutions to some of their concerns. Population-based mental health risk management helps reduce vulnerabilities to stress (see Bradshaw et al., 2006). However, Hinkle (2014) has pointed out the following limitation:

> For the MHF program to proliferate, it will take not only training, education and implementation in often less than optimal working conditions, but also savvy negotiation of often poorly managed political systems that experience some level of corruption and inability to impact the universal stigma that plagues mental illness. (p. 12)

The efforts to give mental health the prominence it deserves in Africa in general, and in Malawi in particular, will continue to be a political as well as an intervention-related battle (Dawes, 1986) that needs budgets and services that are adequately translated from policies (Bird et al., 2011).

Although the MHF program in Malawi appears to have positive outcomes to date, political support will be needed to realize the program's full potential impact on mental health care (Saraceno et al., 2007). As long as mortality rather than morbidity is the basis for funding for any health problem, mental health will consistently receive less attention (i.e., less funding and fewer services; Bird et al., 2011). Thus, identifying the various levers and entry points (Jenkins et al., 2010) is critical to the sustainability of programs like MHF, in Malawi and elsewhere. Jenkins and colleagues (2010) have reported that mental health "recognition by international donors and the African Union of the importance of mental health to the [sub-Saharan] region would be extremely helpful in eliciting and pooling resources for this crucially underfunded area" (p. 233). Moreover, it is important that mental health policies (Gureje & Alem, 2000) and population-based mental health training not sit on the proverbial shelf gathering dust. Hinkle (2014) has reported that "unfortunately, not even the laudable efforts of the WHO or United Nations have been able to bring countries that are in desperate need of basic mental health care together effectively," which "underscores the need for urgent development of grassroots community mental health programs" (p. 12).

Unfortunately, we did not collect specific data as to how many guidance teachers and head teachers participated in the study. Future researchers could find that differences among these two groups of teachers exist.

Conclusion

The MHF program is community-based training that includes basic, universally applicable and context-specific skills. All 40 adult and child MHF stakeholders in Malawi suggested that the MHF

program had a positive impact in their lives, schools and communities. Participants' identification of four interrelated themes—the responsiveness to the Malawian cultural history and context, the availability and limitations of resources, the processes involved in the implementation of the MHF program, and the varied outcomes—begin to illustrate the ways in which the MHF program has been incorporated into school and community contexts, and identify participants' beliefs about what might be necessary to strengthen and expand the MHF program in this country. Because the MHF program was originally developed to address the unmet mental health needs of individuals in an international context, and trainings have been conducted in 25 countries to date, studies such as this, as well as future quantitative research, can be conducted elsewhere to better understand the ways in which the program is meeting its objectives and to identify the types of support that could be provided to MHFs and human services-related advocacy efforts around the world (Hinkle, 2014; Lee, 2012).

Mental health resource allocations are often haphazard in African countries (Lund & Flisher, 2006); however, Patel et al. (2007) have indicated that the evidence supports the cost-effectiveness of mental health intervention, and the current study reports this potential in the schools in Malawi. Mental health cost-effectiveness also is reflected by a select number of other sub-Saharan countries (e.g., Tanzania, Kenya) that have integrated mental health into basic health service delivery and have set an admirable example of systematic implementation of community mental health service delivery (Jenkins et al., 2010). Community caregiving for mental stress, distress and disorders is often uncompensated and has tremendous public health value, since such caregiving can offset expensive services and assist shorthanded healthcare professionals (Viana et al., 2013). This reality has been demonstrated thus far in the schools in Malawi.

Future Directions in Malawi
More traditional healers should be incorporated into mental health services in Malawi (MacLachlan et al., 1995), a perspective that is reflected by some of the participants' comments. Integrating traditional health care (i.e., indigenous healers) can impact people in ways that Western approaches do not (Gureje & Alem, 2000; Swartz, 2006). Community mental health care should take into account the beliefs of those being served, and both traditional and more modern progressive strategies need to be integrated. *Tropical tolerance*, or entertaining competing explanations of mental illness, is imperative when Westerners are assisting with the implementation of intervention programs (MacLachlan et al., 1995), using the *emic*, or worldview of the person, approach.

In Africa, a large proportion of the population does not receive mental health services for four basic reasons—first, few services are available (*resources and needs*); second, when services are sought out they are inadequate (*outcomes*); third, people often prefer self-care and traditional healers (*processes*); and lastly, stigma leads people to hide their mental health problems (*processes and outcomes*; Bird et al., 2011). These reasons are all relevant to school children and communities in that mental health can no longer be ignored as a building block of population health as well as social, educational and economic development (Lund, 2010). This study demonstrates that the MHF program addresses many of these concerns and is making at least a modest impact in Malawi. It would be short-sighted not to acknowledge that mental health problems are related to poverty, marginalization, social disadvantage, reductions in economic productivity and the interruption of educational processes (Alonso, Chatterji, He, & Kessler, 2013; Baingana & Bos, 2006; Bird et al., 2011; Breslau et al., 2013; Friedman & Thomas, 2009; Hinkle, 2014; Patel et al., 1997). These factors are even more worrisome in countries like Malawi that have seen poverty levels rise in recent years (Mattes, 2008). Although the MHF strategy is clearly challenged by these factors, the program has demonstrated an impact on Malawian school children that cannot be denied.

References

Abarquez, I., & Murshed, Z. (2004). *Field practitioner's handbook*. Bangkok, Thailand: Asian Disaster Preparedness Center.

Alonso, J., Chatterji, S., He, Y., & Kessler, R. C. (2013). Burdens of mental disorders: The approach of the World Mental Health (WMH) surveys. In J. Alonso, S. Chatterji, & Y. He (Eds.), *The burdens of mental disorders: Global perspectives from the WHO World Mental Health surveys* (pp. 1–6). Cambridge, United Kingdom: Cambridge University Press.

Anand, S., & Bärnighausen, T. (2004). Human resources and health outcomes: Cross-country econometric study. *The Lancet*, *364*, 1603–1609.

Bach, S. (2004). Migration patterns of physicians and nurses: Still the same story? *Bulletin of the World Health Organization*, *82*, 624–625.

Baingana, F. K., & Bos, E. R. (2006). Changing patterns of disease and mortality in sub-Saharan Africa: Evidence for disease control priorities. In D. T. Jamison, R. G. Feachem, M. W. Makgoba, E. R. Bos. F. K. Baingana, K. J. Hofman, & K. O. Rogo (Eds.), *Disease and mortality in sub-Saharan Africa* (2nd ed., pp. 1–10). Washington, DC: World Bank.

Becker, A. E., & Kleinman, A. (2013). Mental health and the global agenda. *New England Journal of Medicine*, *369*, 66–73. doi:10.1056/NEJMra1110827

Bird, P., Omar, M., Doku, V., Lund, C., Nsereko, J. R., Mwanza, J., & the MHaPP Research Programme Consortium. (2011). Increasing the priority of mental health in Africa: Findings from qualitative research in Ghana, South Africa, Uganda and Zambia. *Health Policy and Planning*, *26*, 357–365. doi:10.1093/heapol/czq078

Bogdan, R. C., & Biklen, S. K. (2006). *Qualitative research for education: An introduction to theories and methods* (5th ed.). Boston, MA: Pearson.

Bradshaw, T., Mairs, H., & Richards, D. (2006). Developing mental health education for health volunteers in a township in South Africa. *Primary Health Care Research and Development*, *7*, 95–105. doi:10.1191/1463423606pc282oa

Breslau, J., Lee, S., Tsang, A., Lane, M. C., Aguilar-Gaxiola, S., Alonso, J., . . . Williams, D. R. (2013). Associations between mental disorders and early termination of education. In J. Alonso, S. Chatterji, & Y. He (Eds.), *The burdens of mental disorders: Global perspectives from the WHO World Mental Health surveys* (pp. 56–65). Cambridge, United Kingdom: Cambridge University Press.

Chen, L., Evans, T., Anand, S., Boufford, J. I., Brown, H., Chowdhury, M., . . . Wibulpolprasert, S. (2004). Human resources for health: Overcoming the crisis. *The Lancet*, *364*, 1984–1990. doi:10.1016/S0140-6736(04)17482-5

Chisholm, D., Sekar, K., Kumar, K. K., Saeed, K., James, S., . . . & Murthy, R. S. (2000). Integration of mental health care into primary care. *British Journal of Psychiatry*, *176*, 581–588. doi:10.1192/bjp.176.6.581

Chorwe-Sungani, G., Shangase, N., & Chilinda, I. (2014). Care of patients in Malawi who have HIV/AIDS and mental health problems. *Mental Health Practice*, *17*, 35–39.

Coups, E. J., Gaba, A., & Orleans, C. T. (2004). Physician screening for multiple behavioral health risk factors. *American Journal of Preventive Medicine*, *27*, 34–41. doi:10.1016/j.amepre.2004.04.021

Craft, A. (2005). What are the priorities for child health in 2004? *Child: Care, Health and Development*, *31*, 1–2. doi:10.1111/j.1365-2214.2005.00491.x

Dawes, A. R. L. (1986). The notion of relevant psychology with particular reference to Africanist pragmatic initiatives. *Psychology in Society*, *5*, 28–48.

Demyttenaere, K., Bruffaerts, R., Posada-Villa, J., Gasquet, I., Kovess, V., Lepine, J. P., . . . Chatterji, S. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *Journal of the American Medical Association*, *291*, 2581–2590. doi:10.1001/jama.291.21.2581

Desjarlais, R., Eisenberg, L., Good, B., & Kleinman, A. (1995). *World mental health: Problems and priorities in low-income countries*. Oxford, United Kingdom: Oxford University Press.

Eaton, J. (2013, October). Document two. In J. M. C. de Almeida (Chair), *Innovation in mental health care delivery and service organization*. Symposium conducted at the International Forum on Innovation in Mental Health, Gulbenkian Global Mental Health Platform, Lisbon, Portugal.

Eaton, J., McCay, L., Semrau, M., Chatterjee, S., Baingana, F., Araya, R., . . . Saxena, S. (2011). Scale up of services for mental health in low-income and middle-income countries. *The Lancet*, *378*, 1592–1603. doi:10.1016/S0140-6736(11)60891-X

Fassinger, R. E. (2005). Paradigms, praxis, problems, and promise: Grounded theory in counselling psychology research. *Journal of Counseling Psychology*, *52*, 156–166.

Friedman, J., & Thomas, D. (2009). Psychological health before, during, and after an economic crisis: Results from Indonesia, 1993–2000. *World Bank Economic Review*, *23*, 57–76. doi:10.1093/wber/lhn013

Furtos, J. (2013, May). Globalization and mental health: The weight of the world, the size of the sky. In C. I. Cohen & K. Thompson (Chairs), *Envisioning a new psychiatry: Radical perspectives*. Presidential symposium conducted at the annual meeting of the American Psychiatric Association, San Francisco, CA.

Goodrich, K. M., Hrovat, A., & Luke, M. (2014). Professional identity, practice, and development of Kenyan teacher-counsellors: An ethnography. *Journal of Counselor Leadership & Advocacy*, *1*, 44–66. doi:10.1080/2326716X.2014.886976

Gulbenkian Global Mental Health Platform. (2013). *Integrating mental and physical health, promoting social inclusion, humanizing mental health care*. Retrieved from http://www.gulbenkianmhplatform.com

Gureje, O., & Alem, A. (2000). Mental health policy development in Africa. *Bulletin of the World Health Organization*, *78*, 475–482.

Hays, D. G., & Singh, A. A. (2012). *Qualitative inquiry in clinical and educational settings*. New York, NY: Guilford.

Hays, D. G., & Wood, C. (2011). Infusing qualitative traditions in counseling research designs. *Journal of Counseling & Development*, *89*, 288–295. doi:10.1002/j.1556-6678.2011.tb00091.x

Hinkle, J. S. (2006, October). *MHF town meeting: Ideas/questions*. Presentation at the NBCC Global Mental Health Congress, New Delhi, India.

Hinkle, J. S. (2007, June). *The mental health facilitator training: Ongoing developments*. Presentation at the 12th International Counseling Conference, Shanghai, China.

Hinkle, J. S. (2009, July). *Mental health facilitation: The challenge and a strategy*. Keynote address at the Association for Multicultural Counseling and Development/Association for Counselor Education and Supervision 2nd Annual Conference on Culturally Competent Disaster Response, Gaborone, Botswana.

Hinkle, J. S. (2010a). International disaster counseling: Today's reflections, tomorrow's needs. In J. Webber & J. B. Mascari (Eds.), *Terrorism, trauma, and tragedies: A counselor's guide to preparing and responding* (3rd ed., pp. 179–184). Alexandria, VA: American Counseling Association.

Hinkle, J. S. (2010b, August). *Mental health facilitation: A global challenge and workable strategy*. Manuscript presented at the Biennial Conference-Workshop of the Association of Psychological and Educational Counselors of Asia-Pacific, Penang, Malaysia.

Hinkle, J. S. (2012a, May). *Mental health facilitation: A global strategy*. Manuscript presented at the Biennial Conference-Workshop of the Association of Psychological and Educational Counselors of Asia-Pacific, Tokyo, Japan.

Hinkle, J. S. (2012b). *The Mental Health Facilitator program: Optimizing global emotional health one country at a time*. Retrieved from http://www.revistaenfoquehumanistico.com/#!Scott Hinkle/c1lbz

Hinkle, J. S. (2012c, October). *Population-based mental health facilitation (MHF): A strategy that works*. Manuscript presented at the Seventh World Conference on the Promotion of Mental Health and the Prevention of Mental and Behavioural Disorders, Perth, Australia.

Hinkle, J. S. (2013a, February). *Population-based mental health facilitation (MHF): Community empowerment and a vision that works*. Manuscript presented at the conference of the North Carolina Counseling Association, Greensboro, NC.

Hinkle, J. S. (2013b, November). *La salud mental en e mundo*. Presentation at the Old Dominion University Counseling Institute, Buenos Aires, Argentina.

Hinkle, J. S. (2014). Population-based mental health facilitation (MHF): A grassroots strategy that works. *The Professional Counselor*, *4*, 1–18. doi:10.15241/jsh.4.1.1

Hinkle, J. S., & Henderson, D. (2007). *Mental health facilitation*. Greensboro, NC: National Board for Certified Counselors-International.

Hinkle, J. S., Kutcher, S. P., & Chehil, S. (2006, October). *Mental health facilitator: Curriculum development*. Presentation at the NBCC International Global Mental Health Congress, New Delhi, India.

Hinkle, J. S., & Saxena, S. (2006, October). *ATLAS: Mapping international mental health care*. Presentation at the NBCC International Global Mental Health Congress, New Delhi, India.

Hinkle, J. S., & Schweiger, W. (2012, September). *Mental health facilitation around the world*. Manuscript presented at HOLAS Second Counseling Conference of the Americas, Buenos Aires, Argentina.

Hoff, L. A., Hallisey B. J., & Hoff, M. (2009). *People in crisis: Clinical and diversity perspectives* (6th ed.). New York, NY: Routledge.

Hongoro, C., & McPake, B. (2004). How to bridge the gap in human resources for health. *The Lancet*, *364*, 1451–1456.

Jacob, K. S., Sharan, P., Mirza, I., Garrido-Cumbrera, M., Seedat, S., Mari, J. J., . . . Saxena, S. (2007). Mental health systems in countries: Where are we now? *The Lancet*, *370*, 1061–1077. doi:10.1016/S0140-6736(07)61241-0

Jain, S., & Jadhav, S. (2009). Pills that swallow policy: Clinical ethnography of a community mental health program in Northern India. *Transcultural Psychiatry*, *46*, 60–85. doi:10.1177/1363461509102287

Jenkins, R., Baingana, F., Belkin, G., Borowitz, M., Daly, A., Francis., P., . . . Sadiq, S. (2010). Mental health and the development agenda in sub-Saharan Africa. *Psychiatric Services*, *61*, 229–234.

Jorm, A. F. (2012). Mental health literacy: Empowering the community to take action for better mental health. *American Psychologist*, *67*, 231–243.

Kabir, M., Iliyasu, Z., Abubakar, I. S., & Aliyu, M. H. (2004). Perception and beliefs about mental illness among adults in Karfi village, northern Nigeria. *BMC International Health and Human Rights*, *4*, 3. doi:10.1186/1472-698X-4-3

Kline, W. B. (2008). Developing and submitting credible qualitative manuscripts. *Counselor Education and Supervision*, *47*, 210–217. doi:10.1002/j.1556-6978.2008.tb00052.x

Lee, C. C. (2012). Social justice as the fifth force in counseling. In C. Y. Chang, C. A. Barrio Minton, A. L. Dixon, J. E. Myers, & T. J. Sweeney (Eds.), *Professional counseling excellence through leadership and advocacy* (pp. 109–120). New York, NY: Routledge.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Luke, M., & Goodrich, K. M. (2013). Investigating the LGBTQ Responsive Model of Group Supervision. *The Journal for Specialists in Group Work*, *38*, 121–145. doi:10.1080/01933922.2013.775207.

Lund, C. (2010). Mental health in Africa: Findings from the mental health and poverty project. *International Review of Psychiatry*, *22*, 547–549. doi:10.3109/09540261.2010.535809

Lund, C., & Flisher, A. J. (2006). Norms for mental health services in South Africa. *Social Psychiatry and Psychiatric Epidemiology*, *41*, 587–594. doi:10.1007/s00127-006-0057-z

MacLachlan, M., Nyirenda, T., & Nyando, C. (1995). Attributions for admission to Zomba Mental Hospital: Implications for the development of mental health services in Malawi. *International Journal of Social Psychiatry*, *41*, 79–87.

Manafa, O., McAuliffe, E., Maseko, F., Bowie, C., MacLachlan, M., & Normand, C. (2009). Retention of health workers in Malawi: Perspectives of health workers and district management. *Human Resources for Health*, *7*, 65–73. doi:10.1186/1478-4491-7-65

Mattes, R. (2008). *The material and political bases of lived poverty in Africa: Insights from the Afrobarometer (Working paper no. 98)*. Cape Town, South Africa: Afrobarometer.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.

Murthy, R. S. (Ed.). (2006). *Mental health by the people*. Bangalore, India: People's Action for Mental Health.

Paredes, D., Schweiger, W., Hinkle, J. S., Kutcher, S., & Chehil, S. (2008). The mental health facilitator program: An approach to meet global mental health care needs. *Temas Selectos en Orientación Psicológica*, *3*, 73–80.

Patel, V. (2002). *Where there is no psychiatrist*. London, United Kingdom: Gaskell.

Patel, V. (2013, October). *Integrating mental health care in priority health programs: Addressing a grand challenge in global mental health*. Manuscript presented at the International Forum on Innovation in Mental Health, Gulbenkian Global Mental Health Platform, Lisbon, Portugal.

Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., DeSilva, M., . . . van Ommeren, M. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *The Lancet*, *370*, 991–1005. doi:10.1016/S0140-6736(07)61240-9

Patel, V., Todd, C., Winston, M., Gwanzura, F., Simunyu, E., Acuda, W., & Mann, A. (1997). Common mental disorders in primary care in Harare, Zimbabwe: Associations and risk factors. *British Journal of Psychiatry*, *171*, 60–64. doi:10.1192/bjp.171.1.60

Pelto, P. J. (2013). *Applied ethnography: Guidelines for field research*. Walnut Creek, CA: Left Coast Press.

Pence, B. W. (2009). The impact of mental health and traumatic life experiences on antiretroviral treatment outcomes for people living with HIV/AIDS. *Journal of Antimicrobial Chemotherapy*, *63*, 636–640. doi:10.1093/jac/dkp006

Petersen, I. (1999). Training for transformation: Reorientating primary health care nurses for the provision of mental health care in South Africa. *Journal of Advanced Nursing*, *30*, 907–915. doi:10.1046/j.1365-2648.1999.01166.x

Petersen, I., Bhana, A., Campbell-Hall, V., Mjadu, S., Lund, C., Kleintjies, S. . . . Mental Health and Poverty Research Programme Consortium. (2009). Planning for district mental health services in South Africa: A situational analysis of a rural district site. *Health Policy and Planning*, *24*, 140–150. doi:10.1093/heapol/czn049

Quimby, E. (2006). Ethnography's role in assisting mental health research and clinical practice. *Journal of Clinical Psychology*, *62*, 859–879. doi:10.1002/jclp.20277

Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., . . . Underhill, C. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. *The Lancet*, *370*, 1164–1174. doi:10.1016/S0140-6736(07)61263-X

Saxena, S., Maulik, P. K., Sharan, P., Levav, I., & Saraceno, B. (2004). Mental health research on low- and middle-income countries in indexed journals: A preliminary assessment. *The Journal of Mental Health Policy and Economics*, *7*, 127–131.

Skeen, S., Lund, C., Kleintjes, S., Flisher, A., & the MHaPP Research Programme Consortium. (2010). Meeting the millennium development goals in sub-Saharan Africa: What about mental health? *International Review of Psychiatry*, *22*, 624–631. doi:10.3109/09540261.2010.535509

Swartz, L. (1998). *Culture and mental health: A southern African view*. Cape Town, South Africa: Oxford University Press.

Viana, M. C., Gruber, M. J., Shahly, V., de Jonge, P., He, Y., Hinkov, H., & Kessler, R. C. (2013). Family burden associated with mental and physical disorders. In J. Alonso, S. Chatterji, & Y. He (Eds.), *The burdens of mental disorders: Global perspectives from the WHO World Mental Health surveys* (pp. 122–135). Cambridge, United Kingdom: Cambridge University Press.

Warne, T., & McAndrew, S. (2004). The mental health assistant practitioner: An oxymoron? *Journal of Psychiatric and Mental Health Nursing*, *11*, 179–184. doi:10.1111/j.1365-2850.2003.00704.x

Weissman, M. M., Bland, R. C., Canino, G. J., Faravelli, C., Greenwald, S., Hwu, H. G., . . . Yeh, E. K. (1997). The cross-national epidemiology of panic disorder. *Archives of General Psychiatry*, *54*, 305–309.

Weissman, M. M., Bland, R. C., Canino, G. J., Greenwald, S., Hwu, H. G., Lee, C. K, . . . Yeh, E. K. (1994). The cross-national epidemiology of obsessive compulsive disorder. *Journal of Clinical Psychiatry*, *55* (Suppl. 3), 5–10.

Weissman, M. M., Bland, R. C., Canino, G. J., Greenwald, S., Lee, C. K., Newman, S. C., . . . Wickramaratne, P. J. (1996). The cross-national epidemiology of social phobia: A preliminary report. *International Clinical Psychopharmacology*, *11* (Suppl. 3), 9–14.

World Fellowship for Schizophrenia and Allied Disorders. (2006). *Families as partners in care*. Retrieved from http://www.world-schizophrenia.org/activities/fpc/index.html

World Health Organization. (2004). *Atlas: Country resources for neurological disorders*. Geneva, Switzerland: Author.

World Health Organization. (2005). *Mental health atlas*. Geneva, Switzerland: Author.

World Health Organization. (2010a). *Mental health and development: Targeting people with mental health conditions as a vulnerable group*. Geneva, Switzerland: Author.

World Health Organization. (2010b). *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings*. Geneva, Switzerland: Author.

Wright, J., Common, S., Kauye, F., & Chiwandira, C. (2014). Integrating community mental health within primary care in southern Malawi: A pilot educational intervention to enhance the role of health surveillance assistants. *International Journal of Social Psychiatry*, *60*, 155–161. doi:10.1177/0020764012471924

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