VALUING COMMUNITY WORKERS IN GLOBAL MENTAL HEALTH: CRITICAL ETHNOGRAPHY OF A PSYCHOSOCIAL INTERVENTION IN POST-EARTHQUAKE NEPAL

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> Without [a] critical perspective, there is a very real possibility that we will be subverted by powerful forces that aim to maintain the status quo … at the cost of any real liberation for those most grievously afflicted.
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> – Kirmayer (2015: 645)

On a hot morning in May 2017, Kalpana and Liana sat cross-legged on the earthen floor of Kalpana's bedroom.[1] The din of breakfast dishes being washed under a tap outside was clearly audible through the corrugated metal walls of the temporary shelter Kalpana's family had inhabited since the 2015 earthquake destroyed their home. Outside the window, the village of Ashrang could be seen etched into the steep terrain of the Himalayan foothills.[2] Makeshift shelters like Kalpana's dotted a vast expanse of terraced fields and a network of footpaths wound down to the highway running along the valley floor some distance below. Despite being a small community comprised almost exclusively of subsistence farmers, Ashrang was socioculturally diverse, with Hindus of varied castes, a sizeable population of Tamang Buddhists, and growing number of Christians all calling the village home.

[1] All names are pseudonyms except for that of the first author.

[2] The name of this village has been changed and its location omitted to protect the anonymity of staff and clients of this small psychosocial service. While there are several places named Ashrang in Nepal, none are in the district where the research was carried out.

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In the two years since the earthquake, mental health and psychosocial services had become available in Ashrang for the first time. Kalpana had completed six months of training to become a "community-based counselor" and was working with her women's cooperative to establish a center where people could access counseling services and referrals to mental health specialists further afield. Liana, an American anthropology PhD student, had come to Ashrang to follow these changes ethnographically. Kalpana had quickly expressed an interest in taking a more active role in the research on her center, not only participating as a key interlocutor but also gaining research skills and contributing as a part-time assistant. Liana had organized a series of training sessions to this end.

This morning's topic was Global Mental Health (GMH), an interdisciplinary field and social movement committed to scaling up mental health services in low- and middle-income countries (Patel *et al.* 2018). In order to achieve this in settings where there are few mental health professionals, Liana explained, GMH practitioners advocate "task-shifting," or delegating some aspects of mental healthcare traditionally delivered by specialists to frontline workers with less training; this can include primary healthcare providers as well as community workers who don't have a healthcare background (Kohrt and Mendenhall 2015).[3] "Like you," she added, and then paused to ask Kalpana what she thought about all this. If you put counselors there, Kalpana began,

> the problems of that place, of people with psychosocial problems can be solved right there in a local way.[4] Their problems can be solved there, according to their culture. And people with more serious problems related to mental health, we can help them by telling them

[3] We use the term "community worker" in this paper to encompass a range of terms for lay providers who play a role within mental health service delivery, including community-based counselors, community psychosocial workers, lay counselors, peer counselors, and female community health volunteers. All meet the World Health Organization (WHO) definition of a "community health worker": a person involved in health promotion activities who is not considered a health professional but has some training (up to two years), and who provides care in community settings (WHO 2018).

[4] Here Kalpana used the English term "psychosocial" rather than the technical Nepali equivalent used by professionals in Nepal's psychosocial care sector, *manosāmājik*.

> where the proper place to go is, staying at the local level. … And they [community workers] themselves also get a chance at the local level to have work.
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> And people from there know how people are there in their own local place—that's another benefit. … [Doctors in Kathmandu] don't know the situation here. … That kind of doctor [psychiatrists] cannot live in this kind of village. Doctors can't come and live in a place with none of the infrastructure of development—health, education, facilities. For that reason also, giving training to local people from that place, if you give them training they can help people from that place with psychosocial problems.[5]

Kalpana's words capture the main arguments for deploying community workers in the field of GMH today. The practice extends mental healthcare access to rural and remote communities while simultaneously enhancing the cultural appropriateness of services. Kalpana's conviction of the need for greater access to mental healthcare in rural Nepal shines through in the conversation above. At the same time, however, she was frank about the stark inequalities that both made necessary and constrained her own role within services. She had been hired because those with more training and expertise simply *could not* live in a place like hers.

Kalpana's account raises important questions from a critical perspective concerned with the workings of power in and through healthcare. Task-shifting to community workers has been widely embraced by GMH advocates as a pathway to tackling inequities by expanding access to care in low-resource settings. But to what extent does the practice address (or exacerbate) the social and structural problems that give rise to mental health inequities? Kalpana paints a complex picture; she suggests task-shifting in this way might open some doors for rural women by creating meaningful employment opportunities, while at the same time relying on their willingness to live and labor under conditions others would deem unacceptable.

In what follows, we weave between ethnographic material and a review of relevant literature and policy to trace the course of events that ultimately led to Kalpana's resignation less than a year after this conversation took place. We then consider what her experience can tell us about the gendered politics

[5] All quotes have been translated from Nepali by the authors unless followed by {En}.

of a global trend toward relying on community workers to deliver mental healthcare in low-resource settings, including its potential to both redress and reproduce inequality. Through our approach, we hope to show how bringing ethnographic attention to value—or more specifically, negotiations over the value of care labor—can offer an important empirical window onto relations of power in the field of GMH.

Background

Over the past fifteen years, the field of GMH has seen a proliferation of interventions that can be delivered by lay people after a brief and targeted training. This trend has been framed as an "essential response" to the "enormous scarcity and inequality in the distribution" of qualified mental health professionals in low-resource settings (Patel 2012: 8; cf. McInnis and Merajver 2011) and is supported by a growing evidence base (Patel *et al.* 2011; Mutamba *et al.* 2013; Singla *et al.* 2017; Jordans, Luitel, Garman, *et al.* 2019; Malla *et al.* 2019; Jordans *et al.* 2021). Some of the most celebrated GMH programs rely on community workers to deliver "psychosocial interventions," which generally focus on social and psychological forms of support such as counseling (IASC 2007). Such interventions are increasingly envisioned as the frontline of mental healthcare systems, reserving specialist medical treatment for the most severe cases (Patel *et al.* 2018).

In Nepal, the limited number of mental health professionals, especially in rural areas, gives a strong impetus and rationale for task-shifting to community workers. In a country of nearly 30 million, there are only about twenty-five inpatient psychiatric facilities, 200 psychiatrists and thirty clinical psychologists, mostly concentrated in cities (Rai, Gurung and Gautam 2020). Meanwhile, rates of most mental disorders are comparable to those in countries with far more robust human resources for mental health, and rates of major depressive disorder are higher than the global average (WHO 2021). Nepal is also estimated to have the seventh highest rate of suicide in the world, with a relatively high proportion of suicides occurring among women compared with other countries (Marahatta *et al.* 2017). The prevalence of mental health problems and suicide in Nepal have been linked to a range of social factors, including gender inequality and women's attendant exclusion from economic and political spheres (Kohrt and Worthman 2009; Pradhan *et al.* 2011; Clarke *et al.* 2014; Marahatta *et al.* 2017).

To date, task-shifting has been most widely embraced by the Government of Nepal in the area of biomedical service delivery. In particular, efforts have been made to culturally adapt and translate the WHO's mental health Gap Action Program (mhGAP) intervention guides to train Nepali primary healthcare providers on the treatment of common mental disorders, including in the post-earthquake context, the landmark "program for improving mental health care" (PRIME), and more recent studies on innovative treatment approaches (Acharya *et al.* 2017; Jordans, Luitel, Kohrt *et al.* 2019; Rimal *et al.* 2021; Salisbury *et al.* 2021). Yet the country also has an established history of training community workers to deliver psychosocial interventions, mostly in the non-governmental sector. In the 1990s, the Center for Victims of Torture developed a culturally contextualized version of psychosocial counseling that could be delivered by lay people with six months of training, which has since been widely adopted and refined by other mental health NGOs (Jordans *et al.* 2003; Jordans *et al.* 2007; Sapkota, Gurung and Sharma 2011; Jordans, Luitel, Garman *et al.* 2019). Counselors with this training have been included alongside primary care providers in several integrated models of care being explored for possible scale-up (Jordans, Luitel, Garman *et al.* 2019; Jordans, Luitel, Kohrt *et al.* 2019; Rimal *et al.* 2021) and are increasingly accounted for in national health policy. Nepal's National Mental Health Strategy and Action Plan 2020, for example, outlined a strategy to train community psychosocial counselors to make mental health services more accessible across the country (MoHP 2021). Likewise, the Ministry of Women, Children and Senior Citizens' "Integrated Action Plan on Psycho-social Counseling Service for Mental Health Management" called for forming a roster of all the people who have received counseling training and making counseling services available to vulnerable groups (The Himalayan Times 2020).

Research on the experiences of community workers in the field of GMH remains limited and paints a complex picture. On one hand, some scholars have emphasized the agency and empowerment of community workers. For example, Lang's (2019) work in India suggests community workers were able to appropriate psychiatric concepts to advance distinctly local care agendas. Similarly, Read (2019) has described how community workers in Ghana reinterpreted their mandate in alignment with their own religious and social values. More commonly, however, community workers have been portrayed as "handmaidens of biomedical expertise," unwittingly enlisted

in the expansion of Western psychiatry (Campbell and Burgess 2012: 381). Ethnographic studies in India, for example, have emphasized structural constraints on community workers that effectively reduce their role to the administration and enforcement of pharmaceutical treatment regimens (Jain and Jadhav 2009; Kottai and Ranganathan 2020).

Beyond this nascent literature on community workers in GMH, two adjacent bodies of work suggest the relevance of a critical approach. First, a growing social science literature interrogates the status of women within the global health workforce, where there is a gender pay gap of approximately 28 percent despite women occupying about 70 percent of jobs (Boniol *et al.* 2019; Women in Global Health 2022). This work builds on decades of feminist exploration of the "care penalty," or the observation that caring roles predominantly occupied by women often go unpaid or underpaid relative to other forms of comparably skilled labor (England 2005). Scholars have traced this phenomenon to social constructions of gender that associate desirable womanhood with nurturing and altruistic qualities, which are in turn framed as mutually exclusive with the "selfish" pursuit of economic profit (Badgett and Folbre 1999; Nelson 1999; Folbre and Nelson 2000). Recent years have seen particular concern over how these gendered assumptions influence the remuneration of community health workers (CHWs), about two thirds of whom are women (Closser *et al.* 2019; Ahmed *et al.* 2022). Many CHWs work on a volunteer basis, a practice that is often claimed by program planners to empower women. Yet a number of studies have found that community health volunteerism has entrenched gender inequalities in different sites globally (Maes 2010, 2014; Maes *et al.* 2015; Closser *et al.* 2019; Jackson, Kilsby and Hailemariam 2019; Najafizada, Bourgeault and Labonté 2019; Ved *et al.* 2019; Marwah 2021). At times, volunteer roles may further jeopardize the mental health and wellbeing of CHWs by imposing unrealistic expectations on their time and energy (Maes 2015).

In Nepal, debates over the remuneration of CHWs have focused on the national Female Community Health Volunteer (FCHV) program, a lynchpin of healthcare delivery in rural parts of the country since the 1980s. Nepali policy makers have consistently argued that paying FCHVs is not only economically unfeasible, but would also undermine the social value of this work deriving from "a tradition of volunteering as moral behaviour" (Glenton *et al.* 2010: 1920). In a searing critique, Maes *et al.* (2010: 4) argued that this reasoning uses "'culture' to justify differential treatment of

already disadvantaged groups." More recent qualitative research with FCHVs has found that many indeed wish to work on a salaried basis despite their strong commitment to community service; lack of pay and the financial and opportunity costs of engaging in volunteer work were identified as major frustrations (Baskota and Kamaraj 2014; Khatri, Mishra and Khanal 2017; Panday *et al.* 2017).

Second, a body of regional critical scholarship has explored how aid and development programs in Nepal—including those with a specific focus on women's empowerment—have frequently been complicit in the (re) production of gendered inequalities. Ramnarain (2015: 677), for example, found that a program mobilizing women's cooperative members in the peacebuilding process reproduced some of the dynamics underlying women's suffering—namely, through its expectation that these women "perform unremunerated and sustained … work in their communities." Likewise, Yadav (2021) has found that gender sensitive disaster risk reduction policies and practices often served to reinforce the unequal gender status quo. A recent paper by Gurung and colleagues (2021) explored gender inequity in GMH research, finding that despite women's mental health being a popular focus of studies, women researchers were half as likely as men to be named first author on scholarly journal articles. Taken together, this literature suggests a need for further social scientific scrutiny of intervention models gaining popularity in the field of GMH today.

Theoretical Approach

This article develops a critical ethnography of a community-based psychosocial intervention implemented in Nepal's post-earthquake reconstruction period. Critical ethnography is concerned with "displacing the lines of the obvious" (Fassin 2013: 123)—that is, with unsettling dominant narratives and taken for granted assumptions that frequently reflect the interests of the powerful—through rigorous empirical research, reflexive writing, and engagement with social theory. Epistemologically, it values "situated knowledges" produced from particular social locations (Foley and Valenzuela 2005; Haraway 2009). Methodologically, it is committed to long-term ethnographic fieldwork, with its capacity to make visible phenomena that are routinely overlooked by other disciplines (Adams 2016b). This approach dovetails with recent work highlighting the limitations of quantitative metrics and asserting the value of rich and contextualized

case studies charting individual lives ("n of 1") in understanding complex global health realities (Biehl and Petryna 2013; Adams 2016a; Biruk 2018). As Adams and colleagues (2016: 12) argue compellingly, it is through such depth of engagement that we find the ability to "explain why and how poor outcomes arise" and "to tell the story of what is needed in great detail."

Our analysis of ethnographic material attends to the link between questions about power and questions about value, a link that counselors we spoke with continually drew our attention to. Following Graeber (2001, 2013), we understand *value* as the way the importance of some action or labor becomes real to us through a socially recognized medium. Graeber's anthropological theory of value has three elements central to our analysis. First, it places sociological notions of values (conceptions of the good or desirable) on par with economic value, arguing that both ultimately deal with the way the importance of action is realized in a socially recognized form. Accordingly, our analysis considers both commoditized (e.g., pay) and non-commoditized (e.g., prestige, social esteem) ways of valuing counselors' labor. Second, Graeber's (2001) definition sees value as always relative rather than absolute. This brings to the fore the importance of competing priorities and specific material and temporal constraints in processes of valuation. Finally, Graeber's theory of value emphasizes the importance of one's community/society to realizing value, reminding us that an individual cannot sustain value in the absence of recognition from the wider social group to which she belongs. Here, we additionally draw on feminist scholarship to shed light on societal assumptions and dynamics shaping the valuation of women's care labor (Nelson 1999; Badgett and Folbre 1999; Folbre and Nelson 2000; England 2005; Tamang 2011; Marwah 2021).

Building on this understanding of value, Graeber argues that the ultimate stakes of politics are not (as is often assumed) the accumulation of value, but the ability to define what value *is*—that is, to define the ways in which the importance of our action/labor can be realized, and thus, the ends that are worth striving toward (Graeber 2013). Following this conceptualization, we understand individual agency as the ability to decide for oneself which ends are worth striving toward and to pursue those forms of value. In the analysis that follows, we trace negotiations over the value of community workers' labor in a Nepali psychosocial intervention and their consequences for one counselor and the village she served.

Methods

This article draws on fourteen months of ethnographic research (2016–2017) on post-earthquake mental health initiatives. The research was developed and led by the first author with the guidance and support of all co-authors.[6] Fieldwork involved seven months of participant observation in mental health-related trainings, meetings and events in Kathmandu followed by seven months of participant observation in the mixed-ethnicity village of Ashrang where a community-based psychosocial intervention was being rolled out. During latter period of fieldwork, Liana lived with Kalpana's marital family—subsistence farmers belonging to the historically marginalized Tamang ethnic group—and shadowed much of Kalpana's everyday work at the psychosocial support center.[7]

The research also involved a group interview with key stakeholders in the post-earthquake mental health and psychosocial response and fifty-five individual interviews with mental health professionals, public health officials, program coordinators, counseling clients, carers, spiritual healers and community leaders. Interviews conducted with professionals in Kathmandu were mostly in English while interviews conducted in the Ashrang took place almost exclusively in Nepali. For five months, Kalpana provided support during interviews as a part-time research assistant. Although she does not speak English (and thus did not provide interpretation), she was able to intervene in cases of linguistic misunderstanding and enriched conversations by posing her own questions. However, her many other responsibilities meant that she was only able to join a small minority of interviews conducted.

Liana spoke conversational Nepali at the time of fieldwork and conducted the remaining interviews and all participant observation independently. However, her Nepali was not fully fluent and she often missed points or had to ask for clarification. At times she may have misunderstood or failed to understand local expressions, or interpreted sayings and metaphors in literal sense where they should have been understood in context. This is an

[6] Throughout the research period, Liana was a research affiliate of the national NGO Transcultural Psychosocial Organization-Nepal (TPO-Nepal) and benefited from guidance and supervision by staff.

[7] Ethical approval was obtained from SOAS University of London and the Nepal Health Research Council. As per this approval, we avoided all direct observation of clinical activities (counseling sessions) as well as interviews or direct questioning with current clients; in these cases, we focused instead on interviews with caregivers.

important limitation of the study, which we have tried to attenuate through triangulation of fieldnotes with audio recorded interviews transcribed and translated with the help of bilingual team members.

Liana's positionality as a White American graduate student also influenced the data we were able to gather. In Nepal, her identity was commonly read as privileged one associated with disproportionate access to cultural and economic resources. This meant that many of her fieldwork encounters were shaped by gradients of power and potentially interests beyond knowledge production (e.g., nationalism, hope of access to opportunities), which may have led to over- or under-sharing on certain topics. Moreover, as an unmarried woman in her twenties, Liana found it much easier to develop close relationships with women in her field sites; as such, male perspectives may be underrepresented in our analysis. Finally, Liana's status as affiliated researcher to an NGO that was an implementing partner for the intervention could also have influenced responses, for example, causing fear that critiques might lead to loss of support.

The Life of a Community-based Psychosocial Support Center

Defining Value: Autumn 2016

Liana first met Kalpana in November 2016, about one month into Kalpana's six-month psychosocial counseling training. The week's venue was a mid-range restaurant off the busy ring road encircling Kathmandu, in a neighborhood crowded by INGOs and embassies. Kalpana had been nominated to attend by her local women's cooperative in Ashrang because she was one of the only members who had completed grade twelve. Her husband and in-laws decided she should accept, with a major incentive being to earn money for rebuilding the family's home.[8] Laughing, Kalpana later explained to Liana that she had no idea what the training was for when she registered for it.

[8] This appears to be a common motive for engaging in community health volunteerism in India and Nepal (Baskota and Kamaraj 2014; Closser and Shekhawat 2021). Closser and Shekhawat (2021: 11) make the important point that CHWs are "situated within family structures where power is a function of both age and gender" and the forms of value worth pursuing are often dictated by senior relatives rather than personal aspirations.

> I found out only later what "psychosocial problem" means. … At first taking the training I felt like this was completely new and different. I had just finished twelfth grade. … And exactly when I started that training, went to that training, on the first day, I didn't get it. What is this all about? On the first day I was extremely confused.

The program Kalpana had joined was at that time being hailed as the first truly sustainable psychosocial counseling initiative in Nepal's history. Although counseling was introduced as early as the 1980s, it had mainly been offered by NGOs on a project-to-project basis (Acland 2002). The 2015 earthquake constituted an important turning point for government ownership in the mental health sector. In its role coordinating the disaster response, the Government of Nepal was drawn into an international humanitarian assemblage in which mental healthcare delivery was highly prioritized and resourced (Seale-Feldman and Upadhaya 2015). Following the WHO's "building back better" policy, there was pressure to ensure that this surge in interest and funding translated into long-term national mental health system gains (WHO 2013; Chase *et al.* 2018).[9]

It was in this post-earthquake moment that plans for a state-funded psychosocial intervention initially took shape. Although I/NGO actors lobbied for the program and provided initial donor support, all agreed it was essential to involve the government in long-term financing and leadership. As one key stakeholder recounted:

> We had very good technical people, technical organizations ... working on psychosocial component but to some extent it was not sustainable because the government had not taken the ownership. .... So we convinced the government saying that yes, we will be providing support but the government needs to take ownership. {En}

[9] One major development during this period was the first adaption of the WHO's mhGAP Humanitarian Intervention Guide for the Nepali context, co-sponsored by the WHO, Nepal Ministry of Health and Population and the NGO TPO-Nepal; this was used to train most primary healthcare providers in affected districts on the diagnosis and treatment of mental illness (Richards 2016; Sherchan *et al.* 2017; Chase *et al.* 2018).

Ultimately, one government department agreed to cover the costs of staff and infrastructure for pilot psychosocial support centers in fourteen earthquake-affected districts, with the goal of eventual national scale-up. It was further decided that these support centers would be implemented through an existing network of women's cooperatives.

Each of the selected cooperatives nominated one member to receive the six-month training to become a community-based counselor. About five other members of each cooperative received a one-week training to become "community psychosocial workers" providing basic psychosocial support and referrals to counselors. In addition, local FCHVs were trained to provide psychosocial support and to identify and refer clients. Training was provided by experienced Nepali psychosocial counselors at a Kathmandu-based NGO, who were also tasked with providing clinical supervision to the new trainees throughout the program's first year. "Luckily," one trainer explained, "the donors are not pushing too much. They have worked with [us] for a long time and are very supportive."

Yet getting the program off the ground required one crucial compromise on the part of non-government partners. The collaborating government department stipulated that staff would need to volunteer their time, receiving only a "motivational incentive" of between NRs. 2,000–7,000 per month.[10] This was considerably less than I/NGOs paid counseling staff and the national minimum wage for domestic laborers (Sah 2018). A staff member at one of the non-governmental partner organizations elaborated:

> The government has set a minimum standard of salary that they felt they can support throughout. So the criteria was set which was a bit difficult for these women. Because the government felt that these were women volunteers we give them the opportunity for six month's counseling training and now they should also be ready to work on a less salary scale so that this is an initiative they can sustain in many places, was the version of the government. … They feel that it's a woman's cooperative … because they are part of the woman's groups it's also their contribution to the society.

[10] While the program guidelines use the term "motivational incentive," counselors and staff at partner organizations often used the word "salary," as reflected in the quotations to follow. Community psychosocial workers received NRs. 2,000 per month while counselors received NRs. 7,000 per month.

It was government actors, then, who defined the way in which the importance of counselors' labor could be realized. And like a number of other health and development programs in Nepal (Glenton *et al.* 2010; Maes, Kohrt and Closser 2010; Ramnarain 2015), this one proceeded on the assumption that women should engage in care work for the social and moral rewards of "contributing to society" *instead of* the pursuit of a salary.

Feminist scholarship sheds some light on this assumption, which permeates many CHW programs globally (Glenton *et al.* 2010; Closser *et al.* 2019; Marwah 2021). While the notion that offering economic rewards for care work may interfere with altruistic sentiments is commonplace, research suggests it is not supported by empirical evidence (Nelson 1999; Folbre and Nelson 2000; England 2005; Marwah 2021). Rather, scholars have argued that this assumption stems from a dualistic view of men and women, which organizes thinking such that activities traditionally associated with each come to be seen as antithetical to one another (Nelson 1999; England 2005). Tamang's (2011) work in Nepal nuances this conversation, arguing that tacit assumptions about gender and labor vary widely across social groups. She suggests that notions of the "Nepali woman" endorsed by state and international development actors are disproportionately shaped by high caste Hindu norms and ideology. This dominant representation, similar to those problematized in Western settings, generally portrays women as intrinsically motivated to care for others and lacking opportunity and agency to perform wage labor, whereas men are envisioned as public-facing "breadwinners" for their families (FWLD 2006). However, this vision fails to capture gender norms within a wide range of families of different caste and ethnic backgrounds in Nepal, including Kalpana's (Tamang 2011; Yadav *et al.* 2021).

Questioning Value: Spring 2017

In April 2017, just after Kalpana completed her training, Liana moved to Ashrang to follow the establishment of her psychosocial support center. Through community orientation sessions, around fifteen clients had been identified and referred for counseling. Kalpana was enthusiastic about her new role. She recognized a preponderance of distress in her community and it was intuitive to her that people with less access to family and community support would benefit from talking with a counselor.

But Kalpana soon faced a number of significant challenges getting down to work. The chairperson of her local women's cooperative, who was meant to help her establish the center, prioritized the salaried work she did elsewhere and was rarely available. "She only does work for the cooperative once a month," Kalpana explained, "She has no worries. She already has her own job." Moreover, the cooperative had struggled to find women willing to support Kalpana in the role of community psychosocial worker for the low incentive being offered (NRs. 2,000 per month); of the two women eventually recruited, both resigned within a few months. Kalpana also experienced barriers to clinical supervision as a result of the geographic marginality of her village. Ashrang was not only hours away from the Kathmandu-based NGO where her supervisor was based, it was also a steep hike from the nearest road and had no overnight accommodation for visitors. As a result, most of her supervision took place over the phone.

Another significant challenge was finding a place to house the counseling center. Lack of funds and the disruption of the earthquake had conspired to leave the women's cooperative building unfinished for several years. Despite multiple promises of action, an overgrown cement foundation hidden in a wooded crook of the hillside remained the only evidence that a building had ever been in the works. The next obvious choice for the center was to rent a room in the small market along the highway below Kalpana's village, making the space more accessible to clients traveling from other parts of Ashrang. But after paying staff incentives and buying new office furniture out of the yearly budget they received, the women calculated that they could only afford to spend NRs. 1,000 per month for rent. Rooms in the market area cost about four times that. Finally, they settled for a room in one of the few houses in Kalpana's village that had survived the earthquake, a visibly damaged concrete building inhabited by a large family. Located off an unmarked footpath a steep thirty-minute hike from the road, the center was difficult to find for all but the closest neighbors. The necessity of asking for directions moreover precluded client anonymity.

Kalpana quickly learned that most clients were not willing to make the trek to visit the counseling center for sessions. She told me,

> It's in an inaccessible place. And usually clients say they will only come to a place that is central. If it is in an inaccessible place they don't come.

When Liana pressed her on why people were not willing to invest more time and energy in attending sessions, she reflected,

> This subject is new in Nepal. It's new and at first they don't believe in it. The way it is in … our mind is you either go to the Shaman or you go to the hospital.

In a context where most had never heard of counseling, the moral significance of the service Kalpana provided her community was not immediately recognizable to others. Nor did her new role of "community-based counselor" seem to garner the respect and recognition of more established community service roles such as FCHV. On the contrary, research suggests Nepali mental health professionals routinely grapple with stigma and negative stereotypes such as "*pāgalko dākṭar pani pāgal ho*" (the doctor of mad patients is also mad) [Kohrt *et al.* 2020: 3; Gurung *et al.* 2017].

Kalpana was thus forced to continue visiting clients' homes to provide counseling. This could entail hikes of up to two and a half hours each way. Often Kalpana arrived to find that a client was out working in distant fields, delaying counseling sessions substantially. More than once, she returned home from field visits after dark, navigating the slippery hillside footpaths by the glow of her mobile phone. This was a source of considerable worry for her mother-in-law, who continually urged her to come home earlier.

Over time, these working conditions began to wear on Kalpana's motivation:

> When clients come, so does my interest in working. When clients don't come, it is difficult for me. … On that salary, I haven't been able to go out looking for clients. … After becoming counselors, like in all other work, we have limits.

The words "on that salary" are an important qualifier here; Kalpana's objection to the added labor of conducting home visits was not absolute, but rather emerged specifically in relation to the low "motivational incentive" she received.

At NRs. 7,000 per month, Kalpana was earning one-third the salary of manual laborers in Ashrang's new brick-making cooperative. This was not an income that elicited respect within Kalpana's marital household, which

departed in significant ways from the normative imaginary of Nepali gender roles discussed above (Tamang 2011). In Kalpana's Tamang Buddhist family, men and women alike contributed to the daily struggle for economic advancement. All of Kalpana's sisters-in-law worked full-time in Kathmandu and her mother-in-law had run various side businesses over the years to supplement income from farming and animal husbandry. Her family were vocally incredulous over the low financial incentive she received for her counseling work at a time when they urgently needed income to rebuild the family home.

Sushila, another counselor in the program whom we interviewed, reiterated these concerns:

> The salary is … not even enough for our mobile phone expenses! And they say work for that much. It's impossible. … We also need to be taken care of. … We can't do it hungry! That's what I'm trying to say. After we work, there should be something for us. … That's what friends in other districts are usually saying too. "We won't do it if it's like this," they say. … This [work] is very necessary for the community. Every day the number of suicides is increasing. … But in order for this work to be done, you also have to do something for the one doing it.

Crucially, the low financial incentive did not challenge Sushila's conviction of the importance of the service she provided for her community. Kalpana, too, remained convinced that counseling was an effective and essential service in Ashrang. "I believe in this a lot," she told Liana,

> At first I didn't that much. When we started to care for clients, seeing the reactions they gave—even if not everyone was completely cured, but some have gotten much better. If we took that training and one out of ten people got better, I still find that to be a big thing.

In the post-disaster environment of 2017, counselors reasoned about the value of psychosocial care against the backdrop of a deeply felt rise in suicidality in their own communities, where helping one client could mean saving a life (Marahatta *et al.* 2017). None of the psychosocial support center staff we spoke with questioned whether their work made a meaningful contribution

to society. What they did question, however, was why their contribution was not recognized in the same medium as other forms of skilled labor—namely, decent pay.

Kalpana's and Sushila's comments register a critique of the "love *or* money" reasoning frequently mobilized to justify underpayment in caring professions (Nelson 1999; England 2005). Similar critiques were raised by Indian CHWs interviewed in a recent study of the world's largest women community health volunteer workforce, who saw the personal and social benefits of their work as inextricably linked with—rather than opposed to—earnings (Marwah 2021). Feminist scholarship lends further support to these critiques, interrogating both the logic of the "love or money" binary and its economic and political fallout; in particular, scholars have argued that the "human capital" women accrue through care labor is "less transportable" than the financial capital accrued through fairly paid employment, leaving them "in a weaker bargaining position in the family (Badgett and Folbre 1999: 311). This observation has been borne out by research with CHWs in a number of sites globally (Closser *et al.* 2019; Jackson, Kilsby, and Hailemariam 2019; Najafizada, Bourgeault and Labonté 2019; Ved *et al.* 2019).

Disparate Values: Summer and Autumn 2017

In the latter half of 2017, Kalpana's involvement in counseling declined steadily. Through the rains of June and July, Kalpana and her clients were busy planting the rice that would feed them for another year. Systems of labor exchange among neighbors meant that Kalpana's responsibilities extended beyond her own family's fields. As the monsoon wound down, Kalpana continued to do household work nearly full-time. The family's cow had a calf, and their water buffalo and goats were growing. With most of the family's steep hillside property converted to terraced rice paddies, Kalpana spent every morning and evening hiking to abandoned fields uphill to cut grass for fodder.

Household work intensified in September as Kalpana's family prepared for the most important holiday of the year. Dashain entailed over a week of hosting, visiting and feasting for which relatives returned home to the village from the cities. As the only daughter-in-law still living in the village, Kalpana was responsible for vast amounts of cooking and cleaning. By the

time Tihar festival rolled around in November, she had effectively ceased to meet with clients.

Kalpana's conversations with Liana during this period did not suggest a firm and final decision to disengage, but rather a complex daily calculation of how to prioritize the multiple competing demands on her time. Seeing each morning that her aging mother-in-law couldn't manage the day's house and farm work on her own, Kalpana opted to stay home and help out. If she earned more, she said repeatedly, her parents-in-law would sell off some of their livestock, reducing her daily burden of household work significantly.

In this way, it gradually became clear that a fair salary was not only not at odds with Kalpana's aspirations of serving her community as a counselor, but was indeed a necessary precondition for pursuing these. Even if Kalpana's own sense of the moral significance of her work had been enough to motivate her to carry on, Graeber's (2001) theory reminds us that value can only be sustained in a medium that is widely recognized by others in one's immediate social environment, and is moreover always relative. At the time of this research, Kalpana's family faced concrete material demands that precluded any member devoting too much time to unpaid work—no matter how honorable—and they did not take steps to relieve her of the many domestic obligations that interfered with her work. Kalpana thus found herself in a distressing double bind, unable to be a good counsellor and a good daughter-in-law at the same time. On several occasions Kalpana voiced the effects of this in the idiom of psychosocial suffering itself, complaining that her low "salary" was causing her "so much *tension* {En.} (stress)."

As the program's first year drew to a close in late 2017, the sustainability dreams of mental health advocates were faltering. The longevity of the prized government budget and the aspiration to "scale up" to other districts were both called into question as the national shift to federalism cast confusion over the authority of local governments to allocate their own health and social care budgets. In November 2017, staff from a mental health NGO traveled to Ashrang to lobby newly elected local leaders on behalf of the psychosocial support program. Their efforts ultimately bore fruit and a regular budget was secured for Ashrang's psychosocial support center. But when Kalpana learned that the same low incentive was being offered in lieu of a full salary, she resigned and the center closed. This meant an end to counseling for the clients she had been supporting, many of whom were themselves women from marginalized backgrounds. Sadly, one of Kalpana's former clients took

her own life only a few months later, raising difficult questions about the consequences of her resignation for the community.

By the time of Liana's follow-up visit in late 2018, about half of the psychosocial support centers established through the program had met a similar fate. In some cases, counselors had taken positions with INGOs earning significantly more for the same labor. One program planner explained:

> [F]rom the women's group they felt that this [incentive] was too less to maintain. And they were getting lots of good offers from other organizations. … Yes those woman's groups who have been trained, after they worked with us for some time there was a big demand and they started working in some international non-government organizations. {En}

These women appeared able to mobilize the skills and experience they had acquired through the program to pursue their own valued ends: a decent salary for meaningful work.

Yet such outcomes were only possible, Kalpana pointed out, in places where there were INGO offices and funding for this type of work—places, in other words, that were less marginalized than Ashrang. Kalpana, by contrast, was able to exercise some limited agency only by disengaging from the program. Rather than being empowered to pursue ends she felt were worth striving toward, Kalpana returned to the full-time house and farm work that had occupied her before her training.

Importantly, some of the psychosocial support centers established through the program continued to function. Liana was able to briefly visit two of these centers and it was clear that the social and material conditions of counseling there differed markedly from those in Ashrang. Counselors leading both centers were from advantaged caste/ethnic backgrounds, were older than Kalpana, had strong ties with their local women's cooperative, and received ample support from other cooperative members. In addition, both centers were housed in women's cooperative buildings conveniently located in roadside market towns.

The divergent trajectories of psychosocial support centers established through this program speak to the complexity and contingency of processes of valuation. Graeber's anthropological theory of value accommodates this

complexity, drawing our attention to the ways sociocultural ideas about the good intersect with the economic to shape determinations of the importance of psychosocial care labor relative to other competing demands at any given moment. At the same time, it is clear that gendered assumptions made by Kathmandu-based government actors powerfully influenced the conditions of possibility for individual counselors, with effects that may have been disproportionately felt by the most disadvantaged: those who had no access to alternative employers, whose families depended on them to contribute financially, whose local cooperatives lacked resources and facilities, and whose social realities were not reflected in normative imaginaries of Nepali women and families underpinning the program.

Discussion

Adams (2016b) has argued that the politics of global health are more ambiguous than those of its predecessor "international health." The long-critiqued language of "development" has increasingly given way to a language of human rights and calls for a democratization of knowledge. National governments are being called upon to assume ownership of sectors long dominated by I/NGOs, raising thorny questions about the meaning and terms of "ownership" in this context. At the same time, growing support for the deployment of community workers has created new roles for marginalized groups within care delivery. This article has sought to illustrate how an ethnographic focus on value can help us gain critical purchase in this shifting terrain.

The approach we have elaborated builds on Graeber's (2001, 2013) anthropological theory of value. It involves the classic method of "following the money," but it also entails paying attention to non-commoditized forms of value that clearly factor into the deliberations of individuals and institutions, such as social esteem. Drawing on feminist scholarship, we have further explored gendered assumptions about how these forms of value relate to one another. Rather than associating power merely with the accumulation of value, we have asked where power sits to *define value*. Specifically, we traced deliberations among governmental and non-governmental actors over appropriate forms of remuneration for women community workers in a Nepali psychosocial intervention and their consequences for one counselor and the community she served. What emerges from this analysis

is a complex picture of the gendered politics of task-shifting to community workers in GMH.

On one hand, Kalpana's experience illustrates how the deployment of community workers may in some cases reproduce social and structural inequalities that have been associated with psychosocial suffering. Delegating clinical responsibilities to women without adequate pay not only threatens the longevity and quality of their work (and thus the level of care accessible to the poor, rural beneficiaries they predominantly serve), it also reinscribes normative gender roles that locate women's place outside the wage labor market, as moral backbones but never breadwinners of their families. As feminist scholars have long argued, these roles both reflect and cement gender inequality, as the social capital reaped from care labor fails to secure for women the same autonomy and authority conferred by financial capital (Badgett and Folbre 1999). Ultimately, Kalpana resigned in spite of strong motivation to do professional counseling work. In this case, decisions made in Kathmandu about the ways in which women community workers' labor could be valued foreclosed the possibility of meaningful empowerment.

On the other hand, our case study suggests community worker programs may hold the potential for fostering agency under the right conditions. Kalpana found counseling work interesting and meaningful, and she routinely asserted that a fair salary would have secured her liberation from domestic responsibilities so that she could perform it to her satisfaction. Other counselors were able to use skills acquired through the program to pursue well-paid counseling positions within international organizations. In this way, our findings are consistent with assertions that community work can offer women pathways to greater mobility, economic autonomy, and self-actualization. However, a living wage may be required to realize this transformative potential, particularly for those from disadvantaged backgrounds (Closser *et al.* 2019; Jackson, Kilsby and Hailemariam 2019; Ved *et al.* 2019). Our argument, then, is not that task-shifting to community workers is inherently empowering or exploitative, but rather that decisions about the value of community workers' labor are a key determinant of the equity impacts of this practice.

These findings dovetail with a growing literature on the fine line between healthcare volunteerism and labor exploitation in global health (Maes 2012). Despite decades of feminist scholarship challenging the notion that financial reward is antithetical to emotional sentiments presumed to be integral to

good care (e.g., love, empathy, altruism), this dualistic thinking continues to be mobilized within community worker programs internationally. In the case of psychosocial care, low pay may indirectly fuel some of the very problems interventions set out to address. Research in Nepal has linked elevated rates of mental disorder and suicide to gender inequality and associated economic insecurity among women (Kohrt and Worthman 2009; Pradhan *et al.* 2011; Clarke *et al.* 2014; Marahatta *et al.* 2017). Delegating clinical caregiving responsibilities to a predominantly female workforce without adequate financial remuneration risks further entrenching inequality (Maes 2012; Closser *et al*. 2019) while missing a valuable opportunity to alleviate economic insecurity through the creation of qualified employment opportunities (Lund *et al*. 2018; Chase *et al.* 2020).

To date, these issues have received limited attention in critical studies of GMH (with the notable exception of Maes 2015) which have predominantly focused on power differentials between "Western" and "non-Western" actors in the field. While this postcolonial framing has been invaluable in highlighting important problems of culture and power in GMH, it also at times risks obscuring the expertise and agency of mental health professionals in the Global South (Heaton 2013, 2018; Bemme and D'souza 2014; Patel 2014; Cooper 2016; Wu 2016). Within this critical literature, Campbell and Burgess (2012) have suggested, community workers are too often portrayed as unthinking agents of Western biomedicalization.

By contrast, the value-oriented approach we have developed here has sought to shift the focus

> from an external, objectified and static conception of the political significance of differences in social and cultural patterns to an internal, subjective, and dynamic conception of what is at stake from the standpoint of the people directly affected. (Turner 1979: 12)

This approach avoids *a priori* judgments about the interests of groups impacted by GMH interventions, asking instead whether the conditions exist for individuals to exercise agency in deciding for themselves whether and how to engage. Adopting this lens in our case enabled greater attention to power differentials within and between communities served by interventions, revealing how task-shifting may become classed and gendered in ways that are specific to local social contexts. Like Burgess (2016), we see a need for

further research on gender in GMH that accommodates the complexity of women's social realities. An intersectional lens that attends to the interactions of gender, class, and caste/ethnicity is essential (Crenshaw 1991; Tamang 2011; Yadav *et al.* 2021).

Implications for Policy and Practice

These findings come at a critical juncture in Nepal's history when there is an active conversation unfolding about the roles and relationships of various cadres of community workers following the country's recent transition into a federal system. This transition has allowed local governments to exert autonomy and independence in developing their own policies and programs. For example, in the recent years, realizing the need for mental health services in the wake of the Covid-19 pandemic, several local governments have recruited psychosocial counselors from their own budget. Around 50,000 Female Community Health Volunteers are currently the main channels through which the health system operates in ground level in Nepal (Khatri, Mishra and Khanal 2017), and there is growing evidence that low financial incentives are a major frustration and barrier for this group (Baskota and Kamaraj 2014; Panday *et al.* 2017). The Community Mental Health Package Nepal 2074 has provision for community workers' involvement in delivering mental health services, including awareness raising, case detection, follow up and home-based care. Those charged with taking forward these changes within the health system have the opportunity and potential to address the problems and constraints faced by Nepali community workers historically.

Findings of the present study offer several insights that can help policymakers and program planners achieve this. First, our research lends support to international calls for adequate financial remuneration of community workers (GHWA 2008; WHO 2018). The Community Health Impact Coalition recommends offering CHWs a competitive salary as well as non-financial incentives and employee benefits (Ballard *et al.* 2018). While some community workers may benefit from the social status associated with volunteer work, defining value in primarily social and moral terms may inhibit engagement of the most disadvantaged, thus reproducing class and caste/ethnic inequalities. Financial compensation may be particularly important in the field of mental health, where stigma and divergent cultural conceptions of distress can limit the positive social recognition experienced by providers (Angdembe *et al.* 2017; Gurung *et al.* 2017; Kohrt *et al.* 2020).

Second, we see a need for greater involvement of community workers in decision-making about mental health policy and programs. Crucially, women counselors in this program were not consulted about the forms of compensation they considered acceptable and beneficial. Instead, the program was designed on the basis of normative assumptions about what matters to Nepali women—assumptions that have been challenged by feminist scholars globally and which obscure the diversity and fluidity of gender norms in Nepal through which the political effects of programs are refracted (Maes, Kohrt and Closser 2010; Tamang 2011; Ramnarain 2015). Going forward, we suggest giving community workers a voice both in initial decisions about how their labor will be valued and in the course of implementation, as they confront challenges that hinder their work. This is not only essential for realizing the potential of these programs to empower providers but can also pre-empt issues that lead to the provision of second class care for the communities they serve, including inadequate clinical supervision, poor accessibility and high staff turnover.

Limitations

Our approach has several limitations. One of its risks lies in understating the considerable variation in ideas about value existing within institutions, and between institutional allies (such as the various non-governmental actors partnering in this program), as well as the gaps between scripted institutional and unscripted personal motivations of staff members. We were particularly hindered by our lack of interview data from government decision-makers at the national level; this was due to time constraints and the lack of clear leadership/responsibility for the program at the time fieldwork was conducted (in the midst of federalization). We are currently planning future research that will address this limitation of our analysis by collecting retrospective accounts of government staff initially involved with the program. This will enable a more nuanced discussion of the relationship between governmental and non-governmental stakeholders and the meaning of "government ownership" in this setting. A further limitation is the study's primary focus on a single community-based psychosocial support center. While this methodology enabled a richly detailed account of complex social phenomena, the lack of a comparative case study of equal depth precludes drawing conclusions about the factors that explain the divergent outcomes psychosocial support centers in different sites; our planned future research

will explore this further. Finally, the intervention studied is not representative of the majority of task-shifting initiatives in Nepal presently, which have predominantly focused on training primary healthcare workers. Most psychosocial support work in Nepal is delivered by non-specialist health workers or by counselors employed by I/NGOs who are paid a salary. While this limits our findings' current generalizability, we feel our conclusions are highly relevant to future plans for the scale-up of state-funded psychosocial counseling delivery laid out in recent policy (MoHP 2021).

Conclusion

As modes of mental healthcare delivery continue to evolve under the auspices of GMH, the politics of intervention are also shifting in ways that demand critical attention. Growing support for the involvement of lay "community workers" has created new professional roles for members of disadvantaged groups, engendering possibilities for both empowerment and exploitation at the frontlines of care. We have sought to show how ethnographic attention to *value* can enrich our understanding of the social and political effects of task-shifting to community workers. Drawing on fourteen months of research, we explored how the expectation that women community workers volunteer their time led to distress and disengagement for one counselor and ultimately to the closure of her community's psychosocial support center. Our findings suggest decisions about the value of community workers' labor are an important determinant of the equity impacts of GMH interventions. We recommend adequate financial compensation and greater involvement of community workers in decision-making to ensure interventions address rather than exacerbate the root causes of mental health inequity.

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