Gendering Psychosocial Care: Risks and Opportunities for Global Mental Health

Recent conversations in *The Lancet Psychiatry* have thrown light on the ways global mental health institutions reflect and reproduce wider social inequalities.[1] Gendered practices of employment and remuneration are an understudied dimension of this problem. The past decade has seen a proliferation of psychosocial interventions delivered by lay community workers, a predominantly female workforce. Under the right conditions, 'task-shifting' in this way can address geographic and socioeconomic inequities in access to care and support women's empowerment. Yet such interventions also carry the risk of further entrenching gender inequalities when female community workers are viewed instrumentally as a source of more affordable clinical labour. As a group of women scholars and clinicians involved with psychosocial interventions in Nepal, we write to sound a note of caution amidst the burgeoning enthusiasm for task-shifting in global mental health.

In 2016, psychosocial care in Nepal reached an important milestone: the first government-financed psychosocial support centres were established, with plans for national scale-up (see Panel). Unfortunately, this achievement required a crucial compromise: because hiring salaried counsellors was deemed unsustainable, the programme recruited volunteer counsellors from women's cooperatives, reasoning that these women were intrinsically motivated to serve their communities. Instead of a salary, they received an 'incentive' about half the current minimum wage. The programme's realization was thus predicated on a local moral economy in which women are expected to care for others without financial reward.

A fourteen-month ethnographic study of the programme highlighted complex implications for gender equality.[2] Initially there was enthusiasm and even competition within women's cooperatives for the opportunity to receive counselling training. After beginning to practice, however, counsellors began to voice concerns over inadequate remuneration. Most were young married women who bore the heaviest burden of domestic labour in their families while occupying the lowest rungs of the social hierarchy. The cash incentive offered was insufficient for them to be recognized as full-fledged professionals or get reprieve from domestic responsibilities, resulting, in many cases, in women bearing a double workload. Ultimately, remuneration issues led many counsellors to resign within the programme's first two years.

The field of global mental health is increasingly concerned with addressing the social determinants of distress and disorder, among which gender inequality figures prominently.[3] In employing frontline workers, psychosocial care programmes have a rare opportunity to go beyond palliation to address the root causes of suffering. Offering women in low-income communities a pathway to financial autonomy, meaningful employment, and professional recognition can contribute to lasting social and structural change.

Conversely, engaging women in demanding, skilled work on a volunteer basis not only reinforces the systemic undervaluation of women's labour, but exploits this to make care available more rapidly in the absence of resources. A growing body of global health research documents the preponderance of women in low- and unpaid roles and the gendered social, financial, and mental health consequences of healthcare volunteerism.[4-10] In the context of mental health, this intersection of gender and clinical hierarchies poses an additional risk: that psychosocial interventions will continue to be direly underfunded, and thus underutilized, relative to pharmacological interventions delivered by a predominantly male workforce of medical professionals.

As a decade of global mental health advocacy pays off and governments begin to invest in national programmes, we need to think critically about the risks of depending on low-paid and volunteer labour to fill the 'treatment gap', particularly when the onus falls primarily on women. One of the most powerful rhetorical manoeuvrers of the movement for global mental health has been reframing the treatment gap as a crisis demanding urgent response. While this has successfully rallied resources and will for change, we must be cautious not to let the rhetoric of crisis foreshorten our vision, justifying immediate intervention at the expense of more profound, long-term transformation.

The question is this: Are community psychosocial workers merely a stopgap for the world's poorest – stemming a deluge of need without looking upstream to its sources? Or are they key players in a forward-looking movement to achieve a more equitable distribution of mental health globally? If the answer is, as we hope, the latter, we urge governments, donors, universities, and I/NGOs to look carefully at the working conditions of frontline psychosocial care providers they employ. If members of this emerging cadre do not receive a competitive salary, paid holiday and maternity leave, and opportunities for professional development and advancement, we must pause to question whether our interventions are still in step with the evolving vision and values of global mental health.

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Author contributions

This Comment was prepared on the basis of all four authors' professional experience with psychosocial support programmes in Nepal. Chase drafted the manuscript drawing inspiration from conversations with the other three authors over the course of four years of collective involvement with these programmes. Gurung contributed conceptually to the paper by providing expertise in research on gender and mental healthcare; she provided comments on two drafts of

this manuscript. Shrestha contributed information on the programme described in the Panel and made further comments on two drafts of this manuscript. Rumba contributed to the development of this paper through extended conversations on the basis of her experience of a community-based psychosocial counsellor and research assistant. All authors have approved the final version of this manuscript.

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Declaration of interests

None to declare.

Panel: Establishing a Sustainable and Scalable Psychosocial Support Programme in Nepal

After years of piecemeal and unsustainable NGO-led development of mental health and psychosocial care, the 2015 earthquake mobilized new resources and political will for launching national programmes in Nepal. While the Ministry of Health began investing in mhGAP training of health system staff, the Ministry of Women, Children and Social Welfare agreed to finance the establishment of psychosocial support centres staffed by a separate cadre of community-based psychosocial counsellors. Although training and seed funding were provided by I/NGOs, the Ministry committed to long-term ownership and financing of the programme.

In the pilot stage, launched in 2016, psychosocial support centres were established in 14 earthquake-affected districts. Each support centre was staffed by one psychosocial counsellor with six months of training and 10 community psychosocial workers (CPSWs) with five days of training and regular supervision and refreshers. Psychosocial counsellors and CPSWs were volunteers with secondary education recruited through local women's cooperatives. The programme specifically recruited married women as they were less likely to migrate away from their communities. Clinical training followed an existing model of evidence-based, culturally adapted counselling.[1,2]

An unpublished evaluation conducted by programme partners showed significant improvements in counselling clients. However, a number of challenges prevented national scale-up beyond the pilot stage. First, nearly half of the women trained as counsellors have now resigned, most citing inadequate remuneration. Second, the lack of integration within wider health and social care systems meant counsellors worked largely without ongoing support and supervision after their initial training. Finally, Nepal's shift to federalism in 2017 transferred financial decision-making mechanisms from the Ministry to local governments. Through targeted advocacy by I/NGO partners, local governments continue to finance about half of the centres established during the programme's pilot stage.

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