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Community Transformation and Collective Healing: Lessons from Pakistan, Brazil, and Zambia

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Abstract

Community psychology has long sought to be global in its scope and focus, particularly having liberation as a primary and overarching goal of the field. Despite seeking to stand in solidarity with marginalized and disadvantaged persons, the field has been criticized as remaining largely western-centric in its worldview and epistemology. The historic disconnect between systems of mental health –as traditionally defined within a western context – and the experiences of marginalized and indigenous peoples around the world necessitates greater consideration of local methods of healing with greater accessibility, cultural credibility, and sustainability within local communities. In this article, the authors utilize traditional mechanisms of healing in Pakistan, Brazil, and Zambia as case studies to advocate for a community based mental health promotion model that weds: 1) prevention and health promotion; 2) professional allopathic service providers partnering with paraprofessional and traditional health practitioners; and 3) community engagement and political literacy as a transformative and empowering mental health system of care that targets the individual and the community as source and location of intervention and healing. Results are aligned with community psychology goals and intended outcomes and suggest an action-oriented model in which the community serves as actors in and agents of their own collective health and healing.

Keywords: global community, trauma, collective healing

Introduction

Community psychology has long sought to be global in its scope and focus and stand in solidarity with marginalized communities (Nelson & Prilleltensky, 2010). Yet, the field has been criticized as remaining largely western-centric in its worldview and epistemology (see for example Cruz & Sonn, 2011). The historic disconnect between systems of mental health –as traditionally defined within a western context – and the experiences of marginalized and indigenous peoples around the world necessitates greater consideration of local methods of healing with greater accessibility, cultural credibility, and sustainability. In social contexts in which the experience of collective and intergenerational traumas are commonplace, culture and community are integral; the dialectic of oppression and liberation remain imperative to pathways to individual and collective health and healing.

Global community psychology is uniquely positioned to consider the complex interplay of these systems-within-systems (Brofenbrenner, 1979) and the community aspect of collective healing. Thus, the purpose of the present exploration is two-fold: 1) to make visible the healing practices of communities often silenced in community psychology discourse and; 2) to discuss ways in which culturally distinct, community based methods of healing are being utilized within communities in Pakistan, Zambia, and Brazil with little access to professional psychological services to transcend prevailing social conditions and transform individual and collective well-being.

Background: Beyond diversity in community psychology

It has been fifteen years since Anthony Marsella (1998) challenged community psychology to prepare for a multidisciplinary and multinational orientation that might redress its historic ethnocentric assumptions and practices. Yet, while many community psychologists may include the term "globalization" in their research, there remains a dearth of work that is centered outside of a western worldview. A cursory review of community psychology literature demonstrates that the research is insular citing relatively few works of researchers outside of the U.S. even the notable and relevant contributions of Frantz Fanon, Steven Biko, or Linda Tuhwai Smith to name but a few international scholars known for their contributions in liberatory community psychology. Similarly, the field's inclusion and work in diversity is limited with only 25% of publications related to diversity (Martin, Lounsbury, & Davidson, 2004). However, inclusion of diversity variables alone does not indicate primacy of cultural context or more importantly, a culturally-centered analysis. Kral and colleagues (2011) argue that, "while community psychology is at its core a contextual enterprise, it is a cultural enterprise as well" (p. 47). There have been recurrent calls for community psychology to better understand the context of diversity through the employment of cultural knowledge and methods (O'Donnell, 2006; Trickett, 1996). Given its theoretical value on the principle of diversity, the absence of theoretical evolution in this area is remarkable yet incites opportunities to move beyond

rhetoric to greater understandings and incorporation of cultural episteme that may advance the stated goals of community psychology.

Global experience of continued colonization, oppression, subjugation, and general disempowerment, underline the relevance of community psychology imperatives and demonstrates the continued need for community mental health services. Yet declining funding for community mental health services in the U.S. and the dearth of or limited access to professional services globally necessitates a widening perspective of ways to intervene and promote individual and collective well-being (NAMI, 2013). Given the confluence of oppression, liberation, and community well-being, Jones and colleagues state that transformative change in community mental health entails a "far-reaching social justice-oriented reconfiguration of traditional power hierarchies" and "will come from the historical margins, driven by traditional subjugated knowledges…" (Jones, Harrison, Aguiar, & Munro, in press, p.1). Such a definition is clearly aligned with a global community psychology rooted in local cultural knowledge.

Introduction to Case Examples

Across the U.S. and indeed globally, communities have actualized ways to build upon local cultural, spiritual, and traditional health mechanisms to transform individual and collective health, even in the face of colonization, oppression, and few health resources. Pakistan, Brazil, and Zambia are used as case examples given the authors' work in these countries and with its citizens and expatriates. These countries share histories of colonization and economic volatility as well as have continued political and ethnic issues that affect individual and community mental health. While the countries have differing health resources, all of the countries boast rich cultural and community traditions that may serve as conduits of health and well-being. Thus, each country will be presented as a case study in which the following is used as points of analysis: overview of the sociopolitical and ecological landscape of collective well-being in the country; profile of mental health within the country (using both western and local conceptualizations where warranted); availability of and access to western and traditional health services; and information on collaborations across allopathic and traditional or community medicine.

While it is the authors' intention to methodically present and analyze this data across all cases, the very nature of transnational work, particularly with low-resource countries with few mental health resources often precludes consistent data from being available. Thus, inherent limitations to this work are that the analysis is limited by a) cultural variance across geographic boundaries; b) vast linguistic diversity which affects language around health (particularly mental health) in addition to languages of publication; and c) the lack of economic and academic resources to publish mental health related data in accessible sources. For these reasons, it should be noted that the authors have included data from both national and international sources. Despite these limitations, the following examples of culturally distinct, community based ways of intervening offer insight into methods of galvanizing the strengths of local resources to increase access to care in low-resource settings.

Lessons from Pakistan

The Islamic Republic of Pakistan hosts a diversity of ethnic, religious, and linguistic populations. The pluralistic nature of this society and its reliance on ethnic and sectarian alliances has fostered structural violence and largely contributed to the conflict-related trauma experienced by ethnic Pakistanis and can be traced to this nation's period of colonization (Haleem, 2003). The colonial history of Pakistan is complex and largely connected to British colonial rule of the South Asian subcontinent (Malley-Morrisson, 2009). Since the nation's birth through the 1947 British Partition of Colonial India, Pakistan has battled with neighboring nations over border disputes, confronted internal struggles rooted in linguistic and ethnic conflict, and negotiated against sectarian divide. The bloodshed and trauma endured during mass relocations of populations within Pakistan during the Partition of British India has recurred during multiple armed conflicts and geographic boundary negotiations (Debnath, 2009; Menon & Bhasin, 1998; Reidel, 2008). This bloodshed has continued through the thirteen year-long regional war in Afghanistan.

Despite this significant national history of trauma, there exists little international awareness concerning overall health and wellbeing or local health service provision for this nation. Current research and trauma recovery work with refugee and immigrant populations primarily uses western paradigms. Given Pakistan's history of colonization however, applying western models of psychology to this national population without awareness of or respect for traditional healing methods may be perceived as an extension of ethnocidal policies and practices experienced during the British Raj.

Health and Psychological Wellbeing in Pakistan

Prevalence data regarding overall health and psychological well-being from a western epistemology is scarce. Very little data is available on the mortality, morbidity, and service use of attenders of mental health services in Pakistan (Karim, Saeed, Rana, Mubbashar,

& Jenkins, 2004). Farooqi (2006) found that of adult psychiatric patients the most prevalent western diagnoses comprised of affective disorders, schizophrenia, anxiety disorders, somatoform disorders, and personality disorder or conduct disorders. Other research studies conducted by Mumford and colleagues (1997, 2000) suggest the overall prevalence of depression within the national population to be somewhere between 12.5-53%. Overall trends suggest that rates of mental illness or distress are significantly higher in rural areas than with urban populations (Mumford, Saeed, Ahmad, Latif, & Mubbashar, 1997). These trends may relate to lifestyle, available resources, or levels of poverty.

Similarly, a dearth of prevalence data regarding classification of problems commonly identified by Pakistani native faith healers currently exists, despite the fact that the practice of native faith healing is highly adhered to throughout Pakistan. Saeed and colleagues (2000) found that native faith healers in Pakistan typically identified *saya,* or the casting of a shadow by an evil spirit, to be the most prevalent disorder. Other conditions include *possession by jinn,* or evil spirit and *churail possession,* or possession by demon. Notably, the native faith healers identified 8% of attenders as suffering from purely medical problems and advised to seek health services.

Traditional and Community Health Services Available in Pakistan

Religious healers are typically the first point of health care contact for Pakistani persons with illness(es) and their families; this appears especially true for the mentally ill in Pakistan (Karim et al., 2004; Farooqi, 2006). These patterns of healthcare-seeking can be explained by Pakistani's strong faith in religious healers. Religion and spirituality are seen as central to understanding healing for many practitioners of Islam (Swaroop, DeLoach, & Sheikh, 2014). Islamic traditional healers incorporate both medicinal remedies and spiritual techniques into their practice (Farooqi, 2006; Inayat, 2005). Consistent with this research, Swaroop, DeLoach, and Veeramasuneni (2012) found in their study with Pakistani women displaced due to war and flooding that many women reported seeking assistance from both western medical providers and traditional faith healers who were reportedly more accessible.

Although native faith healers and spiritual leaders are most sought for mental health services throughout Pakistan, additional forms of traditional healing are prevalent within this nation. Traditional healers include a variety of local practitioners of ancient or herbal medicine such as the khalifs, gadinashins, Aamils, magicians, palm readers, folk healers, Pirs, imams, and hakims. Recent research has indicated that in addition to Islamic faith or spiritual healing, the most commonly used traditional healing practices in Pakistan are homeopathy, naturopathy (Tibb), acupuncture, chiropractics (Jerrah), sorcery, and *danyalism* (Farooqi, 2006). Homeopathy is widely popular with the lower-middle class of Pakistan, presumably due to the belief that this type of medicine is more natural than western biomedical models, with fewer side effects. These healers have organized their own associations with corresponding teaching colleges and registration authorities (Karim et al., 2004). Hakims, or practitioners of Ayurvedic medicine, have also formed their own association in Pakistan. Hakims are formally registered with the Pakistani medical and dental council.

Community Health

Recent initiatives also demonstrate local commitment to health and wellness within Pakistan. The Pakistani Government has developed National Health Policy Guidelines involving a community-based health worker program with lady health workers (LHWs). Through this program, women are trained to bring health information, basic healthcare, and family planning services to traditionally underserved areas within Pakistan. According to WHO and the Global Health Workforce Alliance (2008), 96,000 LHWs are involved in this initiative, bringing health education and service provision to their home villages. Oxfam (2011) notes the implications this community medicine program has for the empowerment of Pakistani women, asserting that women are more visible and mobile within the communities served by LHWs. Oxfam (2011) additionally noted the influence of a paid position on education, training, work experience, and increased decision-making power for LHWs within their own families and communities. LHWs in Pakistan have forged relationships across class and caste barriers and have taken collective action against sexual harassment. While challenges for this program still exist, it is believed that this LHW initiative has built upon socio-economic changes currently taking place within Pakistan such as rapid urbanization, increased exposure to media, increasing acceptance of female education, and women's increasing desire to work outside the home.

Partnering with Traditional Health Practitioners

Given the paucity of data in relation to western nosology of mental health in Pakistan along with the undeniable use of traditional healing methods for healing, Farooqi (2006) and many others suggest that cooperation between Pakistani spiritual healers and western health care professionals is highly needed. The growing number of LHW's appears to also be a

potentially powerful avenue for collaboration, particularly regarding the mental health of Pakistani women and children. While collaboration has yet to occur, such formal cooperation would acknowledge and build upon local strengths and resources connected to community wellness, empowering a population typically silenced in international discourse. In order for this cooperation to take place, western mental health practitioners - including community psychologists - must build an understanding of the lived experiences of Pakistani populations as well as the power and potentiality of its community and spiritual resources to transform. This comprehension appears crucial given Pakistan's history of colonial subjugation, historical loss, and the continued deleterious effects of war and drone strikes.

Lessons from Zambia

Zambia is a resilient country, one which emerged from over a hundred years of variations of British colonialism and continues to resist foreign control of its natural resources, particularly its copper production (EISA, 2006). Yet, the natural resources and strengths of Zambia can be overshadowed by the country's host of social and economic issues. As one of the sub-Saharan countries most ravished by the HIV/AIDS pandemic, it is estimated that approximately 13% of the adult population is affected by the disease (although urban areas have infection rates as high as 20%) and 600,000 children have been orphaned as a result of the disease (UNAIDS, 2012). The country has an alarming estimated age of mortality: 45 and 47 years for women and men respectively; the economic position of the country is equally concerning (WHO, 2009). While consistent data is difficult to procure, it is clear that unemployment remains a critical issue, particularly for youth in urban areas; the majority of the population lives below the national poverty line (ibid). Neighboring conflict in the Democratic Republic of the Congo and Zimbabwe have led to forced migration across the borders due to the relative openness and safety of Zambia. This has placed further strain on existing social structures (Mayeye et al, 2004).

Health and Psychological Wellbeing in Zambia

The prevalence of mental health disorders in Zambia is difficult to estimate given the lack of mental health infrastructure, but it is estimated that 20% of the population suffers from a diagnosable mental health disorder (Simenda, 2013). Many of those hospitalized for the most significant mental health concerns have co-morbid neuropsychological issues secondary to HIV (ibid). Primary issues affecting mental health include: HIV/AIDS; neuropsychological issues related to substance use, particularly alcohol and cannabis; marital and relational issues; gender based violence including rape; spousal homicide and exposure to other types of violent crime (Mayeya et al., 2003; Simenda, 2013).

Community Health and Local Mental Healthcare

Given the national prioritization of HIV/AIDS related care, mental health lacks national prioritization and access to mental health services remains difficult. To date, the majority of the limited services available are curative in nature focusing primarily on tertiary intervention (Mwape, Sikwese, Kapungwe, Mwanza, Flisher, Lund, & Cooper, 2010). While accurate numbers of mental health providers is difficult to access, recent data suggests that there are a meager three psychiatrists and two psychologists in the entire country (Simenda, 2013). Clinical officers and lay counselors who receive brief training primarily in HIV counseling provide the few existing services. Barriers to care are compounded by the fact that 60% of the population are estimated to live in rural areas, where there is an overwhelming dearth of access to health services, including mental health care.

Critics of Zambia's mental health system point to issues such as the now antiquated Mental Health Disorders Act of 1951 in which pejorative and stigmatizing language such as "imbecile" and "idiot," remain part of the legislation (Mwanza, Cooper, Kapungwe, Sikwese, Mwape, & the MHaPP Research Programme Consortium, 2010). While there is activism for contemporary legislation grounded in universal human rights and dignity, this legislation remains the prevailing law. In addition to needed legislation, much attention has been granted to Zambia's "brain drain" issue, namely the epidemic of trained healthcare providers and other professionals leaving the country. While few formal mental health services exist (as typically defined in the West), it is estimated that 70–80% of individuals seeking mental health solutions consult traditional health practitioners before seeking help from allopathic practitioners (Mayeya et al., 2004). This is aligned with local understandings of mental health. Local terminology is often used to refer to mental illness such as: *Kufunta, Ukupena, Usilu* and are pejorative in nature and rooted in the belief that the mentally ill have regressed into childhood, been possessed by a spirit, or caused by witchcraft (Mayeye et al., 2004). Thus, traditional mechanisms of healing may be preferred over western medicine.

Traditional Healing in Zambia

While Zambia lacks professionally trained mental health providers (by western standards), it has a vast association of traditional health practitioners. With over 40,000 registered traditional healers as part of the national THPZ, Traditional Health Practitioners

Association of Zambia as well as additional healers in the National Council of Ng'angas, it is estimated that there are 20 times more traditional health providers as there are allopathic providers of medicine (Mayeye et al, 2004), particularly in remote areas where the need is highest.

Partnerships in Health Services and Prevention Efforts

In an attempt to galvanize the strength of infrastructure and trusted accessibility of traditional healers, WHO, UNAID, and the Zambian Ministry of Health have partnered with THPZ to advance HIV/AIDS education and treatment. Globally, in public health traditional healers are being recognized as primary care providers (WHO, 2008) who benefit the health and well-being of the collective. Such providers appear to be even more integral in communities where allopathic health provision is limited or inaccessible, such as in Zambia. It is widely viewed that much of Zambia's health crisis is rooted in preventable illness, the country has and is witnessing wide spread advocacy for major transformation in its healthcare system and praxis (Mwape et al., 2010). In a study of clinical officers and psychiatric nurses, participants noted that early detection and early intervention were among key steps necessary in transforming healthcare (ibid). Outcome data from the collaboration between traditional health practitioners and allopathic providers is difficult to access and appears to still be in its infancy. Yet, it is pertinent to the present exploration as it increases access and opportunity to promote health to the masses. The WHO's declaration of the imperative nature of these partnerships and its emphasis on community based efforts to promote health is consonant with that articulated by Zambian clinical workers.

Missing from these recommendations and Zambian health discourse is the connection between social issues and individual health and well-being. For instance, there is evidence linking poverty with poor mental health outcomes (Burgess, Joyce, Pattison, & Finch, 1992; Jarman, 1992). In noting the intractable relationship between poverty and mental health, Ethel Mpungu noted, "We need to be mentally healthy to get out of poverty" (IRIN, n.d.). Yet, mental health has not been identified as one of Zambia's basic health priorities. Lack of recognition of the social determinants of individual and collective health – including mental health- appears to only serve to further perpetuate the declining health of this nation.

Overall, the mental health situation in Zambia is considered critical. Clearly there is an urgent need for more mental health providers across all levels of training. This is a particular opportunity to train and cultivate African psychologists from an African psychological orientation. Mpofu (2002) notes that

> "African psychologists [must]…disabuse themselves of assumptions of the 'natural goodness' or 'innocence' of western or mainstream psychological conceptions by: (a) Engaging in serious intra-cultural debate with their client base (i.e., parents, children, community leaders) on psychological constructions relevant to the local communities, who invents the constructs, how the constructs evolve, in what settings, and for what purposes. They should also seek to understand how they could be better resources to children, families and communities who may be in need of psychological interventions as well as how to work collaboratively with traditional healers, spirit mediums, and prophets (p.184).

The psychological community may learn from its public health counterparts by partnering with organizations such as THPZ given their knowledge, expertise, and credibility. The number of traditional healers in Zambia clearly surpasses the number of mental health providers who could feasibly be trained in the country in the near future. This is at once a sobering lesson and opportunity to work in more collaborative and strategic ways.

Lessons from Brazil

Brazil, the most populous country of Latin America, is a country of striking contradictions. A country lauded as being a "racial paradise," is primarily comprised of indigenous peoples, individuals of Portuguese ancestry, descendants of Africans brought to the Americas for enslavement, immigrants (and their descendants) from Japan and the Middle East, and those who identify as *mestizo* or of mixed ancestry (Vargas, 2005). Despite the description of racial harmony, Brazil's racialized history is complex rooted in an intractable dialectic of Portuguese colonialism, enslavement of Africans, mass violence and displacement of indigenous people, and continued racial and economic stratification that define Brazilians' social location. It is widely known that enslavement persisted in Brazil until 1888 being the last country to eradicate slavery. This legacy continues as Afro-Brazilians continue to lack access to health care, education, and employment at the same rates of White Brazilians (Vargas, 2005). Afro-Brazilians are disproportionately targeted by police brutality, suffer disproportionate rates of HIV/AIDS and other preventable disease, have high rates of joblessness and poverty (Vargas, 2005).

The social location of Afro-Brazilians is juxtaposed against the economic and political gains witnessed in the global arena. Brazil has seen consistent economic growth over the past decade surpassing the UK as the seventh largest world economy (World Bank, 2013). Despite what may be viewed as social and economic

gains, significant disparities in economics exist. Recent data from the Institute of Applied Economic Research suggests that Brazil ranks 148 in a group of 150 countries in its Gini index, indicating an alarmingly high degree of social inequality (IPEA, 2012). This inequality is even further pronounced across racial categories.

Health and Psychological Wellbeing in Brazil

These disparities are evident in health as well. Brazil's Health Minister publicly acknowledged the racism in Brazil's health system (Osava, 2006). In the northeast region of the country which hosts the largest concentration of persons of African ancestry, infant mortality rates are double that of the south, endemic and transmittable diseases also occur at much higher rates in the north and northeast regions (Pan American Health Organization, 2008). Hospitals and access to medical care vary based upon location with greater access being in more highly populated areas, which are typically wealthier areas. Depression rates in the country also appear to be associated with social class. There is increased incidence among the working class and economically impoverished groups while there are lower rates among the upper middle class (Fregni, 2007). Such health disparities are not surprising in a country that encompasses health as a constitutional right in light of its continued sorted racial praxis and economic stratification.

Community Health and Mental Health System Accessibility

Brazil's mental health practice is also situated in its history and social context. There was an early community orientation toward health and education, advocacy against marginalizing and institutionalizing individuals with mental health and developmental challenges (Minoletti, Galea, & Susser, 2012). Brazilian educator Paulo Freire is probably best known for his work in liberatory education which served as a major contributor to liberation and critical psychology. Brazil was also part of early regional efforts to increase integration of social and health care systems through the adoption of the Local Health Systems Model as well as the creation and strengthening of legislation protecting mental health rights (Minoletti, Galea, & Susser, 2012). There has been mixed political prioritization and support for these efforts since that time.

Recent discussions of psychology in Brazil indicate that the country is second only to the U.S. in number of psychologists. With over 140,000 practicing psychologists, Brazil may surpass the U.S. in total number of psychologists in the future (Hutz, McCarthy, & Gomes, 2004). While levels of education, credentials, and licensure differ across countries, this trend is remarkable. It is noteworthy that despite Brazil's previous work in liberation education and psychology, present day training consists primarily of North American and European models of psychology and the majority of faculty training students were educated outside of Brazil, primarily in the U.S. or U.K. (ibid). Moreover, Brazilian psychologists are most often employed in urban areas primarily in private clinic settings. Given that a large percentage of Brazil's population reside outside of urban areas and are unlikely able to access private clinics, the limited presence of psychology to such private settings is concerning as it renders psychological services out of the reach of the masses.

Despite this trend, Brazil stands in contrast to many of its Latin American neighbors. Brazil is one of only three Latin American countries to make strides in transforming its mental health system. Brazil developed a system of psychosocial care centers modeled after similar centers in Italy specifically for individuals with severe mental health issues (Minoletti, Galea, & Susser, 2012). In addition, Brazil is part of a regional mental health network, RedeAmerica (RA), funded by the NIMH, which seeks to promote community mental health services through the promotion of public mental health research, which is lacking in the region. Particularly noteworthy is that one of the key premises of RA is that community based mental health services must be given priority and that it should include service provision in the communities in which affected individuals live. Such efforts should be lauded as it aims to contribute to what is known about mental health and ostensibly can contribute to preventive and promotion efforts.

It is evident that while there is investment in RA, the practice of psychology in Brazil has moved from one centered in a transformative community agenda to one focused primarily on individual, tertiary treatment encounters most accessible by the elite. However, outside of the practice of (western) psychology, there are a number of other practices and structures in place in Brazil that are also relevant to the present exploration.

Community Health Initiatives

The Unified Health System or Sistema Unico de Saúde (SUS) was created in 1988 by the Brazilian government. Through the SUS, interdisciplinary primary care teams consisting of a physician, nurse, nurse auxiliary, and a minimum of four community health workers from the local community visit households within an identified target area (generally 100-150 households) (Minoletti, Galea, & Susser, 2012; Vaz, Goncalves, & Abreu, 2013). Recent estimates

indicate that there are over 250,000 lay community health workers in Brazil providing monthly health visits (Minoletti, Galea, & Susser, 2012). The range of services offered is vast including general health education, check-ups, minor medical intervention, as well as prevention and health promotion. While many of Brazil's largest cities have only implemented this model in recent years, the program is continuing to expand. It is unclear the extent to which mental health is included explicitly, yet this communitarian model presents a unique opportunity to introduce or strengthen mental health prevention and treatment efforts. Given the community embeddedness of the community health workers, this is also a model that is likely locally sustainable over time. It is reported that the largest barrier is the human resources as many physicians and health workers lack the commitment to work in marginalized areas (Minoletti, Galea, & Susser, 2012; Vaz, Goncalves, & Abreu, 2013). Thus, the dialectic of health disparities and social conditions remains inexplicably linked to economic investment as well as potentially internalized oppressive messages about subaltern members of a community.

Culturally and Spiritually Based Health Services

With the rich cultural traditions of Brazil, there are also existing cultural and spiritual communities and practices that serve as avenues for health and healing. Specifically, Brazil has a history of integrating Spiritism within its psychiatric hospitals. Spiritism is described as a science, philosophy, and religion and most frequently attributed to Allan Kardec in France (Lucchetti, Aguiar, Braghetti, Vallada, Moreira-Almeida, & Vallada, 2011). According to Spiritist philosophy, some mental disease can have malevolent spiritual origin or is rooted in untreated issues from previous lives. There are a number of hospitals and treatment facilities associated with the Spiritist tradition. While there is little available data, a recent study indicated Spiritist hospitals accounted for 50% of psychiatric admissions in Sao Paulo (Zapatelli et al, 2011). It is noteworthy that Lucchetti and colleagues (2011) found consensus that spiritual interventions are not substituted for psychiatric treatment, rather serve as complementary treatment in Spiritist hospitals. Moreover, patients in Spiritist associated facilities endorse a wide range of faith traditions. It is evident by the number of facilities that Brazilians are open to Spiritist hospitals and find the complement of western allopathic and spiritual interventions offered as beneficial.

In addition to the Spiritist tradition, Candomblé, an Afro-Brazilian religion brought to Brazil by enslaved Africans primarily from West and West Central Africa remains a central spiritual practice, particularly for Afro-Brazilians (Harding, 2000). Historically, Candomblé leaders have been not only spiritual leaders, but also served as activists and utilized their social capital to advocate on behalf of their communities. DeLoach and Petersen-Coleman (2010) found in their work with Candomblé devotees that Candomblé also served as a spiritual and cultural conduit of collective identity, health and healing. The researchers concluded that for favela residents, Candomblé served as a trusted and accessible avenue of support and healing from trauma and resulted in greater sense of pride in their African ancestry and greater sense of community connectedness. Given the prominence and location of *terreiros* (or place of Candomblé worship), which are community-based settings, these were deemed to offer physical, emotional, and spiritual respite within the favelas. The location and structure of Candomblé *terreiros* coupled with the psychological and spiritual benefits, uniquely position it for utility in community psychological efforts. More specifically, given the continued subjugation of people of African ancestry in Brazil, Candomblé appears to be a source of empowerment and serves as a community of resistance.

Shared Lessons and Implications for Transformative Change

It is evident from the case examples presented that these communities have found effective ways to galvanize local cultural and spiritual traditions as well as allopathic medicine as a means of transforming community mental health and well-being. Following are primary lessons emerging from these international examples of community health initiatives:

1. Across settings, access to supports is increased when efforts are made to work within existing cultural and spiritual systems of care as well as using models of community health.

It is clear from the examples provided that the path to transformative community mental health cannot merely be an increase in psychologists or mental health workers. The shortage of mental health workers in Zambia is undeniably dire. Yet, as witnessed in Brazil, the increase in psychologists may not be correlated with declines in mental health issues or increases in collective well-being. In all of the countries noted here, large numbers of communities turned to traditional mechanisms of healing prior to, in lieu of, or in concert with western medicine or mental health. The vast network of community health workers in Brazil and Pakistan provide a striking example of how paraprofessionals are being trained to engage in prevention, promotion, and even intervention. While it is unclear the extent to which mental health is incorporated into this existing infrastructure, this offers an opportunity to galvanize these as resources for

mental health.

2. Integrating psychology throughout interdisciplinary systems promotes community transformation.

The presented examples of community health exemplify how interdisciplinary teams have been established and the international support for integrated mental health services. This is consonant with recent directions in the U.S. to create integrated medical teams more inclusive of psychology (Bennett-Johnson, 2012). As seen with the case studies, transformative community mental health must necessarily be local and participatory.

Participatory action is empowering and allows individuals to be actors in and agents of their own health and the collective well-being of their communities. Montero (2009) speaks to the significance of participation:

> "An important characteristic of participatory methods fostering liberation is related to the role power plays within its goals. Participation empowers the people and is also directed towards their conscientisation. . . its emancipative character is evidenced in its capacity to empower participants, strengthening their resources and developing their ability to acquire new resources and redefine themselves as able citizens with rights and duties and the capacity to defend their achievements and demand what is due to them. It is also a democratising instrument, as this type of collective action and reflection strengthens civil society" (p. 76)

Relatedly, while there was clear connection between mental health and other aspects of health in these models, there remains a disconnection from other necessarily intertwined systems such as education. Given the role of education in transforming communities (see Freire, 1972 for example), such an absence is conspicuous. Moreover, education has been demonstrated to potentiate positive mental health outcomes and empower women and girls globally (UNFPA, 2013); it is imperative that education be made more central as a source and location of prevention and intervention.

3. Any community transformation and healing must necessarily consider macrosystemic interventions that shift the social landscape in which any community mental health would take place.

As mentioned previously, all of the countries highlighted share histories of colonization and continue to struggle with social inequality largely related to ethnic and economic variables that may arguably extend from their colonial legacies. Lacking in all of these examples is a clear articulation of community and political activism for social change to bring about collective well-being. It was clear in both Zambia and Brazil that issues related to mental health policy and legislation have been highlighted as necessary for advancements in community mental health. While such legislation is certainly beneficial particularly in advocating for the political and economic resources necessary to strengthen service provision, such efforts remain ameliorative at best.

Community and liberation psychologists have long decried the association between social conditions, liberation, and well-being (see Fanon Project, 2010). Thus, community transformation and healing necessitates acknowledgement of this relationship and redressing the social conditions that give birth to many of the issues outlined. For instance, in Brazil it is clear that much of the social strife and concomitant mental health sequelae disproportionately impact its Afro-Brazilian population. Zambia has been an "independent" nation for less than 50 years, it continues to lack complete control of its own natural resources, and has been decimated by the HIV/AIDS pandemic. Pakistan has its own legacy of colonialism, ongoing ethnic and religious strife, and continues to be disaffected by the regional Afghanistan war. These complex sociopolitical conditions serve not just as the history but the *present day* milieu in which nationals of these countries live. To only advocate for treatment in such conditions renders practitioners complicit in neocolonialism and conscious participants in the medical industrial complex (Fanon Project, 2010). Insofar as community psychology seeks to create and support empowered social milieus, such is the work of engaged global community psychologists.

Thus, these community examples also demonstrate that transformative community mental health must necessarily be decolonizing. Given the histories of colonialism, it is remarkable that across all of these countries, indigenous and culturally grounded methods of healing continue to thrive. In Zambia, the sheer numbers of healers (over 40,000) in THPZ indicate that despite centuries of colonialism and current forces of globalization, cultural tradition remains powerful and salient. So much so that WHO and other international health organizations have conceded that it is most prudent to partner with Zambian traditional health practitioners. Similarly, there are related patterns with Pakistani and Islamic faith healers, Brazilian Spiritist hospitals, and followers of Candomblé in Brazil. Not only are individuals and communities experiencing traditional mechanisms as being therapeutic and more accessible, their very presence in the face of

colonialism may demonstrate healthy political resistance and cultural continuity (DeLoach & Petersen-Coleman, 2010).

Conclusion

It is clear that there is much to be learned from the presented models of health. It is evident from the international examples provided that even within low-resource settings, communities engage in remarkable efforts to heal, restore, and transform. Results lend support for a community based mental health promotion model that weds: 1) prevention and health promotion; 2) professional allopathic service providers partnering with paraprofessional and traditional health practitioners; and 3) community engagement and political literacy as a transformative and empowering mental health system of care that targets the individual and the community as source and location of intervention and healing. Such a model would be participatory and decolonizing in nature. As demonstrated from community based methods of healing existing within Pakistan, Zambia, and Brazil, transformative community based frameworks may include galvanizing extant resources or models of mental health, integrating local mental health services into educational systems, and engaging in community and political activism for social change to redress social conditions that undermine and negate empowerment, healing, and wellbeing. It is noteworthy, however, that while there may be points of convergence, allopathic and ethnomedicine or traditional healing models may be philosophically and/or epistemologically incompatible. It is not the intention of these authors to conflate or dilute the respective approaches, rather, to present the possibilities of collaboration in the interest of health promotion in low-resource settings. Further exploration in this area is necessary to better explicate: the extent to which said collaborations are possible, existing barriers, and the ways in which such a model may potentiate community mental health.

Recommendations

The purpose of the present exploration was to give voice to the transformative healing practices of communities that have historically been silenced in global community psychology discourse. Given the dearth of research focused on community mental health in these countries, further research is sorely needed. Pakistani communities are currently living within constant conflict, drone strikes, and have been plagued by multiple recent natural disasters. Yet, much of this populations' lived experience receives little international attention. Thus, little is known about Pakistani mechanisms of health and healing. HIV/AIDS continues to decimate Zambia and the entire sub-Saharan region. Three psychiatrists and two psychologists for a entire country that has seen its collective life expectancy cut in half is beyond what many western mental health providers' comprehension. Greater partnership with traditional practitioners as well as research regarding their identified needs to strengthen collective response is prudent. Clearly more scholarly attention is needed to chronic grief/loss, advocacy for greater resources and current mental health legislation, as well as capacity building to support local sustainable programming. Despite Brazil having thousands of psychologists at its disposal, disparate social conditions create different castes in life with discordant health outcomes. Further research on their community medicine model and particularly the ways in which community health workers may be able to advance mental health initiatives is warranted. Finally, the resilience of the individuals and communities highlighted is remarkable. Research regarding the particular cultural and protective factors may be helpful in global efforts to strengthen individual and community resilience, particularly in the context of continued subjugation.

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