In search of 'community': A critical review of 'community' mental health services for women in African settings

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Key messages:

- Studies assessing women's mental health services across the African region have been dominated by a concept of 'community' that is place-based.
- Singular, simplistic definitions of community do not account for the dynamic and lived implications of this complex term, which lies at the intersection of a diverse set of issues that define women's experiences in LMICs.
- Multifaceted conceptualisations of community are crucial to building effective and inclusive community mental health programmes.

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Abstract

Community is deemed a central resource for the improvement of health, across disciplines, contexts and conditions. However, what is meant by this term is rarely critically explored. In Global Mental Health considerable efforts in recent years have been directed towards scaling up 'community' approaches, with variable success, creating the need to better understand approaches to its use. Our study contributes to this need, through a critical review of studies engaging with the term 'community' in relation to women's mental health services in African settings. Our review explored 30 peer-reviewed articles from the past 15 years, which were systematically evaluated for quality of evidence. Studies were then analysed using a blend of conventional and directed content analysis to unpack perspectives on the term's use in intervention and phenomenological studies. We identified four broad categories of community: (1) *place* (shared geographical location or institutional affiliation), (2) *practice* (belongingness to a shared activity or profession), (3) *symbols* (meanings and experiences associated with shared community life), and (4) *identity* (diagnostic identity around a mental health condition). Analysis identified *community of place* as the most common primary focus of interest across the sample, with 80% of papers referencing this dimension. We noted that in studies where *communities of practice* were the focus, this was in relation to leveraging local knowledge to inform or support service delivery of intervention programmes, often designed by outsiders. Implications for future policy and mental health services research are discussed.

Introduction

Community (miss)understood?

The turn to the community is a pillar of many global health sectors. Since the launch of the Alma Ata Declaration (WHO, 1978), belief in the power of 'community' to contribute to the achievement of health improvement has been positioned as a solution to many challenges. However, across many social science disciplines there is much ambiguity surrounding the term community, alongside the recognition of its importance to health systems and services. A seminal study reviewed 94 connotations tied to the term, suggesting that 'there is no complete agreement as to the nature of community' (Hillery, 1995, 119). Sociological scholarship such as the work of Anderson (2006) finds that the notion of community revolves around common threads that unite individuals, in particular cultural practices, identity, or geographical locations. Others emphasise psychological and relational processes, such as Ka Sigogo & Modipa (2007) who define the term as a sense of coherence that enables people to make sense of their social worlds, thought processes, and the creation of a stable common character.

Health programmes that invoke ideas of community are often united by an interest in principles of health promotion – where individuals and groups are supported in a process of developing and increasing ownership over their health outcomes (Laverack, 2001). In practice, the implementation and delivery of community health programmes hinges on pre-existing definitions of who counts as 'the community', most often organising around dimensions of geographical location (community-based) or diagnostic communities. Community health, for example, is defined by McKenzie and others (2011) as the health status of a defined group of people, and the actions needed to enable their wellbeing. Such efforts are often rooted to definitions of community that align to geography, ethnicity, age, or other individual characteristic of difference. More critical approaches to community health are anchored to principles of empowerment, guided by an understanding that many health

inequalities and poor health outcomes are the result of power relations that impact the ability of certain groups to access the resources needed to be healthy (Nelson & Prilltensky, 2010). Evidence from a range of health fields, particularly infectious diseases like HIV (Campbell et al., 2012) and Ebola (Wilkinson et al., 2017) highlights challenges of working with pre-determined definitions of community, established by assumptions that 'the community' is always a positive and homogenous spaces. For example, many HIV peer support programmes have failed due to underappreciation of the challenges of collaborating between -groups with differing access to resources and power to enable health and wellbeing in a shared geographical space (Campbell 2003; Campbell & Cornish, 2010). Mass drug administration for treatment of Neglected Tropical Diseases has also been hindered by miss-conceptions of community; overlooking how gender inequalities and income disparities within a community of place hinder the efforts of health volunteers in significant ways (Parker & Allen, 2011). In the Global Mental Health space, interventions delivered by 'the community' have been championed for some time (WHO 2001; Saxena, 2007). However, the level to which meaningful community engagement has occurred is often queried, despite decades of efforts in this area (Jain & Jadhav, 2009; Burgess, 2016). As calls for investment to expand 'community engagement' in Global Mental Health emerge, it is critical to understand how efforts to date may be enabled or hindered by the ways in which we conceptualise, and take for granted, the meaning and use of this idea of community.

The search for community in (Global) Mental Health? A case study of women's mental health in Africa

Between 2000 and 2015, the number of disability-adjusted life years (DALYs) lost to mental health and substance use disorders increased by 52% in the African region (WHO, 2016). A gender disparity in mental health and illness has been highlighted by epidemiological evidence in the region, (Steel et al., 2014) with a large body of research

indicating strong ties between the risk of common mental health problems and the unique social realities that characterise many women's lives in African settings, including gender-based violence, HIV/AIDS and the experience of violence and forced displacement (Author, 2016; Rees et al., 2011; Cook et al., 2004; Silove et al., 2017).

In the face of these needs there are parallel concerns surrounding mental health resource allocation and investment (Cooper et al., 2020, Docrat et al., 2019) particularly in the African region (Skeen et al., 2010). For example, average spending on mental health across the continent is less than 1% of the health budget (Saxena et al., 2007; WHO, 2014). Human resource shortages result, in part, from a gross underinvestment in services, with an average of 0.9 mental health workers per 100,000 (WHO, 2014), and recent evidence suggesting that fewer than 1 in every 10 people in need access mental health care in South Africa (Docrat et al., 2019).

In response to these challenges, the World Health Organisation (WHO)'s 2013 Global Mental Health Action Plan was launched, building upon more than a decade of efforts to advocate for integrated community mental health (WHO, 2001a,b,). For example, the 2001 World Health Report, which focused current attention to mental health inequalities, also foregrounded the importance of community to mental health praxis. The 'care in the community' model, which formed the heart of deinstitutionalisation movements around the globe in the 70's and onward, argued the importance of accessing services closer to home, with supports that extend beyond treatment and include resources to live a full life. In 2007, following the launch of the Movement for Global Mental Health (MGMH), these arguments were bolstered by a series of studies that emphasised the success and challenges of various models of care to enable delivery and scale up of services in the community (Hanlon et al., 2014; Patel et al., 2009). A number of African countries have developed policy frameworks in the last two decades, with Ghana, Zambia and South Africa being some of the first African

countries to develop national mental health policies committing to decentralising services toward community care (Faydi et al., 2011; Fisher et al., 2007) building on longstanding efforts in this vein in these countries (Petersen, 2004; Lund et al., 2010; Mirzoev, 2012).

However, despite these efforts, a number of barriers remain to implementation in several areas. Many authors highlight the limited information on culturally relevant concepts of mental ill health, which can have an impact on quality of services and uptake (Ventevogel et al., 2013; Mendenhall, 2019). Effective implementation of community driven policies is also limited by system and structural challenges, including poverty, social norms and service quality (Author, 2016). Furthermore, colonial legacies have contributed to the dominance of biomedical models of health and illness used health systems in Low- and Middle- Income Countries (LMICs), resulting in interventions that engage with local idioms of distress being overlooked across the field (Fernando, 2012). Beyond this, limited financial investment, resource shortages and civil conflict have contributed to delays in reducing the implementation gap. The most recent data on mental health expenditure published in 2017, states, average spending on mental health in low and lower-middle income countries, is less than 1 USD/person (WHO, 2018). In these regions, 80 percent of funds go to mental hospitals (WHO, 2017), only 21% of countries in Africa have new mental health legislation (WHO, 2014; Eaton et al 2019).

Community mental health efforts have been suggested as a response to these challenges and can take many forms. Typically, they take the shape of community-based services (such as community-based care), community-led support groups (including service user groups) and prevention initiatives that target a specific geographical area (Burgess, 2013). The role of social networks and their organisation is central to community mental health care, with many arguing for services to be grounded within the strengths and personal values of those experiences distress (Burgess & Campbell, 2012; Thornicroft et al., 2016).

Community engagement occurs within these spaces across a continuum of levels of involvement, ranging from no control to full control by community members (Dalton et al., 2016). Lempp and colleagues' (2018) recent work suggests that a majority of community programmes in LMIC settings (specifically focusing on service user and caregiver communities) reflect low to middle range of engagement by members. Despite longstanding acknowledgement of the importance of greater community ownership within health programming from a range of disciplines (Haldane et al., 2019) this trend continues, often at the detriment of health outcomes, as programmes where individuals or groups are informed of services without any other involvement have been proven to be insufficient (Abayneh et al., 2017). A growing focus on widening the scope of community involvement has been recognised through the expansion of service user involvement (Haldane et al., 2019), and co-production approaches (Bovaird et al., 2015) in some parts of the world for some conditions, including mental health (Rose & Khalil, 2019). However, there is an urgent need for community mental health programmes to move towards power-sharing models where community members share decisions and responsibility and ultimately move towards full control of decision making to determine outcomes with more clear distinction about who comprises which community, and whose voices matter most in which spaces (Rose & Kalathil, 2019, Burgess & Choudhary, under review). To enable this, more explicit definitions and understandings of who and what community is and when the term is used in the context of mental health improvement is needed.

It is at this juncture that this paper makes its contribution. In an era where notions of 'community' are increasingly mainstreamed in global health improvement efforts there is a need to explore how 'community' is deployed within mental health services. Our paper reflects on these challenges through answering the following research question: How does the Global Mental Health field make sense of the notion of community? We explore this through

a critical review of the current body of literature on mental health services for women in Africa.

Methods

We conducted a critical review (Grant & Booth, 2009) of literature published on women's mental health services in Africa from 2005 to 2019. Critical reviews are differentiated from other types of literature reviews via their interest in and reflection on how a field of interest approaches a topic, highlighting contradictions, inconsistencies and limitations that shape praxis. Pare and colleagues (2015) assert that the strength of a critical review lies in its ability to highlight how a particular field could benefit from strengthening, suggesting direction and focus for future development. As such, critical reviews are not comprehensive in scope. In line with many critical reviews, we did not use fully systematic methodologies for our review and instead present a snapshot of literature during this time period (Pare et al., 2015; Grant and Booth, 2009). While we do not report our process in as much details as typical systematic reviews (e.g. prisma-flow charts) the following sections detail our process and methods to enable replication, with an emphasis on the analysis of papers collected.

Conceptual framework

For the purposes of this review, we were guided by a social psychological approach to community that engages with the full complexity of the term. Caroline Howarth (2001) achieves this through defining the term as: *'... the way [groups and collectives] are talked about, constructed, and defended by those who reside in them and come into contact with them' (2001, 4).* By starting with this perspective, we acknowledge that the notion of 'community' is a dynamic, socially constructed concept, allowing for a wide range of its dimensions to be included. This helped narrow our focus in the wide field to work related to women's mental health services, into two types of studies: (1) those describing interventions,

and (2) those exploring women's lived experiences of mental health and services (i.e., phenomenological studies), which sought to inform the future design of interventions. Inclusion of studies on interventions help to capture ideas on how groups with power that come into contact with communities (academic, policy spaces) construct and define them, while phenomenological studies allow us to maintain a focus on how those who reside in 'communities' make sense of similar ideas and concepts related to mental health.

Inclusion and Exclusion Criteria

We included primary and secondary research (including reviews) using both quantitative and qualitative methods. Selected articles included those reporting on psychological and/or psychiatric services delivered in the community and in clinical settings, one-to-one or in a group format, as well as studies of lived experiences, where community was a central focus. Studies from LMICs outside Africa were excluded. We also excluded articles whose primary focus was physical illness where mental health support was a secondary concern. This included papers that described physical and sexual violence services without a significant mental health and psychosocial support component. Descriptive epidemiological studies describing prevalence and/or access issues, without mention of an intervention focus were also excluded. Our decision to focus on papers published from 2005 onwards attempts to reflect the rapid change in mental health policy and services in the continent driven by the formal launch of the Movement for Global Mental Health in 2007.

-Box 1: Search terms about here-

Information Sources

The primary search was conducted in the summer of 2016 by AS, for the period between 2005-16. We carried out a literature search using PsycINFO, PubMed, Scopus and Ovid databases for peer-reviewed articles on mental health services for women in LMICs. We opted to exclude grey literature in line with the MGMH priorities around evidenced

based practice, which gives priority to high quality evidence when informing policy, practice and development within the GMH field (Wainberg et al. 2017; Barbui et.al, 2017).

The databases were searched using a string of terms related to mental health services, interventions, programmes, support and care (Table 1). This initial search gathered 2406 results across all databases. Items were screened by abstract and title review by AS, and duplicates removed, leaving 25 full texts that were downloaded and screened by AS and RB. During full text review, one paper was removed leaving a final sample of 24. In July 2019, we updated our search (completed by LE) using the same search strategy/string to check for any additional papers published in the two-year period[1]. An additional six papers met our inclusion/exclusion criteria and were added to our sample.

-Table 1 about here-

Characteristics of our final sample of 30 articles are presented using a simple Excel spreadsheet (see supplementary data table 1). This facilitated the collation of information from articles including mental health condition of focus, design, treatment approach, and references to the notions of community.

Evaluation of quality of evidence

While critical reviews often do not include assessments of quality (Grant and Booth, 2009) we opted to explore quality of evidence given our focus on peer-reviewed literature, and the importance of quality evidence to policy development in this area. This also allowed us to overcome some of the limitations inherent with the more subjective nature of critical reviews connected to the less systematic strategies used in selection of papers (Pare et al., 2015), as was the case with our study. We applied two tools to examine quality of evidence;

[1] The production of this paper was delayed due to pregnancy/maternity leave of the senior author, which established the need for updated review in 2019.

(1) the Method for Evaluating Research Guideline Evidence (MERGE), and (2) the Critical Appraisal Skills Programme (CASP) for qualitative research.

MERGE guidelines are a comprehensive document developed in consultation with epidemiologists in Australia that provide non-specialists with well-defined ways of evaluating public health interventions in simple ways. Guidelines include six checklists to guide evaluation. Selected articles were coded based on the extent to which they met scoring criteria, and the assessor was encouraged to score each article with respect to the overall quality of the study (refer to MERGE evaluation criteria).

For this review, the first two checklists were most appropriate. The first is used to assess reviews of the effect(s) of intervention(s). Of thirty articles, only one was evaluated using this checklist (Table 3). The second checklist is used to assess studies on the effects of intervention; and we used this checklist to evaluate seventeen studies (Table 4). Fourteen articles were coded as 'A' and four received the code 'B1', indicating high quality.

MERGE criteria did not apply to qualitative or review articles; therefore, we employed the CASP tools to examine the quality of these papers. Eight qualitative articles were assessed using Huang et al. (2019)'s scoring system (Table 5). Four articles received the maximum score of eight (meeting all criteria), two articles were scored seven (meeting all but one criteria). The authors then developed scoring criteria for the remaining four review papers using the CASP guidelines available and scored the relevant papers (Table 6)

None of the articles received low ratings on the MERGE quality review criteria, and responses to the CASP tools also indicated an overall moderate to high appraisal of the selected articles, with some scope for improving review papers. The quality assessment was conducted by AS, validated by LE and supervised by RB.

Content Analysis

The use of content analysis is common within critical literature reviews (Pare et al, 2015). As our interest revolved around the use of the term 'community' and the types of communities explored within women's mental health services, we applied a content analysis to measure both frequency of references to the term and explore meaning derived from the context in which the term was employed. To do this, we used a blend of conventional and directed content analysis (Hsieh & Shannon, 2005). The directed approach allowed us to maintain a theory-driven approach to identify concepts of community, using three broad categories to guide our organisation of data: Community of place; symbolic communities; and diagnostic communities. This choice was informed by our conceptual framework, and other work on community mental health in this context (Burgess, 2013) A conventional approach helped to maintain an inductive element while allowing us to move beyond our initial preconceived categories if the data demanded it (Kondracki & Wellman 2002). By blending these two methods, it allowed for us to identify any potential theoretical contributions to notions of 'community' exhibited in the field of mental health in the African region. All papers were uploaded to NVivo (Version 16), and references to communities coded by LE. 321 codes were extracted from the papers and organised into a thematic framework through iterative discussion by LE and RB, to cross check interpretations. The initial framework identified 13 themes, and a fourth category of community 'communities of practice'. Following discussion and further refining of themes, these were reduced to 12 themes describing the four categories. The coding framework is presented in supplementary table B.

Results

Article Characteristics

A majority of the studies examined in this review were located in the southern and eastern regions of Africa. Forty percent (12/30) report on studies from South Africa exclusively, 13% (4/30) from Kenya, and 10% (3/30) from the Democratic Republic of Congo. There was one study each in Zimbabwe, Uganda, Malawi, Rwanda and Tanzania. The remaining six were multi-site studies and included relevant case studies across several African countries, including the above listed. Over half the articles (60%) reported on studies conducted outside of South Africa, which is a significant increase from the previous decade when over 70% of the studies were conducted in South Africa (Hanlon et al., 2010).

In terms of study design, two-thirds (67%, 20/30) of the papers employed quantitative methods, however under half of these involved a probability sample (35%, 7/20). The other ten used either qualitative methods (20%, 6/30) or a combination of quantitative and qualitative methodologies (13%, 4/30). Table 7 demonstrates the distribution between articles that had an interventional component in contrast to those that focused on investigating the experiences of women living with mental health issues. Full details of all papers are presented in supplementary data table A.

Representations of 'community'

All thirty articles referred explicitly to the term 'community' (or 'communities'), however the frequency of occurrence of the term was vastly different across articles. Our results indicated that *place-based* notions of community were central to interventional efforts for women's mental health care. Across the entire sample, 80% of papers made reference to this type of community. A further three categories of community were explored in the analysis: *systems of practice*, *symbolic relationships* and as *diagnostic identities.* Within each category, additional themes described specific manifestations of each type. A fifth category; complex focus, was created to account for the fact that papers touched on 1 or more category. Table 7 provides a broad overview of how each paper's primary focus of community was

distributed across the two categories of studies. It highlights that across our sample, intervention studies were more likely to focus on place-based dimensions of community (10/21) than complex (7/21) notions of communities. Phenomenological studies were more likely to have a primary focus on the complexity of communities (7/9). While this table appears to suggest that no studies took interest in symbolic communities, this is not the case – it is just that these types of communities were not the primary focus of a paper and discussions of symbolic community appeared in combination with other types of community (complex). This is made clearer in our detailed account of how the four types of community are represented across each paper, which is described in Table 8.

A summary of community dimensions is presented in Figure 1. Sixteen articles refer to multiple types of communities simultaneously, reflecting a more complex notion of the term. Intervention studies were more likely to have single category focus(57%, 12/21). Where they included a complex focus, the most common combination was category of place and diagnostic identity. Articles presenting phenomenological studies of women living with mental health issues referred more frequently to complex communities (77%, 7/9). The following sections of the paper discusses each of the four domains of community in further detail.

Community as 'place'

Community is often defined by a shared geographical boundary. Physical and structural boundaries act as key confines for groups of individuals, their experiences, and in some instances, their ability to access mental health services. This conceptualisation refers to a shared geographical location or an institution or an economic reality, usually describing somewhere that individuals interact with others on a regular basis (McKenzie et al., 2011)

Studies with interventional components were largely focussed on a singular place-based conceptualisation of community. A majority of studies under this umbrella described

non-professional local structures for support, which were distinct from more formal service spaces (such as primary health care facilities). Interventions were carried out in the home or a communal area that women were easily able to access and trusted as safe spaces. A number of articles noted the local relevance of *places of worship* as a place that provides a sense of community in regions with strong ties to faith-based and/or religious healing. A smaller number of studies in our sample linked community of place to more formal sites for healthcare delivery, such as *primary health care facilities*. Only a handful of studies specifically referred to specialist mental health care facilities.

Community as a 'system of practice'

Community as a system of practice acknowledges the active dynamics of community; something that is created around a shared activity or profession, or idea of belonging (such as a community health worker) implying that individuals within this community share a common understanding of the elements that define a practice and its impact on their own as well as other community members' lives (Li et al., 2009; Pyrko et al., 2017).

Phenomenological studies focused more on this dimension of community. Two forms of communities of practice were identified in the articles reviewed. The first system of practice referred to trusted members of the community that delivered interventional services; most often *lay or non-specialist health worker*. For example, the deployment of mother-mentors or other peers from the community, who due to their status as trusted or respected status were accepted as service providers. The second system of practice revolved around groups of actors who generated local knowledge such as *local leaders or traditional healers.* This knowledge was often used to inform the design of interventions.

Community as a 'diagnostic identity'

Our findings show that in studies where emphasis was on a community united by a shared diagnostic identity (i.e., a mental health condition), there was a simultaneous attempt

to understand the gendered experience of women. This resulted in efforts to have interventions provide safe spaces for communities of women as they navigated mental health conditions. Diagnostic community was the primary focus in only four studies; (two of each type). More often this category appeared as an intersection with other aspects of experience; such as in relation to comorbidities (specifically HIV/AIDs), and other gendered social realities, including risk factors associated with women's social roles, namely violence or motherhood. Intervention studies also included this as a focus.

Community as a 'symbolic relationship'

A less frequently cited dimension of community in our sample was symbolic communities. These include communities of identity, linked to intangible dynamics of being, such as gender or religious beliefs. The symbolic context that emerged within these studies, referred to the experiences and meanings that shape and are shaped by African women's lives. More than half of the articles describing such symbolic relationships were phenomenological studies.

In this cluster of studies, the term 'larger community' was often used in reference to the belief systems and norms that make up a cultural context. We found that gender norms were considered in the design of community programmes, particularly to increase acceptability and safety of women living with a psychosocial difficulty. While cultural norms may act as a barrier to seeking mental health support in some cases, a number of articles in this review also recognised the ability of culture to establish a positive symbolic environment through which women develop understandings of their mental health conditions (Reed et al., 2013; Akinsulure-Smith, 2014; Burgess & Campbell, 2013). This was primarily the case for phenomenological studies, rather than intervention studies.

Discussion

Our review aimed to critically examine how the idea of community is represented in studies of mental health services for women in African settings, a desire informed by a longstanding preoccupation and idealisation of community as a bottomless well of resources to bolster and support healthcare across in the region (Campbell, 2007). Beyond this, the wider dynamics of community explored in this study (symbolic, practice and identity), are manifestations of the everyday realities that frame the possibilities for achieving and maintain good mental health, and health more broadly (Rose and Kahlalil, 2019)

Our findings highlight that a small but expanding body of intervention work includes multi-faceted perspectives of community for women affected by mental health difficulties. In our sample of papers, seven intervention studies - those most likely to be used in planning or developing future programmes - had a complex community focus, with two engaging with all four categories of community (one reporting on a trial and one systematic literature review). However, only two papers in this group engaged with symbolic notions of communities; one on gender, and another on 'culture' in a broad sense. Conversely, phenomenological papers, which by design aim to represent the perspectives of community held by everyday citizens and service users, made up a much smaller portion of the sample (9 of the 30). Seven of nine did not have a single primary focus, attending equally to multiple types of community and their interactions in people's lives.

Despite this, the most dominant frame of reference used was community of place – which highlights an ongoing prioritisation of pragmatism over complexity, which can limit successful health outcomes. For example, Paul Richards' (2018) recent account of community-based responses to Ebola highlighted how a pragmatic top-down approach emphasising community of place strategies, led by WHO and global actors at times derailed indigenous organising in Sierra Leone around other dimensions of community. For example, secret societies and associated traditional practices, which enabled local innovation in the

absence of formal intervention, were interrupted by external presence. Within mental health spaces, a recent review highlighted that complex interventions that took into account structural, relational, familial and individual dynamics were likely to be more effective, and high and low-income settings alike (Castillo et al., 2019).

The emphasis on community of place combined with communities of diagnostic identity in our sample of studies likely reflects the legacies of deinstitutionalization and the transition of care to community settings in mental health. The fact that many of our studies also include references to non-medical sites (i.e., churches/faith healing spaces) recognises the ways in which 'care in the community' has also manifested in positive ways. However, effective community care must also begin to reflect on and respond to the non-service related realities of community spaces – wider social norms, economies and structures – which also shape possibilities in terms of treatment and care (Author, 2013; Pathare, Brazniova & Levav, 2018). Our findings suggest that we have much further to go in ensuring that intervention related studies account for these dynamics.

While we found that the term 'community' was commonly used in a range of studies, explicit detail was rarely available on what it meant when it was used in intervention studies. This, combined with the increased likelihood of intervention studies to focus on singular dimensions of community of place, may result in interventions that are less likely to engage with complex ideas of community. This may be the result of a tendency for mental health interventions to approach dimensions of community as static factors – where the presence and importance of culture, gender and poverty are acknowledged, but responding to their intersections and impacts in the lives of service users and related wider communities is not the focus of response. Our findings suggest a need for community interventions to adapt a more intersectional approach to engaging with community factors connected to women's mental health services, in line with calls for the global health field more widely.

While geographical considerations for mental health service design are pragmatic in a public health sense, focusing on geography alone limits the ability for lived experiences of individuals and their dynamic interactions to shape interventions. For example, studies from other regions highlight the dangers of overlooking service-user experience in mental health service design, with the growing wave of co-development and co-design approaches across mental health (Susanti et al., 2019; Rose & Kalathil, 2019) confirming the importance of such efforts.

Findings highlighted an increased involvement of individuals with lived experience as active agents in informing intervention development and delivery, drawing on communities of practice for partnerships and enhanced the delivery of care. However, in many instances, these relationships seemed to rely largely around increasing pragmatics of care, rather than creating spaces to engage with the content of women's experiences of psychosocial distress in order to define parameters of treatment. In many parts of the continent, significant gender-related barriers as well as stigma associated with mental health problems are common concerns (Myers et al., 2016; Wainberg, 2017; de los Angeles, 2014). The perceptions of women's experiences, their journeys of distress and its management are embedded within overlapping and cross-cutting notions of community, and therefore must form a central component of community health interventions.

In our review we opted to evaluate the quality of studies included in our analysis. While this is not often done in critical reviews, we felt this was important given the field's interest in developing a sound evidence base to inform future interventions. Quantitative studies (which accounted for all but two of the intervention studies) were ranked as mid to high quality. While phenomenological studies, which focus and report on the views and experiences of women (and to a lesser extent their families), were highly ranked in our assessment, such literature is often excluded from traditional systematic reviews, given

arguments about quality, transferability and bias (Hannes et al., 2013). Where evidence hierarchies mean that where the work most likely to engage with complexity is least likely to inform service design, our findings suggests the need to infuse studies evaluating and designing interventions with more complexity, as one route to better reflecting wider dimensions of community. Recent work by Mannell and Davies (2019) argues that evaluations of complex interventions have been limited by their emphasis on experimental and randomised control trials, which constrain the types of questions that can be asked, and consequently, the understandings of impact that we develop. Their suggestion to produce deeper studies of interventions, aligns well with findings from our analysis, namely the need to widen the ability for studies of interventions to explore more than single discrete outcomes (and with it, single notions of community) but to also evaluate the relational processes, structural dynamics and lived realities of people who participate in them; which many cite as our best routes to understanding community (Howarth et al., 2014).

Our findings also carry important implications for the recently published WHO mhGAP Community Toolkit (WHO, 2019), which provides guidelines for community mental health programmes to enhance engagement and mobilisation of local resources. The development of this toolkit emphasises the importance of placing 'community' at the centre of mental health system design and the need for communities to discuss mental health. Its multi-sectoral approach describes a tiered framework for prevention, management and recovery elements. The document proposes a meaningful framework to assess community needs and resources, including guidance on the kinds of questions to be asked. Most importantly, it encourages all community mental health stakeholders to be reflective in their planning of services.

Despite its strengths, our findings suggest a number of gaps in the framework's current structure. First, a clear definition of community is missing and a majority of

references to ‘community platforms’ imply a more passive perception of community, likely influenced by viewing it as a location where things can be anchored, rather than a place where actors have agency to drive their own change. Second, while it acknowledges ‘community’ as a platform to unite groups such as health professionals, social welfare workers and local leaders to build partnerships (‘systems of practice’), the role of everyday citizens or service users in shaping interventions and services is not well articulated. The strengths and agency of those with lived experience in shaping community mental health services, and of community members as active players able to determine and promote their own mental health is overlooked. One route to addressing this is through a widening of our definitions of community, through promoting and advising methods that allow reflection on who counts as relevant community stakeholders (i.e this is defined and decided in each ‘community’ site) and the dynamics that shape actor engagement (symbolic dynamics such as gender and power). This approach could lead to the development of more meaningful service encounters around community mental health.

Third, a place-based emphasis on community minimises the importance of knowledge interactions between people with mental health difficulties and formal healthcare providers, as well as the impact of these dynamic interactions on mental well-being. The result is a reification of a knowledge hierarchy that underestimates the benefit of cultural and contextual mental health knowledge to wellbeing, including locally appropriate idioms of distress which often do not map on to existing frameworks of mental health disorders (Faregh et al., 2019; Irankunda et al., 2017; Bragin et al., 2014; Familiar et al., 2014). A revised toolkit could map out strategies and pathways to acknowledge and incorporate the needs identified by local idioms of distress, into processes of service development in local areas. Participatory action research provides one route to achieving this, but this is a currently limited practice within Global Mental Health spaces, though growing calls signal its importance (Burgess, Jain,

Petersen & Lund, 2020; Roberts et al., 2020). For example, recent work in Colombia has highlighted the ability for participatory action research cycles to illuminate how local idioms of distress related to post-conflict mental health diverge from mainstream mental health recovery models, and emphasising the importance of issues like security (in a political context) and family contributions to achieving mental health and wellbeing (Burgess & Fonseca, 2019).

Finally, the toolkit does not sufficiently respond to the challenges that the implementation of mhGAP has presented in complex community contexts such as post-conflict settings, where a bio-medical model of mental distress has been described as being inadequate (Ventevogel, 2014, White & Sashidharan, 2014), or the drivers of distress linked to structural realities such as poverty, violence and inequality (Burgess & Fonseca 2019). These settings reflect a complex social and political economy of mental health, where intersecting factors such as multiple forms of intimate-partner violence, child marriage, forced recruitment by state and non-state armed groups and gendered barriers to access to protection and support networks mean that what is meant by community is fragmented, resisted and constantly in flux. To fully engage with how these varying dimensions of place drive mental health outcomes, work with communities will also need to interventions that promote simultaneous action on structural dimensions of community that drive distress along social causation pathways (Author et al., 2020).

We note a number of limitations of our study. First, while about half the studies included in this review were conducted in South Africa where English is commonly used, the remaining were conducted in countries where English is not the first language such as Rwanda, Burundi or the Democratic Republic of the Congo (Walstrom et al., 2013; Kohli et al., 2012; Mankuta et al., 2012; Murray et al., 2018). We were restricted to English as this was the primary language spoken by the team. Given the diversity of languages in the region

and its implications for the meaning of community, the review would likely have benefited from including articles from other languages widely spoken in the continent. A second limitation is our focus on the African region given the relevance of community to a global audience. However, given the importance of a deep understanding of structures and cultures to community in relation to mental health and psychosocial support literature, a narrower geographic focus enabled our critical analysis to be more focused. However, we recommend that future studies explore these aspects in other regions, as specific dimensions of community may matter more or less depending on the region of focus. Third, we did not include grey literature and focused on published evidence only, which may have limited the scope of the review. For many critical reviews, a comprehensive search of all relevant literature is rarely conducted, instead focusing on synthesis and analytical methods of a subset of literature to highlight challenges facing the field (Pare et al., 2015). While our critical approach provided an in-depth analysis highlighting gaps and contradictions in the current use of the term community, a more traditional systematic review, using more nuanced search terms (i.e separating out search terms such as mental health AND women) could have provided additional papers and information on areas of concern with respect to women's and community mental health. This suggests that future studies may want to apply more systematic methods within critical reviews (while including both qualitative and quantitative papers), to further strengthen the claims that emerge from more critical reflection on bodies literature.

Current interests in community are an important priority for Global Mental Health and the Global Health field more broadly. In the face of limited human resources for health in the African region, a complex approach to community that puts local people at the forefront of effective service planning and delivery is a must. However, to do this effectively, while avoiding the pitfalls of previous community efforts across the global health landscape, will

require a clear and comprehensive understanding of community life developed at the outset of intervention studies and their evaluation; acknowledging ideas that go beyond geography or diagnosis. One pathway to achieve this, could be through expanding the use of participatory approaches within intervention design, and evaluation. Participatory intervention design that engages with women's lives and multiple domains of community at scale (i.e beyond focus group discussions, to include wider communities) has been applied in other women's health spaces. For example, community conversations has been used as a route to plan for interventions around women's and children's health in (Mutale et al., 2017), and to inform trial design in Nigeria, collecting complex perspectives of community life involving more than 300 participants reflecting a range of community identities (Burgess et al., under preparation). Through using such approaches, a wider range of interests and factors related to mental health could to be brought forward, resulting in more effective and inclusive community health programmes for women's mental health on the continent, and beyond.

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