

Tools for the journey from North to South: a collaborative process to develop reflexive global mental health practice

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ICDR-Cameroon is a group working on disability and inclusion issues in Cameroon. Through their mental health work, various complex social, ethical, and relational issues have been encountered and the need arose to engage in a reflexive process that would integrate shared experiences, the broader discourse on global mental health, and other resources. The group participated in discussion, story sharing, research, and critical analysis, a process from which a document called ‘Tools for the Journey’ was created as a road map for the group’s work. The document includes a position statement outlining the group’s stance on various issues, in addition to additional resources. This paper describes the group’s reflexive process in creating Tools for the Journey, the benefits of this process in terms of group and individual understanding and development, and the challenging themes encountered in their work in Cameroon.

Keywords: Global mental health; mental health; global partnerships; North-South collaboration; cultural competence; Cameroon

Introduction

Mental health issues affect individuals and their communities worldwide, are closely associated with poverty, and have come to be recognized in the global health community as a major concern. According to some sources, mental health issues are also worsening with globalization and economic downturns; these concerns, among others, are resulting in increasing rates of depression and suicides (WHO 2010a; WHO 2010b). Maltreatment and human rights violations of persons with a diagnosis of mental illness or psychiatric disability have also been documented globally (Drew et al. 2011). As such, there has been a call to bring mental health care to poor communities in the global South, where the medical care system may not be well-established and/or programs have not been developed for managing mental health issues (e.g. WHO 2010b).

As formal mental health services are brought to communities within the global South, a number of issues and concerns have been raised. Bringing ‘Northern’ psychiatric care to the South has involved the export of a diagnostic system and the introduction of medical

treatments, including medications. The idea that mental health pathology is a universal concept, and whether mental illness in other cultures falls within the lines of the categories created by the American psychiatric system (which dominates international psychiatric classifications), has been questioned (Watters, 2010; Walsh et al. 2013). Also, medications and other psychiatric interventions utilized in Northern nations may be not only irrelevant and inapplicable to individuals in non-Northern cultures, but carry the risk of great harm. Psychiatric medications are expensive, are well known to have serious deleterious effects, and are dependent on close monitoring to be effective (Jerrell, McIntyre and Black, 2012; National Institute of Mental Health, 2010; also see Ingleby in this volume). Perhaps even more importantly, the implementation of medically oriented psychiatric care may undermine culturally established ways of identifying, coping with, and recovering from mental health issues (Watters, 2010; also see White and Sashidharan in this volume).

Therefore there is complexity in choosing words to describe life situations and conditions related to mental health; words have connotations and meanings, and need to be chosen carefully. In this paper, we take as a starting point the understanding of *mental health* as it is used by the World Health Organization to mean individual well-being, including opportunities to realize personal potential, cope with the usual stresses of life, work productively, and make contributions to community and social life (WHO, 2007). We understand good international mental health work as incorporating perspectives on mental health that draw from many health and medical traditions, give priority to equity issues, and take into account similarities and differences between national, cultural, and population groups. When we use the terms mental illness, mental disorder, and psychiatric disability, we recognize that the meanings underlying them need to be discussed, problematized, and contextualized as they can have different meanings, and are used in different ways around the world.

In this paper we use the term *mental illness* to mean that a person has been recognized as experiencing distress or disorder related to mental health, as well as the name given to the experience of living with a mental health problem; in addition, we recognize that these terms and diagnoses can be controversial and are not globally understood. For example, schizophrenia is understood to be a mental illness that has been widely recognized in Northern countries and is a designation (a label) given to a person who is living with a recognized set of symptoms and behaviours (APA, 2013) but the word can be used in different ways depending on the context. The terms *psychiatric disability* and *psychosocial disability* can be used to describe the experiences of distress and problems in daily functioning due to impaired function arising from mental health disability; these terms also more explicitly link mental health to disability perspectives and human rights (UN CRPD, 2008; Wildeman, 2013).

The purpose of this paper is to describe how one group, ICDR-Cameroon, experienced the

ethical and practical struggles of mental health work, and how the group engaged in a reflexive, critical process aimed at making sense of our experiences, developing and transforming our ideas about mental health, and informing and directing our future work. This process included consideration of theoretical and professional complexity, personal growth and transformation, and resulted both in the group being clearer on its own values and practices, and in being able to introduce new members to its perspectives. A strong motivation for engaging in this process was the desire to work in partnership with Cameroonian organizations and individuals who are also engaged in health, disability, and educational initiatives. One outcome of the process was a practical guide to use in the group's mental health work.

Tools for the journey: How our work in Cameroon led us to discover the necessity of a road map to move forward

ICDR-Cameroon is part of the International Centre for Disability and Rehabilitation (ICDR). Formed in 2004, the ICDR is housed at the University of Toronto Rehabilitation Sciences Sector; which comprises the Departments of Occupational Science and Occupational Therapy, Physical Therapy, Speech-Language Pathology, and the Graduate Department of Rehabilitation Science. ICDR partners with colleagues and organizations in low- and middle-income countries to conduct research and education in the rehabilitation sciences to improve the lives of people with disabilities globally (Cameron et al. 2013; Parnes et al. 2009). (Additional information on the ICDR can be found at <http://www.icdr.utoronto.ca/>.)

ICDR-Cameroon is one of the subgroups of ICDR that includes faculty, clinicians, graduate students, and community members based in Canada, primarily working as volunteers or on student field placements. Some of the members are from Cameroon. ICDR-Cameroon works mainly in the North West Region of the country, and our three foci are improvement of the quality of life of people with disabilities, the promotion of health, and the advancement of rehabilitation services in the area. A key part of our mandate is the sharing of information and technical expertise between rehabilitation and other professionals in Cameroon and in Canada. Some in our group, are white, heterosexual, middle-class, professional, female Canadians. Some of us are immigrants to Canada, from Cameroon or from other countries. All of us have lived in the context of societies that are grappling with inclusion issues, post-colonial relationships and legacies, identity politics, and injustices, although each of us has experienced those issues differently. All of the members of the group share a vision that supports attempts to build more inclusive societies, and a desire to ally with those who have experienced social exclusion and marginalization. All of us have experienced, in some ways, the feeling of being powerless at some points in our lives, and the desire to be part of social and occupational justice initiatives, using participatory approaches, such as those described by Paulo Freire (1970) and Smith et al. (2009).

One area of interest for the ICDR-Cameroon is mental health. This has led us to work in collaboration and partnership with local disability, health, and educational organizations in Cameroon to hold numerous workshops on mental health for various professionals. These workshops have addressed mental health related topics such as art therapy, client-centred practice, the use of cognitive behaviour therapy in African contexts, and the impact of the recovery and psychosocial rehabilitation movements on mental health services in North America, with discussion about relevant applications for the Cameroonian context. Although it is desirable to also engage in activities in Canada that promote exchange of ideas and understandings related to the lessons learned in Cameroon about mental health and distress, we have yet to formally apply these lessons to Canadian practice.

As we continued to deepen our involvement and understanding of the region, challenging and sometimes difficult situations arose. We realized our approach to understanding, and subsequently working in, mental health in Cameroon needed to be more systematically explored so that we could clearly understand how our own locations and perspectives influenced workshops, experiences, and discussions. Thus we continued the journey by more formally engaging in a *reflective* and *reflexive* process to deepen our understandings of the complexities of mental health, distress, and ill health.

Reflection is the ‘expertise-enhancing, metacognitive, tacit process whereby personal experience informs practice’ (Wald et al, 2012:1). Reflection occurs when we remember and learn from experiences, but does not necessarily include judgment or evaluation about the broader social and political context. Our understanding of *reflexive* practice (also known as reflexivity) is that it is a process of critical reflection and engagement with how one’s social locations, privileges, and positions of advantage and disadvantage, shape one’s beliefs, values, and assumptions, including recognizing one’s particular moral stance, for example, in the valuing of human rights. Reflexivity includes becoming aware of the way one sees and understands the world, and how, both implicitly and explicitly, these perspectives relate with broader social norms (Landy, et al 2013; Delany, et al 2009).

Taking stock of where we were: exploring what we were seeing and what we had already learned

This project began as an informal discussion with our group as different members brought experiences and readings to meetings. We felt it was important to create a space to discuss and problematize our understandings of mental health, daily life, distress, poverty, and illness. Members of our group had been influenced by many sources in the years leading up to this discussion. A variety of anthropological and indigenous studies, as well as personal accounts and films, helped us to understand the roles that White/expatriate/Northern visitors have had in the North West Region of Cameroon (for example, Watters, 2010; Peters, 2009;

Maynard 2004; Pool 1994; Murphy 1989; Lemke, 2001; Nyamnjoh, 2005; Ngassa, 2003; Makuchi, 1999; Mbuy, 1991, and Teno's film work: <http://www.jmteno.us/>).

In addition to these written and visual resources, members of the group had a wealth of combined experience and stories on encountering complex issues in the Cameroonian context. After all, it was because of the dilemmas we encountered in 'doing' mental health work in Cameroon that we discovered our need for exploration. We realized that this exploration would need to be of the ethical, moral, and personal dimensions of our practices, the intersections of these dimensions with different understandings of what 'global mental health' means, and notions of how to work in collaboration with people who hold different values.

Each person in the group has a unique social location, experience, and interest and we thus recognized that our process and outcomes for this project would need to reflect this diversity. Despite this diversity, we chose to aim for a consensus-based written document. We hoped this document would provide a tangible starting point for group members that are new to the experience of working with psychosocial issues in low-resourced settings, and that it would also be helpful for our professional members who are experienced but would continue to face challenges in their involvement in our projects. We called our document 'Tools for the Journey: A Mental Health Resource Package'.

A collaborative process for developing 'Tools for the Journey'

Formation of a working group and its mandate

Members of ICDR-Cameroon were invited to join a smaller mental health working group whose purpose was to create the 'Tools for the Journey' package. We defined a set of issues that we were struggling to answer and hoped to address with this project. These issues became a set of guiding questions for our project:

- How do we (i.e. the ICDR-Cameroon group) define mental health in Cameroon? Do we define it as mental illness? In what ways will our definition(s) intersect with or differ from local Cameroonian understandings of mental health?
- How do we 'help' without inadvertently undermining local ways of helping and healing?
- How do our North American views of mental illness help and/or hinder our work in Cameroon?
- How do we approach local ways of understanding and coping with mental illness in situations where to us they seem damaging?

- Are there specific things we can do to try and make our mental health program more culturally relevant and sensitive?
- Should we be integrating mental health into our work with physical disabilities? If so, how?
- How can we ensure that our volunteers or students working on mental health projects are appropriately trained? How much experience should they have?

The working group also decided on the form of the document we were to create, which was initially conceived as having two parts. Part 1 would be a position statement outlining the philosophy and values about mental health that ICDR-Cameroon wished to uphold and promote in our work; and our beliefs around mental health as they relate to Cameroon, to disability and development in Cameroon, and how these values and beliefs are situated within the broader context of the global discussion about the complexity of mental health work. Part 2 would be practice guidelines, which would be a set of practical activities and processes necessary to implement the group's values in their work. As our process continued, the necessity for three additional components was discovered: an ethical decision-making framework, a collection of stories, and a list of resources and references. It is worth noting that although our final document is helpful to group members, it was the *process* of developing it, and our engagement with these issues and questions as a group, which were significant in developing our understanding of the issues, our values, and positions.

Reviewing the literature

In creating our document we drew from the evidence base of mental health, mental illness, psychiatry, and occupational therapy, relating to general mental health care, mental health care in international contexts, and specifically to the African/Cameroonian context where available, to develop an understanding of the global situation. This process led to a better awareness about the history of psychiatry and mental health issues in Africa, the 'treatment gap' in mental health care between the global South and North, the identification of positive and innovative approaches and interventions, and the complexity of collaborative critical work and partnerships.

Creation of a position statement

The group then participated in a discussion in which we brainstormed our collective knowledge from experience and from the literature. We identified the following questions:

- What do we know about mental health as it relates to disability (both disability as a result of mental illness, and other disabilities)?

- What do we know about mental health and mental illness in Cameroon specifically?
- What do we know about our “Western/Northern” ideas of mental illness and its treatment, and how this relates to other cultures?
- What do we know about mental health as it relates to development?
- Are there any unanswered questions that come out of our discussion?

Key points from this discussion were identified and consolidated to form the guiding values in our position statement. The values identified are as follows:

1. Mental health is more than the absence of illness, rather it is a state of well-being.
2. Mental health is an important concern for the work of ICDR-Cameroon
3. Our mental health work involves a vulnerable population and is a delicate area of practice
4. We value a variety of perspectives on mental health and healing
5. Integration of mental health into development work
6. The importance of human rights and the family and community
7. Mental health work will incorporate advocacy and intervention at various levels ranging from individual to the global community

Each value in the document is followed by a position statement that further explains and explores the value specifically in relation to our work. The values and position statement were sent to the larger ICDR-Cameroon group for review and feedback. See Appendix for the final version of the position statement.

Formation of practice guidelines

Our practice guidelines were developed by reviewing each value in our position statement, in relation to the following areas of concern: mental health interventions (which kinds to promote and which to discourage, as well as how to decide), involvement of students and volunteers in mental health practice (e.g. appropriate experience, training, orientation), how to involve persons with lived experience of mental illness in our work, appropriate ways of teaching about mental health, and processes that would assist us in upholding our values, such as reflective practices and ethical decision making frameworks. An example practice guideline, designed to carry out our value regarding the importance of a variety of perspectives on mental health and healing reads as follows:

In building our understanding of culture, we will pay particular attention to mechanisms of healing and support that already exist within it. We will gather

information, document our understandings, and teach it as a part of our mental health activities. For example, we will collect and share the stories of those with mental illness as well as those of people providing services to them.

As with the position statement, the practice guidelines were sent to the larger group for review and feedback.

Gathering of stories

In ‘storying’ our experiences of mental health in Cameroon it soon became apparent that there was a wealth of information and understanding available to us through these stories. As well, our stories highlighted the incredible variety and complexity of issues that arise, and the richness of the culture in which these issues are embedded. As one occupational therapy student, Ana, stated in her written story,

My experiences in Cameroon have helped me to understand mental health from a different perspective. It has reminded me of the fundamentals of occupational therapy and the power of story sharing. Cameroonians reminded me of the simplicities of connecting as people, taking the time to feel and know each other through our lives.

The importance of stories became one of our guiding principles, and it was also decided that a collection of stories should be added to our mental health document. These recollections of personal experience were collected from group members as well as our Cameroonian colleagues, and serve as a reservoir of collected experience of knowledge, a set of varied illustrations of key issues, and as a springboard for discussion.

An ethical decision-making framework

Discussion of the various issues encountered in our projects highlighted the ethically complex nature of our work. Even in the best of circumstances and with careful planning, there are scenarios in which it is difficult to determine how best to apply our principles. Intertwined with this difficulty is the need for on-the-ground volunteers and students to make good decisions when facing ethical dilemmas, sometimes within a short time frame and/or without much opportunity for consultation with other group members. We decided that an ethical decision-making framework would be an essential part of our mental health document. The IDEA Ethical Decision-Making Framework and its worksheet (Trillium Health Centre, 2008) was modified slightly to fit with international mental health work, including in the Cameroon context. The framework provides a step-by-step process for making decisions according to ethical principles, and facilitates critical thinking.

Embracing Complexity

Several broad issues led us to initiate our reflexive process, and this process in turn served to further clarify and illuminate these issues. This section will describe some of these issues, how our group grappled with them, and some of the conclusions we formed on how to approach them. We have used texts and stories from the literature and from our group members to assist us in providing a richer description of these issues. Although the examples are specific to the context of the North West region of Cameroon, we believe that similar themes arise for those working in other contexts.

Labels and diagnoses

In the nosology of mental illnesses, they [traditional doctors in Cameroon] classify them in three major groups according to the following causes:

Group 1 – from God (fate), Group 2 – a spell cast on the patient by an enemy, Group 3 -... ‘contry-fashion’ - the wrath of the ancestors is a deeply rooted belief...that by not performing a particular traditional ceremony as requested by tradition, one’s ancestors could be provoked and when they get angry one could be befallen by ill luck of any type. (Ngassa 2003:193,211).

Health work often begins with the naming of a health condition or disease. It is important to understand and respect the variety of philosophies about, and descriptive terms used, to label and to understand mental health conditions and people in distress in a local area. Many people in the North West Region of Cameroon continue to believe strongly in the traditional ways of diagnosing health, including mental health, problems. We recognize that understanding the many perspectives that we might encounter takes time and is an ongoing process.

International classification systems are also promoted in mental health work. Watters (2010) problematizes the exportation of the use of the American system of categorizing people with mental health concerns and illnesses using the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (APA, 2013). Our readings and discussions have helped us to understand other ways of understanding classification, health, well-being, and disease, such as those of traditional doctors mentioned in the study by Dr. Ngassa (2003).

One of the labels which we really grappled with is ‘homosexuality’. Having sexual relations with someone of the same sex is illegal, and often seen as immoral, in Cameroon (Awondo, 2010; Gueboguo, 2009; Nordberg, 2012). ICDR-Cameroon members don’t see homosexuality in this way (although it is of course worth noting that North American culture

has undergone its own process in this area, with homosexuality only being removed from the DSM in 1973). We questioned whether we should explicitly name our concerns, our values, and our potential actions given the legal constraints existing in Cameroon. After much discussion, we settled on being explicit in our practice guidelines by stating that we would not pathologize or categorize in ways that would conflict with human rights, and that we would not support stigmatization of homosexuality as a deficit or disorder, nor support 'treatment' of it.

Some partners find these kinds of perspectives threatening or difficult, while others have appreciated our clarity and willingness to discuss human rights in the context of health and mental health. We do expect that our stance on this issue has the potential to limit the willingness or ability of some groups and individuals to work with us. This is a risk we have knowingly taken because we felt it was not authentic for group members to be vague on the issue, it was ethically untenable to conform to local norms, and potentially duplicitous to not clarify our views to local partners.

Witchcraft and sorcery

The [foreign] doctor concluded...that Raymond was most likely suffering from something like anxiety or depression. Raymond felt otherwise. The pieces fit together easily in his mind. His illness was caused by witchcraft on the part of his uncle, most likely with the help of a secret society and most likely with the help of other members of his family (Peters, 2009:55).

During short trips to Cameroon it is easy to avoid discussions about secret societies, witchcraft, and traditional beliefs. But as time goes on, and we talk and learn, the depth and variety of these beliefs in many family and community groups becomes apparent. While the specific beliefs vary from place to place and are changing with global influences, in general the people of the North West pride themselves on maintaining cultural beliefs and practices. We are learning to not make assumptions about who holds to traditional beliefs and how we can work with them; well-educated individuals, including health professionals, can be just as strong believers as others. We realize the need to create a safe enough space that people can clarify beliefs, which can be stigmatized in more formal systems such as medical care and in settings where there is more affluence or education, and talk about how to co-exist in healthier ways that do not marginalize people.

Colonialism and exploring issues of privilege

A good deal of research has shown that indigenous peoples were not simply

passive victims, crushed or shaped any which way by the juggernauts of colonialism and missionization. Nor did they simply respond – with a mind of their own perhaps, but still after the fact – to these external forces...from the start, people of the Grassfields co-participated in the creation and proliferation of new medicinal structures. Far from sitting back, waiting for what European occupation might bring, Cameroonians were keen observers of the new structures with an eye on how they might be evaded, adapted, or enthusiastically adopted (Maynard 2004:29).

Exploring our experiences of privilege as they relate to our work in Cameroon brings forth added layers of experience and complexity. Many group members have experienced discomfort when unwanted positions of status or privilege have been thrust upon them. At the same time this status is a gift, at times freely or even lovingly offered, and to refuse it may cause hurt or confusion. Privilege and status are sometimes offered because we are Canadian and/or white, while at other times status is more related to age, or to being a guest. Although disquieting to our sense of equality, these privileges are extended to Cameroonians who are older or are visitors as well. In the midst of our contemporary experiences, we are aware that our privilege connects to a larger and very influential historical context, in which colonized persons have at times internalized their oppressors' negative stereotypes of their culture, and developed a sense of inferiority and self-doubt as a result (Smith et al, 2009). And, still more complex and confusing is the fact that when we are in Cameroon we willingly participate in, and even depend on certain aspects of privilege connected to our affluence as Canadians, such as access to safer transport and better medical care. We are aware that our personal decisions as they relate to privilege have political implications, and we are all struggling to navigate our way through these challenges.

Religion

There is magic and there are herbs that have wonderful power. If you have not studied them, people can use them to harm you...these are facts which the white man of God did not know. You don't read such things in books. They are things of this land and those who worship the land can do them (Jumbam 1980:146).

There are several different perspectives on religion within our group. Exploring the historical, political, and current circumstances of organized religion in Cameroon is of interest because it impacts all facets of work and daily life, including mental health. In the North West region people often talk of the importance of religious affiliation, and of what is perceived as the growing influence of sects, cults, and other religious organizations and movements (see for example, Mbuy 2003).

Interacting in Cameroon's religious culture can be challenging for some of us, who are used

to living in a somewhat secular society where protections, processes, and cultural norms around privacy are in place to build an inclusive and diverse society. In Cameroon religion is not seen as a private matter and it is much more integrated, organized, and dominant in public life. It is important for us to recognize our emotional responses to the various forms of religion expressed in Cameroon, and learn how to cope with these emotions and manage our reactions.

Treatment

[My uncle] had heard so much about Azembe that he had finally decided to take his sister to see the famed healer. My uncle claims that this was one of the most difficult and painful decisions he has had to make. You see, my uncle is what we call in the family the staunch Catholic and a well-educated man. He has often been heard dismissing these healers with a sweep of the hand. Charlatans, he calls them.

Not that he did not have respect for traditional medicine. He did. He even revered some of the healers whom, he said not only knew their roots, barks of trees, and potent leaves but also had a total grasp of the psychology of their patients, an acute understanding and respect for the philosophies that govern their daily existence within their families and environment. But my uncle also said that many of these self-proclaimed witch-doctors, medicine men, ngambe men (diviners), sorcerers – the list goes on – were quacks...he said what these people did mere quackery, plain and simple (Makuchi 1999:6-7).

Given our motivation to work in partnership with people to support positive existing practices, one of the specific questions we are currently considering is ‘How then do we acknowledge and work with traditional healers, when there is the risk of ‘quackery’ or misunderstandings about why we would want to partner with them?’

The power of occupational engagement is another treatment issue that has been discussed. Many in our group are occupational therapists and feel strongly that attention to and use of everyday occupations can be therapeutic and healing. Our occupational perspective is not a medical perspective, but draws from a ‘coping with life’ approach (Townsend et al. 2007; Watson et al. 2004). While there are no recognized occupational therapists in the region, many health professionals in both medical hospitals and traditional practices (Ngassa 2003; personal communication, Fon of Nyenjei, February 26, 2013) use occupation in their practices.

Conformity and social groups

Although issues of belonging to social groups is highly complex, Cameroonian culture is highly community oriented (Geschiere et al. 2000; Page et al. 2010; Pelican 2008) and appears to be less individualistic than the dominant cultures of North America. This sense of community forms a great strength in caring for community members, and we are highly aware of the unfortunate reality that any shifts toward individualism, even when for the sake of lofty goals such as human rights or critical thinking as promoted in higher education, inevitably deteriorate the collectivist nature of local cultures. We recognize that current discussions of the limitations of individualist notions of human rights, premised on particular assumptions about the individual nature of what it means to be human, can be detrimental to communities and to collectivist notions of good mental health. As both theoretical and practical work continues to evolve globally, other, perhaps more collectivist, ways of understanding human rights in relation to mental health will emerge, which recognize the nuances and tensions of integrating individualist and collectivist values.

While individuals vary in their personal values, the importance of conforming to, and not questioning, social norms is an attitude fairly inherent to the collectivist culture. While this may appear oppressive to an outsider, digging deeper allows one to see the many advantages of this way of being and connecting. At the same time, this pressure to conform can cause great difficulty for individuals, particularly when they cannot, or choose not to, conform, or when shaming is involved. This would include people with physical or psychiatric disabilities who cannot function in ways that are typically seen as ‘proper’.

As we grapple with these issues we are aware that our own culture uses social pressure to place limitations on individual expression as well, though often with different areas of emphasis (for example the pressure to be a ‘productive’ member of society). However, we do encounter values around conformity in our work that are at times in contradiction to our values, such as strict gender expectations. At other times these values are simply unexpected and unfamiliar. One example is the perceived importance of conformity to social norms around dressing appropriately as a sign of being a member of a community (Fokwang, 2012) and of wellness in recovery from mental illness.

Conclusion: Moving into Partnership, and the importance of process

The process of clarifying our values and what they mean in practice has allowed us to consider partnerships in more nuanced ways. We now visualize this theme of negotiating partnership as having two overlapping tracks. For simplicity’s sake, one is the path of ‘quietness’, and the other is the path of ‘finding our voice’ at the appropriate time. These are not mutually exclusive paths; rather they are approaches that can be used within partnership conversations.

The path of quietness is more appropriate in short-term work and in the beginning stages of exploring and developing relationships and partnerships. Students visiting Cameroon for the first time and for a brief period, for example, are encouraged to adopt an attitude of quiet listening. Those working in the short term seem to be able to adapt this stance without too much discomfort. The second track, about finding our authentic voice, applies as we develop longer-term relationships with partners.

As a result of this dual track perspective, we now take the stance that we can come to an agreement with some partners and organizations on projects, even when values are quite different. At the same time, working through this process has helped us to understand more deeply that we do need to recognize the lines that we will not cross to maintain a partnership. We have experienced varying responses to the reality of our values differing from those of partner groups. At times partners have been quietly hesitant to discuss these differences out of respect, while at other times we have felt disrespected or even bullied, in reaction to our stated values. Our experiences deepen and extend with some organizations and people; with others, if we find that we are constantly challenged and our values (or ourselves) are not respected, we can draw back. At other times, discussion has strengthened the partnership and assisted us to move forward. We are learning to have difficult conversations when necessary, and are continuing to learn ways of discussing that show respect and care for all the individuals involved.

The process of partnering and negotiating relationships is ongoing, and inherently valuable. Our journey of exploring these themes with both verbal and written discourse has also been essential, and we feel strongly that it was our *process* of developing ‘Tools for the Journey’ that has deepened our ability to connect our values to our work, in a way that simply adopting or adapting a previously existing document could not. Thus we would encourage others to undergo a similar discussion process rather than adopting or modifying pre-existing materials related to values, ethics, and global mental health. Our own process is constantly evolving as new people, new partners, new resources, new opportunities, and new challenges emerge. Our journey continues.

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Appendix 1: Value and Position Statements

1. Mental health is more than the absence of illness, rather it is a state of well-being.
Our position:

- We support the World Health Organization’s definition of mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (see http://www.who.int/topics/mental_health/en/index.html).
- Mental health intersects with many other factors such as disability, age, gender and access to health care.
- People are not necessarily distinctly mentally healthy or mentally ill, because in reality mental health exists on a continuum between the two. People exist at various points on this continuum at various times, and most people will struggle with mental health related problems at some point in their life, even if these problems are not severe. As such, we have frequently used the term “mental health issues” in this document to encompass both mental illness (a situation where a person’s mental health issues are severe enough to cause disability), as well as less disabling mental health concerns.
- We recognize that mental health problems are often preventable, and that resiliency and coping are important parts of mental health promotion.
- We recognize the inherent value of occupation and of community in developing and maintaining good mental health.

2. Mental health is an important concern for the work of ICDR-Cameroon

Our position:

- We recognize that mental health issues exist and they are affecting people, families and communities. Mental health is a concern for people in the North West Region of Cameroon.
- We recognize that mental health and disability are highly related and inseparable. Mental health issues and mental illnesses can create impairments. People living with mental health issues can be considered to be disabled. Those with physical disabilities are at greater risk for mental health issues and vice versa.
- We recognize that many people presenting with other forms of disability may have mental health needs that are not expressed or met, and our group seeks to change this.

3. Our mental health work involves a vulnerable population and is a delicate area of practice

Our position:

- Those with mental health issues are a particularly vulnerable group, and in the case of those with both physical disabilities and mental health issues, are doubly vulnerable.
- Mental health has an intrinsic relationship to culture, as do ways of healing. As such, our work in mental health is particularly vulnerable to our cultural interpretations and our cultural baggage, which can cause harm to individuals and community. As a

group we will need to recognize, value, explore, and understand culture and cultural beliefs in order to be effective and to prevent harm.

- We recognize that ways of healing and mechanisms of support already exist for people with mental illnesses, and we must strive to not undermine these in our work.
- We recognize that mental health is a very complex area and that our understanding of it will need to be continually revised as we learn more about it.

4. We value a variety of perspectives on mental health and healing

Our position:

- We recognize that a variety of ways of understanding, helping, and healing exist, both within our own Canadian context, within the North West Region, and globally.
- We will recognize the importance of stories and language in our work.
- We recognize that a biomedical framework, while contributing valuable knowledge, is insufficient in explaining mental illness or providing answers to heal individuals and communities struggling with it. Our solutions will need to be more complex, realistic, and holistic. We recognize the complexity and diversity of individual and cultural interpretations of mental illness within the region.
- We will strive to learn all we can from the variety of knowledge that exists and incorporate learning from what has been helpful and harmful in various parts of the world, into our work. We will learn from “Western” Psychiatry in terms of both its discoveries and strengths, but also its mistakes.
- We will foster a culture of acceptance and understanding where others are invited to share their experiences and interpretations.
- We will not pathologize ways of being that are “normal” in the Cameroonian context, and will seek to understand behaviours and interactions that are new to us.
- We will broaden our view of mental health to incorporate resilience and coping.

5. Integration into development work

Our position:

- Since mental health is highly related to disability, and because many people with mental health issues present to other services, including disability services, our group will attempt to integrate mental health into all of our projects.
- The focus of this integrated work will be on resilience, coping, wellness, meaning, and mental health promotion.

6. The importance of human rights and the family and community

Our position:

- We recognize that mental illness and mental health issues exist in a context of family and community.
- We recognize the inherent tension between the community-oriented strengths of Cameroonian culture and a perspective that focuses on individual rights.

- We also recognize the importance of human rights for people with mental illness, and our work will seek to reduce stigma and promote acceptance.
- We recognize that family and community can be great strengths and great sources of support and healing for those with mental health issues and mental illness. We hope to balance these strengths with an ethos of human rights for those with mental illness, while recognizing that some people will never fully have autonomy due to their impairments and disabilities.
- We will support the already-existing strength of integration of people with mental illness into daily life, and will not support strategies that would diminish this resource, such as segregation or institutionalization.
- We will operate within a broad context of human rights while not allowing this approach to limit individual needs/service, and we will provide individual needs/service without forgetting the broader human rights perspective.
- We will not pathologize or categorize in ways that would conflict with human rights, even where this may be more consistent with the dominant local culture.

7. Mental health work will incorporate advocacy and intervention at various levels ranging from the individual to global community

Our position:

- As with all of our work we will seek to meet individual and family needs, bring about healthy change to the community, and work at the policy/government level to promote much needed changes. The spectrum of our framework will extend from working with individuals, families, regions, the country of Cameroon, to the global community.

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