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Gender, caring work, and the embodiment of kufungisisa: Findings from a global health intervention in Shurugwi District, Zimbabwe

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A B S T R A C T

This paper analyses the findings from qualitative interviews conducted as part of a cross-disciplinary pilot study into the efficacy of the Friendship Bench for promoting mental health amongst rural women living in Shurugwi District, Zimbabwe. Informed by UNICEF's nurturing care framework, the pilot study hypothesised that women's caring capabilities would be enhanced if a cost-effective intervention could be found for those suffering from common mental disorders (CMD), locally referred to as *kufungisisa*. Focusing on the women's accounts of their embodiment of *kufungisisa*, the paper further highlights the important role that gender plays in women's experience of common mental health disorders. More critically, it identifies the ways in which patriarchal social relations may be reinforced through the spaces of global health interventions such as the one reported on here. The paper concludes with a moment of self-reflection. Specifically, it poses the question that our paper, and the global health intervention it reports upon, would look very different if the women's experiences of *kufungisisa* were considered not only as they appear in the present but at the intersection of social and spatial relations that have much longer histories.

1. Introduction

In this paper, we focus attention on a global health intervention undertaken in Shurugwi district, Zimbabwe, which is a predominantly rural area situated in the south of the country in Midlands province. The intervention targeted common mental disorders (CMD) such as depression and anxiety whose prevalence amongst women living in the district was identified during previously undertaken survey research and reflects the growing awareness that poor mental health is a significant public health problem in resource poor settings (Patel et al., 1999; Bird et al., 2010). Based upon the model of 'nurturing care' established in the 1990s (UNICEF 1990; Black et al., 2017, 2020), it was hypothesised that improving the women's mental health would be mutually beneficial to the health and nutritional status of their children. As Black et al. (2020) recently outline, although interventions targeted at health and nutrition are essential to improving a child's chances of *survival*, they may not impact on their capacity to *thrive*. With this in mind, the intervention utilised the 'Friendship Bench' model of therapy established by Dixon Chibanda in 2007 (Chibanda et al., 2011). Chibanda developed the Friendship Bench as a low-cost programme of therapy designed to improve the mental health of women living with CMD in Zimbabwe's urban areas, and this appeared an ideal approach to adopt for women living in the country's rural settings given the role that community-based resources are believed to play in tempering the "relationship between local stressors and mental health" (Greif and Dodoo, 2015: 58).

The impact of the intervention on the women's mental wellbeing and by association its potential to support improvements in their capacity to care has been reported upon elsewhere (Fernando, 2021). As geographers and social scientists involved in evaluating what was an interdisciplinary intervention, we wish to engage here in a more wide-ranging discussion of the findings. With this in mind, the paper begins by highlighting the influence of a range of social and spatial relations that coalesce to produce low-lying but impactful levels of mental ill-health amongst the women who participated. As the nurturing care framework recognises, the extreme poverty that these women endure may increase a child's exposure to food insecurity, violence, and more generalized issues of family stress (Black et al., 2017; Britto et al., 2017). As we shall come on to discuss, poverty was a primary factor shaping the women's embodiment of CMD (Patel and Kleinman 2003; Lund et al., 2010) as it is in other contexts where a strong interrelationship exists between the two in socially deprived areas of otherwise wealthy

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countries (Shortt and Rugkåsa 2007; Stafford et al., 2008) and in relation to other mental health conditions such as postnatal depression (Coast et al., 2012).

This leads us to a second contribution of the paper. The intervention we discuss was, like many nutrition interventions, enacted at the household level and as such *within* the spaces where gender-relations are often most powerfully framed (Maxwell and Smith 1992). As Nyantakyi-Frimpong (2021) remarks of their study into child nutrition in northern Ghana, women's engagement in agriculture has a mixed effect on children's nutritional status. On one level, their involvement may ensure a degree of food and nutritional security either through the production of food for consumption or as a way of generating much needed income. This was certainly in evidence in our study, where many women were able to access small areas of land, the 'women's field' or *tseu* in Shona, to grow crops for household consumption. However, patriarchal gender relations play an important role in shaping access to these spaces of household food production and engagement in this labour does not diminish other gender-based norms regarding their domestic responsibilities. As Dodson and colleagues describe, "it is women who bear primary responsibility for buying, cooking and serving food … [and] women who are also commonly producers, preparers and traders of food" and it is women who "come together to create informal safety nets of food-sharing, mutual assistance and credit groups" (Dodson et al., 2012: 4). As we come on to discuss, such "gendered time-use" not only impacts on children's nutritional status as Nyantakyi-Frimpong (2021) describes, but also upon the women's mental health status.

The significance of gender extends beyond the fact that the spaces of our intervention were closely aligned with the spaces within, and through, which such gendered relations are played out. While the intervention design recognised this – for example, a gender consultant was employed to advise the project team, we seek here to respond to Riva and Mah's (2018) contention that geographers should more fully account for the interconnectedness between people, context, and population health interventions. The argument that Riva and Mah make is an important one. As they contest, it is vital to understand the context within which an intervention takes place as this may play a crucial role in determining its success. Here, context is understood to include characteristics that stretch beyond the physical properties of the setting for an intervention such as the social networks and power relations that operate between actors (2018: 355; see also Williams 2018). Significantly, we observe through our analysis of the interviews some of the ways in which social norms relating to patriarchy and women's reproductive and productive roles are reinforced not only through relations of power that operate within the household but within the intervention itself.

While our engagement with Riva and Mah's contention draws from the empirical findings of the paper, our final contribution does not. Rather, we pose a question that is more self-critical in its framing and is prompted, in part, by what we regard as the absent presence in the design of our own research. Specifically, the area where the intervention was implemented, where the women's homesteads were sited, was originally established as a so-called 'native reserve' (see Ranger 1985). These territories were formed as part of a racialised logic which sequestered prime areas of farmland in favour of white British and European interests, squeezed African reproductive and productive life onto lands that were located in the country's worst agroecological zones – Natural Region III is semi-arid, prone to drought, and the soils are predominantly low fertile coarse granitic sands (McGregor 1995a, 1995b), and discouraged African peasant farmers from maintaining livelihoods that undermined the labour demands of the settler economy. In a bid to orchestrate African mobility to suit its labour needs, scholars concur that there was a tacit agreement between racial capital and patriarchal interests. Thus, while the migration of African men was increasingly enforced to provide cheap labour for a booming mining and commercial agriculture economy, the immobility of African women was demanded by 'native' leaders in the interests of the subsistence agricultural economy where they bore primary responsibility for food production and preparation (Alexander 2006). Here, we see the past in the present.

In our conclusion to the paper, we return to Riva and Mah's argument that the evaluation of interventions such as our own must account for the complex interaction between people, the places they inhabit and the programmes that are enacted to promote health and wellbeing. We do so because we suggest that what is missing from their critique and from our own research is a fuller account of the importance of socio-spatial relations that operate according to temporalities that are not usually accommodated in evaluations of population health interventions. Returning to Nyantaki-Frimpong (2021), one way to address this question is to adopt a political ecology of health perspective which would allow for an analysis that explores the ongoing influences of processes that have historical antecedents (see King 2010; Jackson and Neely 2015). For example, the structural adjustments programmes of the 1980s are described by Nyantaki-Frimpong as a "scar" that "continues to linger in Ghana today" (2021: 8). This sense of a lingering, malevolent presence is also apparent in our study. As we note, the areas where the intervention was undertaken has been shaped by processes associated with settler colonial rule and by the reinforcing of patriarchal social relations that continue to shape the women's lives (Alexander 2006; Kesby 1999).

Although this was not something that our participants directly addressed, we suggest in conclusion that adopting a different framework would have allowed us to better capture the ways in which processes operating at varying temporalities as well as across a range of spaces and scales are vital to understanding the women's experiences with CMD. Rather than explicitly drawing on political ecologies of health literatures, here we suggest Nixon's (2011) work on slow violence, and geographical engagement with it, is an appropriate frame to adopt. As Pain and Cahill recently observed, the spatialities of slow violence "are multi-scalar and multi-sited, part and parcel of daily life, social relations, culture and institutions" (2022: 361). They move on to argue that slow violence is something that 'creeps' or 'bleeds' through space, families, communities, land, cities and so on. And they question how we make slow violence visible. We come back to this question in our conclusion because we concede that a framework that only accounts for the appearance and causes of harm in the present unwittingly ignores the "[v]iolences that are made hidden and invisible" (Pain and Cahill, 2022: 362).

2. The Friendship Bench intervention: background, methodology and analytical approach

As noted, the research we report on here was undertaken with a sample of women who were a part of the Sanitation Hygiene Infant Nutrition Efficacy (SHINE) trial between 2012 and 2017 (see Humphrey et al., 2019). SHINE enrolled a cohort of 5280 pregnant women and aimed to determine the effects of improved infant nutrition and/or improved water, sanitation, and hygiene (WASH) on child growth and development. In addition to its evaluation of the impact of these health and nutrition interventions on the children, researchers on SHINE employed a range of indicators to establish the health status of their mothers. This entailed assessing their physical health, including nutritional profiles (34.7% of households met minimum dietary diversity score) and HIV status (16% were HIV positive), as well as undertaking assessments of maternal mental health using a range of internationally recognised as well as locally developed measures: Edinburgh Postnatal Depression Score, WHO Disability Assessment Schedule, Generalized Anxiety Disorder Assessment, and the Shona Symptom Questionnaire (see Tome et al., 2021). The results revealed that just under nine per cent of the women (n = 343/3941) had signs of depression based on both etic and emic measures (see Backe et al., 2021), but no community-based treatment interventions were available to support them.

The need for such services has long been recognised in urban areas of the country where the prevalence of CMD is higher, especially amongst

women (Patel et al., 1999, 2001; Chibanda et al., 2011, 2017). Research since the mid-1990s has sought to better understand people's experience of CMD using "idioms of distress" that reflect socially and culturally meaningful ways of expressing individual and social suffering (Nichter 1981, 2010). In Zimbabwe, symptoms of depression and anxiety are commonly understood, at least amongst the Shona-speaking population, as *kufungisisa* ('thinking too much'), *kusuwisisa* ('deep sadness'), and *moyo unorwadza* ('painful heart') (Chibanda et al., 2011; see also Abas et al., 1994, 2003; Patel 1995a, 1995b). Importantly, these idioms are captured within clinical practice of which the Friendship Bench is one example (Chibanda et al., 2011; Abas et al., 2016). As Chibanda et al. (2011) document, introduced in support of the mental health needs of people affected by *Operation Murambatsvina*, which involved removing informal settlements in *Mbare* suburb, south of Harare in 2005 (Kamete, 2009), the intervention provides a programme of problem-solving therapy via the Friendship Bench. Subsequently scaled up to deliver low-cost therapy across 60 primary care settings in the city, the intervention has since been adopted as a national programme as well as adapted to include additional support provided through *Circle Kubatana Tose* (CKT) groups. Translated from Shona, CKT means 'holding hands together' (Chibanda et al., 2016).

Despite its established efficacy, the Friendship Bench intervention had not been previously trialled in rural settings such as those in Shurugwi district. The women enrolled in this project (n = 30) had all been identified as experiencing depression and lived within the catchment areas of one of 6 rural health centres (Gundura, Makusha, Mazivisa, Tana, Tongogara, and Zvamabande). The health centres were chosen because they were close to the town of Shurugwi (formerly Selukwe), a nearby mining town and administrative centre, were accessible for women who dwell in isolated households where travel is difficult, and because Shurugwi is where the study team has its field base. Of the 30 women enrolled, 27 completed the intervention which was initially undertaken over a six-week period and was supported by trained Village Health Workers (VHWs). The ten VHWs recruited to implement the trial, 8 were females and two males, received five days of residential training and were vital to the success of the intervention because they were known to, and most importantly, trusted by the participants (authors 2021). During the six-week period of the intervention, portable benches, originally intended to be used for the weekly therapy sessions were replaced with handwoven mats made from recycled materials. The mats were regarded as more appropriate for a rural setting and the location for the sessions varied depending on the participant's household context. Peer-led CKT groups were introduced after the third individual session, with the women organised into three clusters with the aim of identifying income-generating activities, including: making mats, bags, hats, cooking sticks and hoe handles for sale; buying and selling vegetables; and raising chickens (authors 2021).

In this paper, we focus on the findings from qualitative interviews conducted with ten women who participated in the intervention. In order to explore a range of experience, women were selected based upon VHW judgements about their participation as well as potential as information-rich cases. The sample size allowed for credible and meaningful insight given other characteristics the women shared (e.g., ethnicity, gender, poverty, rural dwelling) and their collaboration, sometimes together, in the CKT groups. The interviews lasted between 30 and 60 min, were conducted by a Shona-speaking researcher introduced to the participants during weekly therapy sessions, and were recorded, transcribed and translated by them. All translations were cross-checked with another Shona speaker. The primary purpose of the interviews was to engage the women in a discussion of their experiences of CMD, their awareness of the problem within their wider communities, as well as to better understand their response to the Friendship Bench and its associated forms of peer support. The collated materials were subject to a coding process based upon the framework method often employed in multi-disciplinary health-related research (Gale et al., 2013). A coding frame including deductive and inductive codes was established through a repeated process of coding and group review until codes were acceptable and consistent (MacQueen et al., 1998). Findings from the interviews are presented using anonymised case-codes applied to the individual participants rather than pseudonyms (e.g., 70009).

2.1. Thinking too much

In the opening sections of the interviews, the women were encouraged to talk about their understanding of, and experiences with, CMD and most especially *kufungisisa*. The aim of these questions was to better understand how knowledge about the condition, for example, its causes and symptoms, which was imparted by the VHWs during the individual sessions, had been received by the participants. Somewhat unsurprisingly, their somatic and emotional experiences of depression and those they witnessed in other women were related to the conditions of material deprivation that they all faced. As one of the respondents, a woman with two school-age children, described, "[s]ome of the things are cause by lack … lack in general" (70008). As she went on to explain, this not only impacted her ability to farm as she did not have the inputs necessary for cultivation, but it also affected her children because she was unable to pay school fees. Such a lack, she stated, "leave you feeling disturbed". Similarly, another of the women referred to the association between lack of food or money to pay for her children's school fees and "thinking too much" (70018). However, for most women, *kufungisisa*, which as we shall discuss was embodied in a variety of different ways, was rarely seen to result from poverty alone. It was generally described in relational terms; for example, as a response to the inability to partake in transactional relations such as those described (buying food or paying school fees) and most especially as a consequence of their relationships with often absent husbands.

The women's accounts of the poverty/patriarchy nexus and its relationship to their embodiment of CMD often took the form of detailed stories of the circumstances surrounding their illness. In the following account, the participant is describing how the Friendship Bench intervention helped her to better communicate with her husband and resolve problems that were causing her to 'think too much'. As the woman described, "[w]e had problems that were really bad … so bad that whenever I wanted to just 'delete' it, it didn't go away" (70009). It is in her retelling of the intervention's positive impact that the complex interplay between poverty, gendered social relations, and embodied ill-health is revealed. Beginning with the central role that lack of resources play in the often-fraught interactions with her husband, the woman states: "I used to have a problem. Whenever we got money in this household, I would not get along with my husband … whenever we had money we would really fight". Whether the fights involved physical violence is not clear, although other women recounted similar stories illustrating the extent to which domestic violence features in their lives: "[t]hey said she has *kufungisisa* because she was always beaten up by her husband" (70016). In another example, one of the respondents referred to the impact of domestic violence on the mental health of their children: "[h]e will be thinking about what is going on at home for instance if his mother was beaten up, he will be worrying about her. So that causes them to also think too much" (70015).

Despite the imminent threat of domestic violence revealed in these stories, which is a well-acknowledged public health and wider social issue in Shurugwi as in other areas of Zimbabwe (Iman'ishimwe Mukamana et al., 2020), for the woman narrating her story it was not this that was the main focus of her concern. Rather, at the heart of their disputes were gendered norms about the way in which scarce resources were allocated in the household and her associated feelings of disempowerment: as she narrates, "[h]e would ask for his share and I would refuse because there are things I wanted to use it for" (70009). As her account expands, it became apparent that a child born to a previous partner featured heavily in the household disputes, so too the husband's unwillingness to support other family members. Again, it is in recounting the perceived benefits of the Friendship Bench that the

woman reveals the extent to which the interplay of poverty and patriarchy affected her somatic and emotional experiences with *kufungisisa*: as she explains, "[a]ll he does now is ask to know what I want us to do with the money … When I said I would like for us to start poultry farming he agreed for me to keep raising funds and to also avoid me going for gold panning". This woman's greater ability to take part in the decision-making process, which included diversifying her livelihood strategies, appeared to have a significant impact on her sense of self: "I can feel that I am the mother of this house. I feel alive. I used to pinch myself when I no longer felt as though I still existed".

For other women, however, the influence of patriarchal social relations on their experiences of CMD remained a powerful one. In a more typical example, the participant explains how living within a patriarchal system leaves them unable to contribute to their household provisioning. As she described, "[i]f I suggest that I can make mats, he can say 'ah, you are wasting time'". As the participant went on to explain, making mats, which often formed a part of income generation schemes set up through the *Circle Kubatana Tose* (CKT) groups, eased her symptoms of depression because she was able to contribute "meaningfully towards something" (70029). As we shall come on to discuss shortly, the implications of this for their children was also made apparent by the women. In this instance, the participant described her experience of *kufungisisa* as involving her being "too slow" to remember to feed and bath her child. So, although husbands or male partners were often absent from the women's lives, whether temporarily or permanently, it is reasonable to observe that the embodiment of *kufungisisa* generally involved encounters with men. As this participant describes:

> I can be living with my husband here and he could ask me why I was talking to the woman who lives next door, or he could ask why I came late from fetching water from the river, or that when I went to the well I came late, or when you went to town you came late. So, you then end up thinking about it all when alone, that, what is this man trying to say? What does he mean? What can I do for him? What can I say to him? Since he is a man, how can I respond to him? So that doesn't stop … you will be afraid of what he might say. And that leaves you with an unstable mind (70004).

2.2. Embodying Kufungisisa, immobility and the capacity to care

There were many other ways in which the women in our study described their own and others' embodiment of *kufungisisa;* these varied from descriptions of their poor emotional state, such as feelings of sadness or feeling unsettled, somatic sensations for example crying, headaches and tiredness, through to expressions of agitation, irritability, and, in some instances, behaviour more generally associated with severe mental health conditions like hitting oneself. In keeping with other studies in Zimbabwe and elsewhere (see Backe et al., 2021), weight-loss also featured in the women's accounts. As one described: "I always used to look as though I was 86 years old. Even after having eaten a lot of food, I still used to appear as if I don't eat well" (70009). For another participant, experiencing *kufungisisa* meant that they went through the motions of eating but their enjoyment of food and of feeling full disappeared: "I just nibble a bit and will already be full because I will be feeling that I have big 'pimple in my heart' so that would have already made me full" (70022). Such somatic and emotional experiences are well covered in the literature (Backe et al., 2021; Kaiser et al., 2015), here we focus on the interconnection between cognitive dimensions of *kufungisisa* and (im)mobility, care, and caring. Of particular importance are the ways in which the participant's experiences of excessive thinking, worrying, and negative rumination, which have been described in other studies of depression (see Davies et al., 2016; den Hertog et al., 2021), are implicated in disrupting the women's ability to interact with and care for those around them.

That there is a connection appears apparent from the following participant's description of the effects that 'thinking too much' had upon them: "when I get depressed my head starts aching, and I will be feeling hot and even if someone asks me something at a time when I won't, when I will still be thinking deeply, I won't respond" (70004). Other participants witnessed this expression of *kufungisisa* in other women: "if you talk to them, they may not listen to what you will be saying, or they may give a totally different response to what you would have asked them" (70018). What these women appear to describe is a sense of stasis; this was not an expression of absentmindedness or forgetfulness described elsewhere but rather a feeling of unresponsiveness and an inability to engage in everyday forms of social interaction. For some of the women, the strength of this sensation was such that they felt unable to interact at all: "[w]hen I think too much I get palpitations, I feel weak …, all my work falls behind because I will be overwhelmed", as she continues, "I sometimes decide to sleep with the hope of waking up with good thoughts" (70029). Similarly, another participant described sleeping all day when they experienced *kufungisisa*. Such responses appear to push against accepted behavioural norms associated with the moral economy of work; however, these were not the only expressions of immobility that the women described.

In the following account, for example, the participant describes being stuck "in one spot" when they experienced depression and they did not "know what to do or what to start with or when to stop" (70008). The same respondent recognised stasis in other women with depression, although this time in terms of their inability to leave their homes: "that particular person [with depression] may find it difficult and may just keep to herself all day. She may even spend the day alone at home …, which then keeps troubling her". While it is difficult to determine whether the participant was describing their own experiences through this story, this sense of being immobilised by *kufungisisa* was expressed by other women too: "[a]s well as keeping to yourself, staying indoors with the door locked … you won't even concentrate on what's happening" (70022). It is important to recognise the interconnection here between such experiences of emotional stasis and other forms of immobility and the women's capacities to care. As one participant explained, "I never used to care about him in the past" (70015). When asked what she meant, the participant replied, "Ahh, honestly I didn't care because I was thinking too much, yes I knew it was a child, but I didn't care about him". For other women, their experiences of *kufungisisa* deteriorated into violence. As one described, "[w]henever I had something that was troubling me [and my child did something wrong] … I would beat him up so much that I would end up feeling bad" (70022).

Such accounts of violence towards their children were rare and more usual were examples of how *kufungisisa* left the women unable *to* care rather than lacking *in* care. At such moments, children appeared to rely on the support of other families around them. As one of the participants explained, "sometimes they [children of mothers with CMD] end up going round in other people's houses and wait to eat with other children when they are being fed" (70009). As we shall come on to discuss, the inability to provide for children was sometimes framed in terms of a moral imperative such that, despite their shared experiences of mental ill-health, the incapacity to care was associated with personal failure. Indeed, this sense of moral disapproval was apparent in the response provided by the previously mentioned participant: "They just don't care, the children just know where they are supposed to go and sleep at night. That's when they see that the children are back". However, we end this section on a more positive note. As many of the women explained, it was the impact of *kufungisisa* on their children's health that prompted what this same participant described as a "return to sanity" (70009); that is, a movement out of the emotional state they associated with depression. Indeed, as another suggested, the ability to care for their children relied on the capacity to "shift my thoughts from where they are" (70029). How this movement from depression to recovery was achieved, and the role played by the Friendship Bench and the Village Health Workers that implemented it, is the focus of the following section.

2.3. Patriarchal geographies and the moral economy of work

Before turning more directly to the role the Friendship Bench played in women's movement in and out of periods of *kufungisisa*, it is worth reflecting a little further on the importance of gender-based norms to the lives of the women in this study. As Dodson and colleagues (2016: 3) suggest, albeit of gender relations across southern Africa more widely, "everywhere, women have to juggle multiple productive and reproductive roles, balancing the need to earn an income (or grow food) with the need to perform other domestic tasks such as cooking, cleaning and childcare". Similarly, the participants we interviewed referred in some way to the pressure placed upon them by the multiple roles that they are, as women, required to perform, especially as these related to providing for the economic needs of the household and the often-conflicting demands of their children, husbands, and other kin relations. As we suggest in the opening to this paper, it is important to acknowledge that such gender-based norms are not only a reflection of hegemonic cultural values associated with a patriarchal society but also of their adaptation and change to economic and social relations instituted during and since settler colonial rule (Alexander 2006). Indeed, as Kesby (1999) argues, gendered identities have been made and remade since this period and, yet, despite the role they played in the country's Independence, the lives of many women are "fundamentally and unequally" structured by patriarchy. This is especially the case for women living in the communal areas where customary laws and cultural norms continue to hold a powerful sway over women's access to land and resources as well as over domestic duties and responsibilities (Chiweshe et al., 2015).

What concerns us here is the way in which the Friendship Bench intervention negotiated and renegotiated these patriarchal geographies, especially as they played out at the scale of the household and the communal areas. As already mentioned, oftentimes in our research gender relations appeared at the intersection of poverty and patriarchy and the women's embodiment of *kufungisisa* was shaped by encounters with male partners who sought to exert control over decision-making associated with scarce resources; even when absent or when maintaining more than one household. The possibility of female agency in actively reproducing the discourses and practices associated with patriarchy in such a situation is certainly a real one; as Kesby remarked, women's consent and acquiescence "requires constant reproduction" (1999: 29). Our interviews with the women revealed that their movement in and out of periods of mental ill-health might similarly be associated with the reinforcing of gender-based norms. As one of the participants explained, their VHW helped to develop strategies for communicating with her husband: "when my husband comes, I need to welcome him happily because when I was depressed, I never used to greet him … [w]e wouldn't talk to each other in the house" (70022). The participant continued by explaining that she was taught how to greet her husband differently, perhaps 'appropriately', and that, even in situations where he "was rude", she would "still play nice".

Following Kesby (1999), the VHW's role in supporting this participant appears to reinforce patriarchal relations as much as to challenge or disrupt them. This was not the only example and appears unrelated to the gender-identity of the VHWs; in the case cited above, the VHW was female. However, a more common theme that emerged from discussions about the women's interactions with the VHWs related to what we might refer to as the moral economy of work; that labour, which Nyantakyi-Frimpong (2021) refers to as "gendered time-use". Here, it is important to recognise that patriarchy "entails intense lived experiences and everyday relations between men and women" that are often locally contingent and operate across multiple domains (Chiweshe et al., 2015). In the case of work, married women living under customary laws operating in the communal areas of Shurugwi rarely described themselves as having rights to land and access to resources associated with crops that fall within the male sphere, for example maize, cotton, or tobacco. Nor did they generally have rights over cattle production, although they did have engage in other forms of animal husbandry (e.g., ownership of chickens and goats). However, as we note in the introduction, women are often able to negotiate access to small areas of land, the 'woman's field' or *tseu*, which allowed them to grow crops for household consumption and sale. Alongside the sale and use of animals they had ownership of, other 'accepted' forms of income generation included, for example, basket-making and craft work, beer brewing, and harvesting *mopane* worms and other 'wild' foods.

As Mushongah and Scoones (2012) observe, such activities form a vital part of household livelihood strategies, and it was the latter range of activities that were deliberately targeted as a part of the Friendship Bench intervention. It is here that the intervention appeared to intersect with, and perhaps further reinforce, patriarchal social relations operating within the communal areas in Shurugwi. Through their sessions with the VHWs, as well as with other women encountered during the CKT groups, our participants describe being encouraged to undertake individual and collective income-generating activities. Not only was this regarded as a way of managing conflict with their husbands but also as a way for them to diversify their household income. As one of the participants explained, "I was taught not to be lazy but to rely on the work of my hands" (70016). For this participant, who began making door mats from rags following lessons provided by her CKT group, it was not only the skills that she learned that mattered but the self-reliance that it offered. As she continued, "I am happy that I can now do my own handiwork … without involving my husband." Although her husband, like other men, did get involved in her activities, advising that she sell the mats for more than she was selling them for, it was the independence from him that mattered: "If there is anything I want, I know that I have my money and I buy it" (*cf*. Ferguson, 2015: 95). Other participants mentioned the emphasis placed upon the moral imperative to work, as another explained, her VHW similarly discouraged her from "sitting around all day thinking too much" (70015). When prompted to explain how this related to her experiences of *kufungisisa*, she stated:

> What made me open up my mind was that my VHW asked if I felt able to start a business after securing capital because I always used to complain about not having any food … That is when I looked for corn snacks and dried kapenta and gave my children to go and sell at school. Then on that money I was able to pay fees for my child (70015).

The work that the participants describe, which the intervention encouraged them to partake in, reflects the types of social security system imagined for inhabitants of 'native' reserves under settler colonial rule and continued into the present in the form of the informal and distributive economy (Ferguson, 2015). Here, waste products, sometimes in the form of rags but also in the form environmental pollutants such as discarded plastic bags, were transformed into items that were sold or battered and the income generated used to pay for agricultural inputs, food for household consumption, or items for re-sale (e.g., corn snacks or kapenta). The resultant income, albeit a meagre one, offered the women some relief from the grinding poverty and patriarchal relations that they described as being responsible for their experiencing *kufungisisa.* Yet, although such income generating activities were associated with improvements to the women's mental health (authors 2021), there remains a nagging sense that the intervention, at-one-and-the-same-time, acted to reinforce those very same gendered social relations and to perpetuate precarious livelihoods. After all, the livelihoods that were promoted were not sustainable ones and tended to involve activities that were concerned with the kinds of "survivalist improvisation" that Ferguson (2015) outlines. There is a further question here but one that we cannot answer empirically: that is, the extent to which we were witness to a form of slow violence. Afterall, the land that women cultivated are the same ones their forebears were squeezed onto, and these are the same spaces where customary laws and patriarchal authority were invested in to support the labour needs of the settler economy.

3. Discussion and conclusion

As our paper powerfully demonstrates, the women in our study situate their experiences of *kufungisisa* at the intersection of poverty and patriarchy. These are factors that are intimately tied to their lives in the communal areas. Although they are no longer confined to them by restrictions implemented under colonial settler rule and reinforced by complicit local authorities, they remain bound by customary laws and practices which continue to reinforce patriarchy as a system of domination (Chiweshe et al., 2015). Conflict with male partners in households where patriarchal authority retains its grip was often the cause of the women's mental ill-health and resolutions found through the problem-solving therapy implemented under the Friendship Bench programme at times involved acquiescence rather than challenge. The women's capacity to move from episodes where they were 'thinking too much' to those where their minds were 'opened up' more often than not involved work. There was a moral economy at play here, the women described their embodiment of *kunfungisisa* through reference to their immobility as well as to their self-declared 'idleness'. The role of the village health workers and the CKT groups was vital in enabling them to move from one mental state to another, whether this came in the form of exhortations not to be lazy or through the sharing of knowledge and skills that supported them in generating income. Here too, the women's recouperation remained constrained by patriarchal norms and rarely did their endeavours stray into established male domains.

While reflective of the responses provided by the women during their in-depth interviews with the research team the above also provides insight into the importance of exploring the interconnections between context, people, and population health interventions. Here especially the potential for gender relations to be played out not only between the women, their male partners and other family members but also between the women and the village health workers who were responsible for delivering the intervention. As we note, the messages received by some of the women, especially as they related to their productive roles within the homesteads, normalised patriarchal gender relations rather than offered the women ways to mitigate them. Such an observation supports the call made by Riva and Mah (2018) to take better account of context in studies like ours; however, the final point in our conclusion seeks to extend their critique. Specifically, we refer to Nixon's conceptualisation of the aftermath, which he utilises in his consideration of the often inequitable and uneven pathological effects that present themselves long after the occurrence of environmentally toxic events. In many regards, the term signifies a sense of immediacy, referring as it does to the period following a significant and usually destructive or harmful event. Yet, for Nixon, aftermath also has a much longer timeframe. Discussing the clash in temporal perspectives between indigenous resource activists and mineral extractors, he notes, for example, the difference between "short termers" who "extract, despoil, and depart" and "long termers" who "*live inside the ecological aftermath*" (2011: 17. Emphasis added).

Shurugwi's landscape has undoubtedly been shaped by the short termers that Nixon describes, as it has long been home to formal and informal gold, chrome, and platinum mining operations that in some instances may render the environment a toxic one to inhabit (Nharingo et al., 2015; Chatiza et al., 2015). Indeed, many of the women we spoke with were directly engaged in informal mining and many others reported that members of their dispersed households were eking out a living in this way. However, when we stepped back from our interpretation of the women's accounts, we began to question whether we might be bearing witness to some of the "gradual injuries" that communities present with when they are "exposed to slow violence" (Davies 2019: 411; Pain and Cahill 2022). Put differently, we questioned whether the women's accounts of their experiences with *kufungisisa* reflected those of Nixon's 'long termers' who, in this case, were living amidst the toxicity of a settler colonial aftermath. Afterall, for the women involved in our research, the land they inhabit, with its poor and infertile soils, unreliable rainfall patterns, and vulnerability in the face of climate change (Brown et al., 2012), is a fact of life born out of zoning strategies originally implemented by the country's settler colonial government (Berlant 2007; McGregor 1995b). It is important we stress here that we are not seeking to overlay the women's accounts of their mental ill-health with our own interpretive framework. Rather, we use this observation to pose a question. Specifically, what would our intervention have looked like if we situated the women's experiences of *kufungisisa* not at the intersection of social and spatial relations that operate within a household as it appears in the present but within a context whose origins are traceable to forces unleashed over tens, maybe hundreds of years previously? Conceptualising the problems of the present through such an historical lens would, we conclude, lead to a very different kind of intervention altogether.

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Data availability

Data will be made available on request.

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