You Cannot Just Simplify: Context, Culture, and Creativity in the SUCCEED Africa Training

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What the SUCCEED Africa training adaptation process taught us about what it really takes to build rigorous, responsive training for good quality mental health interventions across diverse contexts.

There is a temptation, when designing training for community health workers in low-resource settings, to equate rigour with simplicity. Strip it back, the thinking goes. Use plain language. Keep it short. Make it easy to deliver. There is nothing wrong with any of those instincts, as far as they go. The trouble is that they do not go far enough. What the SUCCEED Africa training adaptation process showed us is that real rigour is not achieved by reducing a programme to its thinnest transferable form; it happens through doing the hard work of understanding each context deeply enough to translate.

SUCCEED Africa is a multi-country, community-based rehabilitation study for people living with psychosis, operating across Nigeria, Zimbabwe, Malawi, and Sierra Leone. The training programme prepares peer support workers, community support workers, and supervisors to deliver a complex, community-based recovery-oriented intervention in contexts marked by significant resource constraints, linguistic diversity, and the very specific challenges that come with working in communities where mental health stigma and psychosis are felt in radically different ways.

Here is what it took to build training that could hold all of that, and still be taught in three weeks, assessed with a validated tool, and reliable enough to produce skilled, confident, supported providers.

Starting from the pilot findings

Any serious training development process begins with evidence, and in this case the evidence came from the pilot phase itself. Facilitators across all four countries documented what worked and what did not. Process evaluation findings were collated. Participants were asked. The picture was consistent enough to be striking and varied enough to demand country-level responses.

Role play was, without exception, the most powerful facilitation method, and participants across all four countries asked for more of it. They wanted to practise, to make mistakes in a supported environment, to hear how a conversation might go before they had to have it for real with someone in genuine distress. This is not surprising to anyone who has trained as a nurse (see previous blog). But as four independent country teams confirmed the same thing with equal strength of feeling, that deserved to be acted on. And it was: we increased the number of role plays, made sessions more interactive throughout, and restructured the training schedule to reduce cognitive overload. We also provided field orientation as a transition phase between training and working.

Other pilot findings were more uncomfortable. In Sierra Leone, case vignettes caused genuine emotional distress because they were too close to participants' own experiences. In Zimbabwe, some of the training delivered in English instead of Shona was substantially less effective – a finding that sounds obvious in retrospect. In Malawi, terminology that seemed settled beforehand became contested in the training room, with peer researchers and clinicians holding different views about how conditions and people should be named. Each of these findings pointed to the same conclusion: the training still needed to evolve.

What context means in practice

The word contextualisation is used so freely in global health that it risks becoming meaningless. In the SUCCEED adaptation process, it meant something quite specific, and quite demanding.

It meant translating all training materials into vernacular languages before delivery. And it meant country teams leading the review of case vignettes, rather than the UK coordinating centre. It also meant running a terminology-setting exercise at the beginning of the second module, because experience showed that if teams did not actively negotiate shared language at the start, disagreements would come up later in more disruptive ways. What counted as a

plausible example or a recognisable story was different in Lagos and Blantyre and Freetown and Harare. This kind of contextualisation requires a particular approach from the training designer: you have to willingly accept not being the expert in the room.

Lived experience should be structurally embedded

The part of the SUCCEED training adaptation process that was most consistently generative was the involvement of people with lived experience of psychosis. And that involvement required careful attention to ethics and support structures.

One of the strongest elements of the pilot across multiple countries was identified to be peer researchers curating the learning content and co-facilitating training sessions. In Sierra Leone, people with lived experience sharing their stories were described as creating an atmosphere of trust that clinical facilitation could never replicate. In Zimbabwe, candidates willing to share from a hope perspective changed the tone of training in ways that participants reflected on explicitly. The message from the pilot was unambiguous: lived experience involvement was central to its effectiveness.

But the pilot also produced a harder finding. One participant with lived experience of psychosis had a relapse during training and required admission. This was a reminder that peer support workers are not simply a delivery resource, but people with their own ongoing relationship to the experiences the training is discussing, and that relationship has to be actively supported.

There is a lesson here for anyone designing mental health training more broadly. Co-production with people with lived experience is not only an equity measure, but also a quality measure: it made the training more effective. But that happens only if the structures that support peer facilitators are given the same attention as the curriculum itself.

Creativity as a quality indicator

Creativity in the design of mental health training for me means the intellectual work of finding the right form for complex content in a given setting. Take shared decision-making, which has a substantial clinical and theoretical literature. Rendering it legible and useful to a community support worker with no prior clinical training, who will be applying it in a home visit in a peri-urban neighbourhood in Malawi, is genuinely creative work. It requires you (and your team) to really understand the concept before you can translate it. Good training materials are the ones where someone thinks hard beyond the content of what to teach – and thinks about how the learning would actually happen, how it would feel to receive it, and what the learner would need to do with it the following week.

The development of the graduated fieldwork schedule is a good example here. The pilot found consistently that two weeks of classroom-based training was not enough to produce confident, competent providers. But more classroom time was not the answer, instead we restructured the entire learning journey: classroom and role play in Week 1, graduated field practice with pilot PSW and CSW mentors in Weeks 2 and 3, supervised independent practice with assessment in Week 4. Through this competence in relational, community-based work was built through supported practice. Of course, the training environment has a responsibility to approximate the conditions of real delivery as best as it can.

Rigour and responsiveness can work together

Tthe SUCCEED training adaptation process demonstrated vividly that fidelity and contextualisation are not opposing forces to be managed as a trade-off. The SUCCEED approach was to maintain the core structure and competency-based assessment framework, while insisting that how the training was experienced at each site was the responsibility of the country team, supported by a collaborative adaptation process. What changed between pilot and trial was how the training felt – more interactive and contextually alive, better supported emotionally, and more honest about the demands that community-based psychosis support places on the people who deliver it.

That is, in the end, what rigorous training for good quality mental health interventions needs to be. Beyond technical correctness and efficient, smooth delivery, it needs to be genuinely adequate to the complexity of the work, and to the humanity of the people doing it.

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