City Research Online

City, University of London Institutional Repository

Reflections on doing training for the World Health Organization's mental health gap action program intervention guide (mhGAP-IG)

China Mills[a] and Kimberly Lacroix[b]

[a]Health Services Research and Management, City, University of London, London, UK; [b]Bapu Trust for Research on Mind and Discourse, Pune, India

ABSTRACT

The World Health Organization's (WHO) mhGAP-Intervention Guide (mhGAP-IG), is a tool designed for non-specialists to detect, diagnose and manage common mental disorders. In this paper we specifically focus on how the mhGAP-IG is understood and used in the training of non-specialists – as part of a task-sharing strategy key to scaling up mental health in LMICs. Specifically, this paper is interested in how mhGAP training enacts pedagogic modes of address that invite, enact and circulate particular ways of knowing and doing mental health. Despite being highly scripted, we cannot know from the mhGAP training manuals how training actually takes place in practice, or about whether local contextual epistemologies of distress are able to interrupt or resist universal tools. This is important because while the IG and its training may be designed for expansion and global use, this doesn't tell us much about how they are actually used, enacted, appropriated, or resisted around the world. The research detailed here draws upon interviews with people involved in designing the mhGAP-IG and/or delivering training, and focuses on moments when training takes off or diverts from the script. The data detailed here shows instances when people's own philosophies of life and understandings of distress shape the training they deliver. Instead of assuming that universal tools such as mhGAP enact top-down medicalization, we attend to the complex practices engendered by mhGAP and the nuances of local adaptation.

Introduction

In 2010, the World Health Organization (WHO), as part of their Mental Health Gap Action Program (mhGAP), developed guidelines to standardize interventions to close the 'treatment gap' between need for mental health interventions and availability of specialist care especially in low and middle-income countries (LMICs). The mhGAP-Intervention Guide

(mhGAP-IG) is the result of this – described by the WHO as "a simple tool to help detect, diagnose and manage the most common mental, neuro- logical, and substance [MNS] use disorders" (WHO, 2011, p. 2), focusing on eight priority conditions, "identified on the basis of high mortality and morbidity, high economic costs, or association with violation of human rights" (WHO, 2009, p. 2). The mhGAP-IG is seen as the "principal clinical tool being used as part of the scaling up strategy of the mhGAP program in countries" (Dua et al., 2011, p. 9), which aims to inform 'task-sharing' within global mental health through providing an evidence-base for "supporting non-specialized health-care providers to redistribute clinical tasks previously reserved for mental health specialists" (WHO, 2017a, p. 75). The mhGAP-IG is designed to be used globally, with some suggest- ing that it "should become the standard approach for all countries and health sectors" (Patel et al., 2011, p. 1442). To date, it has been "used in over 80 countries and translated into more than 20 languages" (Keynejad, Dua, Barbui, & Thornicroft, 2017, p. 1).

Training of trainers, supervisors, and healthcare providers in how to imple- ment mhGAP-IG is conceived as key to the tool's global expansion, and in 2017, the WHO launched two new mhGAP training manuals – Training of Trainers and Supervisors (ToTS), and Training of Health-care Providers (ToHP) (WHO, 2017a; see also WHO, 2017b). The mhGAP training resources (including session outlines, activities, learning outcomes, and assessments) aim for uniformity and standardization, and while generally scripted and formulaic, are assumed to be adaptable to local context, and are consistent with a cultural model of pedagogical practices used widely in global health (Maes, 2017).

Global standardization through scripted training could be read as a form of widespread medicalization. Yet while training manuals detail how train- ing should take place, they do not illuminate how people conceive of and make sense of training, nor how training actually takes place in practice. Despite compelling arguments for the role of ethnographic research in glo- bal mental health (Jain & Orr, 2016), there is little detailed ethnographic evidence about how the mhGAP-IG training manuals are actually used in practice around the world, and particularly how they are perceived by those who use them (Mendenhall et al., 2014), or by those who are diagnosed through them. This paper seeks to address this gap in the literature by focusing on how mhGAP-IG is talked about and practiced, exploring how mhGAP-IG training operates pedagogically to invite, "enact and circulate" particular ways of knowing and doing mental health (Fullager, Rich, & Francombe-Webb, 2017, p. 1–2).

This paper focuses on how mhGAP-IG training is talked about and prac- ticed in different contexts, through interviews with people involved in designing the mhGAP-IG and/or delivering training, and on one of the

author's reflections on being involved in mhGAP-IG training in India. Thematic analysis of the data shows tensions between standardization and local adaptation, but also evidences creative adaptations of the guidelines linked to people's own philosophies, and societal understandings, of mental health. Next, we outline our methodological approach, followed by a the- matic analysis of interview data, ethnographic reflections, and discussion.

Method

This paper presents a thematic analysis of interview data with those who designed and/or use mhGAP-IG. It combines a practice-based approach with a narrative approach – focusing here on narratives about and reflec- tions on practice. The paper is part of a larger study documenting the 'social life' of mhGAP-IG, with a focus on the alignments and contrasts in how it is *done* in multiple sites by different actors. The focus of our research is on both the *doing* (Mol, 2002) of mhGAP-IG – how it is *done*, what it *does* and the ways the mhGAP-IG *does* mental health (for example, as universal and as 'illness') (Mills & Hilberg, 2019); and on how the prac- tice of mhGAP-IG is narrated by different actors.

The research is guided by an analytic approach which understands clin- ical guidelines and medical tools, such as mhGAP-IG, as culturally consti- tuted objects, whose conditions of production and 'social uses and consequences' deserve analytical attention, and thus traces the 'social life' of medical objects – their biographies as they circulate through different contexts and as they are ascribed meaning (Whyte, van der Geest, & Hardon, 2003, p. 3). The development of guidelines, such as mhGAP-IG, signifies a politics of standardization in practice' (Timmermans & Berg, 2004, p. 21), where guidelines act as "coordinating devices" which structure and sequence practice (p. 77), and configure people and things. Here guide- lines can be understood as emergent practices, and as "central mediators in the construction and reproduction of novel worlds" (Timmermans & Berg, 2003, p. 22), and of global configurations of mental health.

Specifically, this paper focuses on how mhGAP-IG is understood and used in the training of non-specialists. In total, 17 semi-structured inter- views were carried out: with 7 (out of 21 members) members of the ori- ginal mhGAP-IG Guideline Development Group; and 10 interviews with individuals who have experience implementing and delivering training of mhGAP-IG in LMICs, more specifically in India and across West Africa. The interviews lasted between 30–90 min and were conducted by the two authors, covering a range of topics reflecting on how mhGAP-IG is 'done' in practice.

Ethnographic literature on medical practices argues an important distinc- tion between actually 'doing' practices and talking about doing practices. Yet while "interviews about practices and their underlying knowledge are not the practices themselves", they can be key to practice-oriented research for eliciting "implicit structures of meaning" (Bueger, 2014, np). Yet the more implicit elements of practice can be difficult for interviewees to express in that they may have become normalized, invisible, or are carried out with little conscious awareness (Trowler, 2013). To provide more depth to the research, the interview data was supplemented by observational reflections from one of the authors on her previous work as a research offi- cer in an implementation project framed by mhGAP objectives and guide- lines in India. The use of interviews and observation is consistent with our analytic approach because "a practice approach lends itself to the use of hybrid methods" (Trowler, 2014, p. 25). This is not meant to imply that there is some truth which could be better accessed by observing mhGAP- IG in practice but instead to be clear that talking about doing something is different from doing it, while at the same time narratives are themselves social practices that are emergent products of negotiation (De Fina & Georgakopoulou, 2008, p. 379).

The interview data was analyzed using thematic analysis – a diverse set of "theoretically flexible" approaches providing "robust, systematic frame- work[s] for coding qualitative data" through identifying themes (patterns of meaning) across a dataset (Braun & Clarke, 2014, p. 1–2). The thematic analysis was informed by Braun and Clarke's (2014) reflexive six-stage pro- cess. The data was coded twice (by hand and using software) to enable deep familiarization with the data (key to thematic analysis) and to enable attention to both frequency but also to uniqueness. Identification of themes was an "active process of pattern formation and identification", in contrast to the assumption that findings exist in the data, waiting to be discovered through analysis (Clarke, Braun, Terry, & Hayfield, 2019, p. 18). This means that researcher interpretation and subjectivity were "integral to the process of analysis" (Clarke et al., 2019, p. 6), which is a "decision-making process" (Elliott, 2018, p. 2850), and not a source of bias to be minimized as might be the case in more positivist research (Braun & Clarke, 2013). To deepen critical reflection and achieve complexity and depth of engage- ment with the data (Clarke et al., 2019), early findings were discussed at two workshops with invited global mental health specialists.

The research has ethical clearance from University of Sheffield (UK), and Sangath, Goa (India). Those who implement global tools may experience differential power dynamics than those who design them, therefore all interviewees cited here have been anonymised. We have named the coun- tries or regions in which interviewees work but have left out some specific

details which compromise anonymity. We recognize that this is problematic as it overlooks the specifics of local contexts – something that global tools and guidelines themselves could be critiqued for doing.

In this paper we focus on the overarching theme of 'Training', which emerged from inductive thematic analysis (as participants were not expli- citly asked about training). Seven sub-themes were identified, and will now be detailed, with illustrative quotes, in turn.

Analysis

Tensions between global standardization and local adaptation

Tensions between the standardization required to make global guidelines, and the kinds of adaptation needed for local practice, are evident through- out the data. A key feature of adapting tools to local contexts is that train- ers can choose modules depending on local relevance and context. The ToTS manual states: "When adapting the ToTS training to local context, care should be taken to avoid adding or removing slides, eliminating activ- ities or interactive components, or removing the opportunities for partici- pants to practise these skills" (WHO, 2017a, p. 6). There is a growing literature documenting the development of country-specific versions of mhGAP-IG, where the guidelines are seen as a "generic template that requires adaptation and contextualization to suit the particular needs of the health system in a given country" (Abdulmalik et al., 2013, p. 1). Here local context is acknowledged as a matter of translation and having a choice between predetermined training components. Local context is conceived of here as differing organization of health systems, availability of resources and different models of training.

One psychiatrist and trainer working in West Africa explained the "nitty gritty" of adaptation as involving a 2–5 days workshop with key stakehold- ers (sometimes including people with lived experience) to explore how peo- ple understand key mental health concepts, what drugs are locally available, what skills non-specialists have and who can prescribe drugs, and to learn about country-specific laws. A psychiatrist and trainer working in India detailed a different understanding – explaining that the mhGAP-IG imagines mental disorders as universal and "context neutral", where "psychiatric diagnosis is a mechanical process, it's like arithmetic … if you have criteria then you fit this or that using a checklist. It's about mental computations, not context". When asked about their extensive experience in cultural adaptation of the mhGAP- IG the same trainer explained: "let us say in British context you will say, er, John is very sad, in an Indian con- text you will say Ram is very sad. And that's all that is". This trainer high- lighted that design for universality meant that cultural adaptation is

minimal – involving only "some tweaking". This places the emphasis on the design of mhGAP-IG and not on the contexts in which it is adapted, suggesting that the design for global use (and its embedded practice of standardization) can have limitations that only become visible in local contexts.

Tensions between design and use

There were notable differences in understandings between those who designed mhGAP-IG and those who implement it – who "didn't have the power to shape it but who use it" (as one interviewee stated). Some of those who designed mhGAP-IG saw the Guideline's strength being to influ- ence political will and to guide training, not as

> a diagnostic tool or an intervention – it's a set of clinical guidelines but doesn't tell you how to communicate diagnosis. Complexity cannot be captured in a 100 page guideline. But its often thought of as a commandment to 'follow the algorithm'.

Yet some of the mhGAP-IG trainers we interviewed felt that its main function was as a tool to recommend relevant drugs. According to one trainer in India, the mhGAP-IG "is a good tool from a pharmaceutical and a psychiatric perspective but its not suited for primary care" because it has been "designed with psychiatrists in mind". This is interesting because the mhGAP-IG was actually explicitly designed for use by non-specialists in primary care settings (WHO, 2016). This emphasizes that mhGAP-IG is imagined and used differently by different professional groups, in different contexts, and by those who have different kinds of involvement in its design and use.

Lack of, low quality of, and eurocentric nature of, training

Lack of, low quality of, and Eurocentric nature of, training in LMICs was mentioned in a number of interviews. One trainer in India, reflecting on their own training, explained that:

> Earlier I was - I mean - I had no clue that there is a tension between global and local. Because my training … as a psychiatrist … was pretty much in a global, er … milieu, and my practice of psychiatry and mental services were also in global milieu …

It was from using mhGAP, that this trainer realized that "the service providers as individuals are rooted in their own culture, and users are rooted in their own culture. So my training will be only of limited utility". Another person involved in the implementation of mhGAP-IG in a number of African countries, stressed the need for a "proper evidence-base for training, that isn't just regurgitation of European training and that is not hospital based". Here 'global' mental health as put forward by international

organizations such as the WHO, seems to contrast with, and potentially limit engagement with, local contexts and cultural practices.

Local contexts were also talked about in relation to lack of resources. One trainer emphasized that there's "no point in training nurses if they don't have resources", including what they felt to be lack of availability of essential medicines in some LMICs. Here training and scarce local resour- ces are imagined to intersect in different ways in different contexts, espe- cially around availability or lack of access to medications. Psychosocial interventions were assumed to be more complex in part because they were thought to involve more training, potentially leading to using mhGAP-IG as more of a prescribing tool. Commenting on the shift in mhGAP-IG 2.0 to include more psychosocial interventions, one of the Guideline Development Group members commented that while "prescribing is easy and straightforward", especially with availability of essential medicines in many places, delivery of psychosocial interventions is much "complex because it requires time, training, expertise, supervision". It was felt that this risks "medicalising social problems" because it can be

> difficult to differentiate between a depressive episode or normal reaction to adversities, and therefore could be a risk of emphasising the use of medicines for situation that would require social, psychosocial approach.

Standalone training was also questioned by trainers. One trainer of doc- tors in India noted that "the knowledge can be improved, er, but their practice was pretty much the same". Here knowledge and practice are seen as distinct, and the success of training is assumed to lie in changes in prac- tice and behavior.

Time constraints

Time constraints of delivering training, across various African countries, meant "making it simple" raising the "classic point of how much do you sacrifice quality in the name of task sharing"? One of the trainers working in West Africa explained that mostly there's not enough time to cover all the priority conditions in one training, so prioritization becomes important, with a discussion beforehand about which conditions to teach – these usu- ally being epilepsy, depression, and schizophrenia. The same trainer pointed out that we "always say we'll get to the other conditions later but usually don't". Psychological interventions are usually added into subse- quent training, if any is provided. Similarly, training in basic skills, such as empathy (discussed in mhGAP-IG's General Principles of Care, WHO, 2016), which were seen by the same trainer as above to be "poor in busy African clinics", were not seen as important and "skipped over even by local trainers who just get straight onto the drugs". The interviewee

reflected that, "this might be because trainers don't always have these skills themselves". It was felt that mhGAP-IG 2.0 developed in response to this   by emphasizing more strongly the essential nature of basic skills, such as empathy. One trainer in India, working in a context where doctors in pri- mary care have approximately one minute per patient, ascribed time con- straints as key to resistance to training from doctors.

Resistance

Resistance to mhGAP training seems to link to local and national context (including, doctors allotted time with patients, and amount of training in other areas of health that doctors are expected to undergo); as well as resistance to task-sharing through attempts to preserve professional juris- diction. For example, a trainer working in India, explained that the WHO training resources assume that those being trained "are curious but people   are not, they don't care", and in fact "doctors hate training":

> when I used to go for this training, people used to get very very angry. They used to say that, why have you come for the training and we don't need this training.

The trainer ascribed this dislike of training partly to doctors' "not caring" about mental health, and also as an issue with the design of mhGAP-IG (which was felt to be designed from a predominantly psychiatric perspec- tive). In this context, the trainer felt that "training just doesn't work", illus- trating how local and national context shape reasons for resistance to mhGAP-IG. While task-sharing is central to the mhGAP project, one trainer reflected that it was not approved of by many psychiatrists working   in West Africa, who didn't like nurses carrying out tasks when they thought "only a psychiatrist can do".

Language and translation

One participant spoke about the ways in which a service program using mhGAP-IG in India, developed regional scripts to address the distance between global mechanisms of intervention and regional perceptions of distress:

> to make people understand why psychosocial interventions for depression [were needed] we have to figment a phrase 'boli ka ilaz aur goli ka ilaz' (*treatment of talking and treatment of pills*) because for them treatment meant pills so ya … we had to adjust with their understanding […] because to them psychosocial interventions one does not receive it from an expert or a mental health professional it can be done within the community within the family.

Another interviewee directly involved in data collection within low income communities in India shared their experience on using translated

global tools, emphaising the need for further re-scripting into regional languages,

> we would communicate it in the local language … because if we were to use that language we were sure we would not get the response that we want to the question.

Others emphasized concerns that translation may not always be possible:

> with respect to translation I personally feel at many places we found that some words are really not translatable and some people some word don't exist in the use of people that we are working with … I don't know how to fix this.

Another participant shared that in their experience there is a need to not 'adjust' language to local understanding but to break it down further to simplify language and play with existing structures,

> When you say it as it is … as is written then it feels very formal, the person in front of you who is answering it, he is very … he thinks that you are interrogating him or he become very conscious. […] And the questions that are there, they are blunt, so the person in front also becomes a little guarded.

This highlights that within local contexts the need for adjustments and break down of technical or 'formal' language is also part of the practice of adaptation of global tools.

Creative shifts in training practices

In some instances, resistance to training, and local contextual barriers, shaped the ways mhGAP-IG training was practised, leading to creative shifts in how training was delivered. For example, in response to the lack of time and anger of doctors, one of the trainers working in India devel- oped their own approach to training:

> the way I used to approach this was that I - I never started from mhGAP, I never started training on mhGAP videos, or what is mhGAP and what is depression, and what's the prevalence and all that. I used to start my training, er, making it very very personal. I used to say that you are shouting at me, so … let's talk about your anger, forget depression. Let's talk about your anger. Let's talk about your mental health. And then we used to talk about their own mental health, and from then they used to get, er, very aggressive with it, and then I used to introduce the concept of depression, … what mhGAP says and what drugs should be used, and so on and so forth.

This shows that trainers appreciated that "the way you deliver the training" (trainer in India) is contingent, shifting, driven by the immediate setting within which the trainer and the training participants are situated, and not necessarily pre-determined by the training manual.

As interviewees explained, the training resources do not provide the whole story about what training looks like in practice, and neither of course does the interview data detailed here. Therefore, we now turn to

some ethnographic observations from one of the authors involved in mhGAP training in India.

Observations of mhGAP training

This section is written in first person by one of our authors.

I was part of a local implementation research team set up to assist in the measurement and recording of a program designed to integrate mental health within primary health care in one district in central India. One of the tasks I was involved in was to collect, calculate, organise and analyse the results of the pre and post-tests completed by general physicians who had been trained in mhGAP BASE course and STANDARD modules on Depression[1], Alcohol Use Disorder[2] and Psychosis[3]. The tests consisted of cross-country questionnaires that assessed knowledge and attitudes of doctors and other non-specialists trained on priority mental disorders in India. As I began to look through the data, I began to wonder about the trainings themselves, such as who had facilitated them, and what methods were used? I was informed that while the project team had organised and made all the logistical arrangements for the training, a local psychiatrist who was part of the District Mental Health Program in that district delivered the training. When asked about training methods I was directed to a folder which consisted of WHO mhGAP IG training aids, including power point presentations that provided a step-by-step guide on what was to be delivered to the trainees. Instructions on what to focus on and how to deliver the content were placed as notes the end of each slide, and research data, videos, exercises were included.

I noticed, as I interacted with the psychiatrist who conducted the trainings and the doctors who were trained by him (and who now performed the role of diagnosing and prescribing psychotropic medicines at the primary care centres), that even though the doctors were trained in diagnosis they were reluctant to make a note of it in the documents which recorded patient interactions. For the programme this highlighted the need for supervision of the doctors, but this also pointed to the need to go back to the training that the doctors had received.

As I began to enquire further about the process of training I was informed that each of the training presentations were too long and that the doctors would lose many days if the modules were to be covered in their entirety. To accommodate the doctors' schedules, all 4 presentations were shortened and delivered in just 2 days. When I looked at the results of the test sheets completed by the doctors before and after the training, the results indicated that knowledge about mental disorders as medical conditions increased. However, social attitudes towards persons with psycho- social disabilities, especially those presenting with psychosis, appeared to be more stigmatised following training than pre-training (as rated on items in the World Psychiatric Association's (WPA) stigma toolkit attitude and social distance towards persons with psychosis). Having received training about the condition, its prognosis and care, doctors' post-test results reflected an increase in ratings on items reflecting unfavourable attitudes towards persons with the condition than their earlier ratings on the same items just prior to the training. Why did the post test results reflect such a change in attitudes? Was it a problem with the content of the training? Was the problem in the training technique that was employed? Was it about the trainees themselves – the doctors who were reported by the research and implementation

team to not be interested in the training but who participated on account of an official mandate by the state department? Or was it about the way each of these were brought together under the rubric of training: an unwilling audience, a disinterested trainer, and content that was *pre-scripted*? The script assumes that the expert trainer is already self-aware about their own social attitudes towards persons with psychosocial disabilities and thus would successfully transfer those to their trainees.

Discussion and conclusion

This paper provides a unique perspective on mhGAP-IG by drawing upon data from interviews and participant observation. Through thematic ana- lysis, seven themes were identified, showing: tensions between global stand-ardization and local adaptation; some differences in understanding between those who designed mhGAP-IG and those who implement it; reflections on the lack of, low quality of, and Eurocentric nature of, training; the issue of time constraints in delivering training and using mhGAP-IG in practice; resistance to training (mainly linked to time constraints, and professional resistance to task-sharing); issues around translation; and creative adapta- tion of training.

Standardization in training and clinical decision-making is central to the WHO's global expansion of mhGAP-IG and shapes the kinds of local adap-tations that can take place in relation to mhGAP-IG training. Similar to the work of Timmermans and Berg (2003, 2004), our research shows that standardization and global expansion are messy processes, where varied actors are shaped by but also shape the scripted resources they are asked to follow; and that standardization is nuanced, emergent, and varies in differ- ent contexts. The interviewees expressed differing understandings of the adaptability of mhGAP-IG to suit local contexts. While one spoke of exten-sive adaptation with local stakeholders, another trainer found adaptation to be limited by the mhGAP-IG's design and its inbuilt assumptions that mental health is universal (assumptions not held by all those interviewed). This places the emphasis on the design of mhGAP-IG and not on the con- texts in which it is adapted, suggesting that the design for global use (and its embedded practice of standardization) can have limitations that only become visible in local contexts. Our data also shows that understandings of mhGAP-IG at times differ between those who designed mhGAP-IG and those who implement it. For example, one trainer felt the main strength of the guidelines, in contexts where resources (and especially time) are short, is as a diagnostic and prescribing tool, in contrast to one of the creators of mhGAP-IG who saw this as a "misuse". Another trainer saw mhGAP-IG as designed from a psychiatric perspective, in contrast to the stated intentions of developing the guidelines to be used by non-specialists in primary care.

Our data show that mhGAP-IG, like other clinical guidelines (Timmermans & Berg, 2003, 2004), plays an educational and pedagogical role. For example, the translation of mhGAP-IG in India was not only lin- guistic but also involved shifting and 'adjusting' local understandings of what constitutes 'treatment' to include psychosocial interventions delivered by a professional. This is consistent with Maes (2017) research into training models within Africa's AIDS industry, where well-intentioned programs provide narrow training in "technical forms of care" and interpersonal skills that risk reorienting localized forms of care to more clinical concep- tions (p. 76–77) and that overlook "the political economies that shape the global health industry" (p. 72). The limitations of pre-scripted and stand- alone training is discussed in the interviews with mhGAP-IG trainers, and in the observational data, where there were concerns that knowledge can be changed without impacting practice, and knowledge may not always impact our social attitudes and behavior. This is consistent with wider lit- erature on training, which suggests training alone does not always change practice (Salmon & Young, 2017; Timmermans & Berg, 2003, 2004).

While the mhGAP training manuals are highly scripted, this doesn't necessarily translate into how mhGAP training is actually delivered in diverse contexts. Salmon and Young (2017) show that training in clinical communication often assumes that clinicians "just need to learn skills" (p. 261) through pre-scripted materials, rather than starting with clinician and patient realities in the contexts of different illness experiences. This they argue calls for the need to also pay attention to "practice-based evidence" – which takes as its starting point local realities, possibilities and understandings of care (Salmon & Young, 2017, p. 263). Our data shows examples of trainers generating and engaging in 'practice-based evidence', where those delivering the training have mixed feelings about the mhGAP resources, meaning they sometimes go 'off-script' to creatively reimagine training (where for one trainer this meant de-centring mhGAP-IG and instead engaging briefly with doctors through sharing experiences). Training is shaped not only by those who design resources but also by the assumptions and life experiences of the trainers, by conditions governing the deployment of training in local spaces and by the social milieu within which trainer and trainees are located.

This paper show that how mhGAP training *does* mental health is closely tied to how mhGAP is *done* by those who enact it (from using it in per- haps unintended ways, to 'tweaking' it to local context). Differences between saying and doing are a limitation of this research, signaling the need for further ethnographic research into how mhGAP-IG is done in practice, and the ways it is enacted, appropriated, or resisted around the world.

Notes

1. Depression Attitudes Questionnaire (Botega et al. 1992).
2. Attitudes (Selected from the Marcus Alcoholism questionnaire).
3. World Psychiatric Association's Stigma Toolkit which assess attitudes and social distance towards people with psychosis.

References

Abdulmalik, J., Kola, L., Fadahunsi, W., Adebayo, K., Yasamy, M. T., Musa, E., & Gureje, O. (2013). Country contextualization of the mental health gap action programme intervention guide: A case study from Nigeria. *PLoS Medicine*, *10*(8), e1001501. doi:10.1371/journal.pmed.1001501.

Botega, N., Mann, A., Blizard, R., & Wilkinson, G. (1992). General practitioners and depression—First use of the Depression Attitude Questionnaire. *International Journal of Methods in Psychiatric Research*, *2*, 169–180.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London, UK: Sage.

Braun, V., & Clarke, V. (2014). What can ''thematic analysis'' offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-Being*, *9*(1), 26152.

Bueger, C. (2014). Pathways to practice: Praxiography and international politics. *European Political Science Review*, *6*(3), 383–406. doi:10.1017/S1755773913000167.

Clarke, V., Braun, V., Terry, G., & Hayfield, N. (2019). Thematic analysis. In P. Liamputtong (Ed.), *Handbook of research methods in health and social sciences*, (pp. 843–860). Singapore: Springer.

De Fina, A., & Georgakopoulou, A. (2008). Analysing narratives as practices. *Qualitative Research*, *8*(3), 379–387.

Dua, T., Barbui, C., Clark, N., Fleischmann, A., Poznyak, V., van Ommeren, M., … Saxena, S. (2011). Evidence-based guidelines for mental, neurological, and substance use disorders in low- and middle-income countries: Summary of WHO recommendations. *PLoS Medicine*, *8*(11), e1001122. doi:10.1371/journal.pmed.1001122.

Elliott, V. (2018). Thinking about the coding process in qualitative data analysis. *The Qualitative Report*, *23*(11), 2850–2861.

Fullager, S., Rich, E., & Francombe-Webb, J. (2017). New kinds of (ab)normal?: Public pedagogies, affect, and youth mental health in the digital age. *Social Sciences*, *6*(9), 1–12.

Jain, S., & Orr, D. M. (2016). Ethnographic perspectives on global mental health. *Transcultural Psychiatry*, *53*(6), 685–695.

Keynejad, R. C., Dua, T., Barbui, C., & Thornicroft, G. (2017). WHO mental health gap action programme (mhGAP) intervention guide: A systematic review of evidence from low and middle-income countries. *Evidence Based Mental Health Online Health*, *21*, 30–34. doi:10.1136/eb-2017-102750.

Maes, K. (2017). *The lives of community health workers: Local labour and global health in urban Ethiopia*. London and New York: Routledge.

Mendenhall, E., De Silva, M. J., Hanlon, C., Petersen, I., Shidhaye, R., Jordans, M., … Lund, C. (2014). Acceptability and feasibility of using non-specialist health workers to deliver mental health care: Stakeholder perceptions from the PRIME district sites in Ethiopia, India, Nepal, South Africa, and Uganda. *Social Science & Medicine*, *118*, 33–42. doi:10.1016/j.socscimed.2014.07.057.

Mills, C., & Hilberg, E. (2019). 'Built for expansion': the 'social life' of the WHO's mental health GAP Intervention Guide. *Sociology of Health and Illness*, *41*(S1), 162–175.

Mol, A. (2002). *The body multiple: Ontology in medical practice*. Durham, NC: Duke University Press.

Patel, V., Collins, P. Y., Copeland, J., Kakuma, R., Katontoka, S., Lamichhane, J., … Skeen, S. (2011). The movement for global mental health. *British Journal of Psychiatry*, *198*(2), 88–90. doi:10.1192/bjp.bp.109.074518.

Salmon, P., & Young, B. (2017). A new paradigm for clinical communication: Critical review of literature in cancer care. *Medical Education*, *51*(3), 258–268. doi:10.1111/medu. 13204.

Timmermans, S., & Berg, M. (2003). The practice of medical technology. *Sociology of Health & Illness*, *25*(3), 97–114. doi:10.1111/1467-9566.00342.

Timmermans, S., & Berg, M. (2004). *The gold standard: The challenge of evidence-based medicine and standardization in health care*. Philadelphia, PA: Temple University Press.

Trowler, P. R. (2014). Practice-focused ethnographies of higher education: Method/ological corollaries of a social practice perspective. *European Journal of Higher Education*, *4*(1), 18–29. doi:10.1080/21568235.2013.833485.

WHO (2009). *Mental health gap action programme (mhGAP) guidelines for interventions on mental, neurological and substance use disorders*. WHO mhGAP Guideline Process. WHO. http://www.who.int/mental_health/mhgap/evidence/mhgap_guideline_process_ 2009.pdf

WHO. (2011). *mhGAP Newsletter*. January 2011. https://www.who.int/mental_health/ mhGAP_newsletter_jan2011.pdf?ua=1.

WHO. (2016). *mhGAP intervention guide – version 2.0*. WHO. http://www.who.int/mental_ health/mhgap/mhGAP_intervention_guide_02/en/.

WHO. (2017a). *mhGAP training manuals*. WHO. http://apps.who.int/iris/bitstream/10665/ 259161/1/WHO-MSD-MER-17.6-eng.pdf.

WHO. (2017b). *mhGAP Forum 2017 – summary report*. WHO. http://www.who.int/men-tal_health/mhgap/mhGAP_forum_report_2017.pdf.

Whyte, S., van der Geest, S., & Hardon, A. (2003). *Social lives of medicines*. Cambridge, MA; New York, NY: Cambridge University Press.