

Knowing the right to mental health: The social organization of research for global health governance

Sonya L. Jakubec* & Janet M. Rankin**

Citation: Jakubec, S.L. & Rankin, J.M. (2014). Knowing the right to mental health: The social organization of research for global health governance. *Journal of Health Diplomacy*, Vol. 1, Issue 2.

Editor: Rachel Irwin, Stockholm International Peace Research Institute

Guest Editors: Ronald Labonté, University of Ottawa; Arne Ruckert, University of Ottawa

Managing Editor: Mark Pearcey, Carleton University

Manuscript Type: Research Article – Peer Reviewed

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*Associate Professor, School of Nursing & Midwifery, Mount Royal University, Calgary, AB, Canada. Email sjakubec@mtroyal.ca.

**Assistant Professor, Faculty of Nursing, University of Calgary, Calgary, AB, Canada.

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SONYA L. JAKUBEC & JANET M. RANKIN

Abstract

This institutional ethnography (IE) explores the right to health in the international mental health field, and a subfield concerned with equitable access to treatment in developing countries and for marginalized people elsewhere. Indicators of mental health and development and the “scaling up” of corresponding treatment and services goals have been at the forefront in this field that is known discursively as “Global Mental Health” (GMH). Those advocating for the rights of mentally ill people from diverse locations have been struggling to produce indicators and evidence that can both account for their experiences in practice, while demonstrating accountability within the rules of global health governance. A specific mental health advocacy organization was a site of institutional ethnographic exploration for this study. Our main objective in this research was to explore how it is that advocates, researchers and policy-makers in mental health engage with the right to health as a feature of contemporary global health governance discourse.

Attending to human rights concerns is important for those advocating for mental health (and other health issues) at broad grassroots and international levels. The Framework Convention on Global Health (FCGH) is a key document intended to support advocates to “scale up” access to treatment. With documents such as the FCGH there is a concomitant rise of new public management and accountability strategies to ensure “aid effectiveness” (Eyben, 2010). These strategies increasingly shape how we know mental health rights and how this work can be undertaken in the name of health diplomacy. Aid and resourcing of local services depends upon workers’ knowledgeable communication of these notions of accountability and related deliverables. A knowledge and consciousness of the “order building” (Ilcan, 2006) is an alternative to new and better theorizing of global health diplomacy. What happens at the intersection of accounts of health rights, mental health and development practice that legitimize some notions of rights while obscuring others? Uncovering the practice of this diplomacy through critical institutional ethnographic approaches is a timely critique that points the direction to alternatives to increasingly objectified theories infiltrating global health diplomacy.

Introduction

Social justice and health rights language carry a number of competing interests (Braveman, 2010). It is a language currency that is increasingly present in mental health (Maingay et al., 2002) and health and development work more broadly (Funk et al., 2010; Gable, 2007; Benatar et al., 2010). This paper provides an analysis of how knowing the right to mental health and development, within a global health diplomacy discourse, disrupts *actual* mental health and diplomacy. We use an institutional ethnographic method of inquiry to build a critique of the modes of nominalization, objectification and theorizing (as discussed by Stefan Ecks, China Mills, and others as a discursive “GMH”) in global mental health that currently dominates contemporary global health governance. This analysis of the mechanics of building knowledge about global issues of mental health shows how health diplomacy is being socially organized and coordinated in ways that are helpful as well as harmful for health rights and development goals.

Through institutional ethnographic examination of research survey forms used to determine whether/how the lives of people affected by mental illness are changed and improved within an advocacy initiative we uncovered two distinct ways of knowing about the right to mental health. We show how global health governance concerns for measurable results in poverty reduction infiltrated the ‘evidence’ about mental health that could be produced. Knowledge was transformed from a detailed and particular understanding about individuals’ and community’s’ rights to mental health focused on livelihood and inclusion, to a concern about household income. Household income – a nominalized mode of knowing important in accounting for global health governance – supplanted the knowledge about what was actually happening. We provide insight into these issues through a description of a mental health NGO’s experience of moving knowledge into “evidence” for global health governance.

Background

To understand the theoretical challenges in global health diplomacy for mental health, one must understand how a socially organized “Global Mental Health” (GMH) conversation contributes to the current keen discursive interest in the organization of global health diplomacy (Labonté & Gagnon, 2010), and various international relations and necessary political skills (Kickbush, 2011; Kickbush & Kokeny, 2013). The interests specific to mental health are no exception, with a current swell of discussion of global reforms for mental health infrastructure such as care frameworks (Thornicroft & Tansella, 2013; Omar, et al., 2010), treatment packages (Benegal, et al., 2009; Patel et al., 2009), skill packages with implementation rules (Belkin, et al., 2011), and the uses of performance measures (Belkin, et al., 2011; Chan et al., 2010; Chisholm et al, 2004; Marais et al., 2011). Perhaps the most important aspect of contemporary GMH discourse, and the focus of this paper, is the focus within GMH on what should count as “evidence” (Chan et al., 2010; Awenva et al., 2010; Marais et al., 2011; Mirzoev et al., 2012) for decisions about resourcing. In this paper we uncover dilemmas that arose during the making and remaking of a Canadian funded research project in Ghana, West Africa, and how alternatives to the dominant theorizing of GMH emerged.

The Contextual Landscape: Scaling Up Global Mental Health

Global Mental Health (GMH) is currently used in conversations related to global governance as a conceptual way of understanding mental health within current processes for world health and development. GMH is featured prominently in the global health diplomacy discourse and is tied into practices of the globalization of Western psychiatry or other practices of “transcultural psychiatry.” Critical examination of the troubles that are generated in knowing mental health across sites have been addressed in the lead author’s previous work (Jakubec, 2002; Jakubec & Campbell, 2004; Jakubec, 2005) and the work of others (Jain & Jadhav, 2008; Jain & Jadhav, 2009; Read & Doku, 2012). This prior work problematizes the transferability of psychiatric mental health practices across geography. We extend that critique here. Our critique of GMH as a feature of global health diplomacy presupposes a critical evaluation of the globalization of psychiatry and western psychological ideology and practices. We discuss these ideas here, albeit briefly, in order to establish a ground upon which to see how the right to mental health is coordinated broadly inside taken-for-granted assumptions about GMH.

To understand GMH as a context for current global health governance necessitates an understanding of the interest in “Dollars, DALYs and Decisions” (Chisholm, Saxena & van Ommeren, 2006, 7) that arose in the early 1990s as part of the mounting concern about the global burden of diseases. Disability Adjusted Life Years (DALYs) emerged as an epidemiological tool that enabled a way to measure years of lost productivity. DALYs were considered an improvement to prior measures that focused on mortality from disease. DALYs, as a way of knowing the burden of disease, were pioneered by World Bank economists. They remain a dominant technology of global health diplomacy and health decision making for reform (Mills, 2014). Capacity to measure DALYs enabled recognition of mental health problems as a significant feature of global morbidity. They expanded the focus on infectious diseases and other causes of death in low and middle-income countries and provided an important vehicle through which to include issues of mental illness. However, this shift in focus also resulted in the GMH agenda becoming driven by calculations of how much mental illness costs the national and international (capitalist) economy, and how much money can be saved by investing in effective drugs and competent personnel – the core economic interests in the global mental health system (Chisholm et al., 2006). It is from this biomedical-psychopharmacology and economic theoretical base that GMH and global health governance for mental health is being “scaled up” (Chisholm et al., 2007; Chisholm et al., 2007b).

The emphasis by GMH advocates on *human rights* and *international conventions* (Maingay et al., 2002; Patel et al., 2011; Mannan et al., 2013) is a more recent insertion to the agenda and rhetoric surrounding mental health. It is a strategy that is attempting to mirror the seemingly successful movements for disability inclusion and HIV/AIDS treatment (Tarantola, 2000; Maingay et al., 2002; Gable, 2007). Despite the weaknesses and non-binding nature of international conventions approaches (Haffeld et al., 2010), the successes of the HIV/AIDS human rights movement in attracting significant funding has been a model experiment that those interested in advancing GMH could not ignore (Ecks, 2013; Mills, 2014).

Financial resources are crucial to scaling up GMH (Chisholm et al., 2007b). Financing strategic “packages” of treatment (Patel et al., 2009; Benegal et al., 2009) have result in specifically mapped training and services delivery options. They inform ‘pyramids of care’ and “rule” based implementation strategies (Belkin et al., 2011, 1497). These approaches dominate the direction that most GMH projects take (Mills, 2014). Broadly, leaders in GMH envision the achievement of “scaled up” services through newly trained community health workers, and also through improving research and administrative capacity (Marais et al., 2011) of community projects. Specific to this research site in Ghana, West Africa the Mental Health and Poverty Project (MHaPP) emphasized that lack of evidence was one of many barriers to the implementation of policy and practice for mental health (Avenva et al., 2010). Subsequently, several key areas of research have been identified “to inform the development of targeted and effective interventions in mental health care in Ghana” (Read & Doku, 2012, 29), including aggressive poverty reduction and development approaches (Lund et al., 2011).

Current GMH theorizing and existing models of building mental health services all but ignore the fact that there already *is* knowledge and successful practices of mental health in the areas becoming ‘upscaled’ (Ecks, 2013). However this knowledge is not captured in the targeted highly coordinated and increasingly standardized practices nested within ‘good’ global health governance. Local knowledge and everyday practices that respond to issues of mental illness are not informed by the authorized and ‘scientized’ practices of knowledge that arise in health services research and epidemiological data. Thus, questions of livelihood – what people do day-to-day are eclipsed. Current approaches to meeting the needs of people with mental illness are coordinated by assessments of how much an individual patient can afford to pay out of pocket for medications (Ecks, 2005; Ecks & Basu, 2009). Treatment standards are derived from research conducted by the pharmaceutical industry. In turn the issues that dominate publications; and “human rights” discourse get caught up in the “right to access” particular services and treatments through rapid diagnoses (Patel et al., 2009). Once accessed, treatment is assessed within standardized evidence informed pathways (Belkin et al., 2011).

The Research Landscape: Good Evidence and Good Governance of Global Research with MNGO
The research presented here describes a particular situation of scaling up a mental health project in Ghana. The project, [referred to as the *Access to Treatment Project*], funded with Canadian dollars, was administered by an NGO office in India. We refer to that organization as MNGO and use pseudonyms throughout this exploration as a way of foregrounding the generalizable social relations that were the focus of our study, rather than particular individual or group experiences. Our analysis is an exemplar of how that social organization for global health governance actually happens. It is an empirical tracing of how ‘good evidence’ and knowledge of global mental health is produced for purposes of global health governance. The paper produces a detailed analysis of the texts and coordinative documents that accompanied the Canada-funded initiative that linked into and coordinated the actual work being conducted in India and Ghana. In this way the analysis remains “grounded” in the practices of people in MNGO; the researchers and community workers whose usual daily practice produced a form of “knowing” that was

different, and frequently contradictory to the worked up and “written up” (Darville,1995, 254) version that was generated by the Access to Treatment Project.

Research Approach and Design: Institutional Ethnography

The claims we make in this paper are based in institutional ethnography (IE), a sociological approach to inquiry and analysis developed by Dorothy Smith. IE research is conducted with a particular standpoint serving as the ethnographic lens. People’s knowledge about their own lives is the starting place. From there the researcher directs inquiry out into institutional arenas where this embodied knowledge is shaped. Experiential accounts of MNGOs advocates establish the standpoint for this study.

Smith (1999) proposes that texts produce and enforce a “local order of accountability” (p. 88). They can be investigated for how they are activated by, and connect, individual readers across time and space, engaging them into a system of power relations created and reinforced by the texts, themselves (Smith, 1999). The field observations reported here, of people, their work, and the texts that mediate that work, were conducted with an international mental health and development organization (MNGO) in India and West Africa. In-depth interviews were conducted with local community researchers and advocates, including ‘official’ researchers (mainly social scientists and participatory development workers), policy-makers and program managers, as well as representatives from official donors and other nongovernmental organizations. The lead author also conducted participant observation of MNGO research activities, meetings and conferences at MNGO and Canadian government development centers and agencies. Concurrently, and most relevant to the data presented in this paper, extensive textual analysis of literature (peer reviewed and grey literature) as well as specific research reports and policy documents was conducted. The study received ethical approval from the research ethics board at the University of Calgary.

The theoretical framework of IE was the only theoretical tool used in the field. This framework is informed by what Smith (2005) refers to as the “ontological shift” (p.35) that requires researchers to pay close attention to what people are doing, explicitly avoiding theoretical explanations for what is happening. Thus no established GMH theoretical framework such as ‘cross-cultural psychiatry’ (i.e. Kirmayer, 2010) or ‘poverty reduction’ (i.e. Bloom & Canning, 2003) was employed prior to entering the field. Work with the data was not directed towards proving or disproving a theoretical idea. Rather, from the situated experiences of actual people who engage in this advocacy-oriented research as an activity, people’s work (all their purposeful activity) was examined empirically to map, track and ultimately describe how it intersects with the work of other people and how it was textually mediated within forms, reports and documents. *Relationship* is what this analysis is about; the material, physical things that coordinate the relationships between local sites of work and sites of GMH governance. We focused the inquiry on how the ‘right to mental health’ discourse works.

An institutional ethnographer aims to explicate how people’s actions are socially organized and put together. Ethnographic data provide clues to connections between everyday life and its social organization. The analytic work of an institutional ethnographer is to follow

these clues outwards to their source to show the relations of ruling, domination and coordination at work. The explication reported on in this paper draws out the missing elements of people's stories, observational data, and brings these hidden aspects of global health governance organization into the analysis. Specifically we examined: 1) practical experiences of mental health knowledge development in a time of global health governance; 2) epistemological constraints in the field and the tools and technologies of managing global mental health research (accountability systems in contemporary research for development); 3) the question and consequences of context and use of global guidelines in specific settings; and 4) how research enters intertextual circles and goes to work to reify dominant Global Mental Health (Mills, 2014) and development knowledge.

In this study, the IE method of inquiry provided a way to capture an account of MNGOs approach to supporting people impacted with mental illness prior to the partnership with the Canadian funder (The Bureau) and the opportunity to formulate an analytic description of how the partnership with The Bureau reorganized the people in MNGO, hooking them much more firmly into the ruling relations of GMO and seriously undermining their capacity to do their innovative work. This is the ironic twist – the governed and coordinated financial resources MNGO secured to support and promote their advocacy strategies ultimately undermined those very strategies.

Findings and Discussion

The Research Landscape in the Field: Coordinating Knowledge of the Right to Mental Health

MNGO researchers are local health workers with a myriad of training backgrounds who conduct participatory data collection by way of community consultations to advocate for local services. Like the work of many local organizations providing service, their advocacy work uses the experiences and first-hand accounts of people with mental illness and their caregivers. MNGOs model of community consultation is highly effective. MNGOs vision when they partnered with the Bureau was to advance and disseminate the successes of their unique approach. The goal was to generate resources for MNGO to build upon its own research program and to more clearly articulate its research findings. MNGO benefitted from advice from a consultant at The Bureau whilst developing the proposal. Writing the proposal included many drafts that were shared back and forth between the director of research at MNGO in India and The Bureau advisor. Direction was given about how to frame the research in order to secure the funding. It was during this process that an interest in household income was introduced into the project. The proposal was awarded funding and the *Access to Treatment Study* was created. Prior to the monies being released MNGO was required to hire an economist whose expertise was used to develop the survey we analyze in this paper.

Although the people who were managing MNGO and its research programme were aware that certain compromises would be made within the partnership with the Canadian funders and the subsequent *Access to Treatment Project* that emerged, the director of the research branch at MNGO understood that those compromises would be a “small price” to pay for the learning, research products and the overall gain to MNGO and the communities they worked with.

However, our research tracks how the interests of global health governance intersected with the interests of MNGO in significantly contradictory ways. It illuminates a disjuncture¹ between the intentions (and activities) of MNGO's advocacy work, and the Canadian research that was conducted in Ghana, wherein authorized forms of knowledge were being built textually, using survey strategies. In short, our textual analysis shows how the "right to mental health" became "governed" (for GMH results) and how local work became mediated (in troubling ways) by the ruling practices of global health governance.

The transition of MNGO from a grassroots mental health advocacy group into an agent of GMH was accomplished through a series of consultations that consistently re-worked the original proposal in line with the dominant discourse mediated by 'dollars and DALYs'. The findings, to follow, explore a point of this very intersection; of MNGO's knowledge of the right to mental health with official GMH and global health governance practices.

MNGO before The Bureau

MNGO's mental health advocacy work was built around a grass-roots initiative that involved an extensive "community consultation". The first observation of MNGO's work was in Ghana when the lead author had a chance meeting with a group of MNGO workers. The lead author was teaching in Ghana and a MNGO team of community researchers were staying in the same guesthouse. It was here when she learned about how MNGO's mental health program was built around a process of gathering community members together for 1 to 3 days. The MNGO community researchers partnered with people in the community to facilitate discussions. The process aimed to be completely egalitarian and participatory. People in the community divided into groups – those people who experienced mental illness; their caregivers; any health-care workers who were involved in their care and also other members of the community such as community leaders, teachers, moneylenders and so forth. These groups met separately to discuss experiences and priorities as they related to mental illness. As the community consultation process proceeded, the groups joined together and facilitators supported a process for the numerous stories to be shared among all the members of the community. Documents were generated known as "story boxes" and "life stories". These were developed to capture the varied experiences of mental illness. Strategies for change, resources and direction were spawned within this participatory approach.

One of the critically important initiatives embedded in MNGO's community consultations was what MNGO workers referred to as "livelihoods". For MNGO, "livelihood" is "not about earning a living, but having the means to have a life" (MNGO Research Director, personal communication, September 2005). One description of "livelihood" in MNGO's Ghana Research Program report, captured *before* the implementation of the Access to Treatment study, relied on a field worker's description of what happened for one family following an MNGO community consultation day:

¹ Disjuncture is the trouble of knowing reality in conflicting forms - from a ruling, versus an experiential perspective (Campbell & Gregor, 2002, 48)

One carer in [a remote northern village] said her pito² business collapsed because people stopped patronizing it. However, after the consultation meeting she managed to brew a small quantity and people patronized it. She says she believes the consultation meeting alone positively influenced people's thinking about mentally ill people and that accounted for her gaining back her customers. Brewing pito to sell is the only livelihood she survives on. (MNGO Report, Ghana, 2005)

Story boxes, life story accounts, detailed descriptions of participants' environments and experiences were important documents for communicating MNGO's form of knowledge and knowledge making.

MNGO after The Bureau: How the survey worked

The Bureau funded research revolved around a survey called *The survey for the Access to Treatment*. The survey was designed to ensure that MNGO fieldworkers and volunteers could easily conduct it and was designed to be administered in tandem with MNGO's practices of community consultation and participatory data analysis. The funded study proceeded with an MNGO worker recruiting "households" into the study. The worker would then complete the survey. The survey was developed in English and required the services of a translator in order to generate the responses. It was the MNGO worker's job to enter the data into the survey's pre-established categories. Despite the fact that the "routine" work of MNGO was expected to proceed 'as usual', the prior practices were changed. The skill level and training that was necessary to administer the survey meant that the participatory inclusion of all members of the community (especially those people who had experienced mental illness) could no longer be included as equal contributors to the consultations. As well the "participatory" features of the "process documents" that MNGO customarily generated were overridden by the "rigorous" research requirements of the survey methods.

The survey

The survey itself fundamentally changed the conversations advocates could have with people in the community. The title, "Socio-Economic Study in Ghana" (MNGO Research Report, 2008, 53) at the top of the survey reveals a clue into where the survey originated and what it would accomplish. The survey produced the authorized connection between the questionnaire (developed and administered by MNGO) and The Bureau. As well, the formulation of the survey as a "socio-economic" study (with no mention of mental health) lodges the questionnaire to the ruling concepts of "rights" or access to treatment³, as they are understood to be both indicators of, and that arise out of economics. The required economic analysis insisted upon by the Project Manager, under the direction of the economic consultant, is firmly embedded in the survey questionnaire and thus firmly embedded into the work of the advocates.

² Pito is a cereal-based fermented beverage that is sold in small market stalls in Ghana

³ The narrow formulation of treatment that relies exclusively on a biomedical understanding of the needs of people who experience mental illness.

The questionnaire has 2 sections. "Section A" includes questions for caregivers (demographics, age, sex, marital status of mentally ill person), as well as household economic conditions such as identification of major income earner, income and changes over the six month period prior to the survey, household assets, food shortages and reasons. "Section B" directs questions to the mentally ill person that record diagnosis, treatment type, duration and costs as well as economic and productive activity, income, income change, credit and uses of credit.

The text was designed so that a member of MNGO's research associates or voluntary research staff could conduct the survey. It is a MNGO worker, who fills out the survey form and who selects from the predetermined categories available. The survey, however, separates the MNGO worker from analysis. In part, because the categories do not provide insight into people's lives – their stories and contextual experiences, and in part because the survey is in English, requiring translation. Although the survey data was being collected through processes of recruitment and engagement that were similar to MNGOs established way of inviting families to participate, the sort of family participation that used to happen were also cut off as the categories in the survey determined the interview format, lifting attention from the usual community consultation strategies of building rapport and keenly listening for assessment/analysis that would spark the kind of data for story boxes and life stories that, prior to the Canadian funding were the mainstay of MNGO's approach.

In the survey text, equitable access to treatment is understood through individual and family economic resources as related to diagnosis and treatment. As well, the survey focused on location, "approximate distance from your house to place of treatment," and costs, "how much have you paid for treatment services within the past 6 months". It thus secures individual productivity and income to "access to treatment". It also fastens economic logic to knowledge about 'resources' and to the dominant rationality that diagnosis and treatment enable income and acquisition of assets. These survey practices reinforce the Ghanaian Poverty Reduction Strategy Paper (PRSP) approach to health equity and strategy for health reform, which builds a policy framework to ensure that those who *can* purchase health care *should*, while those determined to be most vulnerable and poor should have standardized low-cost treatment and services provided through social assistance.

The MNGO workers, using the survey to document the diagnosis, treatment, productivity, income, assets and credit available for their respondents, obtain a reading of this data informed by the discursive dominance of the PRSP in which a patient's right to mental health is constructed as "equitable access to treatment" through officially sanctioned poverty reduction strategies⁴. The survey form does not simply record this information; the categories of the survey and related instructions to researchers construct its meaning.

⁴ PRSPs provide the operational basis for International Monetary Fund and World Bank lending and for debt relief. A PRSP describes the macroeconomic, structural and social policies and programs that a country will pursue over several years to promote broad-based growth and reduce poverty, as well as external financing needs and the associated sources of financing (IMF, 2008).

Here we are showing the ‘mechanics’ of knowledge we referred to in our introduction – only when the concept of “equitable access”, as developed in PRSPs is in place can the survey (and the survey findings) make sense, and, inside these dominant ideas that socially organize mental health, a particular construction of ‘the right to mental health’ is enforced.

The process of developing the survey and its iterative drafts and re-design overtook MNGO’s original research plans, to study their own participatory research processes, into a Bureau required shift to measure *equitable access to treatment*. The equity measure established by surveying individual and family resources as they related to diagnosis and treatment of mental illness became a ‘useful and reliable’ measure upon which decisions could be made. The particular resources that were being measured were highly structured; for example, the question that asked about the location of the household: “approximate distance from your house to place of treatment?” and the one focused on the expense of treatments “how much have you paid for treatment services within the past 6 months?” When the survey data was aggregated it revealed how many people in each region could afford to purchase treatment and who had physical access to professional mental health services.

Thus, the work of MNGO surveyors collecting these data was to document the diagnosis, treatment, productivity, income, assets and credit available for their respondents. This was directly counter to MNGO’s community consultation work which found that mentally ill people’s priorities are often *not* related to “access to treatment” and, more often than not, linked into a wide and varied range of needs; different for each community. Nonetheless, formulated this way, the survey results generated an objectified ‘reality’ that was independent of, and displaced the particular perspectives of MNGO’s community consultation process.

Translocal Influence: Producing knowledge of access to treatment as evidence for good governance

The survey questionnaire is the key text that activated the practices of MNGO’s workers and brought MNGO’s practices in line with the regulatory functions of The Bureau. The “mechanics” of knowledge development built into the proposal and funding arrangements were broadly *operationalized* through the survey questionnaire. The survey, ostensibly developed to learn about what was going on in Ghana, actually *produced goings on*. Careful analysis of the survey questionnaire accomplishes a tracing of textual clues that stabilize the survey questionnaire within the discourses from which it originated and that organized what could happen in Ghana (and more broadly across the globe). This happens within what institutional ethnographers call an “intertextual circle” (Smith, 2006, 185). Smith’s (2001) argument on texts as a feature of social organization that “feed[s] into the construction of an objectified ‘reality’ that is independent of and displaces particular perspectives” (176) is instructive here. The text of the Access to Treatment survey questionnaire is produced so as to be “a proper instance or expression of its regulatory categories and concepts” (Smith, 2006, 85). Our textual analysis provides a way to discover the organization of the social relations in the setting in which The Bureau-MNGO’s “Equitable Access to Treatment” study was enacted.

The survey text in use

Analysis of the Access to Treatment survey constructs knowledge about particular categories of “diagnosis” and “treatment” needs, as well as “treatment costs” in relation to “household income”, “assets”, and “loans” (The Bureau/MNGO, 2008). Why these categories of analysis? Determining who has “access” to treatment, by way of purchasing a treatment, is important in the global view of access. Also important to decision makers is knowledge about what is happening in the global economy and global markets that is used to determine where other “investments” into health services may be required. It is a commodification of mental illness and creates a new terrain for economic expansion. The mentally ill person’s distance from place of treatment, the costs of treatment and people’s ability to pay for treatment are all categories in the “Equitable Access to Treatment” survey that provide valuable information for global health governance focused on economic growth.

The survey categories “diagnosis”, “treatment costs”, “household income”, “assets”, and “loans” are also the textual practices that link “Equitable Access to Treatment” into the complex of global health governance frameworks: 1) WHO tools (WHO, Human Rights, Health and Poverty Reduction Strategies, 2005); 2) World Bank Guidelines (O’Donnell, van Doorslaer, Wagstaff & Lindelow’s Analyzing Health Equity using Household Survey Data, 2008); and 3) the Poverty Reduction Strategies agreed upon by each country receiving aid and loans. Viewed within this nested set of organizational policies and texts the survey can be seen as a document that draws upon a collection of other documents that are circulating broadly – the national and international strategies of policy development and multi-lateral organizations to which they are linked. Particular kinds of research results enable decision makers to justify subsidy practices, to decide who can and should pay for treatment and what minimal state provisions can be provided en route to addressing the right to mental health. This circularity entrenches the compelling GMH rationality that we are explicating. It builds and secures a particular form of logical rationality that, broadly seeded, becomes the taken-for-granted framework through which the ‘right to mental health’ can be known about.

Translocal Mobilization of Access to Treatment Knowledge

Reports were written as the *Access to Treatment* study was analyzed. As with the rigid survey design, knowledge that was important to MNGO was subordinated to The Bureau’s required reporting formula. According to the MNGO Research Director, in the official report, she was required to make “disaggregated data available in the economic analysis”. This was not as relevant to the MNGO research director who described how she wanted to use the disaggregated data (the stories and experiences that *had* been collected) differently – more in line with MNGOs prior ‘process documents’. To accomplish this she wrote an appendix (MNGO Research Director, in personal communication, April 2008).

Thus, there are two distinct ‘write-ups’ of the *Access to Treatment* study. The official (required) report, focused on the findings of the survey questionnaire, with its economic indicators. These indicators fit the managed schema and provided a statistical analysis to reflect equitable access to treatment using survey data. The additional report (the appended version) was written in an attempt to hold MNGOS’s customary community

consultation. However, paradoxically, even the appendix emphasized economic indicators (as opposed to “livelihoods” the way they had been thought about prior to The Bureau proposal and funding).

The appendix has traces of how the director’s own thinking may have been subtly “scaled up”. This is apparent in the following story box “*The Role of ZOFA in income generation*”.

The Role of ZOFA in income generation

In this regard, the mentally ill person identifies an animal he or she is interested in rearing and communicates the cost of the animal to ZOFA. An agreement is reached for its purchase for the mentally ill person.

The mentally ill person is expected to start paying for that animal after six months in cash by installments. He/she has six months to complete payment. By the end of one year when the mentally ill person would have finished paying, the animal would have given birth at least twice as in the case of pigs and goats.

It was reported that the number of births is even higher for smaller ruminants like rabbits and guinea pigs. In that case the mentally ill person would have had several of them to sell out to earn as an income. (MNGO. Access to Treatment, Research Report, appended report, 2008, 3).

The story box above contrasts to that of the pito stand that was discussed earlier, and stands in contrast to participatory research about the role of ‘livelihood’ as inclusion and normalization. In this formal appendix to the *Access to Treatment* report about ZOFA (The Zanta Organic Farmers’ Association – a community collaborative organizing gardening, credit schemes, training, marketing) the ‘story’ is focused on productivity with no traces of the other benefits generated from mentally ill people (who were formerly excluded) being included in ZOFA’s program,

When MNGO workers are socially organized to participate in the mechanics of knowledge that build global health governance, their own thinking becomes coordinated inside terms and practices that narrow how they come to produce and assess the benefits of their work.

On the surface it would seem that gathering survey data and preparing a demographic report was a “small price to pay” to be awarded the significant Bureau funding that supported MNGO’s field work and helped the organization “scale up” its own efforts. During the administration of the survey attempts were made to include people with mental illness and families in MNGO’s usual participatory research model. As well, the “data collectors” both for the survey and for the participatory data analysis process included people with mental illness. However, the appearance of “business as usual” is deceptive: MNGO’s usual participatory data analysis work became marginalized. This was not only evident in the way the reports were composed but extended to what happened in the field.

Back in the Field: Global Health Governance Knowledge Influencing The Everyday

In implementing the *Access to Treatment Study* the field challenges began with the training directed towards ‘capacity building’ that was accomplished in workshops and mentoring practices to support the MNGO workers who were to be tasked with administering the survey. One of our informants, Shaheeda, described how she oriented MNGO field personnel to the grassroots work of community consultation and the requirements of the survey. She described how she provided ongoing support, both remotely and in person, through regular country program visits. As the study progressed, an important part of her work focused on the field personnel’s ‘process reports’. Despite the fact that the survey was being conducted, her day-to-day advocacy work continued to rely on the traditional way the field-workers generated information about the community. However, she lamented that after the new ‘capacity building’ training that was funded by The Bureau, the ‘stories’ from the field changed. Shaheeda was troubled by this change and commented:

He [the field worker] is stepping over his world with these recommendations [for WHO and UN human rights]. It is difficult to keep on with what we trying to do with our reporting and analysis, especially with the new research staff who don’t know the roots [of MNGO’s program]” (MNGO Research Director, Shaheeda, persona communication, December, 2005).

Shaheeda characterized what the newly trained field workers were doing as “analysis from fifty-thousand feet.” Using an example of this she referred to a ‘six month field report’ she had recently been involved with. She related how it had been discovered during a community consultation that one mentally ill person who lived in the village was not able to tolerate his medications due to a lack of food. The pills irritated the patient’s all too frequently empty stomach. Shaheeda lamented that when this situation was written into the six-month report “the analysis stopped there.” She added:

After this detailed and personal story, the only analysis and recommendations in this [fieldworker’s] report were about human rights and the WHO. Nothing about the community, village, region, and why this problem is happening, how did we get to this ... where we can go from here. Only human rights and the World Health Organization. Can you believe it? (MNGO Research Director, personal communication, November 2005).

Throughout the MNGO, both in the field and in the research directorate in India, knowledge making for MNGO was transformed through the *Access to Treatment* project. The emphasis on economic analysis to legitimize and align their work within global frameworks filtered broadly into the very consciousness of those people who worked as advocates and who *knew* the circumstances of people’s lives first hand.

Discussion*Household Income Survey Links to Poverty Reduction Strategy*

Countries like Ghana are drawn into health sector reforms, research capacity building and good governance as a condition to obtain aid, to enter the global economy and to participate in trade. Thus health sector reforms in countries that depend on international

aid have relied heavily on household income data, as a stand-in measure for mental health, which is difficult to measure through standard quality of life indicators. It is easier to measure household income, as the “result” of health services. These data can then be constructed as a kind of evidence and “results” and can be used to justify particular global investments and reforms. Because household income is a determination of who can pay, and how much people can afford to pay for their mental health services/care/treatment, it is considered efficient and useful to gather data that complies with poverty reduction (Poverty Reduction Strategy Paper – Ghana, 2005, 47). This assumption underpinned MNGO’s proposal with The Bureau, the survey development, the survey administration and the subsequent report that was generated. It contributed to how mental health could then be seen to be ‘managed’ economically.

Through the survey, the work of the people at MNGO was reoriented towards gathering data that supported the Poverty Reduction Strategy (PRS) hypothesis and reinforced the globalized coordination of mental health services as purchasable interventions. The *Access to Treatment* study is only one of many development projects that, vested in the discourse of results oriented research and organized through poverty reduction strategies, produce this narrow view of health services development generally and mental health rights specifically.

Poverty reduction strategies have been developed by all countries in need of international aid dollars and are developed to meet monitoring and evaluation standards. Ghana signed a PRSP in 2003. PRSPs are the operational framework for lending coordinated by the World Bank and IMF with low-income country governments. A PRSP is understood to describe the macroeconomic, structural and social policies and programs that a country will pursue over several years to promote broad-based growth and reduce poverty. It also determines external financing needs and the associated sources of financing (IMF, 2008). World Bank guidelines on health equity and household surveys (Analyzing Health Equity using Household Survey Data, 2008) establish the guidelines, goals, requirements, protocols, resource needs, methods, and analysis for various studies being designed to support health equity development knowledge. Intended to build a clearer understanding of health circumstances, treatment standards, service norms, and so on – they are heavily relied upon for decision making in ways compliant with PRSPs (O’Donnell et al., 2008). In turn, these texts are linked into poverty reduction strategies that further tie studies such as the *Access to Treatment* study into the aims and discourses of useful evidence for global health governance, such as measuring equitable access to mental health treatment through household income.

Within this operational framework, explanations for health inequalities are closely linked into the poverty reduction strategies through the “absolute income” hypothesis of economists that has been included into the World Bank’s poverty reduction design. This hypothesis asserts that the origin of health inequalities rest in a person’s position in relation to ownership of a hierarchy of goods and services (Marmot, 2000, Wagstaff & van Doorslaer, 2000; Gerdtham & Johannesson, 2004). Policies influenced by the hypotheses direct strategies for improving the distribution of material wealth which is thought to translate into improved health equity (Wilkinson, 1997, 1998). These notions have had a

great influence on poverty reduction strategies, lending formulas and global health sector reforms and governance internationally.

Global Health Diplomacy and GMH Influence on Evidence for Development

In the survey being scrutinized here, the biomedical and pharmaceutical framework as introduced earlier was also a powerful organizer built into the formulation and the analysis and utility of the study (and those like it). In the survey, this is evident in the data gathered through “client individual files and folders in their homes or polyclinics” (MNGO-The Bureau, 2006, 21). This data from patient records was for the purpose of identifying a specific diagnosis as determined by medical personnel and categorized using standardized diagnostic categories, specifying the duration of illness and the kind of treatment as well as expenditure on the treatment as well as measures of health related to household income and productivity.

Bound within the biomedical and economic discourses of “mental health,” a local and particular understanding of how people in the communities in which MNGO goes to work to advocate for rights to mental health become less important. The everyday experiences of violence and environmental degradation, previously documented within MNGO’s participatory action model, are left out of an economic account of mental health. Instead, management of development results are calculations of income, assets and access to credit in relation to diagnosis and treatment experiences. These become the important things that stand in for the right to mental health. This knowledge comes to mean something for global governance and also to transform both the development enterprise and an NGO’s work for local mental health troubles. Current use of the language ‘mental health rights’ and ‘capacity building’ for research and governance contribute to Smith’s (1999, 159) theoretical framing of “ideological codes” that are enacted people through their participation in “intertextual circles” (Smith, 2006, 85). Lambert (2010, 2012) and others (Jakubec & Campbell, 2005) similarly refer to the challenges of knowledge making through useful, but incomplete codes. Uncovering the “context” (Lambert, 2012, ii4), and in our case the context of complex ruling relations of global mental health governance, reveals what is hidden within codified GMH knowledge.

Influence on the Field: Harmonization for Global Health Governance and Disrupted Local Knowledge

Our analysis demonstrates that the disruption of local, contextual knowledge and wisdom about what is needed to support people whose lives are impacted by mental illness is not an unintended consequence of the new global order. But rather this disruption happens by design, and is necessarily part of the harmonized development important to contemporary global health governance. The Access to Treatment survey, developed within the knowledge mechanics of the research standards of GMH, constructed a particular understanding of mental illness and rights to mental health - as equitable access and poverty reduction. Building capacity for participation in GMH as experienced in the Access to Treatment project produced four key contradictory practices: 1) it reoriented the local researcher’s interview and participation with a mentally ill person and family to the science of health economics; 2) it objectified mentally ill people and predetermined what kind of indicators could be used for decision making related to their needs; 3) it limited

who could be involved in the research; and 4) instead of working to support *local* capacities it imported an authorized knowledge from the *extra-local* (Smith, 1999) work of people “doing” mental health that carried with it predetermined sorts of solutions and approaches. While meeting the goals of GMH and global health governance, MNGO’s researchers and community participants would likely interpret the GMH successes very differently.

Conclusions

“Global order-building shapes new forms of conduct dependent upon many types of knowledge, capacities and skills, with shifting effects for questions of social justice” (Ilcan, 2006).

The rapid growth of initiatives to improve mental health through knowledge development falls short of actually engaging with the main social, political, professional and economic constraints to mental health advocacy and rights on the ground. We need more open critique of the epistemological limitations of the current rights-based paradigm and the complicated relations of GMH and global health governance. Practices of moving research into policy and practice should proactively address issues around context-specific data and diverse methodologies for research, inclusion, participation and capacity building. There is a need for fundamental institutional changes in academia, as well as in the global health machinery that promotes disease-based advocacy and health systems, economic research results (Belkin et al., 2011) and global governance reforms while generally discouraging local capacity building, participation and collaboration (Chan, 2007).

Usually taken-for-granted as (simply) the necessary support for people attempting to improve their lives in developing societies, mental health rights and development practice is examined here as an ingredient in a seemingly benign health diplomacy - a new relation of GMH and “poverty reduction”. From one side, the relation-building begins with finding a donor, writing proposals, negotiating an agreement, and learning to manage money and account for its uses; from the other side, it includes a range of (matching) activities - developing policy and programs, creating accountability mechanisms, making contacts, and communicating requirements, and so on. Ethnographic description of the experiences of all the people involved offers multiple opportunities for hearing about the difficulties that arise (Read, 2013; Jain & Jadhav, 2009) as people take up policy in local settings both on the delivery and recipient end of funding programs. Moving on from people’s own stories about their experiences, to the problematic as “implicit in the social organization of the everyday world” (Smith, 1987, 94), evidence of the translocal and institutional relations operating in the setting was collected in our study. This form of institutional ethnographic evidence, while not ‘evidence’ for global health governance in the sense of managing for results, provides an alternative view outside of that ruling relation. The alternative discovery institutional ethnography enables is a discovery of how particular relations coordinate what actually happens to particular interests that are often at odds with people’s everyday aims and intentions of a right to mental health. This “ethic of critique” casts our attention to everyday practices and relations of ruling as a way of reimagining a “third space” of GMH (Mills, 2014, 145).

While the social relations explored here were particular to the exploration of GMH and mental health rights, these relations of ruling can be made visible at multiple sites of global health diplomacy. The approach enables an alternative view to the objectified knowledge of GMH, and rather explicates the organization of GMH - and disorganization of what can be known of the right to mental health in everyday experiences. Beyond the discoveries of GMH coordination, this study demonstrates how institutional ethnography and its social ontology hold promise for explication of other points of rupture, and taking up the “third space” outside of objectified and theorized knowing in the complex relational and transnational work of global health diplomacy.

Acknowledgements

The authors would like to acknowledge the Social Sciences and Humanities Research Council's Doctoral Fellowship as well as the University of Calgary's International Fellowship (India), both of which provided support for the project reported on in this paper. Thanks must also be extended to our colleague Dr. Liza McCoy of the University of Calgary for her supervision, mentorship and guidance with the project.

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