Contingent universals, aggregated truth: an ethnography of knowledge in Global Mental Health

Doerte Bemme

Department of Anthropology, Faculty of Arts
McGill University
Montréal, QC, Canada

August 2018
A thesis submitted to McGill University in partial fulfillment of the requirements
of the degree of Doctor of Philosophy

© Doerte Bemme 2018

Contents

***

Abstract

The interdisciplinary field of Global Mental Health (GMH) emerged in 2007 when a number of researchers called for a concerted effort to scale-up mental health care around the world, especially in low-resource settings. Mental health, they argued, had been ignored by the international community for too long despite the prediction that depression would become the "leading cause of disability worldwide" by 2020. GMH's proposition to close the global "treatment gap" galvanized a diverse set of actors into a novel knowledge infrastructure, complete with its own institutions, journals, NGOs, and funding streams. Yet, critics held that western mental health knowledge was itself too contested to be exported, lacked cross-cultural validity, and relied on a biomedical model that would inadvertently replace cultural and communal ways of knowing and coping with distress. While GMH proponents argued in the name of a shared humanity, universal suffering, and mental health care as a human right, the critics emphasized the cultural specificity of both mental suffering and its treatment.

The debate was an epistemic event in which different ways of knowing mental health collided. It serves as the empirical entry point into my ethnography of GMH as a knowledge infrastructure which produces mental health as a decidedly global target of care – re-configured from the vantage point of low-resource settings and their restrains. During fourteen months of multi-sited fieldwork I immersed myself in GMH's emerging network spanning European and South African research centers, the World Health Organization, the World Bank, and diverse intervention sites. My dissertation shows how GMH gives rise to a globally applicable notion of mental health, which productively unsettles existing organizing principles of knowledge, such as disease categories, disciplinary boundaries, and the very dichotomies of nature/culture, and global/local. More specifically, I bring into view how GMH operates within an interdisciplinary episteme governed by a pragmatist ethos of figuring out "what works", and by a *functional* notion of truth that is open-ended, iterative, and reflexive. Finally, it discusses the implications of these knowledge practices for anthropology's methodology and the contours of the figure of the human at its center. It tentatively delineates the emergence of what I call an "aggregate human," a figure perpetually assembled and disassembled from changing data points.

Résumé

Le mouvement interdisciplinaire de la Santé mentale dans le monde a pris forme en 2007 quand un certain nombre de chercheurs ont appelé à un effort concerté pour élargir l'accès aux soins pour la santé autour du monde, surtout dans les endroits à faibles ressources . Ces chercheurs soutenaient que la communauté internationale avait ignoré la santé mentale pendant trop longtemps, malgré les prédictions indiquant que la dépression serait devenue d'ici 2020 la principale cause d'handicap dans le monde. La proposition de combler les « lacunes en santé mentale » a consolidé un lot d'acteurs divers en une nouvelle infrastructure de savoir, ayant ses propres institutions, journaux académiques, ONG, et sources de financement. Cependant, les actions de ce domaine visant à répondre aux besoins de santé mentale au travers de la médecine basée sur les données probantes ont été aussi la cible de critiques. Les critiques affirmaient que le savoir occidental à propos de la santé mentale était trop contesté pour être exporté, qu'il manquait de validité interculturelle, et qu'il reposait sur un modèle biomédical qui allait par inadvertance rivaliser, ou même coloniser, les systèmes culturels et collectifs pour surmonter la détresse. S'en est ensuivi un débat virulent dans lequel les partisans de la Santé mondiale dans le monde plaidaient en faveur d'une humanité partagée, d'une souffrance universelle, présentant la santé mentale comme un droit de l'homme, alors que les critiques défendaient sa spécificité culturelle.

Ce débat a été un événement épistémique qui a rendu palpable différentes façons de connaitre la santé mentale. Il a été le point de départ de mon exploration empirique de la Santé mentale dans la monde en tant qu'infrastructure de savoir au travers de laquelle la santé mentale apparait comme un objet de préoccupation résolument global – reconfiguré du point de vue des endroits à faibles ressources et leurs limites. Au cours de quatorze mois de recherche de terrain multi-située, j'ai été intégrée au réseau de la Santé mondiale dans le monde qui m'a conduite jusqu'à des centres de recherches africains et européens, jusqu'à l'Organisation Mondiale de la Santé et la Banque Mondiale, ainsi que jusqu'à plusieurs ONG. Ma thèse examine comment une notion de santé mentale applicable globalement émerge des pratiques quotidiennes de ces acteurs, et comment leur travail déstabilise les principes organisateurs de savoir existants, comme les catégories de maladie, les frontières disciplinaires, et les dichotomies entre nature/culture et global/local. Plus précisément, ma thèse souligne comme la Santé mentale mondiale fonctionne en tant qu'épistémè interdisciplinaire dicté par un ethos visant à comprendre ce « qui fonctionne » (what works), et par une notion *fonctionnelle* de la vérité qui est inachevée, itérative, et réfléchie. Enfin, cette thèse discute des implications de ces pratiques de savoir pour les méthodes utilisées par l'anthropologie et pour la figure de l'humain, tout en traçant les contours de ce que j'appelle « l'human cumulé » (aggregate human) qui est perpétuellement assemblé et désassemblé par des données changeantes.

Acknowledgements

Writing a thesis while processing a loss required skills I did not have when I began, but grew over time with the help of others. Now I am faced with the impossible task of pouring my gratitude for the personal and intellectual entanglements that supported my work into the genre of "acknowledgements."

I would like to begin by profoundly thanking the people – be they called participants, informants, interlocutors, colleagues, or collaborators – who gave me their time and trust to undertake this ethnographic exploration into the practices and conditions of possibility of – their work. And let's be honest and acknowledge: nobody ever needed an anthropologist in their life observing what they do. Thus, I do not take it lightly that you opened your doors to me and saw value in my work, for which I am truly grateful. With over 70 interviews and many more fieldwork encounters, I cannot approach them individually. A special thanks goes to Laurence Kirmayer, Brandon Kohrt, Pamela Collins, Alex Cohen, Shekhar Saxena, and especially Leslie Swartz and Crick Lund for facilitating access to important actors in Global Mental Health. Each conversation contributed to this dissertation and my academic future.

I was supported by a wonderful committee of academic advisors. Tobias Rees has kept me on my conceptual toes at all times and encouraged me to explore all things emerging. Our conversations have made me the scholar I am today. My committee members Sandra Hyde and Allan Young have provided me with invaluable advice over the years be they on feminist scholarship or the history of psychiatry. Setrag Manoukian joined my committee later but has been generous with his time and reassurance during this time of transition. With Lisa Stevenson and Anne Lovell as my examiners I benefitted from the feedback of two brilliant scholars I have long admired. I am grateful for their thoughtful comments that helped me develop my thinking about the implications of my work further.

An uncountable blessing is my community of friends and colleagues. The group that morphed in name and composition over the years, from "thought collective", to "hive mind", to today's bi-weekly "writing group" has made everything better; on these pages and otherwise: Thank you, Fiona Gedeon Achi, Julianne Yip, Darcie DeAngelo, Raad Fadaak, Adam Fleischmann, Kristin Flemons, Jonathan Wald, and Nicole Rigollo, for your energy and thoughtful feedback, and for maintaining this wonderful circuit of support, jokes, and care across all corners of the world. My interest in mental health is shared with another group of sharp minds: Liana Chase, Nicole D'Souza, and Hanna Kienzler – thank you for helping me articulate GMH outside existing molds, for letting me learn from you, and for reading what must have been a million drafts over the years. David Reubi and Ursula Read gave important comments on chapter three, and Samar Zora on chapter four. Vincent Duclos, Mette Bech Risor, and Natassia Brenmann, at different times, brought their spark and great conversations to my basement.

I am most grateful to those who helped me understand South Africa in the many facets of its beauty, struggle, and complication. I travelled along queer networks of solidarity that shaped my richly textured world and work there. I appreciate the many links in a chain of introduction that put me in touch with some of the strong spirits Zanele Muholi portrayed in her important photographic work. Fairoze Daniels, Lesego TIhwale, Selaelo Mannya, Ruvimbo Tenga, Alistaire Bart - thank you for taking me under your wings and for the adventures, laughs, and tears we shared. Ladia Aragao and Nompumelelo Rakabe - our love and friendship is always with me. Your wit, strength, and talents have no match in this world. Some of my interlocutors became dear friends as well. Deepak Soowamber, Sujit Rathod, and Sumayiah Docrat - thank you for profound connections made of, and over many matters. Emily Baron, Rita Stockhowe, Isabbel Cooper, and Gillian Hanslo, thank you for lovely times after work. The well of things I learned from Nancy Richards is too deep for words; they are what she does best herself. Your smarts and energy will never seize to amaze me. Thank you and John-Clive, your family, Thobeka, and the many fellow visitors (Moses Kachama!) for giving me a home in Cape Town.

There is older debt too. Stefan Beck, Stefan Sperling, Michi Knecht, Cordula Mock, Anne Sorge, Angela Sanmann, and Sören Kittel each shaped my path to becoming an anthropologist in Germany. The brilliant minds and kind hearts of Jennifer Cuffe, Loes Knaapen, Raul Necochea, Erica Wood, Noemi Tousignant, Pierre Minn, Takeshi Uesugi, Emilio Dirlikov, Hanna Kienzler, Cees van Dijk, Julia Freeman, Stephanie Lloyd, Ari Gandsman, Martina Schlünder, Briony Beveridge, Ian Kalman, Karen MacAllister Annette Leibing, Virginie Tournay, Eugene Raikhel, Duncan Pedersen, Consuelo Errazuriz, and especially Stephanie Alexander were all part of my intellectual trajectory after washing up on Canadian shore.

I am grateful for the support of many institutions and people along my multi-sited trajectory. My special thanks goes to Nikolas Rose for having me at the Department for Social Science, Health & Medicine at King's College London, and for including me in the writing retreats 2016/17. I thank Carlo Caduff (for encouraging me to play with the comic), Tara Mahmoud, and Nele Jensen for their insightful comments. During the write-up phase, the group at CERMES3 in Paris was a lovely community to be part of, for which I thank Jean Paul Gaudilliere and Andrew McDowell. Finally, the Department for Social Studies of Medicine provided me with the vital infrastructure at McGill, aka my beloved basement office. Heike Färber, Elena Bernier, Olga Harmazy and Connie Guiseppe made transitioning through the program easy. And lastly, I thank the institutions that funded my research: FQRSC, SSHRC, CIHR, IDRC, Goodenough Association Canada, and McGill's Institute for Health and Social Policy, and the Wolfe Chair. Megha Sharma Sehdev, Jennifer Cuffe, Nicholas Whitfield, Noemi Tousignant, Julianne Yip, and Julia Bugiel edited my chapters in lightening speed and put up with my second-language quirks. I thank Mirja Peters for hosting me in Geneva, and Simone Knaapen in Amsterdam.

Some people say that writing a PhD is like running a marathon, but it might just be the time between HIIT cycling classes. Thank you, Jean Luc, for turning me purple every Friday and for absorbing my darker energies in a mean electronic beat. And thank you Jacqueline, Olivia, and Mary for doing the opposite at yoga every other day. Julie Laurin, Enbydea Christensen, and Karen Fennell - your beautiful arts marked me deeply, for which I am so grateful.

Above all, I want to celebrate my chosen families. Two houses kept me grounded outside my head and writing process. Thank you Nicholas Whitfield, Joanna Fisher, and Manu Nau for the winter nest, and Rachel Bergmann, Tyrel Park, and Julia Bugiel for the nourishing home we share. I thank my parents, Doris and Hellfred Bemme, for their unshakeable trust in me and my far-away exploits – even though they remain so hard to explain at choir. Your resilience, love for each other, humor, and creativity in the face of life's surprises have always been my guiding light. I dedicate this thesis to two people. My dear friend, Darcie DeAngelo: your magic mind, golden heart, and strange kind of humor (read: best!) have been my secret ink over the past year. And, Nathan Hall, my favorite person to defy categories and sometimes gravity with. Your immeasurable care and kindness got me through this, every day. Thank you for showing up for me, for being my transatlantic rock.

List of Acronyms

DFID – Department for International Development
EMERALD – Emerging mental health systems in low- and middle-income countries
GMH – Global Mental Health
IASC – Interagency Standing committee
ICF – International Classification of Functioning, Disability and Health
IoP – Institute of Psychiatry
KCL – King’s College London
LSHTM – London School for Hygiene and Tropical Medicine
mhGAP – Mental Health Gap Intervention Guidelines
MHIN – Mental Health Innovation Network
MGMH – Movement for Global Mental Health
NIMH – National Institute for Mental Health
PHQ – 9 –Patient Health Questionnaire 9
PRIME – Programme for improving mental health care
PSE – Present State Examination
QoL – Quality of Life
STS – Science and Technology Studies
ToC – Theory of Change
WHO – World Health Organization
WHODAS II – World Health Organization Disability Assessment. Schedule 2.0
WFMH – World Federation for Mental Health

List of images

Introduction

I look around and find myself in a mud hut. Rays of sunlight fall through cracks in the roof, slanting through the dust-filled air. The blinding sun outside gives way to semi-darkness as the door begins to close. The distant sounds of village life beyond these walls start fading. As the door draws shut, all sensory anchors are swallowed by a sudden silence. Darkness envelopes the room, except for the sun's halo cut around the door's uneven frame. Two years of confinement, Francis asks me to imagine, with little human contact and sometimes without food. He is a schoolteacher and father from rural Northern Ghana, where he had suffered from depression. "Six years ago, my mind became confused. I did not know what was wrong with me. I was frightened. My family was afraid", he says. They locked him into this hut. During those years he thought he would not survive the loneliness. "I thought I had nobody", he recalls. When he speaks about his "dark place", he refers to his mind and his confinement in the hut interchangeably. Eventually, he recounts, the doors opened again, inviting him back into the world with its vast open sky, back into his village where the children from his school run and play, welcoming him back with laughter.

I take off the heavy virtual reality (VR) goggles that immerse me in Francis' world and find myself back in my seat in the lecture hall at the Milken Institute in Washington, DC. The seven-minute VR film "Francis", was developed to bring the plight and experience of people with mental health problems to policy makers at the World Bank. The lecture hall is filled with about two hundred delegates from around the world, all of whom are in different stages of dis- and re-orientation visiting Francis' hut. Some giggle nervously as they fiddle with the oversized VR glasses and headphones; some receive instructions on how to wear them correctly and which button to press to start. Several people are already immersed in the 3D environment, their upper bodies twisting in their seats as they explore Francis' 360 degree environment. Wonder and awe play across their faces. Once inside the VR world, a new immersive landscape unfolds, and one's body is momentarily forgotten.

The first scene opens onto the expansive firmament where a single star shines brighter than the others. Francis' story is unique but also generalizable; he is one of the many stars in this sky. His life unfolds in a dream-like atmosphere. Exaggerated and fuzzy color schemes lend heightened importance to ordinary scenes, not unlike Instagram filters. There is the inside of the classroom, which shows Francis teaching children, situating him as a productive and valued member of society. Another scene shows the eerie forest behind Francis' village, in which we see him get lost – or better, appear and disappear in different spots – symbolizing his confusion. And, of course, there is the scene of the mud hut, the dark space of his suffering and unbearable interiority that viscerally maps the experience of depression and abandonment onto each other. An ambient village soundscape weaves its way into Francis' calm and slow voiceover, contrasting sharply with the sudden silence of the dark place. We inhabit the darkness together, for one short minute. When the door finally swings open and he re-enters the world, an initially faint color scheme begins to saturate with richness and exuberance. Francis re-emerges. First, back into his village, and then into an imaginary global space. The image of Francis freezes into a portrait and joins a global gallery of many, lining up into an infinitely receding horizon. The viewer's spatial and affective horizon opens and closes along this dramatic arc: When moments ago we were intimately invited into his life and suffering, Francis now is exemplary, his experience scaled. Through this "tool for empathy", as the Californian production company calls the VR technique, the minds of policy makers and funders are to be changed by sharing Francis' mind and humanity, by visiting his dark place.[1]

---

[1] Months later, I look up the website of the film, which celebrates the potency of VR film-making for global changed, as proven by the World Bank's program director Tim Evans saying, "You guys delivered, BEYOND!" The

Image via mettle.com/francis-vr-film-world-bank-fugitives/

The meeting at which “Francis” was shown took place in 2016 in Washington in conjunction with the annual spring meeting of the World Bank. It was seen as a pivotal crescendo of an advocacy community, which, for the past decade had gathered under the name Global Mental Health (GMH). The meeting itself was entitled “Out of the Shadows: Making Mental Health a Global Development Priority” – and just like Francis being released from the hut, the topic of mental health was to be released from its marginalized place within the Global Health community. GMH advocates hoped to finally step into the light of meaningful funding

---

promotion of the film, however, does not focus on its topic but on its technical specs and high-tech delivery. A number of additional videos feature the production process as a heroic journey of technological mastery by four white men discussing the creation of the “grime and grit” of the Ghanaian surroundings in 3D. Francis himself, the village, and the children racing around the mounted 360 camera feature as the material of this film, not as agents in its making ("Francis," 2018).

commitments from the World Bank, ministries of health, and philanthropies – all of which had, until then, largely excluded mental health care from their funding streams.

This meeting came about as a result of the longstanding friendship between Arthur Kleinman and World Bank Director Jim Yong Kim, who in collaboration with Director General of World Health Organization (WHO), Dr. Margaret Chan, created this forum in order to cross-fertilize the mental health and development communities. Among the participants and organizers of the meeting, the hopes for significant outcomes were highly optimistic and jaded at the same time. Many participants remembered a similar high-level event at the UN in the mid-1990s that resulted in little change. Then, the meeting evolved around the release of the "World Mental Health Report" (1995). Produced by Harvard anthropologists Arthur Kleinman, Leon Eisenberg and Bryon Good, the report urged international policy makers to improve mental health in poor countries by combining the newly available "global burden of disease" data with ethnographic cases. It drew attention to mental health problems as universal suffering in need of international attention and care. Galvanizing the international community to take mental health seriously, it was a kind of 'low-tech' Francis, if you will.

Between these two high-stakes events in 1995 and 2016, lies the emergence of the field of Global Mental Health in 2007. GMH, in turn, gave rise to a novel institutional and discursive apparatus that arguably re-shaped the problematization of "mental health" and the responsibilities and practices for its care. While GMH is not an entirely new field of knowledge, it is also not a mere re-labeling of older activities under the auspices of the psy-ences or international mental health. My dissertation attends to this difference, exploring GMH as the emergence of a new style of reasoning about mental health from the vantage point of low-resource settings.

What is Global Mental Health?

In 2007, the Lancet in collaboration with the WHO, published a special series that urgently declared the existence of a global "treatment gap" of mental health care requiring a concerted response (Patel et al., 2007; M. Prince et al., 2007). Mental health problems had, based on a new method of global health accounting, been identified as one of the greatest contributors to the "Global Burden of Disease" and depression was on track to becoming the most disabling condition worldwide by 2020 (Whiteford et al., 2013). The enormous scope of suffering and unmet need, the series suggested, had not elicited public indignation or an international response towards what Arthur Kleinman called a "failure of humanity" (Kleinman, 2009). The Lancet series thus announced the foundation of a movement for GMH with the goal to promote "access to care", and to "scale-up" evidence-based treatment for mental health problems in low-resource settings. The call to action addressed itself to a broad and multi-disciplinary audience, encouraging contributions from scholars in public health, psychology, psychiatry, health economics, international development, as well as the operational experience of NGOs. Since the first call, GMH has grown into a diverse field of practice with its own institutions, journals, funding mechanisms, and a discursive apparatus that lends conceptual and practical coherence to the field.

The emergence of GMH, however, also elicited a backlash when a number of psychiatrists, transcultural psychiatrists and social scientists began to question the premises of new field. To begin with, there were criticisms of GMH that responded within the logics of evidence-based medicine. Psychiatrist Derek Summerfield posited that the lack of "cross-cultural validity" and western psychiatry's weak evidence base made it irresponsible to export its knowledge to poor countries (Summerfield, 2008). More critique erupted on McGill's transcultural psychiatry listserv in response to GMH's agenda setting article in Nature (Collins et al., 2011, 8), which prompted a number of opposition pieces (Shukla et al., 2012; Timimi, Salie, Shatrunga, & Fernando, 2011). In these earlier discussions, GMH was perceived as a Euro-American endeavor, perhaps driven by the pharmaceutical industry seeking to expand its markets to low-and middle-income countries.[2] A reconciliatory workshop between the main opponents and proponents of GMH was held at McGill in 2012 where their differences were laid out and debated over the course of five days.[3] At the end of the meetings, the British psychiatrist Suman Fernando, one of the strongest critics, laconically summarized the disagreements as follows:

> "I am confused. From what I have learned over the last days of discussion, it is not 'global,' not about 'mental,' and not about 'health.' So why don't we call it 'local,' 'political,' 'recovery'?" (cited in (Bemme & D'souza, 2012)

The debate around GMH continued on the TCP listserv and reached a pinnacle between 2012 and 2014, when it left the space of the listserv and meetings and moved into longer publications. Here is a quick overview of the main arguments leveled against GMH: The strongest critiques described GMH as a neo-colonial imposition of Western psychiatric knowledge on low-and middle income countries (Fernando, 2014; Mills, 2014; Summerfield, 2012, 2013) and cautioned that the biomedical model with its underlying assumption of mental illness as a universal brain disorder would replace religious, spiritual and communal systems of healing and understanding distress (Bracken, Giller, & Summerfield, 2016). Others suggested that local idioms of distress

---

[2] Specific bones of contention over the years of the debate were a Janssen scholarships awarded to students from low-and middle-income countries at the Center for Global Mental Health announced in 2013, but also the earlier investment of Ely Lilly into the first MSc program in "International Mental Health Leadership Program" between Harvard and University of Melbourne in 2001. Even further back, Lilly also made financial contributions to the WHO program "Nations for mental health" in the 1990s (see chapter one).

[3] I wrote up a summary of the arguments here (Bemme & D'souza, 2012), and will discuss the event further in chapter two.

and cultural systems of healing should be taken into account in the production of evidence, e.g. as outcome measures (Fernando, 2014; Laurence Kirmayer & Swartz, 2013). The production of evidence itself was flagged as an uneven playing field due to the high cost and specialized expertise required to make knowledge "count" within the register of evidence-based medicine (Hickling, Gibson, & Hutchinson, 2013). Some cautioned that GMH prioritizes the distribution of medication over psychosocial interventions (Jain & Jadhav, 2009; Laurence Kirmayer & Swartz, 2013) and that the focus on biomedical care forecloses interventions on the social determinants of mental health; e.g., its structural root causes such as poverty, violence, and migration (L Kirmayer & Pedersen, 2014; White, Jain, Orr, & Read, 2017). Care delivery, some argued, should instead be undergirded by values such as equity and social participation (Campbell & Burgess, 2012; A. Das & Rao, 2012) rather than economic rationales vying for a "return on investment" (Freeman, 2016).

Within GMH, issues around cultural adaptation, language barriers, and power differentials were also discussed, albeit as operational challenges testing the "feasibility" of interventions (Kohrt & Mendenhall, 2016; Lund, 2017; Mendenhall et al., 2014; Swartz, Kilian, Twesigye, Attah, & Chiliza, 2014). A frequently mentioned theme of internal critique that emerged during my interviews with GMH actors was the field's prioritization of the so-called "common" mental disorders, such as depression and anxiety, over severe disorders, such as schizophrenia, which are more complex and costly to treat. Many wished for more internal discussions to take place but felt that the initial debate had forced them on the defense and muted internal conversations. There was also a stark dissonance between how critics and GMH advocates perceived the reach and power of GMH. While critics tended to paint GMH as a powerful field with an expansive, dangerous ambition that had captured high-ranking journals such as Lancet and Nature, GMH practitioners saw themselves as a fragile, underfunded and constantly endangered advocacy community fighting for a stigmatized topic within the larger Global Health community.

Research question

My initial interest in GMH was routed through this controversy. When I began my PhD, the debate was at its height and unfolded right within my academic networks.[4] Yet, I was neither a transcultural psychiatrist, nor a GMH advocate. I was trained to study experts and how their knowledge practices furnish and re-shape the world. GMH presented me with an epistemic event in which not only different notions of "mental health" collided, but also different *ways of knowing* it. My interest in GMH therefore zeroed in on the conflicting epistemic rules and objects mobilized in the debate, not on the merits of either side's argument. Born from a number of initially puzzling observations, I set out to study the production of "global" knowledge claims about mental health and illness within the field of GMH.

In the most general terms, my dissertation therefore poses the following research questions: How does a globally applicable conception of "mental health" emerge from the interdisciplinary movement for GMH? And how does this conception outgrow and challenge existing categories and organizing principles of knowledge, such as distinct disease categories, scientific disciplines, the "nation state," and the very dichotomies of "nature/culture" and

---

[4] I encountered GMH initially from the vantage point of McGill where the world-renowned unit for transcultural psychiatry has a long legacy of producing knowledge on the cultural specificity of mental illness (Bains, 2005; Delille, 2018; Delille & Crozier, 2018; L. J. Kirmayer, 2007; R. H. Prince, 2000; Wu, 2016). As such, even though most of the critical scholars came from the UK, the "cultural critique" of GMH was strongly facilitated by the virtual (the listserve) and actual platforms (the ASI meeting) of the unit for Transcultural Psychiatry under the leadership of Laurence Kirmayer. The late Duncan Pedersen, whose team I had been working with before my PhD, was another pivotal actor in facilitating the debate.

"global/local"? I answer these questions through my multi-sited fieldwork, which followed key GMH actors and their networks across scale. My research traversed the geographical and epistemological distance between researchers at European, American and South African research centers, international NGO workers, policymakers at WHO and the World Bank, and lay counselors in South Africa. It set out to understand the specific texture of GMH's knowledge infrastructure and how its actors reconcile the conflicting demands of producing comparable mental health "data" and locally meaningful interventions.

Methodology

How does one best conceive of GMH as a site for anthropological inquiry? Studying the knowledge practices of a globally dispersed network like GMH necessitates a multi-sited engagement (Inda & Rosaldo, 2002; Marcus, 1995). Global networks are made up of concrete and interlinked institutions, projects, people, and events (e.g. conferences, forums, summits, annual project meetings etc.). Moving along this network was always both the results of meticulous planning and of derailments within the field itself that led to particular kinds of access, encounters with specific actors, and to new questions. It also revealed different stakes depending on the node I inhabited. The sites of my engagement morphed as much as my own role in them. My work placed me in offices, lecture halls, conferences, living rooms, restaurants, seminars, backseats, and meeting rooms in London, Amsterdam, Geneva, Cape Town, Washington DC, and Montreal; a student, an audience member, a conference delegate, an interviewer, a panelist, a visiting scholar, an observer, a lead article author, a white person, a colleague, and a friend – I took many shapes.

In terms of the choices I made, it was important to me to insert myself into spaces in which knowledge production could be *observed* rather than merely be engaged with discursively through final outputs, such as presentations, documents, brochures, or articles. Therefore, despite conducting in-depth document analysis and interviewing the famous people in the field, I especially sought out those actors that Paul Rabinow calls “technicians of general ideas” (1995). They are the ones who operationalize concepts such as “scaling-up” and the “treatment gap” in concrete actions and projects. The people I worked with ranged from health economists, data managers, nurses, psychologists, psychiatrists, training directors, lay health workers, public health researchers, epidemiologists, principle investigators, transcultural psychiatrists, as well as policy makers in the UK, South Africa, and at WHO.

Fieldsites

Two main fieldsites grounded my research. They are intensely connected with each other through the professional trajectories of key researchers, an abundance of collaborative projects, and US and UK based funding structures:

1) The Centre for Global Mental Health, which is jointly run by the London School for Hygiene and Tropical Medicine (LSHTM) and the Institute for Psychiatry (IoP) at King’s College London (KCL), is commonly considered one of the most central institutions of GMH. It operates a sophisticated website, runs an MSc training program in GMH, houses the virtual platform called the “Mental Health Innovation Network” (MHIN), and draws together a vibrant research and policy community from across the many institutions situated in London. I spent six months in London (September 2015 – February 2016) affiliated with the Department for Global Health and

Social Medicine at KCL. My access to the Center for Global Mental Health remained relatively uneven during that first stay. Like most academic spaces in London, LSHTM is highly guarded – by bureaucratic procedures, such as costly "bench fees"— but it was also protected as a physical space by the ubiquitous security guards and barriers, visitor logs, and electronic access cards at every entrance. It is a fortress, only to be entered in the company of authorized persons, who collect you from the lobby.[5] In short, neither LSHTM nor the IoP were places to casually hang out in or get an easy affiliation with, let alone a workspace in their embattled open-plan offices. My six-month stay in London was therefore more interview-based than I would have liked, but yielded rich insights and connections through the density of GMH events and experts in the city (funders, researchers, policy makers, and critics). In addition to the interviews, I audited the GMH summer school in 2016, as well as a lecture at the MSc program for GMH, and attended the program's networking social. London's close proximity to Geneva also allowed me to conduct three research visits to the WHO, where I conducted interviews and attended two pivotal events, namely the annual Mhgap Forums in 2015/2016. Further interview trips to Amsterdam, Paris, and Glasgow allowed me to also explore the capillaries of the European GMH network.

2) My second field site was the Alan Flisher Centre for Public Mental Health in Cape Town (hereafter, the Center), where I had a much more immersive experience than in London and spent overall eight months (March-September 2016, and for a follow-up trip in February-April 2017).[6] The Center straddles two institutions as well, namely the University of Cape Town and

---

[5] This heightened security was often explained with reference to the terror attacks in 2009, and at times with a nod towards the bio-hazardous material handled at LSHTM. Over the years of visiting London's academic institutions, however, a noticeable rise in physical security measures, fee barriers, and much dreaded open plan office could be found at many universities.

[6] My first stay in Cape Town was interrupted by a two-week trip to Washington DC to attend the World Bank meeting. There, I engaged with many people I already knew from London, Geneva, Amsterdam, as well as my new

Stellenbosch University. As a research and implementation hub it is intricately connected to British[7] and American funding structures, such as the Department for International Development (DFID) and the National Institute for Mental Health (NMH). As such, the Center hosts a great number of different projects under its roof, ranging from multi-country consortia (i.e. PRIME, EMERALD), to NGO interventions and randomized controlled trials undertaken in the townships of Cape Town, mostly in Khayelitsha. These projects focus mostly on maternal mental health, or on mental health in relation to violence and injury. At the Center, I participated in the day-to-day-activities of these projects. I attended weekly research team meetings (e.g. of the PRIME consortium), helped plan the annual mental health day, conducted interviews with researchers and lay health workers, shadowed psychologists and educators during field visits and supervision meetings, and sat in on training sessions and workshops with midwives and social workers held by members of the Centers across the region.

Ethnographic Data

I conducted 72 open-ended interviews, as well as participant observation throughout the multiple sites outlined above. Participant recruitment was purposive within the GMH expert community. In addition, I used snowball sampling when following up recommendations and contacts emerging from conversations. Participants gave written consent to be interviewed and audio-recorded. They could choose between two options for anonymity regarding the use of their interviews in future presentations and publications (to appear quoted with full name, or as a

---

colleagues from Cape Town. GMH is, after all, a relatively small core group of perhaps 40 people that assemble over and over again in different venues around the world.

[7] The Center initially formed around the group of scholars involved in the “Mental Health and Poverty Project” (MhaPP), which was funded by the UK Department for International Development (DfiD) that started in 2005. The Center itself was founded in 2009, and it was named after Alan Flisher in 2011.

generic job title). Fieldnotes were taken throughout my fieldwork. Ethics approval was received from McGill University and the Human Science Research Council, South Africa.

Partial knowledge, collaborative dreaming

One limiting but deliberate choice I made was to only engage with experts in my research. I decided not to enter therapeutic spaces and I refrained from engaging with recipients of mental health services in South Africa for several reasons. Mainly, this was a scoping decision made at the stage of my research proposal and ethics approval. Yet, the bounds of such early decisions were not absolute and I continued to re-assess this question as my research unfolded. I had not ruled out working in the communities and considered extending my ethics protocol when I arrived in Cape Town. However, as I came to understand the post-colonial and racial dynamics of contemporary South Africa in a more situated way I found that gaining trust, intimacy, and access to people and communities across the existing structural, affective, and often racially framed divides was relationally very much possible, but less so within a research encounter. For many of my friends, acquaintances, and interlocutors, being the subject of research amplified the power dynamics and tensions characteristic of post-apartheid South Africa. Confronting and grappling with the grip of racism is a quotidian, taxing task for everyone. Its force continues to texture the conditions of possibility of relationships, politics, knowledge production, and lifeworlds profoundly. Routed through the smallest gestures and interactions is the weight of the past and its trenches of distinction and differential valorization – now demanding a different trajectory, a different path to spring forth from every encounter and instantiation. Put simply, I came to understand that my being a white, foreign researcher rendered me a problematic, and for some even an impossible, narrator of black and colored people's pain and suffering. I have worked through this conundrum in greater detail in chapter four where I begin to imagine a collaborative space and anthropological practice in which the stories that were not for me to tell could unfold – not on mine, but on shared terms.

By focusing predominantly on GMH experts in my work, I acknowledge that their lives and practices were by no means free from these forces and inequalities. With Wenzel Geissler one might say they were in fact deliberately "unknown" in Global Health settings (2013). Yet it may be precisely because of this equalizing labor – silencing undoubtedly, but also upholding the imaginary of equality everyone is invested in – that academic and NGO actors could engage with me in a collaborative research encounter based on the a shared valorization of scientific knowledge; a connective tissue produced by foregrounding shared, but always partial affinities, in Donna Haraway's sense, which could be placed over and above, or perhaps merely alongside, the politics of identity (D. Haraway, 2006).[8]

And then there is the question of who, in GMH, is an expert? This question is particularly ambiguous given that GMH interventions mobilize a care delivery model called "task sharing" in which lay people are briefly trained to attend to the needs of those with mental health problems. Such lay and community health workers, within this architecture, are deliberately kept in a liminal position, within a middle ground between formal and informal knowledge, as well as between formal and informal employment. They usually come from the same communities as those they care for and are often imagined to be seamless "cultural brokers." Yet, as many have argued they in fact straddle rather difficult tensions between professional hierarchies, language and cultural groups, as well as gender and social norms (Swartz et al., 2014). They are "experts"

---

[8] However, the question remains whether the work of "unknowing" our differences is ultimately more violent and silencing than refusing collaboration based on the acknowledgement of the structural, gendered and racial inequalities that in fact do shape every research encounter. In other words, I must ask myself whether I merely took advantage of that silence, or whether this practice of "unknowing" can in fact be generative of a relationality not predominantly grounded in static identity politics rather than Donna Haraway's politics of affinity (2006).

in that they have received short formal trainings and in that they are celebrated as effective and cost-effective actors in under-resourced health care system. Yet, the conditions of precarity and structural violence they share with those they are tasked to support go largely unmentioned in this narrative.

In my research, I did engage with community health workers but only through interviews, conversations, and within training settings. I did not shadow them during their work in the township communities because I found that it placed an undue burden on these women, for example to ensure my safety. When we met up in the Khayelitsha, many would walk me long stretches towards the local taxi rank or wait with me until other people arrived so I would never have to walk around by myself. All of this took time out of their busy days and I increasingly sought to limit this additional burden.[9] Against this backdrop, I acknowledge the limitations of my work while simultaneously appreciating the work of those scholars who engage with therapeutic spaces in GMH in an immersive and grounded way without facing the above conundrum (Chase & Sapkota, 2017; Jain & Jadhav, 2009; Read, Adiibokah, & Nyame, 2009).

However, what therefore necessarily escapes my empirical lens through my focus on expert knowledge in GMH are the ineffable emotions and experiences that mental health knowledge seeks to frame and therapeutically transforms, but inevitably never fully captures. The ineffable as that which cannot be expressed through language has been explored by anthropologists attuned to the irreducible embodiment and enactment of suffering, especially in the context of colonial trauma and violence (V. Das, 2007; Fanon, 2008; Fanon, Sartre, & Farrington, 1963; Garcia, 2010; Pandolfo, 2018; Stevenson, 2014). In their work, language is

---

[9] Working in Cape Town's townships is not something you can do "on the side" as a mere added fieldsite, they are spaces impossible to explore on your own and without protective social networks or guides, or at least a car. I often went to the townships with my closest group of queer, black activist friends, who were familiar with the environment. We attended Khumbalini Pride in Langa, hung out in local shebeens, and visited "Mzoli's", a daytime Braii and house dance venue in Gugulethu. For my research, I shadowed supervisory team visits in primary care clinics and held many interviews with lay health workers in the community (sometimes at the local chicken joint).

found to be inadequate to give contour to such suffering while the polyvalence of the image and poetic language harbors the possibility for psychic life and trauma to expand, find expression, and reverberate, while remaining ultimately unresolved or fully knowable. In addition, important scholarship focused on the zones of translation between such irreducible lifeworlds and the forms of institutional care made available for, or applied to them, charting not only the regimes of triage and deservingness they produce (Giordano, 2014; Nguyen, 2010; Ticktin, 2011), but also the subjectivities emerging at their interstices (Han, 2012; Matza, 2018; Raikhel, 2010).

While the ineffable and fundamental alterity, understood as that which ultimately cannot be commensurated (Povinelli, 2002), are largely invisible within Global Mental Health, I contend that it is important to better understand the contours of what GMH renders sayable and doable with regards to "mental health" in "low-resource settings" nonetheless. How exactly do they commensurate knowledge across variously conceived differences? At times these practices confirm and extend, and at others they defy and unsettle the fault lines of historical epistemological ordering, upon which distinctions such as expert and lay knowledge, nature and culture, and the colonizer's universal knowledge claims as distinct from the alterity of the subjugated, were built. Instead of further dichotomizing different ways of knowing mental health, I seek to engage the GMH expert community as a field of situated knowledge in its own right, while persistently acknowledging the partiality of my own view and vantage point.

Theoretical framing

While each chapter engages its own set of literature, I want to suggest two major lenses that frame my perspective on GMH, which are not mutually exclusive but should be kept apart. Firstly, I approach the "global" of GMH genealogically and as an actor's category in order to bring into view how GMH emerged as a *specific* global knowledge infrastructure distinctly different from other projects of global aspiration. Secondly, I engage the anthropological literature on "globalization" and discuss how analytics like the network, assemblage and scale inform my analysis of GMH.

1) A genealogy of global knowledge asks in the concrete: How, when, and due to what conditions of possibility did the "global" as a sphere and aspiration come into being? The term globalization itself first appears in North American economic discourse of the 1970s. And while phenomena of increasing interconnectedness and mobility of things and people have occurred before, they were described in distinctly different terms. For example, efforts of standardization in the 19th century - such as time, weights, railways, meters, or meridians - were celebrated as "world" projects (Krajewski, 2005), while the post WWII era created an "international" zone of collaboration between nation states after a catastrophic war. Economic "interdependence" between nations, however, was seen as a threat to national sovereignty during the economic crisis of the 1970s (N. Ferguson, Maier, Manela, & Sargent, 2010; Maier, 2010). The "global", however, as its own sphere only comes into being when economists in the 1970s begin to describe the mechanisms through which multi-national companies escape national legislation, how they carve out a distinctly different space and rulebook for themselves. More precisely, it was first coined by economist Ronald Mueller, and then became popular through his book "Global Reach" (Barnet & Muller, 1976; Muller, 1975). In other words, the economic "global" is bound up with the concrete practices, actors and infrastructures of multi-national companies that began to exceed the national and international order, giving shape to new "global" practices that did not exist before.[10]

---

[10] The 1970s were a decade of "crisis" in which profound sense of rupture brought the relative stability of the postwar era came to an end. The "shock of the global", according to Niall Ferguson, was most palpable in the

Other projects began to mobilize decisively global knowledge practices in the 1970s, yet their infrastructures, ethics, and discourses differed significantly from the economic global. Environmentalism, for example, discovered the "planet" as a connected space and imaginary to care for and protect, facilitated by technologies such as the "Blue Marble" photograph taken from space presenting Earth as borderless and fragile (A. Tsing, 2000), but also by computer models that rendered the "global climate" conceivable (Weart, 2008). Human rights, originally a distinctly international endeavor developed global forms of agitation when NGOs went *against* nation states to demand human rights instead of lobbying for them through the UN (Moyn, 2012). Humanitarianism, similarly, moved outside the mechanisms of the nation state, using the fast deployment of mobile infrastructures to re-assemble staff, tools and material in what Redfield calls a "globalization on the ground" (Redfield, 2013, 78). Humanitarianism more broadly gave rise to new moral sentiment in distinctly global terms couched in the psychological language of suffering, compassion, and moral obligation towards "precarious lives" (Fassin, 2012, 5). The emergence of Global Health around the turn of the century, similarly, situated the responsibility for health outside of national and international responsibility, opening up a space for novel actors such as NGOs, philanthropies, universities, companies, and development actors to produce new regimes of care (Hyde, 2011; Nguyen, 2010), and articulate new ways of measuring and saving lives on a global scale (Adams, 2016; Brown, Cueto, & Fee, 2006; K. Lee, 2003; Rees, 2014; Reubi, 2018b).

Global Mental Health is, in a way, a latecomer to these infrastructures of global knowledge, yet is borrowing from many. It built on older efforts in International Health to formulate a "common language" about mental health across historical cleavages between

---

economic realm, emerging from the tension between the increasing liberalization of international capital markets and the principle of national sovereignty retained in the realm of monetary policy, lead to frequent financial crises (2010, 19).

nations, academic disciplines, and professional groups (see chapter one), but it also developed its own modalities of knowing and acting on mental health. In 2007, the field mobilized the existing templates of evidence-based medicine and the moral gestures of human rights, but also devised a new vocabulary specifically designed to accommodate the complicated epistemological grounding of mental health.[11] It is this *particular* modality of global knowledge developed by GMH that I want to bring to the fore with precision (rather than assuming the "global" as a known and given sphere).

For example, when approaching the "global" as an actor's category an important divergence appeared: The critics of GMH interpreted the global aspiration of GMH in terms of the economic global: as a self-interested and destructive project of expansion. When I asked GMH actors how they understood the "global", they unequivocally said it was a proxy for under-resourced countries and communities. They used it as a marker of neglect rather than as spatial ceiling to their ambition.[12] In order to make such differences visible, I seek to avoid slippages between different global projects – while also acknowledging the scholarship that has turned "globalization" into an analytic lens.

2) The Anthropology of Globalization began to emerge in the late 1990s in response to such global projects, as they began to challenge a discipline premised on rather static or spatially bound concepts (e.g. culture, community). While I cannot discuss this literature comprehensively

---

[11] Let me add a small anecdote, if I may, without disrupting too much the flow: At a GMH conference in Providence in 2016, the director of the GMH division at the National Institute for Mental Health, Pamela Collins, during a coffee break once asked me: "So what do I tell the other Global Health leaders when I go to their meetings [representing mental health]? What do I answer, when they say to me 'Well, you guys have to invent the wheel wherever you, you start from scratch every place?'" The diagnostic and therapeutic instability of mental health care – the lack of biomarkers or firmer epistemic ground – weakened GMH's global argument in the eyes of those who could ground their causes more easily within problematizations claiming to be "true to nature."

[12] The heuristic of the "global" can of course never be fixed once and for all. On its constitution from different vantage points in Global Health, see (Brada, 2011), and on the marketization of the "global" as an experience sold to US medical students, see (Crane, 2013; Wendland, 2012).

here, I choose three key concepts that help me to engage and produce GMH in this dissertation – namely, through the notions of the network, assemblage and scale.

Network. The "network" has become an extraordinarily important analytic because it renders spatial expansion through non-linear connections thinkable, while paying attention to their underlying technologies, infrastructures, and their potential disruption. Networks, while letting go of one kind of boundedness retain the questions of boundaries; that is, of exclusion and inclusion and therefore of power in a more traditional sense (Castells, 2011). Yet, they also lend themselves to an analysis of power as productive, focusing on what they give rise to. Bruno Latour's "actor-network theory" (ANT), for example, while not predominantly developed in conversation with globalization, lends itself to its analysis. His lines of contestation mainly trouble the division of "science/society," "nature/culture," but also the idea of different "global/local scales."[13] Instead, ANT grounds the "global" in localized, material actor-networks (Latour, 2009; Riles, 2001). Latour playfully evokes the image of railroad tracks when he reminds us playfully that: "Scientific facts are like trains, they do not work off their rails. You can extend the rails and connect them but you cannot drive a locomotive through a field"(1999a, 155).

In that sense, I am approaching GMH as both a network and a knowledge infrastructure along which claims about "mental health" can be made.[14] A global notion of "mental health" thus comes into view as produced by a group of people across the world with different degrees of

---

[13] In the "Pasteurization of France" (Latour, 1993) and his article "Give me a laboratory and I will raise the world" (Latour, 1999a), Latour argues that scientific laboratories are built to destabilize the difference of scale between "micro" and "macro" precisely because they are able to "invert the hierarchy of forces" (1999a, 164). Science, he argues, is not operating "inside" the lab in order to release its knowledge to an presumed "outside"/"large scale" of the world. Rather, the world itself becomes modified through novel actor-networks emerging from laboratory practice that it increasingly confirms with the conditions of the laboratory itself. The laboratory extends itself to the world through "long and narrow networks that make possible the circulation of scientific facts" (1999a, 167).

[14] Beautiful work on (humanitarian) infrastructures and new ways to think with infrastructures has been done by (Bowker, Baker, Millerand, & Ribes, 2009; Duclos, 2015; Elyachar, 2010; Larkin, 2013; Redfield, 2008; Simone, 2004; Street, 2014; Tousignant, 2013).

formal education and mobility, their Power Point slides, planes, sticky notes, white boards, cell phone apps, questionnaires, pedagogical role plays, felt markers, desks, drugs supplies, brochures, primary care centers, fences, gates, reports, ID cards, office buildings, video tapes, consultation rooms, tents and benches, diagnostic scales, grocery vouchers, uniforms, pocket projectors, mandala coloring sheets, agendas, pathway diagrams, parliament buildings, voice recorders, marbled lobbies, excel sheets, parking guards, sharing circles, health breaks, data entry tablets, tents, infographics, emergency rooms, policy briefs, data servers, benches, and above all, an internet connection and Skype; all elements to be revisited in a more orderly fashion in this thesis.

Assemblage. This leads me into a brief discussion of the notion of "assemblage", which I think with most tacitly when analyzing GMH. Let me explain why. Although several scholars have developed this concept,[15] it is Collier and Ong's notion of "global assemblages" (Collier, 2006; Collier & Ong, 2005, 5) that is most useful to my work because it captures how global forms come into being in concrete, heterogeneous, and always changing assemblages.[16] Most importantly, this includes the making of "universals" and allows me to stay cognizant of their historical, always changing conditions of possibility. This perspective takes seriously what

---

[15] For example, (Collier & Ong, 2005; DeLanda, 2006; Deleuze & Guattari, 1988; Marcus & Saka, 2006; Rabinow, 2003; Sassen, 2006). Paul Rabinow (2003) has defined assemblages in relative proximity to Foucauldian terms, namely as an "effervescent" formation situated between "problematizations and apparatuses"; or in relation to Rheinbergers' terminology calling an assemblage an experimental "matrix of heterogeneous elements, techniques, and concepts", but not yet an "experimental system" (2003, 56).

[16] Global forms, in their terminology, are "made effective through specific political and technical arrangements" in the space of *assemblage* (Collier & Ong, 2005, 5); they are not ontologically fixed. Their universalism remains specific to and delimited by the "technical infrastructures, administrative apparatuses, or value regimes, not by the vagaries of a social or cultural field" (Collier & Ong, 2005, 11). Concepts such as "culture", or "society" are not timeless analytical fixtures, but part of what is made and re-made in the assemblage (Collier & Ong, 2005, 4); just like the *global* in my case is not the other of the *local*, but the result of institutions and discourses producing both as incommensurable spheres (Bemme & D'souza, 2014).

Foucault has described as a “history without universals”[17]; a methodological reversal, of sorts, that starts an analysis with concrete practices and then passes “universals through the grid of these practices” (Foucault, 2008, 3). Consequently, in understanding the shifting shape of “mental health” historically and in practice, my own conceptual vantage point cannot be grounded in a set of universals – be it “society,” “culture,” “rights,” or a timeless notion of “health” - as these are themselves implicated in perpetual movement and re-assemblage.

Scale. Lastly, the concept of “scale” is both central to the analysis of globalization but also within my fieldsite, given its declared goal is to “scale up” mental health care around the world. In the literature on globalization, the imaginary of different “scales” is ubiquitous. While globalization scholars typically began to theorize in non-spatial terms, such as “scapes” (Appadurai, 1996), “flows” (W. Anderson, 2014), and “networks” (Castells, 1996, 2011), they often reinforced the imaginary of a “vertical topography” (J. Ferguson, 2014; J. Ferguson & Gupta, 2002) separating seemingly distinct levels of power and abstraction (local, regional, national, global etc). Anna Tsing has offered two, yet somewhat contradictory, takes on the notion of “scale” – one that I found particularly useful in thinking through GMH, and another one that my findings challenge. In her review on the “global situation”(2000) she warns us to not take globalization’s “claims for true description”, but to empirically investigate the practices of “scale-making”, i.e. the processes and conditions of possibility through which “sites are constructed, from which convincing claims about units and scales can be made”(A. Tsing, 2000, 330). Global Mental Health is exactly one such site of “scale-making”, as I have argued elsewhere (Bemme & D’souza, 2014) and will further develop here. However, I would also like to engage with Tsing’s later writing, in which she ontologizes “scale” and grounds the concept in

---

[17] His methodological reflections ask of the historian the following, “Let’s suppose that universals do not exist. […] How can you write history if you do not accept a priori the existence of things like the state, society, the sovereign, and subjects?(Foucault, 2008, 3)

the logics and practices of global capitalism – a leap, not unlike the one GMH critics make. Scaling, Tsing argues, has historically been a technique of conquering the heterogeneity of the world through the creation of "uniform blocks, ready for further expansion" (A. L. Tsing, 2012, 505), achieved by rendering things, knowledge and people resistant to diversity and relationality.[18] Projects of scale, she writes, thus create a 'false sense of progress', but never fully succeed at taming the non-scalable, the messy world.[19] It is this latter use of scale in Tsing's work that my dissertation gently pushes back against. I do so by harnessing the generative potential of the incongruence between Tsing's influential contention that scaling necessarily relies on "standardized units that expand without change" (Ehrenstein & Neyland, 2018; A. L. Tsing, 2012, 2015), and my own observations within GMH.

My fieldwork presented me with rather different practices of scaling. Here, for example, the call to "scale-up" served as an aspirational, even a moral horizon, that did not rely on fixed spatial or epistemic units. It articulated the aspiration to do "more" relative to available resources, and was used as a heuristic device of inclusion (see chapter one). Similarly, I show how global knowledge was not merely achieved through standardized units but also through techniques that deliberately allowed for knowledge objects to remain flexible - while still

---

[18] To illustrate this particular notion of scalability she draws on the image of a pixel; a small stable unit that can be expanded to a larger scale without changing the overall framework. This metaphor of distinct, unchangeable units, ready to be nested within a larger scale is then further projected onto the "social" world, bringing into view similar units which she calls "nonsoels" – the non-socially bound up unit. Such units, she argues, have been constitutive of capitalism – as exemplified by the history of the plantation which turned cane plants, slave workers, and the agricultural techniques yielding particular outcomes into isolated "nonsoels" that function in similar ways in any part of the world – precisely because they were designed and maintained to be non-relational, stable units, made to resist transformation through encounter.

[19] "Perhaps, however, public notice has contributed to awareness of a different issue: scalability is always incomplete. Project elements are never fully under control. Even on the sugar plantation, enslaved workers slipped away to form maroon communities, and planting stock arrived with stowaway fungal rots that spread to the whole field. At best, scalable projects are articulations between scalable and nonscalable elements, in which nonscalable effects can be hidden from project investors. In the wake of nineteenth-and twentieth-century enthusiasms for scalability, the world today is crisscrossed by such articulations between the scalable and the nonscalable. Many projects for life — both human and otherwise — take place in the ruins of scalability designs."(A. L. Tsing, 2012)

aspiring to articulate “truth” either in the form of “evidence” (see chapter two) or within the typical Global Health imaginary of finding “what works” (see chapter three).

Contours of an overarching argument

One of the overarching propositions of my dissertation is that the interdisciplinary epistemic space of GMH encourages what Ernst Cassirer has called a “functional understanding of truth,” which he distinguished from a “substantive” notion of truth (Cassirer, Swabey, & Swabey, 2004). Reflecting on mathematics, Cassirer suggested that “functional” truth does not build its concepts with reference to a substantive outside world, but through a concept’s position to other concepts in a field of knowledge. In very simple terms, functional truth is true to the system of knowledge it is part of, and it is verified through perpetual reflection on itself. Substantive knowledge, on the other hand, is verified against a substantive outside world and ultimately grounds in perception. I am tentatively drawing on Cassirer’s idea to describe my interlocutors’ practice to operate with constantly adjusting epistemic horizons - without giving up on the idea of an objective truth while also never claiming of having reached it.

My goal for this dissertation is to capture this partiality and rolling horizon of knowledge that seemed so important to the people in my fieldsite. Despite the rather seamless presentation of this argument here, it resulted from much confusion and surprise as I moved through the many encounters and conversations that made up my field. The initial debate around GMH and my training in STS and medical anthropology had prepared me to see the hardening of facts, their “entitification” into black boxes, artifacts, and boundary objects – you name it. Unpacking their tacit politics and subsequent circulation was what I was trained to do. What I was not prepared for was GMH’s own deliberate techniques of reflexivity, their own unpacking and shifting knowledge claims, and their oft deliberate creation of indeterminacy to accommodate diversity.

The softening of concepts co-existed with, and fundamentally re-shaped, the relentless specificity of diagnosis. What came into view was a kind of global knowledge that "worked" because it was kept flexible, partial, and adaptable. Cassirer's notion of "functional truth" lends itself to describe this rolling horizon that always examines itself; that knows its position in relation to other positions, and works through iterations and revisions, rather than breakthrough.

In a way my thesis also mimics its main finding: it does not argue in the name substantial truth. Like everyone else, I do not contend to have access to the "real real." Instead, I am trying work out what a de-ontologized notion of truth could look like – both as a practice I observed in Global Mental Health, but also for my own knowledge production. As I continue to inch towards a better formulation, Cassirer's distinction might just be one step of the way. Perhaps, I wonder, this is my form of going native, of synchronizing myself with GMH's practice of only ever hardening analytics temporarily. The chapters of my thesis, in different ways, sites and terms, work through the questions this practice raises - sometimes vis-à-vis my field site, but also the methodology of my own discipline.

Chapter summary

Chapter one consists of two parts. It first describes the multi-stranded genealogy of "mental health" within the arena of International Health, to then show how they converge in the formation of GMH in 2007. A montage of historiography, empirical vignettes, and interviews with three directors of the mental health unit at the WHO will bring into view the conceptual architecture onto which GMH was grafted, and from which it broke free. Central to this chapter are the "common language" projects that sought to integrate knowledge across nations, disciplines, disease classification, and advocacy platforms.

Chapter two attends to the practice of Global Mental Health actors to seamlessly shift between different disciplinary languages and epistemic frames, which I call “speaking in tongues.” What this practice (and its surrounding affect) makes palpable, I suggest, are new rules of knowledge production within multi-disciplinary assemblages. While “facticity” was formerly bound up in scientific disciplines (their paradigms, thought collectives, or styles of reasoning), “speaking in tongues” points to as a particular post-disciplinary knowledge production. I suggest that we view this form of knowledge through the lens of what Cassirer calls a *functional* understanding of truth. It powerfully combines with strategies of knowledge *integration* in GMH, i.e. the participatory and always partial alignment of messages with different audiences and platforms.

Chapter three discusses how the evaluation framework Theory of Change (ToC) facilitates the production of knowledge across variously conceptualized differences. It analyzes three cases that use Theory of Change differently, ranging from a hyper reflexive design process to a static accounting tool in the tradition of “audit culture.” While much critical scholarship of Global Health holds that quantitative evaluation techniques and metrics necessarily rely on standardization and universals at odds with the “real world,” I suggest that Theory of Change unsettles these critiques. It comes into view as an epistemic device whose iterative, reflexive, and adaptable processes produce what I call “contingent universals”; concepts that stay true until they stop working in the field, or until the parameters of “what works” shift to a new iteration.

Chapter four is an experiment. It tells the story of how I came to write an article about Nepal and the ways in which mental health and poverty are experienced by villagers in the Chitwan region - without ever having been to Nepal. Writing this article was part of the gift exchange that is fieldwork: my interlocutors gave me access to their work, and I offered them free labor in return. While this is done often, rarely has this complicated collaborative epistemic space been made visible empirically. I trace such collaborative work in its crisscrossing movement between different epistemologies, the conflicts and discomforts at their interstices, and the ways in which this process can confirm and betray the disciplinary conventions of those trained to attend to context, ambiguity, and genealogy. I use this reflection as an entry point into a methodological discussion.

Interspersed with the main chapters are short ethnographic interludes that grapple with the different "spaces" in GMH, exploring their politics and possibilities in a more imagistic register. And finally, the epilogue elaborates on larger arguments and flights of thought emerging from my thesis. At its center is a particular figure of the human - the "aggregate human" - which will be situated within anthropological scholarship but also within the so-called "post-truth moment" of the current political climate.

Positionality

What drew me to do this work? Looking back, my curiosities and comfort zones are as serendipitous as they are part of a biographical fabric that I continue to weave and re-design as I go through life and grow as a scholar. Some immutable stitches may be of interest. My father was an East German diplomat working at the UN in Geneva in the 1980s, where I grew up on the compound of the permanent mission of East Germany. With it came an early imagination of the world of international institutions, albeit merely as a material environment. Family legend has it I once tried to climb onto the globe monument at the United Nations and had to be removed by a security guard; a convenient myth that could be mightily woven into the recent arrival scene in which I was passing the same globe as a PhD researcher to conduct interviews at the WHO. But that is just cheesy, and did not reverberate with the actual memories I had when I re-entering this place I had long forgotten: the unique claustrophobia of the Geneva lake and its encircling mountain range; the sterile wealth and beauty of this city; its tidiness and distant demeanor; the seventies charm of a fading utopia of bureaucratic internationalism. Sprinkled in are the newly arrived problems and their shiny architectures such as the HIV/AIDS pavilion and the new UNHCR building, award-winning without a doubt.

These are the changes to the small town my family left behind in 1988, a few months before the Berlin wall came down and the nation my father had represented ceased to exist. Just like the country, our lives, and minds unraveled in the most unforeseen ways, thereafter scrambling any possibility of a straight line between that kid on the globe to the researcher on globality I am today. I am also the daughter of a math and physics teacher, who in those years in Geneva was bored and restricted by the lack of opportunity afforded to a diplomat's wife and whose own ambition to become a family counselor in this emerging world of the 1990s was curtailed by what was first called a family problem, then diagnosed as psychosis, and later referred to by no, or many names. Her delusions, she told me decades later, involved the bombing of Dresden her aunt lived through – and so did she, years later, vicariously, at our kitchen table. My life and academic curiosity cut its teeth in this intergenerational space of such "real" and "imagined" wars. While the last decade of the cold war provided me, ironically, with a privileged life and a socialist education far away from East Germany, the turmoil unfolding afterwards brought mental illness into my life, at first as a strange then as a familiar companion. My fascination with emergence, conceptual change and the tenuous stability of ordering principles may perhaps be grounded in such experiences of worlds coming undone and being re-assembled in different terms. It is an empirical, perhaps even normative drumbeat in my life as much as it became an academic predilection. But all of this may also merely be storytelling.

Chapter 1 – The emergence of "mental health" as a global object of care

Part I: International Health

This chapter attends to the multi-stranded history converging in the emergence of Global Mental Health in 2007. It traces the genealogy of the notion of "mental health" along both ruptures and continuities in the conceptual and institutional assemblage preceding GMH. Taking a genealogical lens this chapter does not presume an underlying, ontological stability of "mental health" but asks how GMH actors have shaped the epistemic object they set out to treat.[20] As such, it is both a "history of the present" (Foucault, 2012) and an exploration of the conceptual labor I observed during my fieldwork in 2016/17. Through a montage of historiographical review, empirical vignettes, and interviews with three WHO mental health directors, the conceptual architecture onto which GMH was grafted, and from which it broke free, will come into view. The World Bank meeting in Washington in 2016 with which I opened the scene in the introduction can be understood as a point of empirical departure, but also as a point of conceptual arrival in the problematization of "mental health."

The journey of this chapter is necessarily selective, as it covers enormous grounds. I focus on the emergence and entanglement of four "styles of reasoning" that produced "mental health" as an international, and later a global problem: 1) postwar pacifism (restoring peace), 2) psychiatric epidemiology (counting disorders), 3) disability (weighing burden), and 4) development (costing health). A red thread throughout these rather different endeavors is a phrase I encountered with

---

[20] This perspective does not assume that mental illness is a mere construct, or in the critical iteration, an "invention of America"(Watters, 2010). Instead, a genealogical approach follows the ways in which mental health and illness have been problematized and rendered treatable over time, with each of these iterations producing a specific reality. In simpler terms, the journalist Jonathan Rosen used the expression "murky borders do not mean there is no country" when he described the controversies around anti-depressants and the diagnostic category of depression itself. To stick with the image, a genealogical interrogation of the changing ways of knowing and caring for mental health/illness over time traces how their borders were drawn, re-drawn, and guarded, what membership in that country looked like, and how it was governed.

uncanny frequency, namely the aspiration of rather disparate sets of experts to find a "common language." I take the repetitiousness of this trope not as a sign of identity or historical continuity, but as an invitation to explore their distinctly different projects. The "common language" trope serves as an organizing principle as I trace how mental health programming sought to integrate mental health knowledge…

1) across nations: through "world citizenship" and "harmonious relations" (1950-60s),
2) across disciplines: international classification (DSM III & ICD) (1970s-90s),
3) across diseases: assessing disability burden, functioning, and cost (1980s-today),
4) across platforms: multi-stakeholder advocacy language (2000s-today).

One goal of this chapter is to carve a space for the multiplicity of the "universal." As such, it seeks to make visible how finding a common language was undergirded by rather different practices, ethical inclinations, and ideas about the universality of mental health and illness.

Internal history

Let me begin with how the field of Global Mental Health frames its own origin story. Such internal historical accounts commonly convey broad panoramas that trace the evolution of psychiatric knowledge back to antiquity, to the rise of institutional care in 18th-19th century Europe, and the subsequent spread of the psychiatric asylum across the world during the era of modern colonialism (Cohen et al., 2014; Okpaku & Biswas, 2014). This lends a kind of teleological linearity to the evolution of knowledge, supported by the assumption that the problem of "mental health" is stable across time and space. They are commonly constructed from the vantage point of present advocacy goals to highlight both the long durée and importance of psychiatric care but also the marginalization and stigmatization of these conditions within the institutions of medicine and policymaking. The history of mental health's invisibility is then commonly offset by a sudden exposure: A sea change in mental health began to occur in the early 1990s, when mental health arose to recognition through the introduction of a new epidemiological measure, called the DALY, which is short for *disability adjusted life years*. This health metric was developed by the World Bank and Harvard, and supported by WHO, in order to account for the global burden of disease in terms of disability, rather than only of mortality. A formerly hidden dimension of suffering became visible when the disabling but rarely lethal effects of disorders began to be considered. As such, the global story of mental health is a discovery narrative not based in a breakthroughs of basic science, but in changed public health accounting (A. Becker & Kleinman, 2013).

The first Global Burden of Disease report in 1996 stated that mental health contributes 14.5% to the global burden overall (Murray & Lopez, 1996), a number which changed with its methods of counting to 10.5% (Whiteford et al., 2013). In 2007, the Lancet published a special series, which advocated for a global response to this dramatic burden, under the leadership of the journal's editor-in-chief Richard Horton. The series declared with urgency the existence of a global "treatment gap," which was calculated from the differential between two global datasets: the Global Burden of Disease report and WHO's atlas of mental health care resources (WHO, 2001a). The key numbers highlighting treatment gap were that 25% of all people worldwide suffer from a mental illness at some point in their life (WHO, 2001b) and that 75% of people with severe mental illness in low-and middle income countries receive no care at all (Saxena, Thornicroft, Knapp, & Whiteford, 2007). Pointing to such figures, the Lancet authors called for the formation of an interdisciplinary movement for Global Mental Health with the goal to scaling up access to evidence-based treatments.

Following the initial call, a global Delphi consultation process was initiated in order to determine the priorities and strategies that should guide the new field. After the publication of the consultation's outcome in *Nature* in 2011 (Collins et al., 2011), the field faced a backlash, which came to be known as "the debate." Critics held that Global Mental Health knowledge base lacked cross-cultural validity and that the proclamation of a global treatment gap ignored all forms of traditional knowledge. Despite the controversy, GMH went on to flourish. Since its inception, the field has created a distinct assemblage around the goal of closing the treatment gap made up of new institutions and training programs, virtual platforms (such as the Movement for Global Mental Health (MGMH), and the Mental Health Innovation Network (MHIN), specialty journals, and new funding streams.

From 2007 onwards, as one of the foundational authors of the field explained to me, GMH evolved through three phases: an early phase during which the magnitude of the problem was established epidemiologically, a second phase in which the field focused on conducting "proof of concept" studies and producing RCT evidence on interventions, and the third and current phase in which questions of implementation, delivery, and scale-up moved center stage.[21] (This history incidentally also echoes the perfect pathway diagram of any public health intervention: problem > solution > implementation > scale).

Another important historical delimitation has been offered in ethical terms. Vikram Patel, a leading Global Mental Health researcher and spokesperson of GMH, suggested a periodization in which Global Health's predecessor formations Tropical Health and International Health were

---

[21] "If I look at the field over the last 15 years, the time I have been involved in it, I think in the first stage it was all about demonstrating how important it is. And that was all this kind of prevalence studies, and 'look we find depression also in country x', and 'look at the burden of disease', and how important it is. [.] Then there was a lot of intervention research saying 'look, we can do something, its effective'. If we do intervention xyz, adapted or not, it works with paraprofessionals. So I think that was the second phase. And I think now we are in the third phase, were we – we being the field of Global Mental Health – are saying, 'look, we have demonstrated in enough trials that the concept works and maybe the evidence now is strong enough', the concept seems to work. Now we are much more in the third phase were ask 'Ok, now what is the system of delivery? How does that work, how do you implement it at scale, and what is the service delivery framework of those interventions, that you have generally proven to seemingly work, but now need to implement at scale'" (GMH researcher, ID 63, 17. November 2015).

replaced by a new collaborative ethos that displaces the colonial dynamics pervasive in the knowledge production of the past:

> "Global health is the new incarnation of what we once called "international health" and, going back further in time, "tropical medicine." […] Global health emphasizes global learning; thus, while international health was built on the tradition of what the "developed world" could teach those in the "developing world," global health emphasizes what all countries can learn from each other and do together to address the health of all the peoples who must share our planet." (Patel, 2014, 777-78)

I will leave it at this rather brief summary of GMH's own historiography and shift away from generalizing, teleological accounts towards a genealogy along the specific institutional assemblages that preceded Global Mental Health. Central to this discussion are the institutions of international health, especially the WHO and the World Bank, but also the professional bodies, academic actors, and non-governmental organizations that applied themselves to improve the "mental health" of people around the world.

a) International mental health: a common language across nations

World citizenship and the pacifist agenda

Built in response to a catastrophic war, all UN institution were predominantly concerned with restoration and the preservation of "world peace." The newly founded World Health Organization in 1948 was no exception to this overarching mission, within which the promotion of mental health became important to furthering a pacifist agenda (Lovell, 2014; Wu, 2015). The first director general of the WHO was in fact a psychiatrist, Canadian Brock Chisholm, who, disillusioned by the activities of states after the war, pursued the idea of "world citizenship" as the guiding principle of the WHO's work.[22] World citizenship expressed the values of a new scientific internationalism, a commitment to non-racial science and a universalism grounded in a shared humanity (Wu, 2015). These values were also reflected in the WHO's decentralized structure, which distributed much of its power in its regional centers, from where experts for reports, surveys, and studies were recruited (K. Lee, 2003; Siddiqi, 1995).

The notion of "mental health" took on a new meaning within the postwar international arena, one that was markedly different from the core concepts of psychiatry. Instead of focusing on pathologies, a positive notion of "mental well-being" was included in WHO's definition of health from the beginning.[23] Ultimately, it conceptualized mental health in relation to world peace (Lovell, 2014; Wu, 2015). Chisholm writes in 1950, WHO's mission was "to foster activities in the field of mental health, especially those affecting the harmony of human relations" (B. Chisholm, 1950, 1021). Mental misery, not "disorders", was seen as part of the larger postwar condition, which caused other types of health problems:

> "The definition [of health] embodied in the constitution cannot become a reality unless WHO tackles with courage, and in co-operation with the UN and other agencies as well as various other non-governmental organizations, the basic problems responsible for maladies yesterday and today - namely, those of mental, social, and economic misery" (B. Chisholm, 1950, 1021-1022).

In a similar vein, a new non-governmental organization called the World Mental Health Federation (WFMH) was founded at the same time in London, which galvanized a large number of professional associations around the mandate of treating "the damaged minds of people devastated by the war and to find methods of peacemaking by enhancing mental health" (Wu,

---

[22] Chisholm "turned to humanism and world government, believing that the only real hope lay with the people of the world: if individuals could come to their senses and learn to think and act globally, they would form a single human race, embodying his concept of 'world citizenship'(Wu, 2015, 171).

[23] WHO's famous definition of health since 1948: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

2015, 171). WFMH became not only the first non-governmental organization (NGO) that WHO collaborated with (Brody, 2004); it was instrumental in creating the mental health unit at WHO (Sartorius, interview).

With mental health conceptualized as a positive state of well-being rooted in harmonious relationships between people, WHO focused on preventative measures in the tradition of "mental hygiene" education (Okpaku & Biswas, 2014). This shift was distinctly reformist because it occurred "at a time when mental health care in developed countries remained overwhelmingly organized around the confinement of the mentally ill in large psychiatric institutions" (Sturdy, Freeman, & Smith-Merry, 2013,5). Wu has argued that psychiatry effectively transformed itself "from a science regulating social deviants into a discipline concerned about the wider community, including civilians" (Wu, 2015, 167). Now, mental health was for everyone. The new orientation towards so-called social psychiatry began to focus on everyday stressors such as industrialization and urban life, exceeding psychiatry's interwar concerns with war and trauma as stressors among soldiers.[24] This broadened understanding of mental health resulted in community-based, educational, and preventive programming.

Yet, neither the new scientific internationalism, nor the growing interest in mental health in non-western settings, led to concrete action immediately after the foundation of the WHO. During the 1950s, the first director of the mental health unit, British social psychiatrist Ronald Hargraeve, went out to recruit international collaborators for cross-cultural epidemiological research, yet his proposals while being met with interest, were also met by opposition from the

---

[24] After the First World War, concerns had emerged about mental health as a barrier to military recruitment. In the US, when 12% of the 16 million men up for induction were found to be unfit for service due to psychiatric or cognitive impairment, pre-induction tests were developed through the Medical Survey Program (March & Oppenheimer, 2014, i34). Mass screening, however, was found to be costly and exceeded the availability of qualified psychiatrists able to conduct assessments. This led to the development of standardized instruments, which could be carried out by non-specialist personnel in order to detect the psychiatric status of inductees "in a matter of minutes" (ibid, i34).

emerging field of transcultural psychiatry, especially at McGill (Wu, 2016)[25]; a first iteration of the tension between internationalists and cultural relativists that would later play out around Global Mental Health.

The common language projects

Psychiatry at the time presented particularly challenging epistemic obstacles to international collaboration because its longstanding classificatory diversity, or "chaos", as some call it (J. E. Cooper & Sartorius, 2013), made scientific collaboration across nations difficult. While the early versions of the International Classification of Disease, ICD-6 (1948) and ICD-7 (1955) contained sections on mental illness, they were not widely accepted internationally. When the WHO began to take stock of existing classification in the 1960s, a commissioned report found twenty-eight different classificatory systems, eleven of which were national, and seventeen were produced by professional bodies or individual scientists (Stengel, 1959). In practice, this meant that researchers in different countries could not compare their study results, or even follow each other's academic debates. Curious workarounds, such as lengthy case reports accompanying journal articles, sought to make up for the lack of shared diagnostic language (J. E. Cooper & Sartorius, 2013). Psychiatry's lack of standardized diagnostic knowledge also created the possibility of its abuse for political purposes, for example, when the diagnosis of schizophrenia was amended and used to incarcerate dissidents in the Soviet Union (Raikhel & Bemme, 2016). Therefore, the WHO's early efforts to develop a "common language" for psychiatry extended across national, disciplinary, and political cleavages in an emerging international space shaped

---

[25] As Wu (2016), writes: "Anthropologists and mental health professionals who supported cultural relativism issued most of the objections and emphasized that some mental illnesses are valid only within certain cultures, whereas other major mental illnesses are universally similar. Transcultural psychiatrists with McGill University (Wittkower and Fried 1956) concluded that definite conclusions are impossible to obtain from the heterogeneous material obtained by psychiatrists. Newsletters by worldwide experts sought opinions on the impossibility of Hargreaves's attempt to conduct a transcultural comparison of the prevalence of marked disorders" (Wu, 2016).

by the cold war dynamics.

The first so-called "common language" projects started in 1964, building on the emerging techniques of psychiatric epidemiology (Lovell, 2014). The shift towards psychiatric epidemiology returned the focus on pathology, albeit in the name of internationalism and WHO's explicit goal to discredit legacies of racial science - which were in fact still running through the WHO expert system in the 1950s, for example John Colin Carother's infamous publication "The African Mind" (1953). The push towards epidemiological studies was therefore not driven by an interest in establishing local differences but in the creation of a shared knowledge base.

The most famous of the epidemiological "common language" studies concerned itself with schizophrenia. The International Pilot Study of Schizophrenia (IPSS), led by the Taiwanese psychiatrist Tsung-yi Lin, started in 1964 and was conducted in nine countries (Colombia, Czechoslovakia, Denmark, Nigeria, Soviet Union, United States of America, China, United Kingdom, and India). The study set out to prove the universal existence of schizophrenia and the possibility of its detection through standardized tools; in this regard, it declared itself successful (WHO, 1973). Yet, a heated debate arose around its follow-up study DOSMED, which found that patients in the non-western sites had significantly better clinical outcomes than the patients in western sites. This finding has been called the "outcome paradox" (Padma, 2014) and remains a point of contestation in the debates around Global Mental Health.[26]

The early psychiatric epidemiology, which was, in many ways, the starting point of international standardization and of a technocratic approach to mental illness, was undertaken in the spirit of "world citizenship"; their aspiration to "universal" knowledge contained a distinctly anti-imperial, collaborative utopia. Historians Harry Wu and Matthew Heaton have shown that

---

[26] The actors and arguments involved in the schizophrenia studies continue to be mobilized in the debates around Global Mental Health almost 40 years later (Bemme & D'souza, 2014), often against intervention in low-and middle income countries given their superior "cultural" care practices.

the WHO schizophrenia studies were, furthermore, part of decolonizing, nation building projects. Psychiatrists such as Adeoye Lambo in Nigeria (Heaton, 2013, forthcoming) and Tsung-yi Lin from Taiwan, who led the IPSS (Wu, 2016), shaped what would become international knowledge, rather than being colonized by it. As Harry Wu succinctly points out to critics of Global Mental Health who cast the WHO as a neo-colonial force, "the de-imperialization of Western-centered psychiatry had already occurred with the emergence of new scientific communities such as WHO" (Wu, 2016, 202).

Without skipping too far ahead, I would like to create a space for the historic contingency of "universal" aspirations around mental health. Might it be possible to think of the rise of "epidemiological reason" (Reubi, 2018b), as it became the dominant conceptual architecture of Global Mental Health, as being made up of multiple logics and singular events, rather than a grand march towards hegemonic standardization (as GMH critics have it)? WHO's early universalism does indeed resonate with elements that Global Mental Health would later emphasize, such as the notion of a shared humanity, health as a human right, and a collaborative scientific ethos. Yet I would caution against assuming linearity, as their assemblages, and the logics invested in their mobilization are rather different. The early work of WHO's mental health unit also contradicts grand narratives, such as the presumed transition from International to Global Health as an increasing sidelining of the nation state by global health and human rights actors (K. Lee, 2003; Moyn, 2012; Rees, 2014). The WHO mental health unit was certainly embedded in the inter-national sphere, the family of nations, of the UN. But Chisholm's idea of "world citizenship" placed trust in individuals, its internationalism was predominantly *scientific.* The unit built collaborations solely among academic psychiatrists in different countries but did not engage in policy conversations with member state's ministries of health until the mid-1990s, as we will see later on. The state as a central actor only enters the scene at the exact moment when it is commonly assumed to become sidelined.

Letting the "history of" slide into an ethnographic present, and vice versa, I want to now engage with series of specific moments from the perspective of their main historical actors. I call these ethnographic interjections "director's cut" as they revolve around my conversations with three former directors of WHO's mental health unit in Geneva.

Director's cut - Norman Sartorius

I am spending three days in Geneva to conduct another round of interviews. I am staying at the "Foyer L'Accueil", a Catholic nuns' convent in the middle of the city that only accommodates unmarried women. This is my only affordable housing option in a notoriously expensive city where the UN's well-paid professional elites merge with those of global capitalism, creating an air of exclusive cosmopolitanism. The "Foyer" is a special pocket in that architecture; and it is certainly no hotel. Run by a group of nuns, it creates a home for the legions of unpaid interns, working at the UN agencies. The rooms are simple, 1970s artifacts partially covered in faux wood paneling on otherwise paper-thin walls, that carve out small rooms with single beds. Sister Jessy may knock on your door at any time to introduce another girl when she deems there is a connection or a friend to be made. When I am not preparing for interviews, I am exploring stories from the UN's precarious underbelly, listening, at times, to the unpaid intern's lofty aspirations, but all too often to their disappointment about their tasks and dispensability.

My daytime visits to the echelons of WHO and UNHCR, as well as to the residential places of retired WHO officers are of a different texture. Well dressed and at my academic dapper best, I take a bus across the city every morning. Sometimes I catch line 11 destined to "Bout du mondes", the end of the world, which always makes me laugh. Geneva, the birthplace of the world conceived of as the family of nations – is this where it will end? As the bus takes me across the city to interview three directors of WHO's Division for Mental Health and Substance Abuse, I cross decades and fault lines of rival approaches; their tenures together span more than sixty years of WHO history.

Today I am interviewing Norman Sartorius, one of the world's most renowned psychiatrists, who directed the division from 1977-1993. During his time, psychiatric epidemiology advanced greatly and his efforts in the standardization of mental disorders and the production of ICD-10 were widely hailed.[27] I arrive at an unassuming apartment building where he works from his home office. His secretary buzzes me in and I learn that he will only have thirty minutes for me before departing for the airport. Without much chitchat or introduction, we sit down and begin. Sartorius, a charming but very formal man in his mid-eighties, has in fact planned out a full narrative. I barely get to interject as he goes on to outline the "several lines" he believes "preceded the development of global mental health thinking."

He walks me through the decades. Recounting the postwar spirit and widely felt enthusiasm to turn the world into a better place, he speaks of the foundation of the World Federation for Mental Health in 1948, which drew about 2000 organizations together.[28]

---

[27] Sartorius has extensively published on the achievements of his tenure at WHO, of which the following description gives a succinct overview over what can be called the "epidemiological phase" of WHO's programming, focusing on producing international standards, techniques and prevalence data: "1964, WHO convened a scientific group that recommended that psychiatric epidemiology should be given high priority in mental health research and, in the following year, a long-term programme on psychiatric epidemiology was put into operation. It was to have four parts. The first of these (programme A) was designed to produce an internationally acceptable and applicable system of diagnosis, classification and statistical reporting. The objective of the second programme (programme B) was to produce research instruments and procedures for reliable assessment and comparative studies of mental patients in different countries. The third programme (programme C) was to result in information about the incidence and prevalence of psychiatric disorders and lead to the production of a model for epidemiological studies of defined populations. The fourth part of the programme (programme D) was to be carried out concurrently with the other three" (Sartorius, 1993, 147).

[28] Norman Sartorius: "[WFMH] was all full of ideals and you know, noble thoughts and uhm helping each other. Really…it had a considerable support from people mainly because people wanted to feel hope again, and wanted to do something about the world, and it should be better than what happened in the second World War when so much

According to him, it was the WFMH and director Chisholm who brought the mental health unit at WHO into being; it was initially small and staffed by only two people. It grew when mental health was recognized as important to the problems of postwar migration and displacement, and over time was able to hire additional experts in human rights, and then in epidemiology (Dr. Lin). Cold war dynamics in hiring were pervasive: "You can't really have one who is truly pro-American without having somebody who is on the other side. So they hired another person."[29] He himself came on board to strengthen Dr. Lin's epidemiological focus, first as a consultant and then as the head of the interregional team for epidemiology, which he laughingly admits consisted of only one other person. Yet, among the many efforts he recounts – the schizophrenia studies, instrument development[30] – one program stands out to me. It is simply called "programme A", and he endearingly calls it a "travelling circus", an expression I had in fact just recently heard in an interview with a GMH researcher, who called GMH's core group a "flying circus", creating a strange reverberation. Sartorius' travelling circus comprised a group of eight international experts who:

> "went from one country to another, every year a different country talking about a group of disorders, with the local people from that country and the people from neighboring countries. And they so reviewed over a period of nine years or eight years all of the classifications."

Programme A pursued the standardization of psychiatric disorders through collaborative, face-to-face engagements in order to establish a shared way of seeing and understanding a psychiatric

---

was destroyed for nothing. So the WFMH, in terms of its influence it was the one which very much supported the development of a mental health unit at WHO, which at the time wasn't quite sure."

[29] Born in Germany but raised and trained in Yugoslavia, Sartorius himself was aligned with the latter. For example, he highlights to me how Russian psychiatry at the time was considered avant-garde (large hospitals and rehabilitation centers) and how the infamous political abuse of psychiatric classification happened in fact in many places at the time, such as Cuba, China, and South Africa, but was only problematized for the Soviet Union.

[30] A number of instruments were developed that began to facilitate the collection of comparable data, including a tool called the Present State Examination (PSE) (Wing, Cooper, & Sartorius, 1974), the Schedule for clinical assessment in neuropsychiatry – SCAN (Wing et al., 1990), and the Composite International Diagnostic Instrument (CIDI) (Robins et al., 1988).

case at hand. “Seeing”, here, was meant quite literally. The travelling circus in the late 70s and 80s in fact relied on a new technology to facilitate this process: the videotape. Within these meetings, the local experts present were asked to diagnose and rate videotapes of individual cases using WHO’s novel Present State Examination (PSE) instrument. This exercise, according to Sartorius, exposed a great degree of “prejudice” and difference in the rating process:

> “The great professors who rated never believed this was possible. They thought they had the truth and they could silence all of their collaborators but they couldn't silence equally important people from other countries. So, all this led to effect an agreement to the production of a glossary of mental disorders and their classification, which was universally more or less accepted.”

What is striking about Sartorius’ description is that these meetings first had to destabilize the epistemological certainties of all participants in order to create a need for a “common” ground. Two “hardened” knowledge objects – the video and the rating tool –themselves immutable, produced uncertainty, difference, and disbelief among the participants. They eroded the local expert’s authority and power to “silence their collaborators” in an engagement with “equally important people from other countries.” The willingness to engage with the production of a new common ground, and ultimately an “international” way of knowing mental illness, was accomplished through the erosion of a singular form of expert authority. This particular project of universality relied on a handful of men (of course) of high academic stature carrying videotapes across the world, ready to unsettle local authority and epistemological certainty in order to produce the need and willingness to work towards a “common language.” Reflecting on WHO’s approach to standardization, which would eventually be formalized in ICD-9 and 10, Sartorius says:

> “It preceded in many ways the DSM III. Although the DSM III went one step more boldly to, uhm, specific criteria, while the international classification was more in a

> narrative form. It described, it was, so to say, a kind of paragon classification. 'Here is a case and what it looks like,' all of those cases look similar and you see it in your field. All of them, who are similar to this, should be called the same name. While the other side, the American side was much more about specific criteria."

The Oxford English dictionary defines "paragon" as a person or object that "serves as a model *of* some quality."[31] Taking the paragon classification seriously, what comes into view is a technique of standardization that remains committed to what historian John Forrester has called "thinking in cases" (Forrester, 1996). Forrester used this term to describe psychoanalysis as a knowledge practice that relies on the "case" as an irreducible unit of analysis. Of course, Sartorius' effort to produce a standardized psychiatric classification through international collaboration, or perhaps, confrontation, bears little resemblance to psychoanalysis. Yet Forrester's binary between "thinking in cases" with the individual at the center of analysis, and statistical reasoning that takes the group as its unit may be useful for understanding programme A. It could easily appear as a transitory point when case-based knowledge became transformed into countable "types."[32] Yet Sartorius describes a kind of collective "thinking in cases" that preserves their irreducible quality while establishing a shared language. The universalism of the paragon classification maintains the individual case as a unit of knowledge, while rendering it countable in the interest of epidemiology.[33]

---

[31] http://www.oed.com/view/Entry/137415?rskey=O14kUu&result=1&isAdvanced=false#eid, accessed June 23rd, 2018.

[32] Psychoanalysis, he argues, was ultimately challenged by "the rise of statistical thinking [which] put in question the notion of the individual, through the very process of refining what it might mean to have knowledge of *a number of individuals*" (Forrester, 1996, p. 3).

[33] As an aside, case thinking had developed another peculiar echo across different conversations within GMH. Anthropologist Alex Cohen, who is running the MSc program in Global Mental Health at the Center for Global Mental Health in London, spoke to me about his idea of extending thinking in cases to interventions. His idea is to create a "case library" of those interventions that work, inspired by Harvard's business school, which he says teaches business solely through the analysis of case studies. He has in fact pursued such case thinking in two publications (Cohen et al., 2011; Cohen, Kleinman, & Saraceno, 2002).

b) Classification: a common language across disciplines (DSM III)

The "American side", as Sartorius calls it, ultimately went on to disaggregate the case into specific criteria in what is often termed the "DSM III revolution" (Mayes & Horwitz, 2005). Published in 1980, the Diagnostic and Statistical Manual of Mental Disorders III (DSM III) overhauled the US classification system and created a new diagnostic practice, which Andrew Scull calls "'tick the boxes' approach" (Scull, 2015, p.150); this approach would spread enthusiastically and widely and would later be harmonized with WHO's ICD system of classification.

The efforts of standardization in the US where not undertaken to reduce international diversity, but to resolve the tension between different approaches among the psy-disciplines. During the postwar era, American psychiatry was largely dominated by psychodynamic and psychoanalytical approaches, which are commonly grouped together despite their own disciplinary tensions (Strand, 2011).[34] Yet, broadly speaking, both approaches conceived of symptoms as a reflection of underlying psychological dynamics linked to life problems and past experiences. As such, mental health and illness were conceptualized as a continuum with no clear-cut boundaries in DSM I and II. DSM III manifested a fundamentally different approach. It was developed by biologically inclined psychiatrists under the leadership of Robert Spitzer from Columbia University, who outmaneuvered psychodynamic psychiatrists and re-conceptualized the classificatory system with recourse to Emil Kraeplin's idea of distinct and specific disease categories. Biological unity of disorders was not established experimentally, but simply assumed to be undergirding the newly formed categories. Despite the absence of a biological foundation, DSM III symptom lists acquired epistemological stability and legitimacy from their claim to an

---

[34] Cooper and Shepherd write in 1964: "Indeed, as one sympathetic critic has observed: 'With certain exceptions, social psychology and psychoanalysis do not contradict each other, they no longer speak the same language' (Brown, 1961)(Shepherd, 1964, 278).

underlying biology (Scull, 2015, p.150).

The success of the new classification has been attributed to a number of reasons. Some scholars have highlighted a link between the DSM classification and psycho-pharmaceuticals, arguing that DSM disease categories were essentially built around psychotropic drugs. Clinical trials needed to link singular chemical compounds to singular diagnoses in order to prove efficacy and define their markets (Galatzer-Levy & Galatzer-Levy, 2007; Healy, 2009); regulatory practices are thus argued to have produced "natural" entities. Others have highlighted that DSM III harmonized knowledge practices between clinicians, insurance companies, the pharmaceutical industry, and government institutions such as the FDA (Mayes & Horwitz, 2005; Young, 1997).[35] Yet, according to Demazeux, psychiatric epidemiology's "disciplinary matrix", in a Kuhnian sense, never fully achieved the status of "normal science", i.e. producing recognizable paradigms, or a cumulative history of successive discoveries (Demazeux, 2014, p. i61). Despite its great success, the DSM/ICD classification system remains fundamentally contested.

Epidemiological reason

The shift towards psychiatric epidemiology as the dominant style of reasoning in international mental health is worth a pause to fully appreciate the change that occurred. Epidemiological thought originated around the question of mass diseases and their transmission within populations; it only emerged only in the middle of the 20th century.[36] Yet the statistical concepts and models, techniques of enumeration, and the collection of large-scale data about birth, death,

---

[35] Allan Young's work on the emergence of posttraumatic stress disorder (PTSD) demonstrated what Hacking calls the "self-vindicating structure of science," that is, how the coordination of theories, observations and recording techniques produce a facticity that is true to this apparatus (Young, 1997).

[36] "The contemporary style of epidemiology goes back no further than the late 1940s. Its key concepts and principles, those very concepts and principles that are nowadays almost universally regarded as scientifically well grounded, have long been described as flawed by some medical and statistical luminaries, including renowned epidemiologists" (Berlivet, 2005, p.41).

mortality, and the prevalence of diseases and social ills have a longer historical legacy.[37] The rise of statistics was closely related to the emergence of the nation state in Europe in the late 18th century; a moment that Michel Foucault identifies as the beginning of a crucial shift in the art of government from sovereign power to biopower (Foucault, Davidson, & Burchell, 2008).[38]

While epidemiology originally concerned itself with disease transmission and the distribution of transmittable diseases in populations, it expanded its concern to include more distant disease-influencing aspects, which became known as the "risk factor" (Rothstein, 2003, p. 65). Originally developed by life insurance companies, risk factors predicted future diseases and mortality in asymptomatic people (Rothstein, 2003, p. 65) by correlating factors such as 'build' with life expectancy tables. Scientists until then had only approached disease causation experimentally, informed by an etiology grounded in germ theory.[39] The crossover of risk factor thinking therefore proposed a radically different mode of objectivity that did not rely on the constraints of the laboratory and its linear logics of cause and effects.[40] It moved disease and its

---

[37] As historian William Rothstein, drawing on Ian Hacking (1990, 2006), writes, probability theory as a technique for understanding the relative likelihood of alternative outcomes was developed in the 17th and 18th centuries, while statistical analysis emerged in the 18th century "as the quantitative and qualitative analysis of political entities such as states and cities"(Rothstein, 2003, p.3). These two strands of thought were brought together in the 19th century in an effort to account for specific groups and social phenomena within national populations, leading to the recognition that "many social phenomena exhibited remarkable statistical regularities from year to year, including deaths, marriages, births, crimes, and suicides" (ibid.)

[38] Through the aggregate knowledge object of the "population", biopower promotes the enhancement of life rather than the privilege to kill formerly inherent in sovereign power. Yet biopower, despite its ubiquitous application to any intersection of biology, governance, and statistical reasoning, may not be immediately transferable to the inter-national sphere. It remains inextricably linked to the logics of the nation state, and despite the inter-national, and later global efforts directed at saving life and enhancing health, as well as the emergence of what Alison Bashford calls the "global population" (Bashford, 2006, 2014), cannot be assumed to be identical with efforts targeting national populations.

[39] Koch's and Pasteur's germ theory created the bacteriological model of disease causation. Disease causation was thought to be *specific* and determined by a single external agent causing disease, which shaped the expectation of a singular compound for its cure. See Paul Ehrlich's concept of the "magic bullet", a common imagination in drug development, including psychotropic drugs. (Healy, 2009; Moncrieff, 2013).

[40] One of the first cases in which the correlation of "risk factors" would rise to the level of *causal* inference in the absence of knowledge about an underlying biology was the link between smoking and lung cancer in the 1950s (Berlivet, 2005), which led to the "Bradford Hill criteria" for establishing causation through correlation (Hill, 1965). These criteria created a formalized guideline for the inference of causality from statistical correlation; an important stabilization of the style of epidemiological reasoning.

causation beyond the realm of biology and the body as the prime and exclusive site of intervention. But how did epidemiology change the conception of mental disorders as they became countable and knowable in correlation with "risk factors" as disparate as diet, migration status, age, or gender-based violence? In order to answer that question meaningfully, it is necessary to unravel one more genealogical strand; the efforts concerned with assessing mental health through the lens of disability.

c) Disability: a common language across diseases

WHO - Moving beyond diagnosis through "functioning"

The entification of psychiatric disease categories has received much scholarly attention[41], but WHO's parallel efforts to develop a classificatory system that *dissolves* diagnostic specificity have elicited much less commentary. Beginning in the 1980s and early 1990s, WHO, in addition to its traditional focus on infectious disease and diagnostic classification turned its attention towards "disability." It began to produce a number of frameworks,[42] which allowed *any* disease to be assessed through its impairment of "functioning", a concept with increasingly multiple dimensions (e.g. biological, social, and task oriented). This way of classifying disease was

---

[41] The literature here is very diverse ranging from Hacking's historical ontology(Hacking, 1998a, 1998b, 2002), to Rose's work on psychiatry and governmentality (Rose, 1990, 1998, 2006), to more polemic critiques focusing on the globalization of psychiatric categories (Watters, 2010) to name just a few. Following Allan Young's brilliant study on PTSD, which created a powerful analytical template, similar genealogical and empirical excavations have been applied to many other DSM disease categories.

[42] Here, I am sparing you the exact details of the conceptual shifts occurring with each framework: 1976: International Classification of Impairment, Disabilities, and Handicaps (ICIDH), 1988: WHO/DAS (assessment instrument), 1993: World Development Reports (inventing the DALY), 1996: The Global Burden of Disease Report, 2001: International Classification of Functioning, Disability and Health (ICF, revision of the ICIDH), with an integrated assessment tool, WHODAS 2.0 that also became part of the DSM 5, 2006: Convention on the Rights of Person with Disability (CRPD). Also see (Federici, Meloni, & Lo Presti, 2009).

originally driven by the mental health unit[43] as it sought to integrate mental illness with other health agendas. As such, disability frameworks deliberately uncoupled the question of "functioning" from both diagnosis and etiology (Cieza & Stucki, 2008; Federici et al., 2009) in order to create so-called parity between mental health and other health issues.[44] In this classification system, it did not matter what a person's diagnosis was but how it affected their daily life in relation to their environment and the tasks they needed to perform. A singular impairment, for example, the inability to dress oneself, could be associated with a many different disorders; the assessment of functioning had become independent of its determinant. The resulting functioning assessment tools, such as the WHODAS II instrument are to this day important outcome measures in Global Mental Health. To measure improvement or the effectiveness of an intervention functioning scores are commonly combined with diagnostic symptom scores (it is not an either/or).

In her genealogy of the notion of "functioning," Dokumaci (2018) argues that its contemporary iteration contains two different dimensions: Firstly, functioning assessments emerged from the needs of industrial capitalism, when the body became knowable in its capacity to work, and, in parallel, from the need of the emerging European welfare state to created administrative categories of true deserving-ness for social aid (Stone, 1986). Secondly, beyond the definitions of disability in relation to a body's productivity, functioning began to be conceptualizing in relation to what Wahlberg has called "living with" disability (Wahlberg, 2018), for example through the measures such as quality of life (QoL). The latter notion of functioning, Dokumaci argues, is rather different from a strictly medicalized notion of

---

[43] WHO's early disability frameworks were originally driven by the mental health division but were designed to be applicable to all diseases: "Coordinated by WHO's secretariat for mental health and later by the secretariat responsible for classifications and terminology (Cieza & Stucki, 2008, 305).

[44] "[ICF] is also etiologically neutral which means functioning is understood descriptively and not caused by diagnosis. It adopts the parity approach which does not recognize an inherent distinction or asymmetry between mental and physical function" (Cieza & Stucki, 2008, 305).

impairment. New disability scales – like the QoL in her case, or the WHODAS II in mine – arise from a concern with performing tasks of everyday life. Dokumaci argues that both strands of disability assessments are related. While the functional body first became knowable in relation to biology and employability, it was this figure that could then be expanded to include social and emotional aspects of functioning such as happiness, well-being, and life satisfaction (Dokumaci, 2018).

But here I am getting ahead of the story because the WHODAS II and the International Classification of Functioning framework (ICF) only developed in 2001. Back in the 1990s, in parallel to the WHO's disability frameworks detailed so far, another actor began to engage with the question of disability, namely the World Bank. In this institutional context, functioning appeared in its older variation: its relation to the economically viable body, but not so much vis-à-vis an employer or a national economy, but as an asset within international development.

World Bank - Producing the 'burden' of disability for development

In the early 1990s, the World Bank had renewed its interest in the idea of "human capital" as a way to further the development of countries. The idea had been mobilized on and off since the 1970s and led to investments into education, reproductive rights, and increasingly, health (G. S. Becker, 1967; Rigillo, 2010; Sobel, 1978).

In 1993, the World Development Report, entitled "Investing in Health", was entirely dedicated to the topic. The report introduced as new composite metric called the DALY, which the Bank had developed together with the Harvard School of Public Health, and which would change they ways in which health was counted and accounted for globally. DALYs, short for "disability adjusted life years", established a style of reasoning that expressed the health status of a population in the unit of time lost or gained. By combining measures of mortality ("years of life lost," YLL), with those of disability ("years lived with disability," YLD), the summary metric DALYs quantified the "burden" of a disease. One DALY represented the currency of "one year of healthy life" that could either be gained or lost (Bemme & D'souza, 2014). The "burden" of a disease integrated knowledge across disease and space. New comparisons became possible as the burden was compared among nation states or regions, and among different disease populations. It was this comparative exercise that in the mid-1990s began to produce mental and neurological disorders as one of the largest contributors to the Global Burden of Disease.

DALYs were celebrate as the "common international language" the world had been waiting, as was done by William Foege in the foreword of the report Murray & Lopez, 1996b, xxvi). More specifically, it was a language that connected the logics of public health with those of health economics, and development. Accounting for a population's "years of healthy life" lost was a proxy for productive labor within the national or global economy (Bemme & D'souza, 2014). This new merger between epidemiological and economic thinking – which became the basis of much of Global Health – was eventually also embraced by WHO, especially under the leadership of Gro Harlem Brundtland that began in 2000. Norman Sartorius, who had by then already left the WHO, described this new kind of epidemiology and the shift it brought about for mental health as follows:

> "They are very different approaches [from the epidemiology he championed]. I mean the epidemiology was important because you wanted to demonstrate that mental illness is present, it is frequent and serious in its consequences. Dr. Brundtland felt that the best way to show that something is important is to show its cost. That was the origin of the global burden of disease. Because burden costs money. […] It went for depression and anxiety and such things, but it did not include mental retardation for example, which is the most frequent. It did not include dementia. It did not include schizophrenia. It went for the so to speak ambulant mental disorders"

In other words, conceptualizing mental disorders through its "burden" elevated some conditions within the mental health agenda, but relegated others.[45] Development reasoning would indeed become more important in Global Mental Health and culminate in the 2016 "Out of the Shadows" meeting at the World Bank, where the idea was that if countries allocated resources to mental health care they would obtain a "return on investment" (D. Chisholm et al., 2016).

To sum up, disability frameworks created another "common language" around mental health, this time including policymakers and economists into the conversation. Again, we see important differences in the universality of their claims depending on the actors involved. While WHO's initial disability frameworks integrated mental health through the notion of "functioning" as task, social, and emotional fulfillment, Harvard's and World Bank's DALY metrics mobilized disability to weigh the "burden" of a disease in terms of cost to a health system and economy.

In my interviews with a range of policymakers, funders, and NGOs, many stated that it was the rising importance of disability frameworks within their institutions that opened up a space for mental health to be funded. Three officers at the Department for International Development (DFID), for example, explained to me that a new disability framework that came into effect in 2014 rendered mental health related project applications eligible. Similarly, Julian Eaton, the mental health advisor at the Christian Blind Mission, related how his organization over time broadened its definition of disability, which gradually allowed mental health to enter into the scope of their work. Holding on to the different conceptual strands that have shaped the

---

[45] Critics often point out that severe mental illness received less attention from here on because it is more difficult to capture epidemiologically. Other critical voices have linked the rise of the so-called common mental disorders - depression and anxiety - to the availability of SSRI drugs since the 1990s (Stefan Ecks, personal communication, Alex Cohen, interview).

knowledge object "mental health" within the international arena, we are still missing one particularly important turn: from counting disease towards thinking about "care."

Part II: Global Mental Health

a) From counting diseases to counting care

Although Global Mental Health officially came into being in 2007, some of the same actors had already attempted a similar call to action a decade earlier. In 1995, a group of medical anthropologists from Harvard, where the DALY measure had just been developed, published an edited volume called the "World Mental Health Report: Problem and Priorities in low-income Countries" (Desjarlais, Eisenberg, Good, & Kleinman, 1995).[46] The report combined the newly available DALY pie charts with ethnographic case studies. It argued in the register of a universal epidemiology and cultural specificity of mental distress at once, focusing especially on the social determinants of health (e.g., gender, dislocation, violence, poverty as causes of mental health problems). It decried that "hundreds of millions of women, men, and children suffer mental illnesses", but "received [only] scant attention outside of wealthier, industrialized nations" (Desjarlais, 1995, 4). The report was launched at the United Nations in 1995, and a great number of copies were distributed for free. A linear history has it that the high-level meeting remained disappointingly ineffective in soliciting funds or greater attention from the international community, but that in response the WHO initiated the "Nations for Mental Health" program the

---

[46] The first author of the report, Robert Desjarlais, is interestingly one of the many "reluctant anthropologists" I have met in the field of Global Mental Health. He wrote the report at a strategic and pragmatic moment in his early career but did not feel at home in the genre. Even though this report is the founding document of a movement, and people approach him to talk about it at times, he told me he does not list it on his CV. Chapter four will elaborate on this position of the "reluctant anthropologist" a bit further, as I found myself in it as well, to explore its space of possibility vis-à-vis anthropology.

following year, which is seen as the turning point within WHO away from pure epidemiology towards service delivery (Jenkins, 1997). This shift may be even better understood through the person put in charge of the program, who would go on to become the director at WHO's division for mental health under Gro Harlem Brundtland: Italian psychiatrist Benedetto Saraceno.

Director's cut - Benedetto Saraceno

I meet Benedetto Saraceno, who headed the mental health division from 1999-2010, at one of WHO's off-site offices in Geneva, which is located just above a busy walk-in clinic. I take a seat in a waiting room full of patients until I get called up to go upstairs. Saraceno is warm and welcoming, boisterous really, and as I am asking him my first question, he asks me how much time we have got, weighing his answer. I assure him I will not steal too much of his time, an hour maximum, as is the ritual when working with people whose busy schedules need to be acknowledged. Little did I know then that we would speak for three hours.

Saraceno's personality and policies could not be more different from those of Norman Sartorius. Trained in Triest within Franco Basaglia's school of thought,[47] Saraceno curiously embodies the paradox of a leftist, anti-psychiatric psychiatrist, who pursues his ideas through a commitment to science, evaluation, and technocratic knowledge rather than revolution. Going over his earlier career, he tells me about his training in Triest, and how during clinical practice, he found himself torn between the critical project of Basaglia and the emerging forms of evidence-based knowledge: "So I was in a way becoming the scientific arm of the movement, seeing also with some suspicion that I was becoming sort of the technocrat of the reform, but I

---

[47] Basaglia promoted radical de-institutionalization in Italy, where it became law in 1978. He promoted the idea that much of the signs and symptoms of mental illness are in fact a consequence of the asylums in which people are treated. As a psychiatrist, he famously refused to tie down and isolate patients, and he held that psychiatric staff and nurses were equally affected by institutionalization. He ultimately argued that the asylum needed to be abolished. (Basaglia, Scheper-Hughes, Lovell, & Shtob, 1987).

accepted this ambiguity." After leaving clinical work and becoming the director of social psychiatry in Milan, his mission became "to increase literacy of leftist psychiatrists in the area of evaluation, quantitative methods."[48] About his dual commitment and sense of ambiguity, he says:

> "Not for a second was I thinking that the core of the [Basaglia] movement was wrong, and I am still convinced they are right. But I am also convinced that if you want to disseminate a fantastic commitment to the justice, to the equity, to the rights, to the empowerment, and at the end to the clinical improvement of patients, you should use the instrument of science and not just the instrument of ... whatever you call it."

He recounts the impact the presentation of the World Mental Health Report at the UN had on WHO, hinting that the epidemiologically oriented psychiatrists at the time felt quite challenged by it. The report was developed by prestigious researchers from Harvard, who during the launch openly criticized WHO for being absent from conversations about care delivery in poor countries, about human rights, and the social determinants of health. According to them, WHO failed to engage in "public health thinking, complex thinking", as Saraceno calls it. Moreover, they accused the traditional psychiatry of Sartorius[49] and his successor Costa e Silva of ignoring the plight of people living with mental illness and the concrete health systems challenges these countries faced. Saraceno explains:

> "What the report of Kleinman and Eisenberg did was exactly that: Saying yes, but where are you? When things are happening in Togo, in Basutoland, and Honduras – where are you? What's happening?"

---

[48] He elaborates: "I was not too interested in what traditional psychiatry was doing, they were doing shit. I was interested in increasing the critical thinking of my fellows in Triest. So I started doing very simple things, increasing literacy teachings, teaching them to read a clinical trial, to read in English, or to read guidelines for rational use of psychotropic drugs, or evaluation of the closure of psychiatric hospitals, in terms of what happened and what went wrong."

[49] "Norman Sartorius [was] a very traditional psychiatrist, smart, charming. And essentially his legacy is the classification, is the ICD 10, the thing that humanity cannot live without. It was very important because he created what he called the "common language", so it was important that Chinese and Russian and British and Australian they were calling an apple and apple the same way. It was a tremendous effort, he was able to do it and he was in a way, he was the director of a big orchestra of very traditional psychiatrists."

In response to this confrontation, Director Costa e Silva, according to Saraceno, decided to create Nations for Mental Health, an ad-hoc program "exclusively concerned with underserved populations, with the poor, the vulnerable." As part of the financing, the new program accepted funding from the pharmaceutical company Eli Lilly, a move that would later haunt Global Mental Health. Yet, the ideal leadership for this new program, Saraceno recounts, was imagined to be someone external to the "traditional bureaucracies of WHO", which is how Saraceno came to be hired to lead the program. Reflecting on this work, he says:

> "Was it a success? The answer is no. So the impact of Nations for Mental Health in terms of doing, as a real difference, in real countries, is zero. I was very naive, I had two staff and a lot of money. So was it successful? I would say yes, for one reason: it changed the paradigm. It started introducing the idea that WHO is more interested in talking about [long pause] ... not counting diseases, but counting the soldiers of the army in charge of combatting diseases. So the radical shift from Sartorius' time was that [while his] keyword was "diagnosis", the keyword of Nations for Mental Health was "service", "policy", and "program."

This particular focus in programming was further elevated when Gro Harlem Brundtland was appointed as Director General of WHO in 2001. She made Saraceno director of the mental health division and lent extraordinarily strong support to mental health by dedicating that year's World Health Day, Report, and Assembly entirely to the topic. The World Health Report that year was entitled "Stop exclusion – dare to care" (WHO, 2001b), and it cemented WHO's new focus on mental healthcare delivery, policy, and human rights.[50] Under Saraceno's leadership, the

---

[50] "The World Health Report was really an important event, first of all because it changed completely the paradigm. It was not about mental disorders, it was about policy. It was about service planning, it was about human rights, it was about de-institutionalization, it was about empowerment of users. I am proud of the report and of the people who did the report, because the report was not written by me. I was putting together the people, but some people played an important role. Dr. Saxena, who is my successor, was a key person. Dr. Michelle Funk was a key person. Dr. Saxena bringing in more of the epidemiology and Dr. Funk bringing in more of the legislation and human rights part, and I bring in my Triest story of saying, 'well, the key issue here is shifting from hospital to community.' (Benedetto Saraceno).

counting of those delivering care did indeed become a priority, resulting in the WHO Mental Health Atlas, which reviewed the existing mental health care resources worldwide (WHO, 2001a). Together with the health-systems assessment tool AIMS, a rather different global map emerged, visualizing resources for care rather than disease.[51]

Despite Brundtland's embrace of the wider field of Global Health at the WHO (Brown et al., 2006), mental health remained excluded from the major funding streams of Global Health, i.e. the main philanthropies such as the Gates Foundation, and the World Bank. The language of Global Health more generally, however, became an important blueprint for Global Mental Health, especially the strategies of HIV/Aids advocacy, in which mental health advocates saw a similarly stigmatized condition gain global recognition and action (Saraceno 2006).

b) Global Mental Health: A common language for advocacy

The emergence of Global Mental Health is commonly associated with two important publications: the Lancet series (Patel et al., 2007) and the agenda-setting article in Nature (Collins et al., 2011). Both publications have stimulated further analysis, including my own, which tends to discuss GMH's propositions in conversation with the fierce backlash they elicited (Bemme & D'souza, 2012; Bemme & D'souza, 2014; A. Das & Rao, 2012; Heaton, forthcoming). While these contestations shaped my initial interest in Global Mental Health, my fieldwork now allows me to tell the story through its actors.

---

[51] The Atlas project would later become instrumental in quantifying what under Global Mental Health became known as the "treatment gap." Shekhar Saxena, the current WHO director of the division for mental health and substance abuse, sees it as a major shift in WHO programming: "What exists within the country in terms of the resources, what plans are being made by the countries, that became the focus starting from the Atlas. And that I believe is a major change and impresses one message to the countries. It's not the message, the message is just not that mental disorders are common, the message is: what is the gap between what the needs are and what is available? And that made us choose the word mhGAP as the key for our interaction with countries. To say mental health is a condition where there's a large amount of gap."

My last “director’s cut” will draw on the interview with Indian psychiatrist Shekhar Saxena, the current WHO director of the mental health, but also on conversations with other WHO policymakers, to bring into view the common language that emerges around the needs of multi-disciplinary advocacy. This may seem less specific than the rule-bound practices of epidemiology, disability, or health economics. Yet this lack of specificity may be exactly its epistemic trick: in order to build a movement for Global Mental Health, its common language was designed to integrate and accommodate diverse interests, disciplines, and resources. As such, I contend, the management (rather than the standardization) of epistemological diversity became one of the GMH’s most important features.

Director’s cut – Shekhar Saxena (and colleagues)

WHO’s headquarters in Geneva is a functional, modernist, and practical building – a long, textured cube with hundreds of windows looking outward, their sun shutters in different stages of closure. It is a familiar sight, engrained in my visual repertoire from the many TV interviews held before its emblem. It also invites a kind of time travel. Entering through a sliding door beneath the dramatic concrete canopy, the eye meets what the future must have looked like, in 1966. Yet it is not quite able to take it in because gaze and gait are immediately diverted towards the security checkpoint in the middle of the marble entrance hall. Within its rope-lined paths, visitors are guided to various stations. Appointments are checked, photos taken, ID passes printed. Newly legitimized by this assembly line, I now begin to marvel at this space: its marble pomp meets the modernist lightness of high ceilings, which are held by angled concrete pillars, with windows all around. A shallow staircase with too long steps leads past a portrait gallery of WHO’s directors, each step oddly decorated with office plants and succulents, which seem too small and out of place within the grandeur of the hall.

Image by Doerte Bemme, WHO entry hall (The future, in the 1970s)

All showiness vanishes when I leave the elevator leading to the upper floors where the departments are located. The outer walls are lined with single occupant offices. Two hallways run along them, left and right, stretching what must be the full 150 meters length of the building. They have become familiar to me as I strolled them up and down countless times waiting for interviewees, for lack of a space to inconspicuously linger. The one-window offices remind me of the convent I am staying at. Flimsy walls separate them, yet every cell cuts its own slice of the Alps with their window. Some doors are open, others are closed. Most have printed materials, posters, reports, or brochures on a shelf or cart outside – the currencies of this place, on display. The section that is home to the mental health unit lines its walls with posters of past campaigns, mostly from 2001, mental health's big year. I meet my interviewees either in their offices, which often overflow with materials and can barely hold another chair, or in a meeting room located in the windowless core of the building, which resembles a teacher's lounge or perhaps even the supply closet. It is here that I speak with a policymaker who tells me he sees the emergence of Global Mental Health not as a fundamental change in work of WHO but as an important change in messaging. He says:

> "I think the global movement helped produce a common language for advocacy. Well, of course there is [already] a common language in the ICD, there is a common language in the WHO projects – AIMS and the ATLAS – but there was no common language in terms of advocacy. And I think the movement for Global Mental Health created that language."

When I ask him to explain this common language to me, he lists a number of characteristics:

> "I think the big one is WHO's emphasis on the treatment gap.
> It is also characterized by saying 'we have the evidence for good interventions'.
> It is characterized by seeking much stronger linkages with physical disease.
> It is characterized by positive messages."

The treatment gap, he explains, brought together a large number of interests, he explains, it could be supported by everyone no matter the profession, discipline or activist agenda. The same applied to the strengthening of the link between mental and physical health: this message, he says, was suitable for someone advocating for physical health care in asylums as well as for someone researching mild depression and diabetes. In other words, the key concepts Global Mental Health proposed in 2007 were designed as a broad umbrella language for actors to rally behind; they were not taken from any one discipline, but applicable to all.[52]

The next day, when I meet Shekhar Saxena, he turns our conversation to a similar topic. Before the Lancet series and WHO's mhgap intervention guidelines, mental health programming was plural to the point of confusion: "If you ask ten people about what will be the one thing that mental health people should do, there will perhaps be ten answers." Now, he says, there is only

---

[52] However, this inclusive and integrative approach also produced new exclusions. This policymaker also notes that the focus on "positive messages" de-emphasized issues such as severe mental illness, de-institutionalization, and the human-rights issues associated with existing infrastructures and practice *of* mental health care. In other words, GMH constructed solvable problems with existing solutions, foreclosing spaces for the more intractable, less epidemiologically relevant, i.e. smaller-in-numbers, problems.

one answer to this question:

> "So if the minister comes and says, "tell us one thing that we should do", the answer is very clear. It's not that you train more psychiatrists or you spend more money on drugs or you have school psychologists in every school. That's not the answer, the answer we give is now: assess a situation and scale up care based on your resources, and we will help you define what are those strategies [you should use]. That the minister understands. Otherwise everybody goes and asks for different things and there is a lot of confusion, but now the message is one. […] As a public health agency our message is one: in mental health area[s] the treatment gap is too large for us to tolerate that. And so what you need to do is to see how within your existing and likely resources you can expand care and you can make the care better. One message. It works. So in a way the Lancet series helped us to hone down on this very clear message."

What is striking about the common language of Global Mental Health is that despite its distinctive vocabulary, it remains broad and flexible. Terms like the "treatment gap", "scale", or the notion of "care" are broad enough to accommodate different disciplines, agendas, resource levels, and practical inclinations. The use of "scale" here is particularly interesting because Saxena's message impels countries to do "more", but is used as a movable goalpost in relation to funding levels and quality of care. According to Saxena, many countries do not invest in mental health care because they see it as a costly privilege of rich countries. The language of "scale-up" offers a narrative that is ambitious, but also made up of actionable steps – between now and then, us and them. Rather than suggesting a fixed, immutable standard, thinking through "scale" breaks this process down into smaller, or flexible units. As such, scale was mobilized precisely because it is a malleable term that still implies ambition. Scale as an actor's category had a rather different politics from those commonly assumed by the critique or in theorizations of the term in anthropology. A number of scholars have suggested that scale relies on standardized units that expand without change (Ehrenstein & Neyland, 2018; A. L. Tsing, 2012, 2015). Anna Tsing, for example, uses the geometric imaginary of a pixel that scales through identical replications across ever larger spaces (her main reference point being the model of the plantation that was made up of slaves, plants, land, and techniques of standardizing them all) (A. L. Tsing, 2012, 2015). I argue, however, that scale in Global Mental Health is achieved precisely because it refrains from prescribing strict units – be it diagnoses, spatial units, therapeutics, or resources. Scale in that sense may be similar to Marilyn Strathern's reflection on the "relation" as a generative concept that can hold and take any form (Strathern, 1995).

Ships passing at night

At this point it might be useful to bring in the debate for contrast to better understand why this new language, despite its integrative intention, was in fact seen as offensive. The accommodating logic of the "treatment gap", "scale", and "access to care" suggested by Saxena and his colleague was not immediately obvious to its critics. Declaring a global treatment gap by counting only evidence-based treatments appeared to dismiss all other forms of care and coping with mental distress (Bartlett, Garriott, & Raikhel, 2014); it seemed like a tabula-rasa approach that validated only a small slice of expert knowledge and institutionalized care. Similarly, the language around "scale up" was understood as an ambition to expand and dominate, and it invited parallels to other hegemonic projects, such as capitalism and colonialism. Lastly, given the longstanding contestation around mental health knowledge and classification, the very attempt to produce "global" knowledge was seen as an immediate affront to "local" knowledges and rights to cultural self-determination (Bemme & D'souza, 2014).

As will be further discussed in chapter two, the debate amounted to ships passing in the night: not so much because of the differences in their arguments but, I suggest, because the critics held GMH accountable as *disciplinary scientists*. Yet GMH actors inhabited a distinctly *multi-disciplinary episteme* governed by rules of verification that straddled the practices of science, policy, and advocacy. Recognizing this difference sheds a different light on statements like the one Vikram Patel, GMH's made during our interview in Montreal. When I asked him why GMH based its claims on epidemiological data that many consider flawed, he replied:

> "So I do use [epidemiological data like the GBD], but I don't use it as some kind of bible. I mean I recognize its limitations, indeed I think the people who run those studies also recognize the limitations. They are honest enough to know, you know, these are the limitations. But they are very useful for advocacy, because…like I said before, whether it is ten percent or eleven percent, or nine percent, the point is: it's not zero percent. There are people out there with mental illness and those who do have it do not have access to care."

The numbers are good for advocacy; their point is to persuade.[53] What comes into view here is that Global Mental Health's universalism is rather different from the earlier aspirations to universal knowledge about mental health. It is less concerned with hardening and circulating standardized epistemic objects, though this certainly also plays a role, and more with using flexible frameworks that can incorporate diverse knowledges. Back in Geneva, in 2016, Shekhar Saxena explains this shift to me as a success story:

> "The idea of global mental health is much larger than psychiatry. It involves a number of disciplines and a number of people. So that is sort of a third concept that it becomes broader than the disciplines that restrict people from contributing across the disciplines, like the psychologist would not talk to the psychiatrist, they would not attend any of their meetings. I think it was perhaps, well fifteen years back when we started having meetings on mental health, which were cross-disciplinary. And this is really a very rich dividend that we have gained, by putting people together. So in a way the GMH Movement has served us well."

To sum up, GMH's common language crafted around advocacy galvanized a great number of formerly separate actors and institutions. It formed a new assemblage that incorporated parts of

---

[53] As I previously reported, Patel also said the numbers are useful to "shock governments into action" (Bemme & D'souza, 2012).

the old architecture of international mental health, but also ruptured a number of lineages, for example with the World Federation for Mental Health, and most importantly and with academic psychiatry proper (Kleinman, 2012). While the integrative architecture of GMH did not lay claim to any one discipline's approach, it changed the target of intervention by opening up a new epistemic space for mental health to be defined outside of the realm of specialized psychiatry but within the bounds of evidence-based knowledge production. "Evidence" has therefore become the most important denominator in determining what is truthfully sayable about mental health.

Evidence

Evidence-based medicine has its own history, beginning in the mid-1990s, which I can only gloss over here. One of its main characteristics was the fundamental shift from a reliance on singular expert opinion or group consensus to modes of verification based on meta-reviews of trial evidence and further distilled into clinical-practice guidelines (Daly, 2005; Knaapen, 2013; Timmermans & Berg, 2010; Weisz et al., 2007). Much has been written on the emergence of such global "evidence" (Bashford, 2006; Jensen, 2017) and the fragility of its claims in a post-truth world (Kelly & McGoey, 2018). Here, I will continue to stay closer to GMH and how a changing notion of "evidence" affected mental health programming and altered power dynamics and workflows at WHO. As Shekhar Saxena elaborated:

> "We are living in a world where evidence is extremely important. Even the concept of evidence has changed. Earlier, the department could decide that there was enough evidence to promote an intervention. Now we have an oversight by a guidelines review committee, which is sitting outside the department to advise and clear all WHO guidelines. So I now cannot say, to any member state, you should do this, without actually having a very elaborate procedure of coming to the conclusion that there is enough evidence for me to be able to say that."

Consequently, WHO's expertise and authority increasingly took the form of developing evidence-based guidelines for low-resource settings, of which the mhGAP Intervention Guide is the most important one. MhGAP contains recommendations for the diagnosis and treatment of eight priority disorders: depression, psychoses, epilepsy, dementia, substance use, child and adolescent mental and behavioral disorders, suicide, and "other." It is designed as a practical pathway diagram that targets primary-care providers, not specialists. As one informant once jokingly commented, it is sometimes falsely conceived of as "health care system in a box."

Rather than being merely a document, mhGAP has created a prolific knowledge infrastructure: it is used in countless training workshops, and it is supported by online video tutorials, a cell phone app, adaptation toolkits, and a diagnostic "masterchart." The guideline itself and many of its supporting materials have been translated into more than 90 languages (WHO, 2010). While mhGAP organizes much of GMH's practice and research, its focus on adaptation has given it a distinctly participatory and fluid quality. Most people agree that it is imperfect, but that it is evolving. And indeed, the guideline is perpetually tinkered with and updated. The annual mhGAP Forum at WHO, a conference assembling hundreds of mhGAP users, researchers, and policymakers in Geneva every fall, elicits experiences with the guideline, just as the new online tools asks users for their input on the new surface. WHO's epistemic authority now rests on consulting with its users and expertly collating the newest evidence and experiences.

Experts – everyone/no-one

During my fieldwork, I often found myself contemplating the gospel of evidence and what now makes a mental health expert. Clearly, the singular expert authority derived from a "local" system of validation, as we have seen with Sartorius' "travelling circus", is a thing of the past. Yet in this new assemblage, evidence is still personified and embodied, namely in those scholars and activists with the most prolific publication record, and especially in those who combine evidence with charismatic leadership; in other words, those who know how to produce evidence, and more importantly those who know how to *use* it. Let me give you an example that illustrates this difference. Two researchers at the Center in Cape Town were preparing for a TV interview later in the day. Sharing the nervousness of going in front of the cameras, they walked each other through difficult questions:

> "The hardest ones are the simple ones," one of them says. "What if I am being asked something like "What is depression? Or, what is mental health?" I am not a clinician, that really makes a difference in these moments…" They both laugh, but then they get serious about trying to construct a good answer. "Hold on, there is a clip in one of our project videos where this question is very nicely answered. Something very general, like "Mental illness is a malfunction in cognition, emotion, behavior, and functioning," the first woman suggests, "Ah, great. That's a good one, I will say that." Her colleague then continues, "And besides, you can always say "I am not a clinician, but the evidence shows…and so on."

This curious combination of apologizing for not *being* a certain type of expert followed by a reference to existing evidence is a very common formulation. Evidence has an interesting double function here: it points to knowledge that lies *outside* of a speaker's expertise, but allows them to continue to speak with authority anyways. I remember thinking to myself then, "When referencing evidence, no one really is an expert anymore..." When I later told a friend about this observation, she responded: "No, no, you've got it all wrong. *Everyone* can be an expert this way!" When the truth of evidence is seen as external to a speaker or an institution like WHO, a successful expert is first and foremost a good manager of knowledge rather than its maker. This brings me back to my interview with Shekhar Saxena, who at one point emphatically said about WHO's new role: "We do not *do* research, but *use* research."

WHO = NGO?

“We prefer for other people to lead”, Shekhar Saxena says, and I cannot help but look surprised. We are sitting in his office at WHO, his window overlooking the mountain range in the distance. He has just explained to me how the WHO’s role changed over the past decade: what was once a kind of “know-it-all” authoritative expert organization that exclusively produced in-house recommendations became an organization that preferred to use its “convening power” in partnerships with externally led projects. With this came a shift from operating in the interest of nation states to holding them accountable to the expectations dictated by evidence. In this shift, Saxena recounts, the 2007 Lancet series played a pivotal role, since it was the first time that a WHO department opted to be a small partner in a larger project, challenging the institution’s way of operating:

> “Perhaps twenty years back it was not, it would not have been even allowed for WHO staff to write the kind of papers that we wrote in 2007. We would have been stopped from doing that. […] In the 2007 series, we said many things which were not stated policy of WHO – we went out. And, of course, there’s a disclaimer to say this is authored by me and it does not represent a statement of WHO, but at least we were allowed to do that. And we were testing the boundaries at that time. […] WHO to begin with was, it was going to be an intergovernmental organization, governed by, but also serving largely the member states. And over the years it has evolved into an organization that is governed by member states – but serving the people. And that's a big change. So this you will not find in any WHO documents, but this is the change that has occurred: that we serve the member states but we more serve the citizens of this world. And that's a big change. So in many cases the government's priorities are not exactly in line with the people's priorities. So we are really for improving the health of the people, rather than only supporting the government to help the health of the people. And in that context the move by us in 2007, in fact it started in 2005 actually, was a significant step and also significant demonstration of that evolution.”

He finishes that thought with a succinct phrase that captures this fundamental shift: “We were talking about things that the world needs rather than things that countries want.” WHO had effectively become one large NGO, I thought to myself. Its strategic advantage lay in diffusing their power through collaborations rather than centralizing it around a singular institutional authority. As such, the role of the state in Global Mental Health comes into view as much more complex than its mere sidelining suggested by histories of Global Health (see introduction). Instead, according to Saxena, new evidentiary practices allowed WHO to hold nation states accountable, while simultaneously supporting them as the main vehicle to improve the mental health outcomes of their populations. They worked with, through, and against states, while demanding more of them. Saxena summarizes this shift when he says:

> “The Department during the 70s and 80s was doing two things. One is to do epidemiology of mental disorders. And second was to establish that mental disorders are and mental health is clearly a part of the health agenda, which was not so clear at that time [through disability frameworks]. And the partners of the department at the time were more academic departments. The partners at that time were not ministries of health originally. And that was a major shift starting from late 90s and more during, after the millennium turn, which made [the] WHO department much more policy oriented, much more human rights oriented and much more open to NGOs. […] So the trend has been that we need as many partners as we can get, and be very open about giving our material but also our expertise and encouraging them and guiding them to do what we are supposed to do. And that is a turn that has really succeeded very well. So we are utilizing in a strategic way our convening power, our power to influence people, our strong technical inputs. This has really made us much more relevant than we were earlier.”

In order to gain relevance, WHO invited and integrated a new multiplicity of actors under the umbrella of GMH. It diminished its standalone authority and participated selectively in larger project and consortia, such as the PRIME consortium where much of my fieldwork in South Africa took place. While my own lens on the emergence of GMH has favored international institutions, Saxena’s narrative is a reminder that the convergence around a “common language” could be told just as well from the capillaries as from the center. WHO did not singlehandedly craft this language: it originated as much from academic and personal friendships[54] (for example at King's College, LSHTM, and at Harvard, around Arthur Kleinman) as from the legacies of international NGOs, such as HealthNetTPO, BasicNeed, American Medical Corps, and the Christian Blind Mission, among many others. All of these provide equally valid entry points into the story about how a formerly separate group of actors came to work together under the banner of Global Mental Health.

One constant (failure?): Integration

Before ending this genealogical exploration of how "mental health" was produced within the international/global space, I want to draw attention to a strand of continuity, namely the longstanding attempt of what is now mental health to integrate itself into other health infrastructures. Mental health care has long been treated separately in many ways. Segregation was, in fact, its explicit function when asylums were concerned with social control rather than therapy and where located at the outskirts of cities to remove the mentally ill from society. Psychiatry, too, existed at the outskirts of medicine; their institutions evolved separately, rendering mental health and illness a subject of specialized rather than general health care. WHO's efforts to integrate mental health into primary care therefore push against these histories of marginalization and stigmatization.

In the mid-70s, WHO policymakers began to integrate mental health into primary care through a number of demonstration projects, expert reports, and training materials. In 1974, an

---

[54] In fact, friendship is often given as the glue that held both international and global mental health together. Sartorius, for example, mentions that to this day, the grandchildren of the principal investigators of the schizophrenia studies go on vacation together. Similarly, most GMH researchers tell me how well everyone in the field gets along and how friendships among the member of the "flying circus" are really what is making GMH work.

Expert Committee on Mental Health was convened to discuss mental health care delivery by primary care doctors (WHO, 1975), which proposed many of the same strategies used by GMH today.[55] By 1979, the organizations increasing focus on primary care culminated in the declaration of Alma Ata, which famously demanded "Health for All by the Year 2000" (WHO, 1978; WHO & Unicef, 1978), a call for health grounded in social and political terms (Rees, 2014). The curious place mental health holds in this declaration is worth another anecdote. Over the course of my fieldwork, I heard some people underline the importance of Alma Ata for mental health, while others emphasized mental health's exclusion from it. According to Norman Sartorius, both would be right. He remembers the event in Alma Ata as follows:

> "It was a funny thing because the original report produced did not mention mental health, but in the last days the representative of Panama at the time jumped up and said, "What is this business? We have no mental health component?" So they inserted it. So out of that comes the curious fact that the report of the Alma Ata conference contains promotion of mental health, but the recommendations do not."

Since then, mental health's integration into primary care has been pursued with varying intensity (Isaac, Janca, & Costa e Silva, 1995; WHO, 1998, 2008). Almost everyone I spoke with perceives it as the right thing to do, while also admitting that it has largely failed in the past.[56] When I asked GMH researchers how their integration efforts now differ from the past, they commonly respond: evidence-based testing and the new ambition to scale.[57]

---

[55] Both Norman Sartorius and Rachel Jenkins, the former director of WHO's collaborating center in London, highlighted that these early reports were in fact highly sophisticated, but are largely forgotten today due to a lack of institutional memory at WHO and the air of novelty created around GMH. The 1974 report indeed draws on many ingredients Global Mental Health would later promote, for example, the use of lay health workers to address the lack of specialized personnel.

[56] Sartorius, under whose tenure much these early efforts fell, says: "Unfortunately, it does not survive sufficiently well when it is left alone. So while you are there and you say, WHO is doing this and that and they are very enthusiastic about it, but then as time goes by, priorities for mental health are low and some things don't work very well, and people get tired, so it is very difficult to see it continue."

[57] Shekhar Saxena, for example says, of the earlier integration efforts: "[The] difference is that these were all demonstration projects of a very small size. In the last ten years, we are not doing small projects, we're only doing projects where there is a distinct possibility of scaling up to at least regional level if not national level. So we really

However, under GMH the approach to integration has also taken entirely new forms that exceed primary care and the units of national health care systems. As I have argued elsewhere (2014), integration efforts now target "epistemic communities" that are not spatially or nationally defined, such as the advocacy "platforms" of maternal health, HIV/AIDS, non-communicable diseases, and the development agenda's centerpiece, the Sustainable Development Goals (SDGs).[58] As such, GMH could be described as having a reverse trajectory from other Global Health communities that formed vertical programs and stood accused of siphoning resources from horizontal health systems rather than strengthening them.

Mental health never pursued a vertical approach because a silo-ed existence was always its starting point, not its endpoint. The multi-disciplinary, broad language for advocacy was an attempt to dissolve it. Rather than developing hardened epistemic objects and standalone strategies, Global Mental Health sought to integrate itself into others. What comes into view is an immersive utopia, in which practitioners share a vocabulary, tools and, most importantly, indicators with other actors to amplify the field's reach and importance.

c) What is "mental health"? Outlook into a post-diagnostic world

While the critics of GMH focused on the weakness of the epidemiological argument for Global Mental Health – deconstructing the GBD numbers, pointing out the instability of the disease

---

don't do any more projects, which are small projects. We know what works, so now we're interested in doing those things, which have the potential to be scaled up to hundreds of thousands of the population, if not millions. And always keep the ministry of health as a big partner. We don't do projects where the minister of health is not partner, because we don't believe that those projects have a possibility to be scaled up in a very large way."

[58] After being excluded from its predecessor, the Millennium Development Goals, mental health was eventually included in the UN's Sustainable Development Goals. The backstory to this inclusion is a curious and beautiful anecdote about two separate advocacy campaigns lobbying independently in Europe and at New York's UN headquarters without knowing of each other. When the wording on "mental health and wellbeing" was eventually was included in the SDGs, both groups proclaimed, "We did it!." When they were both invited to the World Bank meeting in 2016, they met for the first time on the same podium and listened to each other's success speeches. It was an awkward encounter, to say the least, and a moment in which "global" advocacy circuits closed, yet by no means seamlessly.

categories, and questioning the quality of therapeutic evidence – they did not appreciate the fluidity and plurality of GMH integrative allegiances. The initial language of Global Mental Health borrowed heavily from Global Health, with its emphasis on the "burden" and the technocratic euphoria of solving "grand challenges" developed by the Gates Foundation; yet this was but one of the many epistemological integration projects GMH pursued. In recent years, critical scholars have noted that key figures of GMH have begun framing their message through other languages, such as the social determinants of health, social justice, or ideas around post-diagnostic mental health care. For example, Vikram Patel began advocating for an even further simplified diagnostic spectrum spanning "distress-disability-disorder." Other interlocutors have told me the next Lancet series will be on mental health care beyond diagnosis. These are all knowledges that are seemingly "betraying" the original epidemiological commitment of 2007. This leads us back to the simple question: what are the epistemological contours of "mental health" in this global knowledge production of GMH? I will answer this question with an argument and an image.

An argument: on simplification

Across all projects I observed, I found that a globally applicable notion of mental health was not standardized, but shaped by the need to be low cost and deliverable by non-specialists. As such, "mental health" as it is operationalized through GMH's diagnostic and therapeutic practices is first and foremost *highly simplified*. Psychiatry's overspecialized classification, complex institutions, and costly training were not considered to be particularly useful in most low-income settings. With the "global" as a proxy for "poor" countries and integration as the field's main strategy, Global Mental Health worked consistently towards a de-specialization of mental health knowledge and practice. For example, GMH's most common delivery model is called "task shifting" because it envisions the transfer of care tasks to lay workers,[59] As such, what mental health *is* becomes delimited by the modalities of care delivery. Put bluntly, "mental health" in task-shifting interventions often is whatever can be taught to a lay health worker in the span of a few days, weeks, or in some cases, months.

Simplification also undergirds the majority of GMH manuals, evidence-based guidelines, and training materials; they are developed with scarcity in mind. MhGAP, for example, simplifies diagnosis into eight priority disorders, some of which are composite categories: namely depression, psychoses, epilepsy, dementia, substance use, child and adolescent mental and behavioral disorders, suicide, and "other." These disorders do not follow the institutional divisions between neurology and psychiatry – they encompass conditions outside of the purview of mental health in well-resourced health systems. In the case of MhGAP, this simplified classification was developed by an external evidence committee but, importantly, also in conversation with NGOs, who got to weigh in on the *usefulness* evidence from low-resource settings. Poor settings and their restraints effectively become laboratories for a new classification.

Psychological interventions emerging from GMH also increasingly propose trans-diagnostic therapies. Modularized and flexible, they cut across the diagnosis depression, anxiety, and PTSD (Bolton et al., 2014; Dawson et al., 2015). Entirely new universals emerge from this space, for example, the idea of "problem solving" as a universal propensity in humans that therapy ought to strengthen or restore (see epilogue). In other words, such simplifications, often based on considerations for cost-effective care delivery, are not merely reductive of psychiatric

---

[59] Task shifting as a term may be new, but similar techniques have been recommended and tried at the WHO since the 1970s, in earlier attempts to integrate mental health into primary care. Task shifting has been studied extensively within Global Mental Health to assess its feasibility and effectiveness (Mendenhall et al., 2014), but it has also been problematized as being not an easy position for "cultural" and "language brokers" (Swartz et al., 2014).

knowledge – they are highly productive of different notions of mental health and the modalities of its care. Rather than simply expanding the Western psychiatric canon, as GMH's critics have argued (Mills, 2014; Rose, 2006; Watters, 2010), the conceptual and practical labor of simplification may in fact unsettle it fundamentally, especially when validated through techniques of evidence-based medicine.

Let me conclude with a small vignette that shows the evolution of my thinking on this point, as much as my own blind spots. When I presented this argument during my fieldwork at the Center in Cape Town, in the audience that day was Dan Stein, the renowned psychiatrist currently chiefly involved in the development of the the revised DSM-5 classification. Here I was proposing that the practices of simplification in Global Mental Health may effectively undermine the DSM classification altogether. A vivid and enjoyable discussion ensued, during which I shared my thoughts on the epistemological effects of the work done by people in the room. Yet what humbled me that day was the question of one of my colleagues, who asked me whether, in their daily work of simplifying psychiatric knowledge, they were inadvertently contributing to the production of a two-class medicine in which poor people receive reduced and simplified care, whereas rich people receive specialized care. I did not have a clear answer to her question then, and I am still grappling with it now.

What later came to my mind was a presentation we had seen a few weeks earlier in the same conference room when a researcher explained why she had decided to eliminate the "C" from CBT in her clinical trial on depression in Khayelitsha. The C stands for "cognitive restructuring" and refers to the counselor's work of reframing a person's negative thoughts; it is the part of therapy that focuses on getting people to "think" differently. She decided to cut out this component because she felt that cognitive restructuring was too complex a skill for a lay health worker or nurse to learn. It could also not be manualized in a meaningful way. Instead, she increased the portion of the "B" in CBT, which stands from "behavioral activation." Behavioral activation seeks to motivate a person with depression to be more active to re-insert them into rewarding feedback loops of life. It focuses on getting people to "do" things differently rather than targeting their "thinking." The contrast here between assigning some people "thoughts" and others "behaviors" to improve their mental health makes for an uncomfortable simplification, indeed.

An image

Finally, the image with which I want to end this chapter takes us back to the 2016 World Bank meeting. We are back at the Milken Institute in Washington, where the morning session is a book launch for the DCP3, the World Bank's "Disease Control Priorities" – an economic evaluation series designed to help policymakers triage their limited resources. Bald men in suits alternate at the podium, recounting their triumph in making the impossible possible: a comprehensive volume on mental and neurological disorders for the disease priority series of the World Bank. The light-green volume has found its place in the Bank's rainbow of priorities, made up of essential surgery (blue), maternal and child health (light blue), cancer (dark green), cardiovascular and respiratory disease (yellow), infectious disease (orange), injury prevention (light red), and developmental disorders (dark red). This book affirms the pinnacle of evidence. It merges epidemiological and health economics thought into firm recommendations based on specific diagnostic classifications. It is as immutable and mobile as it gets; downloadable for free from the World Bank's website, it reaches any corner of the world with an internet connection in seconds.

Meanwhile, in the neighboring gallery of the Milken Institute, the Innovation Fair is in full swing, showcasing “affordable ways to improve mental health”, according to the program. The fair presents a selection of the field’s most successful interventions to the attending policymakers, public health professionals, and businesspeople. The hall is filled with staggered booths decorated with scientific posters, glossy cardboard policy briefs, video presentations on tablets, and at times colorful bags and project merchandise. The presenters explain their innovations all day, at times to organized walking tours, which is when the song and dance intensifies. I join one of them and together we move from stall to stall. We meet countries presenting their new mental health strategy (Lebanon and Brazil); NGOs presenting their community interventions, such as “Zanmi Lasante” (Partners in Health) in Haiti, or UK’s “Basic Needs”; a number of academic groups presenting their RCT results, such as Johns Hopkins’ “common elements treatment approach” (CETA); and WHO-adopted programs, such as “Thinking Healthy.” Over here, on this floor, mental illness can barely be detected – it is less specific, willfully ambiguous at times, and often intentionally concealed. We arrive at the booth for the “Friendship Bench”, an intervention that offers counseling sessions on benches outside primary care centers in Harare, Zimbabwe. Dixon Chibanda, its founder, explains the name was chosen deliberately. “Nobody would want to go to a “mental health bench,” he says laughingly. Stigma is certainly one reason for the evasiveness of terms, but not the only one. At the next booth, the speaker encourages us to play a game: “What should we call it?,” she asks. “Everyone, if you had the choice and could give mental health another name, what would you call it?” My group begins calling out suggestions: “wellbeing”, “happiness”, “emotional balance” are offered, with no clear goal to agree or get it “right.” What seems to matter simply is to agree that it should be called something else.

Interlude – Earthquake

Nepal's earthquake erupted last night; the response happens at lunch today.
I am at a Global Mental Health conference in Providence in 2015 and find myself in the middle of the small group of international NGO experts, who work on mental health in Nepal.
Now, they are first responders. Lunch table headquarters.
Interspersed with their peers and colleagues are young scholars hoping to network, a handful of random conference attendants who just came to sit, and I.
Emergency affect and conference small talk, squared.
Have you heard?
So and so is safe. Thank god.
The lunch bag struts some decent flavors. But always too much bread.
One chews, and scrolls on phones, urgently. Contacting people, checking Facebook, writing emails. Feeding incoming information back to the table. Bite sized.
So many buildings destroyed. Even the temple.
What about…?
In the villages it is worse.
What are the next steps? What can we do?
A desk-review. For the emergency responders. Best practice and cultural factors.
Who can do it quickly? Tasks fly across the table and off into an invisible network.
Deadlines, division of labor, intimate connections on display.
I just have my lunch bag to fiddle with and sounds of empathy to make.
In between the heightened lines, normality catches up to tragedy.
Typical laughs and snippets shared among humanitarians.
Expensive looking, well travelled, experienced people.
Places been, foods eaten, scholars met.
Nepal stories, infinitely amplified today.
Once, the monkey screams kept me up all night.
My toddler is so scared of them.
That time we went without fuel for weeks in Kathmandu.
And the ingenious workaround.
The next panels will start soon.
Where are you going?

Chapter 2 – Speaking in Tongues

a) "Within the bounds of your integrity"

It is an unusually warm fall day in Montreal and I am sitting in a seminar room at McGill's Institute for Health and Social policy where a small training scholarship brought together a group of students from history, epidemiology, geography and anthropology to learn how to translate their research into policy recommendations. We nibble on carrots, dips, and other healthy snacks provided by the department and listen to what is expected from us as trainees in the coming months. A round of introductions immediately makes us reflect on our elevator pitch, assessing whether our lingo would be understandable beyond academia. Transforming our findings into actionable knowledge outside of our epistemic comfort zone is obviously something no one in the group has actively pursued before. "Scientists are generally quite bad at this," the instructor says, "They are great at the minute details of their research, but not at putting it out there and affecting change. So you really need to spin and adapt your message to your audience, to your stakeholders", she says, adding after a small pause, "…within the bounds of your integrity, of course."

Her words strike me and put me in an awkward situation in the minutes to come. We are now asked to do an exercise presenting a key finding from our work to an imaginary unconvinced policy maker, our seat neighbor. Having worked on this chapter for weeks, I am tempted to say to the geography student beside me: "My ethnographic work among Global Mental Health practitioner shows that the tailoring of knowledge to diverse stakeholders challenges the very idea of scientific 'integrity', understood as bound by disciplinary conventions." Would that be too confrontational or would it be the kind of message this particular audience needs to hear? I hesitate and eventually chicken out, choosing a safe example about how my research found that "scaling up" trial knowledge without the research infrastructure that made it successful is likely to fail. I am already certain everyone in the room finds this relevant. But this moment of tense indecision about what kind of message to choose and how to spin it stays with me; it follows me all the way into the opening lines of this chapter.

This chapter concerns itself with a phenomenon I have come to casually term "speaking in tongues." It describes the practice of Global Mental Health practitioners to seamlessly shift between different disciplinary languages and epistemic frames, which I suggest to view as a particular post-disciplinary knowledge performance characterized by what Cassirer calls a *functional* understanding of truth. In GMH it powerfully combines with strategies of knowledge *integration*, the participatory and always partial alignment of messages with different audiences and platforms. What emerges through this, I suggest, is a set of different rules of knowledge production. While "facticity" was formerly bound up in scientific disciplines (their paradigms, thought collectives, or styles of reasoning), multi-stakeholder assemblages such as GMH and their participatory processes employ a managerial approach to knowledge, which will be discussed in relation to theorizations of "truth" in Science and Technology Studies.

b) "Those are not our numbers"

"Those are not our numbers," Vikram Patel exclaimed during a Q&A session at the Advanced Study Institute (ASI) conference held at McGill in 2012. "The Global Burden of Disease is a key decision making tool, but that's not our work. Everybody has doubts about the data, but it's the best we have." He was referring to the global prevalence data of the Global Burden of Disease project (GBD), which had for the first time aggregated mental illness as a global problem. The GBD numbers, however, also stood widely accused of being inflated through extrapolative modeling undergirded by only slim or no data for many regions of the world. Hearing the leading scholar of Global Mental Health admit that the GBD numbers were problematic, and distance himself from their production surprised many. He seemed to contradict every introductory paragraph of GMH publications in which these numbers defined the scope of the problem to solve. His words, in that moment, seemed to support the critics of Global Mental Health, who had questioned the statistical construction of a sudden and significant mental health "epidemic" (Summerfield, 2008). Yet, for Patel, the poor data quality of the GBD numbers did not undermine the very project of Global Mental Health. In his logic, the numbers were badly constructed, but also "the best" available; they were both right and wrong, real and made up, at the same time.[60] He referred to the GBD numbers over the course of this five-day conference as evidence of enormous suffering but also as flawed statistical artifacts, making it difficult to tell whether he was agreeing and disagreeing with either proposition. In his way of speaking all angles on the issue were validated, much to the confusion of many in the audience that day.

This scene took place in 2012 at the Advanced Study Institute at McGill, during a series of meetings entitled "Bridging the Perspectives of Cultural Psychiatry and Public Health." The

---

[60] More detailed material from a later interview with Patel in which he reflects on the GBD data: "We went in quite agnostically. We said let us actually look at the evidence, and the impact it has on people's life. One of the important things about the Burden [of Disease], although many people have focused on the numbers, actually most of the discussion is not about the numbers at all, it's about the impact it has on their lives. So whether the burden is 10% or 8% or 12% is irrelevant. The point is whatever percentage it is, what is the impact it has on a person's life. And I think the critics have tended to completely avoid that. They only talk about the numbers, which is just tragic. Me: But these numbers, they changed a lot over time, right? P: So whether it is ten million people who live with the impact of mental illness, or 11, or 9, or 8 it is still measured in pretty objective terms. […] So you know, some countries have a hundred data points and then whole regions have zero data points. And so there is a use of modeling, and it is a problem – there is no question about that. There is no hiding from that problem so what these…pause…researchers in Chris Murray's unit do is they use very complex theories for modeling the missing data, and, you know, there are problems with the modeling. [laughs] But again, do you have solution for that? The solution is to just show a blank slate for the whole of Africa, is that very helpful? For policy makers? For African policy makers, they will say: Well, you know, since we have no data we won't do anything." And so do we have to wait to do research in every little country in Africa before we act? I think that's completely ridiculous."

event deliberately brought together GMH advocates and their critics, staging a tense intellectual encounter between antagonistic scholars. The atmosphere around this event was charged because an agenda-setting article in *Nature* (2011) had in some quarters elicited a fierce backlash. In this particular context, Patel's way of arguing generated a strong affective response. During coffee and lunch breaks people's reactions ranged from confusion, through humorous and playful indignation to genuine upset. One person, for example, commented to me over lunch: "The numbers are either valid, or not – you can't have it both ways." Some people laughed it off as a clever strategy, while others felt that this kind of speech act was lacking a defendable "position*.*" Many, however, acknowledged his way of arguing as intentional and as a *skill*. The episode around the simultaneity of true or false GBD numbers seemed at the time like a unique, fractious moment owed to this particularly conflict laden conference. Yet, over the course of my later fieldwork among Global Mental Health interventionists I came to recognize such shifting frames on an issue as deliberate.

Patel expressed two ways of knowing the GBD numbers simultaneously. What began to fascinate me about this mode of speaking was the disappearance of *contradiction*. The numbers were true *and* false. A neat separation between factual statements and those that reveal the construction of knowledge – a division often conveniently mapped onto "applied" vs. "critical" science – seemed to have collapsed, or perhaps, mutated into something else altogether. I have come to call this phenomenon "speaking in tongues" in my fieldnotes; a shorthand referring to instances in which a multiplicity of disciplinary voices was expressed simultaneously. Speaking in tongues originally refers to Pentecostal spiritual worship practices in which speakers break into languages they normally do not speak. Admittedly with a lot of creative license I used this term to capture the non-ownership of statements flexibly aligned with different epistemic frames and the sense of dispersed agency that went along with it. Contradictory statements, it seemed, merely passed through GMH speakers rather than being owned, embodied or defended by them.[61]

Speaking in tongues puzzled me for a number of reasons. For Patel no decision had to be made between presenting the GBD numbers as a fact or artifact, no contradiction arose between different ways of knowing the issue, and no disciplinary commitment limited the sayable. Where did all the incommensurability go that I was so keen on observing? Everything I knew about the disciplining powers of thought collectives, paradigms, discourses, and experimental systems had limited grip on this situation. Anthropology of Medicine and Science and Technology Studies trained me in the analysis of *truth* claims, yet I found that the very distinction between true or false itself seemed to have mutated. In this chapter, I interrogate "speaking in tongues" as an empirical event and entry point that tells us something about the new modes of knowledge production within multi-disciplinary assemblages.

To unpack this further, I would like to go back to the ASI meetings as the first instantiations of speaking in tongues I observed. These meetings also mark the moment in which it came into its starkest relief because it was explicitly confronted and discussed by a number of participants. Starting here also allows me to trace my own gradual coming to know of the differences in how my interlocutors on both sides of the debate performed knowledge, in order to tease out the rupture between the two.

---

[61] Perhaps slightly irreverent, the term "speaking in tongues" also reminded me that the original spiritual practice was itself easily understood as a mental health problem depending on the epistemic frame. Thus calling the very technique of aligning and juxtaposing different epistemic frames GMH speakers employed "speaking in tongues", for me, held an interesting tension. What I do *not* mean to imply with this terms, however, is that there is anything deceitful, or false about this practice; I do not think it is a "pretense" kind of shifting, but a genuine desire to speak different disciplinary languages.

c) “It is entirely possible to hold different views”

The ASI meetings in 2012 comprised a five-day series of events involving international and local scholars representing the full spectrum of positions in the controversy surrounding GMH at the time. The most outspoken critics as well as leading figures of Global Mental Health were present and so were representatives of NGO’s, a number of anthropologists, transcultural psychiatrists, ethicists, mental health policy experts, and a delegation of psychiatrists from Jamaica. These scholars engaged with each other over the course of five days in different settings including a workshop, a three-day summer school, and a final public conference. The organizers of the ASI meetings had considered holding the first workshop as a closed-door meeting to create an intimate setting in which differences could be debated. Eventually they yielded to the interest of more junior researchers at McGill and allowed a handful of us to attend.[62]

Despite the best intentions of the organizers to be inclusive by allowing a greater number of people to participate, the room-set up reflected this last minute compromise and created dynamics for the day to come. The invited speakers, mostly senior men (except for two women), sat in a square boardroom table set-up which came to be explicitly called the “inner circle”, which was lined by another row of chairs along the walls by younger and mostly female scholars, referred to as the “outer circle.” The main organizer in his opening words laid out that the purpose of this meeting was for the inner circle to discuss their views and that only if time permitted would the conversation be opened up to the outer circle. The tension this spatial and symbolic hierarchy created remained tangible the entire day. People in the “outer circle” were upset as they felt silenced and relegated to witnessing rather than contributing to the

---

[62] My role at the event was particular because I was tasked by an anthropologist colleague to write a conference report for the blog *Somatosphere.* I was given permission by the organizer to write about the event, if I promised to be respectful, but not to audio-record. I therefore took meticulous notes during the event amounting to about thirty pages.

conversation. In response, they began a vivid email exchange among themselves throughout the day reflecting on their positionality and on the discussions unfolding in front of them. While the inner circle's discussion split along the lines of "pro" or "contra" Global Mental Health's agenda, the outer circle had forged a solidarity among the junior, and mostly female participants of different disciplines against the "older guard", who to them represented past ways of doing things. Solidarities and animosities crisscrossed the room that day, assembled and re-assembled in surprising ways. Every coffee break became an opportunity to find one's allies, to debrief, laugh, or vent.[63] Meanwhile, the discussion within the inner circle at times got heated, and the mood was charged and self-conscious.

One of the contentious threads that ran through these five days, and is related to my interest here, started with the presentation a high-ranking public health researcher from the Toronto Center for Addiction and Mental Health (CAMH). Tall, eloquent, and wearing a business suit, his projecting voice combined a rolling British accent with North American confidence. He opened his talk with a joke, drawing his words out for effect: "How morose this room is! These people in the room are making history and we have faces like on a wet Monday." Jovial and confident, he urged everyone to lighten up. His first slide read "Why don't good people who want to do best for people with mental health problems worldwide, agree?" "What," he continues, "if Global Mental Health has identified the right problem, but perhaps the wrong solution? And, in any case, the question really is: How are we moving forward?" His

---

[63] The dynamics of that day between the inner and the outer circle were persistent enough to carry momentum beyond the event as the outer circle decided to write a position paper from the perspective of the junior scholars in GMH. The outer circle felt the antagonistic debate did not reflect their interdisciplinary skillsets, their way of working and listening across different disciplines. What they had witnessed seemed to them like a "clash of dinosaurs" battling along outdated trenches. Ultimately, this paper never came into existence because the initiative, after a first enthusiastic Skype meeting, died a typical global communication death. Despite the existence of a shared google document, it proved impossible to routinely schedule Skype calls across the time zones of Australia, Europe, and both costs of North America. Little did I know that the very tropes, tensions, infrastructures, and their failures surrounding my first encounter with GMH would be with me for a long time to come.

presentation then went to map out agreements and disagreements between both sides, neatly separating them into columns listing “problems” and “solutions”; his rhetoric strategy amounted to a seemingly agnostic production of consensus through the mapping of *common* elements. Sidestepping the tense affect between GMH proponents and critics, he encouraged the heterogeneous audience to focus on what they have in common; to rally around a shared problematization. By positing an a priori desire to “move forward” and by addressing the room as “good people” he lent moral unity to the imagined community he had just created. Before everyone knew it they were part of a group of morally upright people, sharing the same path “forward” through a world that can be divided into “problems” and “solutions.” Furthermore, the scale and importance of this group and its endeavor was not just a room full of squabbling scholars, but an event during which “history” was to be made.

Not everyone, however, felt comfortable being integrated in this manner. In the discussion following the talk, a senior Quebecois anthropologist leaned back and slowly elaborated in a French accent:

> “You are trying to avoid the staging of conflictual positions by incorporating the critique. Science is based on controversy. I am not afraid of controversies, I am more afraid of consensus. Controversy gives us a chance to correct things, and eventually improve things.”

The speaker’s ambition to integrate messages here squared with a different understanding of science as a practice that produces contestable knowledge. The scientific method, to the anthropologist, was guided by the pursuit of truth, not consensus. The speaker’s community building exercise did not carve such a space for himself. What mattered to him was the “common ground” within a field of divergent knowledge claims. Creating a “common ground” relied on techniques of summary and simplification, while his presentation style suggested a tentative and reflexive approach that remained open to input. As such, his imaginary "way forward" did not belong to him alone it was supposedly taken by everyone in the room. Matching the anthropologist's mildly annoyed tone, the speaker responded:

> "In a postmodern society it is entirely possible to hold different views at the same time. For example, Prime minister Harper's policies are effectively harming the mental health of people. Yet, they co-exist with the work of Canada's mental health commission, which is heavily promoted by the same government. One needs to be practical in order to get things done!"

In this statement, consensus comes into view as the necessary prerequisite for *action* - to "get things done" and to find a "way forward." And the production of *actionable knowledge*, relied on the evocation of collective processes and diverse entities, such as the postmodern society, Harper's government, or Global Mental Health as a field – rather than a singular, defensible position. From the vantage point of *action,* it was paramount to hold and validate these differences. Instead of choosing/knowing one position, it became important to hold and *manage* them all at once. Similar to what I have called 'speaking in tongues', this speaker's "common ground" exercise juxtaposed conflicting positions in value-free acknowledgement, before the work of consensus-making and *integration* could begin. While full agreement may never be achieved, as he made clear in his presentation, a "practical" and "good person" ought to commit two things: to finding a shared problem formulation and to "moving forward."

What struck me about both Patel's and this speaker's manner of speaking was that the knowledge they were producing was temporary, partial and remained in flux. Both techniques allowed them to align their claims with the "room", the audience at hand. This way of knowing retained a great flexibility because the boundaries of "the room" would not only change with each session and occasion at the ASI but could also be verbally re-drawn. While the speaker's presentation exercised inclusion and integration of "the room" in front of him, the mechanisms of alignment could also be reversed and worked against “the room” in a gesture of exclusion. Vikram Patel, for example, after many days of arguing with his opponents, said during the final public conference of the ASI:

> “None of this is written for you. Our primary audiences are ministers of health and individuals with mental illness. [GMH] is not a textbook discipline, it’s not for academics. The language they speak is different from this room. Standardization, feasibility, affordability are the language that matters a lot in these contexts.”

In other words, his message, he acknowledged, may fail the scrutiny and methods of this particular room, but it remains true to a distant audience for which it was designed. With the ease, skill, and network of an epistemic traveller, Patel effectively provincialized the audience in front of him. He rendered their disciplinary way of knowing not exactly irrelevant, as it was still acknowledged through ‘speaking in tongues’, but fundamentally partial and poorly aligned with other, perhaps more relevant, audiences. Rather than striving to create ‘universals’ as GMH stood often accused, Patel leveraged his own and their knowledge as powerful *partials*.

This principle of shifting alignments with audiences did not only apply to the literal rooms of the ASI meetings, it also guides GMH knowledge production at large. As outlined in the first chapter, the field's main strategy is to *integrate* mental health care into existing infrastructures and platforms. Over the past decade, GMH’s has re-aligned its efforts a number of times - starting with the Global Health-oriented exercise in the Lancet series, it copied strategies from the HIV’s “health as a human right” movement, and inserted mental health into development and other disease platforms (i.e. SDGs, non-communicable diseases, maternal health, and primary care more generally). The upcoming Lancet series in 2018 will advocate for psychological intervention in post-diagnostic terms, a bold step that challenges the epistemic tenets underlying the psychiatric epidemiology the field started out with. In short, the field over time aligned itself with different discourses and collectives, which in turn generated different kinds of knowledges about “mental health.”

Within this perpetual motion of alignment, “speaking in tongues” and “common ground” exercises come into view as techniques that allow GMH actors to communicate and integrate its message across the many boundaries it aspires to traverse – be they national, spatial, disciplinary, or institutional. Integration as an aspiration, I therefore suggest, has formalized a new kind of epistemic openness in the name of *actionable*, and *global* knowledge. As I will elaborate below, knowledge produced in a participatory, ever shifting, and reflexive formation appears markedly different from knowledge verified within singular disciplinary, scientific epistemic frames. The flexible aspect of GMH knowledge production escaped many of its critical observers at the time of the debate, when their sole focus was on the deconstruction of scientific “facts” – the GBD numbers, the DSM or ICD classification, psychiatric diagnostic tools, and the notion of “evidence” as promoted by evidence-based-medicine.

d) “It is not quite evidence, but it is evidence”

Moving away from the contentious encounter staged during the ASI meetings, I would like to revisit ‘speaking in tongues’ within its own habitat, so to speak, within the everyday of Global Mental Health’s knowledge production. During my fieldwork among GMH practitioners I encountered these techniques frequently: Rallying around flexibly defined problems, mapping out common grounds in stakeholder workshops, and the switching between factual and deconstructing statements were simply the everyday.[64]

---

[64] I got entirely used to functional alignments of arguments. I observed many of Vikram Patel’s starkly different presentations given for various audiences and it would not strike me as peculiar when a research consortium’s health economist advised a country partner that “your government might be much more receptive to development than health arguments” suggesting to frame mental health care as poverty reduction program. Only after my 12 months fieldwork I was reminded of how controversial the perpetual reframing, shifting, and juxtaposing of messages was

Let me give you a few more examples of moments from my fieldwork that I came to label 'speaking in tongues'. One is from a skype interview with Mary De Silva, a leading GMH scholar in the UK, who was a co-founder of the Center for Global Mental Health in London and is now working for the Wellcome Trust. We spoke about the role of evidence in GMH, which made her reflect on the work of the Mental Health Innovation Network, a virtual platform for mental health interventions funded by the Grand Challenges Canada:

> "So, in the MHIN [Mental Health Innovation Network] we explicitly include all forms of evidence, we don't distinguish. We don't say, well this one is better than that, we don't have any quality criteria. The only criteria is that they have to be evaluating it. Which could just be routine health records of the program, or an NGO annual report that says how many people they've treated – which is rubbish evidence. […] It is better to know that than to completely disregard it and to say "Oh this is not an RCT so therefore this is rubbish evidence" because actually it is really valuable for policy makers. So it is not quite evidence, but it is evidence."

Her last expression here, "It is not quite evidence, but it is evidence" encapsulated the phenomenon of traversing different epistemic frames I was trying to describe. Her statement was partial and non-committal to either set of rules valorizing evidence - science or policy - but it was also not evasive. It simply held them in the same space, capturing two ways of knowing "evidence" in Global Mental Health.

New rules?

In the following I will explore how 'speaking in tongues' is embedded in, and an expression of, a number of recent shifts in the production of knowledge in multi-stakeholder assemblages such as

---

perceived when I mingled with social scientists again. Listening to their grievances about GMH, calling out mismatches between what GMH advocates said, published, and did I found myself honestly wondering what they were so upset about. I sometimes caught myself thinking, "Yes, but you cannot take these statements at face value. You have to look at who they were for…" Speaking in tongues had started making perfectly sense to me. Perhaps I was going native.

GMH. I will focus on three aspects: 1) interdisciplinarity as a space of new epistemic affordances; 2) partnerships and the ethos of participation; and 3) how these converge around an ambiguous notion of 'evidence' in GMH.

a) Interdisciplinary affordances

As already discussed in chapter one, Global Mental Health has positioned itself as decidedly interdisciplinary. In a double move, Vikram Patel declared the field to be part of Global Health, "not psychiatry" and emphasized that the field "espouses its values of multidisciplinary approaches" (Patel, 2014, p. 8). Rupturing the genealogies with academic psychiatry and professional bodies like the World Federation for Mental Health (WFMH), GMH embraced the much broader paradigm of evidence-based medicine combined with a participatory and collaborative ethos in lieu of strict disciplinary allegiance. Their main message of bringing mental health care to "scale", they believed, could only be achieved through the engagement of many sectors, disciplines and stakeholders as possible. Choosing epistemological multiplicity over disciplinary purity allowed the field to rally around shared but broadly defined problematizations, such as the "scale-up" of mental health care in low-resource settings. "Scale" was not meant as an imperial ambition, but as an inclusive heuristic device able to straddle differences; an irrefutable common ground between reluctant policy makers.

In other words, GMH's did not guard any specific professional turf or disciplinary canon but went the other way: it broadened the scope and language circumscribing its mandate and object of care – mental health – and it lowered the threshold to membership within its multi-disciplinary assemblage to a commitment to *evidence* and *cost-effectiveness*. Psychiatry's specialized knowledge and costly training programs were relevant to this this endeavor but also seen as 'overspecialized' and therefore of limited utility. GMH focused on simplified mental healthcare care deliverable by lay health workers. Psychiatrists and psychiatric nurses were still considered important but envisioned in roles as supervisors and trainers to maximize their expensive expertise in low-resource settings.[65][66] In other words, GMH fostered a kind of interdisciplinary that created new epistemic affordances; it allowed the field to rupture genealogies with psychiatry and develop a novel set of questions that sidestepped many of the disciplinary dilemmas of psychiatry.

The interdisciplinarity of Global Mental Health, however, did not restore a wholesome "unity of knowledge" as interdisciplinarity is often viewed (Schmidt, 2008). Rather, it produces temporary unity among a number of diverse actors around shared "real world" problematizations. As Schmidt points out, this type of "problem-oriented" interdisciplinarity is most often highly normative as it seeks to affect change in the world.[67] In concrete projects, this kind of interdisciplinarity is often operationalized through tools like "complex systems theory", "theory of change", and "logical frame analysis"; frameworks that allow various types of knowledges to be inscribed together (see chapter three). Here, however, I would like to focus on how this flexible, interdisciplinary epistemic space is undergirded by *participatory* modes of knowledge production in partnerships not predominantly made up of scientists.

b) Partnerships and participation

---

[65] Task sharing interventions are not merely simpler and cheaper version of Western psychiatric care they are highly productive of new classifications and models of care in their own right (see chapter one).

[66] Psychiatry feels threatened by simplification. Professional groups unsurprisingly, have felt uneasy about these simplified and de-specialized forms of care. They see their reputation, influence, and procedures devalued by ever-shorter trainings, the proliferation of credentials. An ad for the Congress of the World Psychiatric Association 2018 alludes to this defensiveness: "Psychiatry needs to continue to develop as an evidence based science and become more and more relevant in a congested and crowded mental health environment." (Andrew C Peters, WPA newsletter November 1st, 2017) The broadening of the term "mental health" and the simplification of qualifications posed a threat to the discipline.

[67] "Positions of unity are developed from a ''problem-oriented'' or ''real-world'' perspective; their goal is to address and to solve pressing problems of society. The societal problems are so complex and interrelated that a disciplinary approach is usually not feasible. Interdisciplinarity is regarded as a tool to tackle these complex issues" (Schmidt, 2008, 57).

Most work in Global Mental Health is undertaken in partnerships. Such engagement with a diversity of actors and "stakeholders" in GMH is facilitated through a participatory ethos formalized in specific evidentiary practices such as consensus, stakeholder interviews and workshops, situational analysis, or policy consultation processes.[68] Even the controversial agenda-setting article in Nature (2011) was sourced through a Delphi panel, a technique to produce consensus among large groups of experts. Delphi consensus holds only a lower rank in the knowledge pyramid of EBM, but its legitimacy derives not only from its weight as "evidence," but also from its quantification of diversity and participation. When defending the agenda, GMH scholars would often highlight the diverse composition the Delphi panel – the number of LMIC country participants, the number of different disciplines, and the proportion of women. The procedure itself, independently of its outcome, gained validity as a display of participatory globality.

Participation as an ethos is also at the core of everyday research and intervention practice. The inclusion of mental health service users, policy makers, clinicians, social services is commonly performed and displayed at every stage from the design all the way to the reporting mechanisms of an intervention. The everyday work within Global Mental Health partnerships assumes diversity of knowledge and capacity as the norm. Not because they are applying a cultural idea of alterity (as critics suggest they should) but because managing differences is a necessity at the operational level. Every GMH partnerships and participatory practice I observed had to contend with a myriad of differences on a daily basis: disciplinary knowledges, contextual factors in each intervention site, political dynamics of countries or municipalities, donor requirements, socio-economic differences among populations but also staff, linguistic challenges,

---

[68] For a genealogy of participatory research from development to health: (Cooke & Kothari, 2001; Kelty, 2017; C. W. Lee, 2014; Lezaun & Soneryd, 2007).

geographies, gender dynamics, technical infrastructures, work styles, research capacity, and the structures and idiosyncrasies of health systems - to just name a few. In this environment of knowledge production through multi-stakeholder participation, “speaking in tongues” mirrored the need to manage the voices of its participants. As a technique it does not amalgamate existing differences into a singular form or truth. It does not dominate or convince, it acknowledges and manages, and sometimes integrates.

Yet, “speaking in tongues” is also a function of power. Shifting between the ways of knowing within a given audience, meeting, or collective is a leadership skill and privilege.[69] I have only observed it being used by principle investigators, public figures, or the leading epidemiologists in GMH projects. To me, they seemed like experts of a new kind.[70] Imbued with the authority to have a managerial perspective on knowledge, they were seen as literate in different epistemologies in order to convincingly integrate diverse knowledge claims into actionable (and also researchable) problems and solutions. For contrast, compare this managerial expert figure with a scientific expert whose authority grounds in the mastery of one specific set of epistemic rules, as described in the episode “Every/No-one is an expert” in chapter one. In temporal terms of outgrowth, I believe, one might say that “speaking in tongues” as a leadership skill turns the former vice of articulating contradicting scientific claims into the virtue of successfully managing plurality of knowledge without friction.

This leads me into a discussion of the notion of “evidence” as the most important trope through which knowledge claims are valorized. Building on the discussion of the rise of evidence-based medicine in chapter one, here I want to explore how “speaking in tongues”, in

---

[69] I kept thinking, if this was done by a lower ranking person within the collective it might simply be perceived as incoherent, but I am not sure. I have never seen it happen.

[70] New perhaps, for now conveniently, vis-a-vis the Mertonion ideal scientist, who is driven by the four norms of universalism, communalism, disinterestedness, and organized skepticism (Merton, 1973).

practice both challenges and reinforces EBM's hierarchy of knowledge.

c) On the use of evidence in GMH

*Version: veneer***.** EBM emerged as a set of practices, norms, and institutions that reconfigured medical practice through the elevation of evidence over other forms knowledge in clinical decision-making. Ideally generated in randomized-controlled trials (RCTs) or other highly formalized experimental systems, evidence-based decision-making promised to render medicine both more rational and accountable (Timmermans & Berg, 2010). EBM since produced clear hierarchies of knowledge that are famously represented in a pyramid that is topped off by systematic reviews of trial evidence, followed by trial evidence, cohort studies, case studies series, on the lowest rank sit expert opinion and consensus. Evidence-based-knowledge production has itself been rendered visible as a complex conduit for power within contemporary state and non-governmental health bureaucracies (Mykhalovskiy & Weir, 2004), as discriminatory towards other knowledge forms (Laurence Kirmayer, 2012), as having paradoxical epistemological effects such as the formalization of 'non-evidence' (Knaapen, 2013) and as an endangered form of knowledge in the post-truth era (Kelly & McGoey, 2018).

Version: ground. In GMH, the notion of 'evidence' and its clear hierarchical imaginary is both powerfully mobilized *and* contradicted. When producing 'evidence-based' care for low-resource settings is the main goal, not all evidence is considered useful. Evidence, I found, was much more ambiguous than the universal veneer of the pyramid leads on. For example, in many cases the experiential knowledge of NGO's and their perspectives on logistical constraints was brought to bear on the evaluation of relevant evidence. WHO's evidence-based intervention guidelines mhGAP invited NGOs to the scientific committee in order to determine whether existing evidence was practically *feasible* and could be operationalized in the settings they work in. Consequently, operational considerations could determine the clinical pathways for example for the treatment of depression in the mhGAP guideline as much as the scientific quality of the existing evidence. Evidence in order to be meaningful needed to be true to its methodology (the pyramid) but also to the "real world" constraints in which it was to implemented. While evidence became perhaps more pragmatic, the reverse is true as well: NGOs became more scientific. The increasing demand for impact and outcome evaluations from funders reshape the activities of humanitarian and health actors. Some scholars have described this as a rise of audit culture (Merry & Conley, 2011; Shore & Wright, 2015; Storeng & Béhague, 2014), or new regimes of accountability (Stein, 2008). For my purposes here, it only serves to notice that formerly separate forms of knowledge practices – intervening and evaluating – have begun to reshape and resemble each other.

*Version: ambiguous***.** During my time at the Center for Global Mental Health in London and the Alan Flisher Center for Public Mental Health in Cape Town, the production of evidence on the effectiveness of interventions was clearly at the center of all activity. In large-scale cross country consortia, local clinical trials, and NGO delivered programs everyone worked towards producing data, knowledge, and ultimately scientific publications. However, while publications in high-ranking journals such as the Lancet, and scientific careers more generally were important motivations to people's practice, there were also limits to the appreciation of 'evidence for evidence's sake'. People often spoke to me about a general fatigue regarding RCT evidence, which generates ever more "proof of concept" but not necessarily scalable or sustainable programs or infrastructures. High-ranking RCT publications were desired but also remarked upon as self-interested as researchers were seen to get their publications, pack up and leave with no sustainable impact. In other words, proof of concept through an RCT was regarded as a stage in the "way forward", not as its endpoint. Getting interventions to "work", doing implementation research, and building long-term relationships with policy makers to sustain programs was described to me once as "unglamorous" because it "does not get you the Lancet paper." Yet, contrary to what it might seem, this comment was an expression of pride and a valorization of self-sacrifice. Not striving for the Lancet paper but impact in the "real world" held higher value in this researcher's eyes. In a similar vein, Mary De Silva highlighted to me during interview that:

> "There have to be other forms of evidence, I mean I think what distinguishes Global Mental Health, one of the reasons why we all get on so well, is because we are not generally just interested in finding stuff out and having lots of papers and big academic careers. We are actually interested in fixing stuff, in changing stuff."

She went on to say that "We have to take whatever evidence we've got. Because we haven't got millions and millions of pounds and decades of time in order to do loads of RCTs." Comprehensive and highest quality evidence production, in her view, could in fact delay action. In other words, evidence does not merely have to be 'true' knowledge it is also required to be 'doable' knowledge within the judgment of multi-stakeholder collectives and NGOs. Pragmatism and humility were thus often foregrounded in the name of action and impact over "knowledge for its own sake." To sum up, EBM has provided a universal language for GMH to trade 'evidence' as a boundary objects among and across its differences. The use, meaning and performance of evidence, however, are not fixed and remain changeable depending on a project's needs, audiences, or definition of 'impact' (also see chapter three).

Evidence ≠ truth. What gradually emerged through these observations for me was that evidence was always powerfully shaped by its requirements to be “evidence *of* something” (truth), but also by the requirement to be “evidence *for* something” (action). Up until this empirical divergence, to me, evidence had been more or less equivalent with the notion of truth – perhaps a different historical iteration of what Daston has analyzed as different mechanisms of “objectivity”(2000), but ultimately converging around the idea of “truth.” Over the course of my fieldwork, however, I increasingly began to ponder: What if the notion of ‘evidence’ and the way it is produced, hailed, performed, and deconstructed, is altogether different from the way we understand “truth” as the centerpiece of science and epistemology? Remembering the instances I labeled “speaking in tongues” and the conference speakers’ imperative to “hold different views at the same time”, I wondered what exactly governs the production and management of actionable knowledge, and how is it different from knowledge claims in the name of “truth.”

Knowing knowledge: Questions for STS

Thinking through my training in science and technology studies, I realized that most work I knew had looked at truth or objectivity as an achievement of the disciplining mechanisms of thought collectives (Fleck, 2012), paradigms (Kuhn, 1970), styles of reasoning (Hacking, 2002), networks (Latour, 1987), or experimental systems (Hans-Jorg Rheinberger, 1997) – but neither of them seemed to help me understand the assemblage of actionable “evidence” as I had observed in GMH. Let me walk through a few of them to explain why.

Fleck showed how a scientific fact is a historically and socially contingent achievements of “thought collectives” and their “thought styles”, which amounts to an inherently socially bound understanding of ideas and their evolution (Fleck, 2012). Kuhn would add to it a mechanism of revolutionary overturning of what he would call ‘paradigms’, maintaining their fundamental incommensurability. For Kuhn**,** GMH would therefore more or less operate in a state of “normal science” in continuation of its existing disciplinary traditions, perhaps showing signs of epistemological crisis in some of its parts, but not actually generating *new* knowledge, just new pieces of the same puzzle (Kuhn, 1970). Latour taught us to pay attention to the networks in which scientific facts are produced, taking into account human and non-human actors who together make, move and inscribe facticity along knowledge infrastructures Latour, 1987). Scientific facts, for Latour, can reshape the world not because they are true to an independent nature, but because they are true to the networks that produced them; reshaping the world in the laboratory’s image, facts can thus freely roam anywhere (Latour, 1983). Indeed, GMH can be described as a project expanding a knowledge infrastructures and facticity that remains true to its own experimental set-up and network. Yet, with this model one cannot account for the flexibility of “speaking in tongues” and the reflexivity of its own methods and ways of producing knowledge.

Rheinberger has urged us to think about the production of ‘epistemic things” emerging from ‘experimental systems’ by generating surprises by means of controlled repetition.[71] He points out that research sit at the border between the known and the unknown with an obscure horizon, because “one does not precisely know what one *does not know*” (Hans-Jörg Rheinberger, 2015, 167). New knowledge, he insists, is unforeseeable. In GMH, evidence may not be foreseeable, but the impact it ought to have on the world is already defined. There is no open epistemic horizon, just an open pathway towards a determined horizon (also, see chapter three).

---

[71] Experimental systems themselves, he highlights, are historically contingent and have marked the “experimental turn of the modern sciences”(2015, 165), according to him they are “veritable *difference machines”* they produce new knowledge through iteration and difference.

What all of these scholars have in common is that they raise and grapple with the question whether science is converging towards a truth outside of our theories or whether knowledge is only ever true to the epistemic apparatus that produces it. They all treat the production of scientific knowledge as process invested in the idea of truth. Their social, material and temporal set-ups are distilleries of facticity.[72] None of these, however, are particularly helpful in capturing the flexibility of a multi-disciplinary assemblage that works through alignment and integration and that only temporarily solidifies its knowledge claims – while showing awareness and reflexivity of this process. As I am exploring what happens when new knowledge does not sit between existing knowledge and the unknown, as Rheinberger suggested, but between 'experimental systems', 'paradigms', 'thought styles' and their 'collectives', I am turning to a new and untimely companion to make sense my GMH interlocutors' way of knowing the world.

a) Rolling horizon: Cassirer's functional theory of knowledge.

Ernst Cassirer has reflected on the processes of concept formation in his work *Substance and Function (2004 [1910])* in which he argued against the Aristotelian and Kantian idea that concepts are shared abstractions derived from sensory input from the world. In this abstractionist view, concepts are ultimately rooted in substance; they can be empirically confirmed through the senses and in isolation from each other. Cassirer, on the other hand, argues that concepts are solely defined by their position within a system of other concepts, laws, and judgments; they are functionally linked, and not atomistically related to an external substantive world. This *functional* theory of knowledge therefore argues against an ontologically "given" reality that can

---

[72] Eventually my exploration always pivot back to Foucault and his discursive formations, as he does not focus narrowly on 'truth' but on the larger conditions of possibility organizing the meaningfully sayable at any given time.

be directly known through concepts derived from observation. According to Cassirer, abstractionism overlooks the epistemic preconditions of perceptual knowledge (Heis, 2011). Concepts therefore emerge and exist within relations and organizational rules. Claims about the empirical existence of something therefore *have to* be made through the concept's position within its system of knowledge. They become true knowledge about the world when the system is objective; that is, logical, coherent, lawful, and systematic. Mathematics, for example, according to Cassirer can generate objective knowledge because its historically evolving systematicity has identifiable, coherent laws, albeit no "given" referent in a sensorily accessible world. In other words, for Cassirer there is no "real world" out there to be sensorily discovered and named, there are only concepts in relations to other concepts which, depending on their degree of systematicity, can produce true empirical statements. In Cassirer's functional theory of knowledge concepts produce true objects, whereas a substance based theory of knowledge assumes that true objects produce concepts through abstraction. Cassirer, however, is not a relativist. In his account the world can be known progressively and science inches towards a rolling horizon of knowledge converging around a notion of truth in functional terms rather than in terms of ontological substance.

> The identity towards which thought progressively strives is not the identity of ultimate substantial things but the identity of functional orders and coordinations." (Cassirer et al., 2004, [1910], 431)

In other words, for Cassirer, universal laws can be achieved and progress is possible,[73] but knowledge is not true to an ontological world, it is true to a system's way of knowing the world.

---

[73] Friedman 2008 writes: "For Cassirer, this history is seen as a process of evolving rational purification of our view of nature, as we progress from naively realistic "substantialistic" conceptions, focusing on underlying substances, causes, and mechanisms subsisting behind the observable phenomena, to increasingly abstract purely "functional" conceptions, where we finally abandon the search for underlying ontology in favor of ever more precise mathematical representations of phenomena in terms of exactly formulated universal laws."(Friedman, 2008)

The reason for this long detour into Cassirer's differentiation between *functional* and *substantial* knowledge is that at the heart of GMH's practices, may be a functional understanding of knowledge. Knowing one's own knowledge and perpetually reflecting on the condition of possibility is exactly what these interventionists do. Speaking in tongues is a routine technique for such reflections; it juxtaposes and takes stock of all relevant epistemic framework to a given problem. The facticity of the GBD numbers is true to its modeling methodology, which can be admitted to be flawed without abandoning the system altogether. But this kind of methodological reflection is not all there is to it. What matters is what you can do with the GBD numbers. What's more is that the knowledge GMH produces is both functionally true to its epistemic scaffolding and system, but also true to what people understand to be the "real world" (variously represented through stakeholders, NGO's experiential knowledge, or operational evidence). Knowledge has to be true to its scientific methodology, which can be inscribed and stabilized, but also to the idea of an inherently unpredictable world, which requires the constant shifting and adaptation of one's knowledge.[74]

What I am trying to get at is that GMH interventionists know the systematic contingency of their own ways of knowing. In line with Cassirer's idea of a *functional* horizon, their knowledge is as true as is possible. "Everybody has doubts about the data, but it's the best we have" (Patel, interview). GMH researchers in that sense are *functional* thinkers, taking into account the conditions of possibility of their own observational knowledge.

GMH scholars know at all times they are constructing knowledge within a number of chosen epistemic frames, which they are able to switch and juxtapose within the participatory forms of knowledge production. GMH knowledge is delimited by the triad of: 1) disciplinary

---

[74] This is why people are so obsessed with methodology. It gives the only frame of accountability. You don't report against "world" you report against the methodology. Reporting against "world" is done through process data.

methodologies (science); 2) "real world" constraints (operational data); and 3) alignments with platforms (participation). As much as GMH was accused of applying a universal understanding of mental illness to the cultural others, in response I would like to complicate this narrative significantly and suggest that GMH utilizes *partial universals* towards a dual horizon converging around a functional notion of "truth" and "impact." The differences between GMH advocates and their critiques lay therefore less in an "either/or" scenario between different ontologies, but between *functional* and *substantial* modes of knowledge production. The fleetingly aligning, hyper-reflexive ways of knowing in GMH was at odds the disciplinarily bound, ontological positions of its critics (who came mostly from anthropology, transcultural psychiatry and psychiatry). They were two ships passing at night: One committed to the idea of ontological alterity, the other to an idea of functional alterity, which can be aligned, integrated and perpetually adapted to all kinds of epistemic differences.

b) Boundary works

GMH's critics made their arguments against Global Mental Health from the vantage point of their disciplines and ontologically committed lenses, drawing on the social determinants of mental health, cultural alterity, post-colonial critiques, and critiques of the validity of psychiatric evidence more generally. In doing so, they positioned themselves decisively outside of Global Mental Health as an assemblage; they sought to challenge and correct their claims and numbers. Global Mental Health actors, on the other hand did not engage in the same way. Driven by a participatory ethos they perpetually extended the invitation to their critics to communicate and contribute to "going forward." They invited them to shared panel, to guest lectures at the Center for Global Mental Health in London, and they staged public panel discussion. And after all, they let me, as an anthropologist, follow them around and observe their practice. I never encountered closed doors.[75] In other words, both sides of the debate performed very different kind of boundary work. While critics tried to correct GMH, GMH tried to integrate the critics.[76]

I want to pay a little bit more attention to the phrase "the way forward" in the repertoire of key operational semantics in Global Mental Health as I found it to be an important mediator of Global Mental Health's open boundaries. Among Global Mental Health scholars, everyone I spoke to acknowledged that the critique was very important and insightful. Yet, what many researchers found inacceptable was the critics' unwillingness to engage in contributing to better interventions, to look for a common denominator and to commit to a shared "way forward." What seemed offensive was not a critical vantage point itself but the insistence to remain on the outside of the assemblage. To them, the procedures of striving for common ground and charting a common "way forward" seemed universal, not so much the content. Even when the debate was at its fiercest, GMH advocates would invite their critics into the discussion. Social science colleagues in London were asked to debate the issues on public panels and were invited to teach a session at the annual summer school held by the Center for Global Mental Health.

The only un-bridgeable difference remained between people committed to working towards the "next steps" on the "way forward" and those who refuse to be integrated in the multiplicity of this assemblage. In the view of GMH advocates, anyone – be it traditional healers or critics - could come to this table, as long as they are willing to contribute to "the way forward." Anecdotes on this theme are plentiful. One of the principal investigators in PRIME, for example, shared this sentiment about the critics with me over dinner during the annual meeting.

---

[75] There were some trust issues and forms of apprehension in the beginning and some meetings that I was not allowed to attend etc. But nobody questioned the importance of scrutinizing one's own knowledge practice. See more in chapter four.

[76] At the policy seminar at McGill, with which I opened this chapter, I had to decide between a topic that I knew people in the room would find relevant and the thing that I found important, but uncomfortable to say. When I chose the former, I catered to an audience with a specific taste and preference in knowledge in order to find a common ground. Speaking in tongues may not breach scientific integrity, as I initially suggested. It may be better described as the very lack of a fixed boundary to breach, due to its fluid alignments with the relevant "room."

In a parallel analogy, he described how traditional healers were difficult to integrate because, he admitted, they may not really get much out of working with GMH.

What struck me was that the only hard limit to GMH was this commitment to the idea of a "way forward." The definition of mental health, the manuals for its treatments, and the forms of delivery could all be debated, re-written, and collectively negotiated. What was not acceptable, however, was the refusal to join this flexible and inclusive approach; a real epistemic "outside" vantage point was somewhat offensive to GMH advocates. Their perpetual integration of all voices – critics, service users, or policy maker - worked towards an imperative of collaboration that was not negotiable, erasing a true outside vantage point on the field. In short, while the path "forward" could be messy and crowded, it could not be questioned itself. It had to be shared. In all of this, I came to think, speaking in tongues is also an expression of this absent boundary work; it is an invitation. It allows for everyone to be in principle heard, acknowledged - even if it is just through juxtaposition – and it opens up the possibility for the work of integration of such differences to begin. It is an invitation that extends the values of "democratic" participation and integration build on its own genealogies that seek to right the wrongs of colonial, and top down approaches in international development (Green, 2010; Kelty, 2017). However, returning to the earlier ethnographic moments, the imaginary of integration and participation as embodying progressive values was poignantly punctured at the end of the ASI meetings. During the final feedback round, after five days of debate, a Jamaican psychiatrist brought back the conflict between the public mental health speaker and the anthropologist. He said:

> "I too fear consensus because Jamaica's history had very dark times. We need to appreciate the very fact that we are able to have disagreements. Checks and balances are needed in order to 'go forward'."

To him, the perpetual integration of contradictory viewpoints into consensus meant the exact opposite from what the participatory ethos intended. He saw it as a form of silencing that resonated with Jamaica’s colonial history. Consensus to him stood for oppression, while open dissent was a function of freedom.

***

Interlude – the Center

“It is not […] particularly real,” Mary De Silva says of the Center for Global Mental Health, which straddles the Institute of Psychiatry (IoP) at King’s College London and the London School for Hygiene and Tropical Medicine (LSHTM). She is one of its founding members and we are talking over Skype, even though we are both in London. I ask her to tell me how the Center came about and I learn that, initially, it was little more than a plot between two colleagues to avoid competing for grants. Establishing a unit across institutions allowed them to apply together. The Center existed only in name and had what Mary calls an “awful website.” When she took the helm, she made the Center more real, by making it more virtual. “Having a good website, having a good Twitter,” and hosting events across London, she says, made all the difference. And, indeed, the Center’s website is sophisticated with its beautiful imagery, constant news feed, and an interactive world map with projects popping up wherever your pointer hovers over a country. It also shows a long list of scholars as “working in Global Mental Health in a cohesive way,” she says. And yet, she says laconically,

> “people come and visit and say “Where is everybody?” …because it is a virtual center. It has people in all kinds of different places, and most people are very kind of associate members, they work peripherally in Global Mental Health. […]. Buuut, for some reason, we have this really good visible external face.”

In other words, the Center *was,* and to an extent still is, a website. It did materialize differently as well over time. People began to fill offices, logos went up on doors, and an MSc training program had paying students file into classrooms. Yet – to this day – none of it is funded. The Center has no core staff, no administrator, no stationary, no designated space. Whatever *is* there is carried by research grants, by soft monies. Office space comes out of overhead, MSc teaching out of researcher's own time. Meanwhile, the program turns a profit for LSHTM and IoP. Despite its precarity, Mary concludes: "We've got people like Vikram Patel, which is great, and obviously our reputation has grown as a result. So I think [the Center] is a useful tool – but it is not anything particularly real."

You would not guess any of this when you arrive at the impressive lobby of LSHTM, when you sign in to a visitor's log and patiently wait to be escorted by an authorized person. When you follow them through door after door, swipe after swipe, as you enter into an architectural palimpsest, composed of different historical buildings, really, which are curiously forged into an open-plan everything: offices, cafeterias, computer pools, and lounging corners. You would not guess the fragility of the Centers' institutional arrangement when you walk through the futuristically swerving, wooden hallway to arrive at the "globe room," an oval conference room whose glass walls are patterned with frosted meridians. Here, I mingle with bright-eyed MSc students excitedly talking about their future careers working to improve the wellbeing of others. They nibble on carrots and hummus, and sneer at rival GMH programs; they are the Center – drawn in by the powers of a blinking map, and bringing forth the virtu-reality of GMH.

***

The Center for Public Mental Health in Cape Town sits in a fenced-in, small compound in Rosebank, a middle-class neighborhood in the southern suburbs at the foot of Table Mountain. Like the Center in London it is highly guarded, albeit from different dangers and by different means. While London protects its institutions from terrorism and non-paying academic visitors, Cape Town's Center guards itself against the violence of the everyday, born from the country's infamous inequality and the legacies of apartheid. Those arriving in the safety bubbles of their cars open the high gates with remote controls; those arriving on foot, like me, wave to the guards to open. Day and night the guards remain on duty, lodged in a small hut that barely gives them shelter from the sun, rain, or chilly winter winds.

Inside, the Center is a curious place. A former children's hospital, its little rooms were designed for little humans; all door-knobs are just above an adult's knee and the child-sized sinks in every office are rumored to stem from a time when water play was *en vogue* for (white) children's psychological recovery. Now these rooms fit one or two desks. Some are permanently occupied, some rotate among visitors and collaborators. This Centers runs on soft monies too. Funded by a number of European or American grants, it keeps expanding (and encroaching on the space of the child psychology clinic, which sometimes causes tension).

Every morning, I walk down the two eggshell colored hallways to find myself a space to work. Along the half-opened doors I see colleagues chat, hold meetings and conference calls, click through columns of numbers, code, or build websites and power point slides. I walk past the printer where a poster reminds us to prepare for "load shedding," the rolling electricity outage scheduled to unburden the grid, which was built for a fraction of people and is now, unreliably, stretching itself to the whole of the post-apartheid population. "Back up your data," the poster instructs. Further down on the wall is a pin board full of group photos, taken at meetings and conferences across the world, a line-up of familiar faces in different compositions; a visual genre in itself for reports and websites. On the same pin board, the PRIME project's photo gallery unfolds, displaying beautifully photographed tales of recovery. With vigor, a woman washes her laundry again, the corrugated metal walls of her shack contrasting with her colorful dress.

I walk further down the hallway, past the data people, who are usually under their headphones, but often happy to take me in. Today, I find a desk with the health economist, right beside the director's small corner office with its standing desk. Sitting is the new smoking, I think to myself every time. I am guilty of both as a group of colleagues and I defy the gravity of health promotion and gather for cigarette breaks in the fenced-in parking lot. My desk today overlooks Rondebosch Commons, a huge unkempt field with wild grass, shrubs, and a picturesque island of pine trees. The Commons, as they are called, are the size of an empty airfield. People from the neighborhood walk their dogs here or go for runs, carrying whistles to call back their dogs—or to call for help. The Commons are a space of recreation but also of provocation considering their position in a deeply segregated urban geography. "Informal settlers" once tried to occupy this space, unsuccessfully as I am being told. The Commons induce a different kind of guilt when enjoyed from an office window behind which GMH actors work to improve the mental health of those in Khayelitsha, Langa, or Gugulethu, just five kilometers down the road – where the average size of a shack measures what is given to two parking spots here.

***

Chapter 3 – What works: Theory of change and the virtues of failure

What works?

Anyone working among Global Mental Health practitioners has come across one particular question, a phrase frequently used at conferences, in research meetings, on power point presentations, reports, and during formal and informal conversations. It is the simple question: "What works?" This innocuous phrase expresses the aspiration to improve the health of others as a technical challenge; its scale and scope are intervention packages and projects, its moral gesture is a 'call to action', not a political rallying cry. Yet, in its simplicity, 'what works' has its own force. It celebrates pragmatism and achievable futures along tentative, technical steps, a 'way forward'. Something can be *done*. Asking 'what works' is not unique to Global Mental Health (GMH) but a feature of the wider field of Global Health and evidence-based policy making. Entire books, government reports, research networks, and prevention programs have elevated the succinct phrase to their names and titles (Nutley, Smith, & Davies, 2000). "What works?" harbors a particular kind of tension characteristic of this current evidence-based moment. It captures the singularity of evidence (it works!), but also the need for continual reassessment to uphold this ephemeral state (it is working!).

In this chapter I attend to practices of impact evaluation of complex interventions that have become central to Global Mental Health' knowledge production. Specifically, the use of the evaluation framework Theory of Change (ToC) lends itself as an empirical entry point into a reflection on how making things "work" differs from, and relates to, the production of "truth" within the evidence-based paradigm. Informed by multi-sited fieldwork among Global Mental Health actors, this chapter explores three case studies that illustrate the differential use of Theory of Change - as a *design tool* in a multi-country consortium, as a *scale-up implementation tracke*r across sites within a city, and as an *accounting tool* to determine the impact of a funder's global intervention portfolio. Through an analysis of the differential use of the technique, this chapter contends that Theory of Change presents us with an epistemic device that allows GMH actors to work and think across difference in novel ways. While ToC can undoubtedly be used as just another static accountability tool of "audit culture", its design holds the potential to create iterative, consensus-based, and adaptable processes that remain open-ended and reflexive. And it is this novel form of evaluative reasoning that I want to bring into view in this chapter.

Many anthropologists in Global Health see it as their role to investigate the underlying assumptions and processes of Global Health's quantitative knowledge production and to carefully trace their blind spots and unintended consequences. ToC itself I found complicates current critiques of health metrics, evaluation, and quantification and raises an altogether different question: What are we to do when our Global Health interlocutors engage in reflexive practices themselves, when their categories and processes present themselves as already analyzed and in perpetual flux? How do we engage with Theory of Change and its iterative knowledge practice, without decrying its reflexivity as some form of false consciousness nor taking it entirely at face value?

a) Critiques of health metrics & quantification

Much has been written about the role of universals and quantification in Global Health, and how standardized units of knowledge such as disease categories, indicators, and risk factors, tied together in health metrics, inform evidence-based policy (Adams, 2016; Jensen, 2017; Jerven, 2013; Merry, 2016; Wahlberg & Rose, 2015). Undoubtedly, numbers are made to matter in Global Health. They account for global distribution of disease, for monies spent, for returns on investments, for people treated, vaccinated, or educated – and most famously they account for "lives saved" (McCoy, Jensen, Kranzer, Ferrand, & Korenromp, 2013; Reubi, 2018a). Techniques of quantification quite literally define who and what counts, they distinguish data from noise, and perpetuate an imaginary of quantifiable progress. Such global health metrics rest as much on the statistical techniques mobilized by nation states (Desrosières, 2002; Hacking, 1990; Porter, 1996), as on newer regimes of "epidemiological reason" (Reubi, 2018b) and "stateless" knowledge (Rees, 2014) produced in partnerships between NGOs, philanthropies, and universities.

Anthropologists vis-à-vis these dazzling global numbers have been rather apprehensive, asking in response: "What counts as knowledge?" and "Whose knowledge counts?", tracing the epistemic inclusions and exclusions in this verification game. Techniques of quantification and their reliance on universals are identified as inadequate in capturing real world complexities. Vincanne Adams, for example, writes:

> "Today key institutions of global health […] envision using a form of global knowledge that is based on universals (biology, disease, vaccines, etc.), in which multiplicity is visible only in and through global (that is, universal) forms of data production that get lumped together as "metrics." (Adams, 2016, 6)

Metrics and techniques of quantification, in their ability to transform social and political problems into apolitical and technical challenges, in such accounts, are said to not tell the right story; their power is to reduce and decontextualize (J. Ferguson, 1990; Merry & Conley, 2011; Shore & Wright, 2015; A. Tsing, 2000). Anthropologists therefore approach them mournfully, from a perspective of loss, using their own mode of knowledge production when accounting for those losses in intricate stories of that which escapes and resists. Less empirical rigor, however, is applied to the numbers themselves - how they came to be, what they came to do, and what their own multiplicities are. Statistics, metrics, RCTs, or data are often treated as a monolith, their politics and possibilities already decided (Adams, 2016; Merry, 2016; Shore & Wright, 2000). As such, anthropology claims to have access to the "real world" through long-term empirical engagement and a conceptual apparatus that understands the human in social, political, subjective, cultural, and affective terms. Attuned to their agency to act and resist, to create and become, to suffer and heal, and to carve out an otherwise, such local entanglements, narrated in reflexive prose claim to capture - imperfectly but knowingly - the messiness of the "real world." It is this kind of multiplicity anthropologists believe must necessarily escape Global Health's metric. And it is this kind of notion of the "real world," and with it the habitual disciplinary opposition between numbers and stories (Moats, 2016), that came undone during my fieldwork.

Throughout my fieldwork, I found that the unpredictability and multiplicity of the "real world" mattered greatly to GMH interventions, not merely as a barrier to implementation or standardization but as an entirely normal feature of an intervention's process that needed to be rendered visible – and measurable – in order to make it "work." I thus began to inverse the direction of my inquiry. Rather than asking how universals and techniques of quantification are applied to the "real world", I asked: How are universals made in the knowledge practices of impact evaluation, and what kind of notion of the "real world" do they help constitute? Here, I am taking a cue from Michel Foucault's suggestion to describe the formation of universals through concrete practices, instead of explaining such practices through existing universals.[77]

While anthropologists have contested and localized universal claims for a long time – especially in arenas of globalization, human rights, and medicalization – rarely have they granted

---

[77] He writes: "In other words, instead of deducing concrete phenomena from universals, or instead of starting with universals as an obligatory grid of intelligibility for certain concrete practices, I would like to start with these concrete practices and, as it were, pass these universals through the grid of these practices. […] Let's suppose that universals do not exist. And then I put the question to history and historians: How can you write history if you do not accept a priori the existence of things like the state, society, the sovereign, and subjects?" (Foucault, 2008).

insight into the fundamental contingency of universals to their interlocutors. In my various field sites in GMH, however, universals emerged as flexible and internally complicated. They were in fact routine sites of negotiation among these actors working towards the creation and maintenance of conceptual stability and measurability across differences in time, space, or other orders. As we will see through the lens of the Theory of Change approach and its uses, this epistemic labor required both the hardening and softening of universal concepts in order to make projects "work."

Theory of Change (in theory)

Theory of change is a participatory technique for the evaluation of traditionally "hard to measure" community interventions (Center for Theory of Change, 2017). It has become immensely popular not only in international development and government agencies, but also among NGOs, philanthropies, and corporate social responsibility programs. The framework enjoyed a particularly strong uptake in the UK's public sector (Blamey & Mackenzie, 2007; Sullivan & Stewart, 2006) and it is from here that it entered into Global Mental Health. More specifically, the Department for International Development (DfID) began advocating Theory of Change (Vogel, 2012), recommending its use in all of their interventions and offering training workshops in the approach. Mary De Silva, a renowned GMH researcher and co-founder of the Center for Global Mental Health in London, learned about it during one of DfiD's workshop in 2012. Her enthusiasm for the approach led her to "single-handedly," as I was often told in interviews, introduce Theory of Change into key GMH projects and platforms. ToC was eventually adopted by GMH funders like Grand Challenges Canada (GCC), who made its use mandatory for all their projects, as well as by one of GMH's flagship projects, the PRIME consortium. De Silva also called for ToC to be integrated into the UK's Medical Research Council's evaluation guidelines, arguing that the current method-driven approach does not account for "mechanisms of change through which [an] intervention leads to real-world impact" (De Silva et al., 2014).

a) Making theory and maps

The idea of theory-driven evaluation, in contrast to method-driven or log frame approaches, is that evaluative practices must attend to the theories of causation underlying an intervention. As Blamey and McKenzie have pointed out, theory-driven evaluation emerged in response to a widely held disenchantment with method-driven approaches in the evaluation community, who increasingly sought to treat "context and underlying assumptions not simply as confounding factors" (Blamey & McKenzie 2007). In other words, theory here is seen as an empirical question rather than a prescriptive template.

ToC structures a collective process of theory-building that articulates how and why an intervention is assumed to work (Weiss, 1995a). As a practice, the stakeholders of an intervention come together in ToC workshops in order to reverse engineer a "pathway to impact." Starting from the definition of the long-term impact that ought to be achieved, the group works backwards along individual steps and their causal relationships and arrives at an actionable present from the vantage point of an utopian future. As the common ToC imaginary goes, through the coming together of facilitators, participants, white boards, sticky notes, arrows, tape, and multi-colored markers, a theory of change emerges from the experiential folds of a diverse collective, building concepts as much as community. The goal here is twofold, to explicate the underlying assumptions of an intervention and to render them testable through indicators assigned to each step. The result of a ToC workshop is a visual pathway diagram, the so-called ToC map, and a set of collectively agreed indicators by which the success of the pathway will be measured. As Erica Breuer, the ToC champion of the research consortium PRIME, writes: “The ultimate ToC”, “should be plausible, do-able and testable and can be represented graphically in a ToC map” (2014, 2). Figure 1 shows what a generic ToC map looks like:

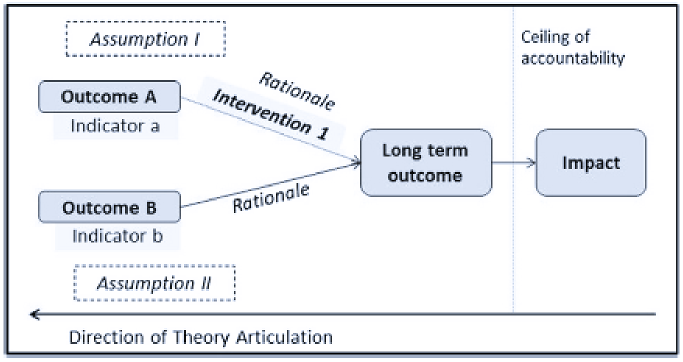

Figure 1 Elements of a Theory of Changes (adapted from Andersen 2004).

This map illustrates the main mechanisms of ToC’s theory-building process, including the reverse “direction of theory articulation” starting from the future impact and moving towards the present. One curious concept of a ToC map is called the “ceiling of accountability”, a dotted line, which separates the measurable project outcome from the long-term impact. This division stands for the factors an intervention cannot control, that ultimately, when all is planned and done, lie beyond its scope. Impact, ultimately, remains suspended an unreachable arm’s-length away, yet it motivates every single step towards it. For all its efforts to adapt a pathway to the “real world”, as we will see, the ceiling of accountability acknowledges the upper limit of control, a space of the untamable; a visual idea of progress that reflects on its own limits.

Despite its final inscription in visual pathway maps, ToC formalizes two surprising virtues: its pathways remain open and, and its theory presents itself as empty. Mary De Silva, in our interview, emphatically pointed out: "Theory of change is not a theory. It is just diagrams, pathway diagrams. There is no theory involved in it at all. Very basic." Beyond the procedural requirements of consensus and measurability, ToC presents itself as a mere conduit or scaffolding for concepts and assumptions to emerge. Furthermore, ToC pathways only temporarily assume a stable form. Ideally it remains open to continued theorizing as the intervention unfolds. Mary De Silva writes: "Developing a ToC must be a continual process of reflection and adaption as barriers to implementation arise and new evidence comes to light, requiring pathways to be changed and strengthened." (De Silva et al., 2014, 5). In other words, ToC pathways do not aspire to be cemented highways, they are designs envisioned to meander through the "real world."

b) A brief genealogy of Theory of Change

ToC has emerged within a larger history of evaluation science, combining techniques of accountability and control with the study of social change (Alkin, 2004). Today's ToC scholars draw their lineage back to US management thought of the 1950s, evaluation science in the 1980s (Coryn, Noakes, Westine, & Schröter, 2011), and to the emergence of so-called theory-driven evaluation in the 1990s (Chen, 1990; Weiss, 1995a, 1995b) after which the approach consolidated and proliferated internationally. Theory of Change thus sits at the intersection of two seemingly contradictory currents of the 1990s: the rise of the *evidence-based paradigm* (which began to devalue consensus-based expert knowledge), and the rise of the *participatory* *paradigm* in community interventions (which began to elevate lay expertise in participatory action research).

The term Theory of Change was first coined in the context of the Roundtable on Community Change initiated by the Aspen Institute in 1995. Harvard evaluation scientist and steering committee member Carol Weiss, in her contribution to the resulting edited volume argued that community interventions are hard to evaluate because their own assumptions remain opaque. Instead, she suggested to base "evaluation on the 'theories of change' that underlie the initiatives" (Weiss 1995, 66). Her understanding of theories, however, did not refer to systematized expert knowledge. Rather,

> "theories represent the stories that people tell about how problems arise and how they can be solved. Laypeople as well as professionals have stories about the origins and remedies of social problems […]. These stories, whether they arise from stereotypes, myths, journalism, or research knowledge, whether they are true or false, are potent forces in policy discussion." (Weiss 1995, 72)

Her emphasis on sourcing theories and the best course of action from all actors involved relates ToC to another strand of genealogy, namely that of "participatory action research." Participation became a technique in international development, turning observational walks and conversations with locals into "tools" for the design of better interventions and the formation of better experts (Green, 2010; Kelty, 2017). ToC is therefore often traced back to figures like Paulo Freire and his ideas of empowering the poor through the explication of their own perspectives on poverty (James, 2011).

The ToC approach consolidated further over time through a partnership of the Aspen roundtable with the social enterprise ActKnowledge in 2002, establishing the Center for Theory of Change that acts as a methodological guardian. With its increased uptake by philanthropies, government agencies, NGOs, development actors, corporate social responsibility programs, and the UN, the approach also evolved.[78] Its success has led to a kind of vernacularization of the term. As one Toc advocate notes, asking "what is your theory of change?" has become "a fashionable way to interrogate someone's assumptions" in many decision making settings (Valters, 2015).

As a technique for impact evaluation, ToC squares a particular circle: its open pathways and participatory input promise to stay attuned to the "real world" while the intervention unfolds while remaining committed to the production of quantitative evidence for the success of the pathway. However, despite the approach's aspiration to remain adaptive to both an intervention's unfolding and diverse participatory input, the depth of its reflexivity ultimately depends on how it is used in practice. Much is possible and little prescribed by the framework.

Theory of change (in practice)

In practice, the use of ToC in Global Mental Health revealed a number of interesting features. The most striking of these was its use in the management of what could generically be called *differences across time and spac*e. Used as a mechanism to design, track, manage and compare actionable pathways, it created both standardized points of comparison and spaces for indeterminacy in almost equal measure – again, within the overall aspirational horizon of making the intervention "work." Mary De Silva in our Skype interview in London made this explicit when she told me:

> "[ToC] is a very useful tool in understanding what is universal and what is different. And I think it is very useful if you have an intervention that works in one place, you can

---

[78] While Carol Weiss's ToC maps followed linear successions of inputs and outputs, complexity and systems thinking gave rise to ToC pathways with multi-factorial inputs, and multiple feedback loops (Coryn 2011). Comprehensive reviews on the uses of "theory of change" have been compiled by actors like DfiD (Vogel 2012), Comical Relief, Oxfam Australia. The Center of Theory of Change and its software TOCO posts a list of clients ranging from USAID, the Rockefeller Foundation, public school boards, the Girls Scouts of the USA, catholic charities, and NGO's like the Hunger Project to companies like NEXUS.

> understand the different components of that intervention and which makes it work. And that makes it easier to adapt to another setting."

What I hope to tease out through the following three case studies is what exactly it means to distinguish between "what is universal and what is different" using the Theory of Change approach. We might find that the process involved has little to do with the kind of static quality Vincanne Adams ascribed to universals. ToC, instead, operates within a rolling horizon of changing parameters in which universals emerge from reflexive conceptual choices and only ever stay temporarily true. To develop this broader argument, I am turning towards case studies of three interventions, all of which are utilizing Theory of Change in different ways: 1) the multi-country consortium PRIME; 2) the Friendship Bench in Zimbabwe; and 3) the Mental Health Intervention network (MHIN).

a) PRIME: "Measure as you go along"

The multi-country consortium PRIME was the first major GMH project to use the ToC approach. In the tradition of Alma Ata, the project set out to deliver the proof of concept on how to integrate mental health care into primary care settings in five test districts in Nepal, India, Uganda, South Africa, and Ethiopia. Funded by DfiD and working in partnership with the countries' ministries of health, the six-year program focuses especially on implementation process. During my multi-sited fieldwork in 2016, I spent six months with PRIME's operational management team in Cape Town when the project was in its final phase. I was therefore able to learn about the ToC process with the advantage of hindsight.

PRIME used ToC since its inception. In fact, it employed the approach as a design tool. Evaluation here was not an independent data collection process conducted post-hoc or alongside an existing intervention, but pivotal to the design of the project. Let me reconstruct this process in broad strokes, as it was relayed to me. The ToC framework was introduced by Mary De Silva at the project's initial meeting in Goa in 2012, where the principle investigators and core members of the five country research teams gathered. The first ToC map was created during this meeting and charted mostly commonalities between the countries. It helped produce the "cross-country level" of analysis. The consortium's long-term aspirational impact was defined as: "Improved health, social and economic outcomes in people living with the priority mental disorders in the selected districts of Prime" (Breuer et al., 2014). From this ideal impact a linear pathway was mapped out using the kind of universal elements one would expect to see in a standardization process – including assumptions about the universality of mental disorders (as defined by the WHO guideline mhGAP), standard units of care, drugs, and delivery mechanisms, as well as assumptions about comparable health systems.

The ToC method was then taken to each of the countries and repeated with different groups of local stakeholders. Here, the ToC pathways began to diverge. Some countries prioritized disorders, left others out, or added new ones, for example epilepsy. Budgetary constraints, policy priorities, available human resources, or the disciplinary expertise of the country PI's, favoring either psychiatry or psychology, were all taken into account in developing the country level ToCs, which then served as a basis for the development of Mental Health Care Plans (Hanlon et al., 2015). These plans also widely differed: South Africa integrated into the chronic disease platform, Uganda into primary health care, India chose implementation sites in hospitals, while Nepal wrote an "aspirational" plan in the face of resource scarcity.

Going back to the cross-country level, the country ToC maps and plans needed to be integrated. Here one would expect a tension arising between comparability and specificity of pathways. This was indeed the case and rather than integrating all maps into one they began operation with a 5 (countries) +1 (cross-country) map. Yet, given that all ToC pathways were designed to be measurable along their steps, their integration occurred on the level of indicators. A shared trajectory towards change was not crafted by standardizing the pathways and their exact elements, but through the integration of indicators. A “masterlist” of about 180 indicators was compiled, defining the ground that was to be covered by the evaluation designs. Four research designs were eventually chosen to cover the indicators: 1) a community survey to detect prevalence rates in the community, 2) a cohort study to follow patients over time, 3) a facility study to determine diagnostic accuracy and detection rates, and 4) a case study to document implementation processes.

Even though interventions diverged and many country team members would not know exactly what kind of interventions their partner countries were implementing, all countries had in common that their interventions were evaluated within this same methodological grid. The four designs cast a wide net of specific data points that could be compared, while also – importantly – creating space for multiplicity and indeterminacy in between them. Meeting with me in London, one of the principal investigators, reflected on this process as follows:

> “Now the Theory of Change is a nice example. […] So everyone did it for their own countries and then we came together again to see “what are the same…” […] In order to reduce mental health problems in people that have depression and alcohol disorder, you need to deliver care. In order to deliver care you need care to be available. In order for care to be available you need to make drugs available, people need to be trained. I mean, that basic part is the same, in all of the countries. And then of course in each country it is a little bit different. In Nepal you need to do *this* in the community and in South Africa you do *that* in the facilities, there is differences. But that kind of main process of change is the same. So I think that is a nice example where you do have uniformity across the process, but also a lot of differences between them. […] Every country had enough leeway to develop something that was the best fit for that setting, to develop research questions or change the method as pertinent to that context, but sticking to a cross-country format. We have that matrix, everybody will have that matrix. Everybody will

> have a ToC and everyone is going to have a facility survey, the community survey and the cohorts and a case study. And you know, it's nice…it also means that we all make the same mistakes. If we did make a mistake, we all make the same mistake throughout. And we did. [laughs]"

The ToC process and the cross-country research designs – as divergent as they were - created a grid of intelligibility that could also accommodate great variations. The common denominators of the process converged around broad terms such a "care", "drugs", "training", "delivery", and distinct levels of "health systems" creating just enough commonality to become a shared "matrix", while also creating space for difference through their lack of specificity.

Measuring change - with changing measures

The "mistake" the principle investigator jokingly refers to in the quotation was the decision that PRIME would not have a control group. On the one hand this decision limited the kind of claims about effectiveness that could be made, but on the other it allowed the consortium to continuously adapt their processes, methodologies, and concepts throughout the implementation. As one of the project coordinators pointed out to me, RCTs may provide formally "better evidence", but for implementers, she said, "a pragmatic approach in which you measure as you go along and identify the gaps and failures is not a bad approach." The changes and adaptations PRIME needed to accommodate over the years were negotiated in relation to the four methodologies, not with the ToC maps themselves which were not further updated. Theory of Change formally stopped guiding the process, yet the ethos of "measuring as you go along" continued. Of the many adjustments to the study design and implementation process, many touched on the integrity of universal concepts, and with them the project's ability to compare across time and space.

Let me give you a few examples.

Diagnostic categories, for example, were sites of adjustments in two ways. Countries were allowed to set their own diagnostic threshold defining depression on the PHQ-9 diagnostic scale. While maintaining conceptual integrity of the tool, each site worked effectively with a different sensitivity. The cut-off point was based on cultural and linguistic validation studies and considerations regarding the capacity of the health system. If a country did not have the resources or political will to treat mild and moderate depression, the cut-off point was set higher to only detect severe depression. The continued use of the same scale across all country teams maintained the same yardstick and conceptual comparability in principle, but also reflected multiplicity, including differently resourced health systems or culturally expressed symptoms of distress.

The second case affected the conceptual integrity of "depression" as a diagnostic item more profoundly. The Nepal team realized mid-study that the description of depression adopted yielded a very low prevalence rate in the community survey. In response, the team decided to adapt their script to the local idiom of distress "heart-mind-problem." As a methodological choice, however, this decision compromised the possibility to compare "like with like" between the study's baseline, midline, and endline data collection.

Another way in which universals became fluid and negotiable was in the space of data management and analysis when so-called *aggregate indicators* were created. And here, the most important indicator PRIME set out to measure was "contact coverage." Contact coverage captures the number of people within the district in contact with mental health care and is particularly important because it directly responds to the idea of a "treatment gap" in GMH; increasing contact coverage means closing the treatment gap. However, the exact conceptual boundaries of this indicator were not clearly defined at the outset of PRIME. No single data point captures this concept; rather, it was broadly covered by a number of indicators within the four study designs. The discussion on to how to aggregate “contact coverage” from the existing data ensued during the final year of Prime. The suggestions ranged from a narrower interpretation of only evidence-based care received at health posts, to a broader notion that included help seeking, such as conversations with a priest, traditional healer, family or friends. Contact coverage proved rather flexible and emerged as both a question and an answer from the existing data. As such, rather than focusing on how aggregate indicators as quantifiable universals have no match in the “real world”, as Morton Jerven has suggested[79], they can also be understood in their capacity to deliberately create a new conceptual space. Contact coverage counts with precise imprecision, so to speak. It enables PRIME to count the people “coming through the door” at a point of care, but it does not necessarily prescribe whose door, where it is, or what kind of treatment has to happen behind it. Aggregate indicators may not necessarily represent the “real world”, they assemble it in different ways, for different purposes. In PRIME, I suggest, this mode of quantification prevented excessive standardization across differences, rather than promoting it. The consortium did not enforce the sameness of their interventions or pathways, but created metrics that allowed them to evaluate a great diversity of therapeutic action within the same grid of indicators. These indicators/universals migrated from collectively defined ToC maps, to national mental health care plans, and morphed into four cross-country evaluation methodologies.

What I am highlighting here is that techniques of counting and accounting have an unnoticed capacity to work through and respond to real world multiplicities within their own logics, reminding us that not all numbers are created equal. In the concrete example of PRIME,

---

[79] Morton Jerven during the “Measuring Global Health” workshop on January 26-27th in London made fun of the imprecision of aggregate indicators by giving the example that a singular indicator for a complex phenomena like the weather would not help people decide how to dress (given that the weather is made up of temperature, wind, likelihood of rain etc.).

quantifiable universals were sites of intense negotiation and fluidity. Disease categories, when measured by the same yardstick, could be internally complicated through a locally contingent cut-off on the PHQ-9. The disease categories conceptual identity could also be sacrificed when necessary, rupturing measurability in the name of making it "work" locally. And finally, the contours of aggregate universals remained open and negotiable well beyond data collection. PRIME's techniques of quantification undoubtedly produce "evidence," yet they do so within the larger ethos of figuring out "what works", over and above the production of an immutable "truth." As I will further elaborate in the discussion, what comes into relief here may be best captured as *contingent universals*; concepts that stay true until they "stop working" in the field.

b) Friendship Bench: "a family thing"

While PRIME used ToC to design its evaluation framework, other GMH actors have utilized it to evaluate existing, often long-running programs. One example is the Friendship Bench (FB) in Zimbabwe, a counseling intervention during which lay health counselors offer problem solving therapy on a bench outside of primary centers. Originally developed by the psychiatrist Dixon Chibanda as part of his MPH degree in 2006, the Friendship Bench today is one of the most successful GMH projects.[80] It makes indeed for a compelling story. The idea of delivering mental health care on benches outside of clinics was originally borne out of necessity, as clinics did not give him access to their space or staff. Chibanda was asked "to build something out of nothing", as he put it during one of our interviews.[81] The Friendship Bench since its inception

---

[80] Success measured by the standards of science (a successful RCT), policy (a publicly funded scale-up across 60 clinics in Harare), and international publicity (the intervention is frequently featured in the news, such as the UK's Guardian newspaper). It was also one of the selected 'innovations' by the Grand Challenges Canada showcased at the World Bank meeting in 2016.

[81] Over the course of 12 months of multi-sited fieldwork I encountered Dixon Chibanda in a number of different contexts, such as the mhGAP forum at WHO, the 2016 World Bank meeting on mental health and development, and had two sit-down interviews and numerous informal conversations and email exchanges with him.

has evolved significantly, a fact that Chibanda tirelessly credits to the lay health workers, who over time shaped the original intervention's manual through new idioms, therapeutics steps, and practices that worked better for them and the community they served (Chibanda et al., 2017). In other words, the Friendship Bench had a life long before it was evaluated through an RCT using ToC, and its original effectiveness has often been credited to the local adaptations made by the lay health workers.[82]

In 2011, Chibanda entered into a collaboration with psychologist Melanie Abas from King's College London to test the intervention's effectiveness (Chibanda et al., 2015). Theory of Change was initially introduced to the Friendship Bench as a mandatory requirement by the funder, the Grand Challenges Canada, but it was enthusiastically adopted and became especially important when the project went into the scale-up phase. In line with the Friendship Benches tradition of evolving through community health workers' input, the ToC workshops focused especially on them and service users (Chibanda, Verhey, Munetsi, Cowan, & Lund, 2016). Chibanda explained this process to me during our interview in Washington:

> "The lay health workers were in there too. So I think the key thing is to have all the stakeholder, particularly user groups and the people who are delivering the intervention to be present. Once you have that combination, very often you come up with solutions. And what's exciting about it is, that, you know, as professionals we are very biased towards a certain way of thinking and doing things. But when you bring in outsiders, you know, it's amazing how they can come up with alternative ways of doing things which are equally effective, if not better."

The resulting ToC map also reflected this participatory commitment to a larger range of stakeholders, as it used a simplified design and bold colors to be relatable to all:

---

[82] As Chibanda points out at many occasions, at WHO's mhgap forum and the World Bank meeting in 2016, those changes were driven by the community health workers over time. Instead of using the terms of the manual, they used vernacular that made sense to them and the community. Learning from and evolving with the insights of those who are delivering the intervention. At one occasion during the WHO mhgap forum he pointed out that lay health workers are missing voices in many GMH venues.

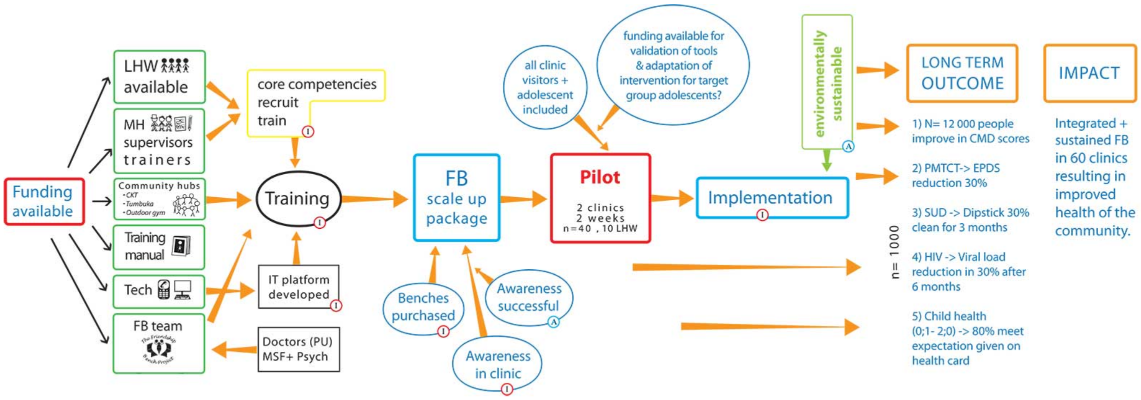

Figure 2, ToC map via www.friendshipbenchzimbabwe.org

Elaborating on the visual quality of ToC maps as knowledge object, Chibanda went on:

> "The good thing about the theory of change maps is you can share them with the lay health workers, you can share it with the most illiterate people in the group. And they can see, because you can explain to them in your local language, "we are moving from this point to this point," or "these are the challenges that we might see" and they can actually contribute. And I think because we have always used this kind of approach where everything is very visual, because we do use older people on the Friendship Bench, you know, so it is very visual. And provided they contribute, it's very easy for them to transform that into a more structured thing and define the steps that are actually taken, define the barriers, define the actual indicators. And the coolest thing…they actually contribute towards coming up with the indicators, just by looking at that map. [Indirect speech] "Oh, ok, one of the indicators here should be the numbers of women who come, or the number of sex workers who come", and you go like "Wow!" [laughs] …you know?"

In this case, the ToC map visual becomes a display of participation, able to transform experiential knowledge into numbers. Here, indicators were not merely reducing complex social worlds, but rather were themselves social and relational nodes, connecting different ways of knowing. They indexed "what counts" in more than one way as their legitimacy drew not only from the power to reduce, inscribe and compare, but also from their ability to connect across hierarchical, generational, and educational difference. ToC maps made "professionals" talk with "the most illiterate people in the group." Presented to me as a visually anchored way of thinking together, ToC offered a small utopia of inclusion – not through social justice narratives – but through a commitment of counting together along a shared, imaginary pathway.

The relational and community building function of ToC maps came even more strongly to the fore when Chibanda spoke to me about their role during the scale-up across Harare. Given his own global mobility and the novel situation that his team was spread across the new implementation sites, he began to route their communications through the teamwork app Slack. The ToC map, already an important analog object before scale-up, now became part of an online platform that tracked the implementation process live as it unfolded:

> "So every team member has a theory of change, which they carry with them all the time. So I am here in Washington, but I can actually access the theory of change, I can communicate with my team, I can see what's happening on the different channels, you know, whether it is for training or supervision for lay health workers. And you know, just to stay on top of things and also to be aware of any personal challenges that people may have, particularly the lay health workers, you know. So it's almost like [laughs] you know, becoming a family thing [laughs] …So for instance, if you have that map, you know, what we experienced today at this site."

ToC here was a "family thing", a relational space and mode of care across spatial distance. This double function of building both theory and community is an explicit imaginary of the approach, reflected for example in the title of its main training guideline "The community builder's approach to theory of change" (A. A. Anderson, 2006). Resonating with Laet's and Mol's famous essay on how the Zimbabwean bush pump through its fluid design produces community around the pump's installation, maintenance and use (2000), I began to wonder what kind of community Theory of Change gives rise to. The communities Laet and Mol imagined to rally around the bush pump – the village, the household, or the nation – were not only spatially bound units, they also existed well before the pump's arrival; both the pump and its community are imagined to last. ToC maps and their pathways, on the other hand, organize temporary orders to begin with – spaces, concepts, and stakeholder communities are only momentarily stabilized; they gather around a given problematization, a given pathway, for a given project duration. People assemble in rented rooms for workshops, they bring bags full of felts, arrows, flipcharts, and sticky notes, and leave with temporarily valid maps to be published in journals, integrated into websites, printed for lay health workers' pockets, or managed within the online platform Slack. ToC, like the bush pump, is a device that constitutes communities, but it does not map onto established entities, such as nations, villages, or even disciplines or professions for that matter. ToC assembles communities of a less specific kind from all of the above, conceived of as teams, stakeholder groups, or what Grand Challenges Canada calls "global communities of practice." As such, ToC may not destabilize the bush pump's national narrative through novel humanitarian devices (Redfield, 2016), but through its capacity to forge novel people-infrastructure to novel ends (Simone, 2004).

Taming "real world" fluidity

In its fluid character, the ToC approach mirrors an understanding of the "real world" as inherently unpredictable and volatile within which to eke out islands of predictability - parameters, concepts and steps that "work" - for a time until they need adjustment. Chibanda explained to me:

> "Right now, we have an ongoing theory of change process. You know, people come in with ideas, they meet over lunch, they meet over coffee and it's also very strong team building experience. Also, as you discuss different components, you discuss different issues related to the next steps…you know, grant writing, looking for funding, ensuring that the wellbeing of the lay health workers is taken care of, you know. How best to

> approach other existing organizations that you can work with, there is always something happening and I think from my experience the theory of change it helps you to stay on top of things, you know? […] It forces you to think of the plan B, and then plan C. Let's say, city health decides "we have no money." […]So it's just all these little things at different levels that you constantly have to handle. And that's the beauty of the theory of change, because once you have that theory of change you can rationalize. You know, how is life going to look like after [the city health official] is going to leave, what changes will happen, who do we bring on board, you know."

When volatility is regarded as the norm, designing incremental steps and their alternatives into actionable pathways is in itself an accomplishment. ToC's ability to generate quantitative evidence of impact is therefore only one of its functions. What is more important to the production of *actionable* knowledge is that it stays true and relationally connected to all the moving parts of an intervention - across time and space and alternative "real world" scenarios.

As such, ToC's logics of embracing fluidity and contingency – as an actors' category - challenges a number of analytical frames in anthropology and STS. For example, ToC literature refers to complex interventions as "black boxes" (De Silva et al., 2014; Valters, 2015) because their interrelated mechanisms, uncontrollable knock-on effects, and causal relationships cannot be fully known, only perpetually hypothesized. In this logic, ToC pries the black box of complexity open and renders it available to scrutiny; a prerequisite to making complex interventions work. Curiously this inverses the notion of the black box of Science and Technology Studies in which technologies are said to become black boxed when they work; they conceal their inner workings and underlying controversies at the endpoint of design processes (Latour, 1999b; Pinch, 1992). ToC, however imagines the inverse: it contends that interventions work when the black box remains open.

c) MHIN: a "community of practice"

The last case study provides a counterpoint to the emphasis on flexibility and reflexivity ToC engenders. It serves as a reminder that the ToC approach can also be deployed in ways that resemble the reductive specter of quantification and audit culture initially discussed. Grand Challenges Canada (GCC), one of the main funders in Global Mental Health, adopted the ToC framework as a mandatory requirement for their interventions. While every GCC funded intervention is required to design a ToC map and report against their chosen indicators, ToC is not the main reporting tool but serves as an additional layer of impact evaluation. Practically that means that GCC projects report their activities twice in different formats - once to the Mental Health Innovation Network (MHIN) in London who collects the ToC data, and once directly to the funder in Toronto. The Mental Health Innovation Network is itself funded by GCC and while its main task is running the MHIN online community platform, it is also tasked with overseeing the ToC data collection and analysis across GCC's portfolio. The evaluation researcher in charge thus trains the grantees in the use ToC via skype, and subsequently collects their indicator data through what is called the "core metric" form. The form, again, highlights the familiar objectives of quantifying impact across different scales, but also the aspiration that the very practice of conducting ToC evaluations will forge a specific kind of community:

> "[ToC data collection] will be undertaken to understand not only the collective global impact of the GCC Global Mental Health portfolio, but also the regional impact your project is contributing to. We see this as a critical part of building communities of practice, regionally and globally." (GCC GMH Portfolio Core Metric Reporting)

Theory of Change here again appears in its dual functions of community building and impact reporting. Yet, in this case ToC's global community of practice does not straddle the implementation sites of one project situated in different countries (Prime) or neighborhoods (FB), but a portfolio of vastly different mental health interventions, undertaken by a great variety of universities, NGOs, or government actors.

Given that ToC asks all projects to define their own pathways and indicators, how are points of comparison created among and between them from the perspective of a meta-analysis? The MHIN researcher explained to me:

> "At the very beginning of the project we ask "what are your indicators going to be for this? Are you going to be training 30 primary healthcare workers and three primary health care doctors and one specialist?" So then at each six months within the project we ask them to report back in relation to that indicator. […] By the end obviously the hope is that they have completed all of that. If they haven't, you know, why haven't they? What were the difficulties they had? And really the idea behind collecting all of those sorts of information is that they manage to complete the outcome of their intervention and they have successful results, for example the reduction in their symptom severity scores. […] The other challenge is, those project are all so different – you now, none of them really with the same aim – different disorders, different populations. How can we ask questions that are looking at so many different things? So I think it will be a job of a lot of subgroup analyses, and that should give us some interesting results."

This quote illustrates two things. First, both the achievement and failure of a projected outcome are considered valuable data; a further questioning of "why haven't they" is important despite the very obvious desire for positive results by the funder. But the quote also illustrates the restrictive linearity of this particular meta-ToC pathway. While indicators are initially defined by the projects – presumably in stakeholder workshops – they are expected to remain stable over time. The core metric, in fact, distinguishes four temporally successive orders, namely development, delivery, implementation, scale-up, and a fifth category simply called "context." Once the projects have defined their indicators, they are reported *against.* This use of ToC has little to do with the meandering, open-ended pathway that integrates real world contingencies as they arise.

The MHIN core metric form turns ToC into a rather static template, universally applied to all interventions in the name of meta-analysis. The quote also illustrated the familiar struggle to compare "like with like" for the sake of analysis. And here again, commonalities between the pathways are created through the work of aggregation and integration, until suitable subgroups organized around comparable features emerge. While the ToC approach in this scenario may hit common marks of audit culture and "coercive accountability,"[83] this article sought to demonstrate a broad range of the aspirational and actual scope of reflexive theory-driven evaluation such as ToC - which I suggest present us and our analysis with something rather new.

Implications

Reflexive impact evaluation practices like Theory of Change unsettle a number of analytical lenses anthropology and critical scholars have applied to evidence production, health metrics, and the globalization of psychiatric knowledge. Broadly speaking, a majority of scholarship has described how networks, discourses, and practices shore up and harden epistemic objects and facts. With Theory of Change I found myself confronted with a reflexive mode of knowledge production in Global Mental Health that both hardens and softens its concepts, within the larger ethos of making things "work." As such, it presents us with an empirical outgrowth, a surplus to which we, in turn, may need to adapt our analytical toolbox to as we go along. Let me conclude with three reflections on the consequences of ToC's open-ended evaluative horizon.

---

[83] Grantees have to report their activities twice in different formats, adding bureaucratic labor and subtracting human resources from other activities. Such mandatory accounting also shapes the relationship between interventions and their distant evaluators as the flow of ToC data to London is enforced by the threat of a loss of funding. As a researcher explained to me: "It is one of the things they have to do in order to keep their funding going, which I think is essential because I cannot imagine to manage such a portfolio without that extra push. I am very grateful for that otherwise I think it would be very hard to get information."

a) Contingent universals

Anthropologists and historians of psychiatry have paid great attention to the constitution of mental illness as a target of intervention throughout history (Foucault, 1988; Hacking, 1998b; Rose, 1990; Young, 1997). This scholarship has shown how psychiatric disease categories were shaped and enforced by western institutions of science, medicine, and social control. The postwar era saw the emergence of psychopharmacology and specific, yet consensus-based and descriptive disease categories (Healy, 2009), which greatly standardized clinical and insurance practices, consolidated the field of psychiatric epidemiology (Lovell & Susser, 2014), and allowed for a wider circulation of psychiatric knowledge across geographies (Rose, 2006). The march of standardization in psychiatry has been traced along important events such as WHO's schizophrenia studies in the 1970s, and the evolution of the DSM and ICD classificatory systems. Yet, few today – inside and outside of psychiatry - would disagree that the field's nosology is epistemologically contested and unstable. Some have argued psychiatry never reached the state of Kuhn's "normal science", in which knowledge can be reliably reproduced (Demazeux, 2014), others have questioned the cross-cultural validity of the psychiatric nosology (Summerfield, 2008); the diagnostic and therapeutic specificity is clinically routinely blurred by off-label prescription (Alexander, Gallagher, Mascola, Moloney, & Stafford, 2011) and leading institutions such as the NIMH questioned the DSM's usefulness in advancing research.

This backdrop brings Global Mental Health's knowledge practices – and its use of Theory of Change – into relief as both building on, but also productively undermining the standardization of "mental health" as a coherent target of intervention. While GMH relies strongly on the techniques of psychiatric epidemiology, the field has simultaneously begun to mobilize a much broader notion of "mental health" (see chapter one). In other words, GMH in many ways does not simply adopt and export the nomenclature and techniques of psychiatry, it has significantly re-shaped “mental health” as a target of intervention. The popularity of an evaluation technique that flexibly adapts to variations of many kinds, and requires interventionists to test their underlying assumptions may not be surprising after all; it may in fact be ideally suited in working in the epistemologically unstable/variable field of “mental health.”

As I have shown in this chapter, ToC inscribes and mobilizes “mental health” as a target of intervention across, but arguably also through differences. As a technique ToC can accommodate rather than eliminate “real world” differences, including how mental illness and care are conceptualized and delivered in different sites or programs. In other words, the instability of “mental health” as a target of intervention was not a blind spot but an ordinary feature interventionists contended with; variability was the norm rather than an exception, even though not all differences were equally desirable and manageable. Permissible changes were negotiated within bounds, often vis-a-vis the demands of meaningful quantification.

Yet, considering anthropology’s own analytical canon and tradition, I would like to ask: What happens to the very idea of “universals” when concepts can stay open and internally flexible along a changing pathway? Can the “universal” be a moving target? Contingent universals, I suggested here, render things comparable across scale and differences without forcing identity. In addition to the creation of comparable data points, this form of quantification also created spaces of indeterminacy that allowed every instantiation of an intervention to be unique.

Going back to Mary De Silva’s initial assertion that ToC helps to “understand what is universal and what is different” we now see that this open-ended process does not rely on a fixed, or substantially grounded distinction. Understood through ToC this means that they could easily swap places; they index functional positions, not ontological alterity that could be ultimately known. ToC seeks to measure the "real world" in flexible terms, which only temporarily harden into printable pathways. The very act of quantifying a process does not signal a simple detachment from the "real world." Instead, the "real world" is - selectively - reconstituted within these flexible terms, whose epistemological horizon is not a scientific notion of "truth", but the notion of "what works."

b) Iterative reason, virtuous failure

This ties in with the increasing importance of implementation science, which has more generally begun to valorize negative findings as understanding barriers and challenges to achieving impact has become just as valuable as positive outcomes (De Silva & Ryan, 2016). The open-endedness of this probing process into "what works" is beautifully captured in a quote by a PRIME researcher:

> **"**I think in reality the way health systems and implementation science works, it isn't as clear cut as "did it work? Or not?" It is about where did it work and how, and how do we take these lessons to other places. So I think that's really the key question. So yah, I don't know…how well…it is certainly not as scientifically rigorous as taking something and doing an RCT. I mean it gives you *better* evidence, but you can't recreate that trial setting in practice. Because you don't have the resources, you often don't have external people, you don't have the same amount of supervision. So even though you have tried it in a randomized controlled trial that still doesn't guarantee you that you will implement something, even in the neighboring district, that will work."

ToC**,** one might say, depending on its use, allows for epistemic openness – by design. In a curious way, one could say that ToC transcends the distinction between *bricolage* and *design,* and their associated politics. As Peter Redfield, drawing on Levy-Strauss, points out, anthropology had traditionally assigned the colonized the role of the bricoleur, the one who muddles through skillfully, forms and builds and makes do with what is at hand. The colonizer, on the other hand, is conceived of having design, techne, and rational planning (Redfield, 2000). ToC might be an interesting intersection between these politics and spaces: it may be *bricolage by design.* Taken to its extreme one begins to see that there may be no singular standard left to achieve, no ideal diagnostic or procedural template to match. All there is, is iteration.

I began this chapter with a reflection on how the ubiquitous question "what works?" harbors a tension between the singularity of outcome oriented impact (it works!), and a process oriented maintenance of this functioning state (it is working!). What struck me about ToC is that it converges both poles – it produces quantitative data while simultaneously accounting for the processes, assumptions, and contingencies that preserve the ephemeral state of something working. In other words, this tension is never resolved, but folded into an open-ended horizon, an evolving epistemic space.

One of the consequences of this iterative practice is that ToC emerges as a formidable mechanism to turn vices into virtues: What in static evaluation frames would have registered as implementation failure emerges now as "new lessons learned."[84] A wrong assumption undergirding a pathway is nothing but a future adaptation, another step on the pathway, and another scientific article to be published. Narratives of iteration and adaptation skillfully avert those of failure.[85] Through a high turnover and rapid pace of "lessons learned," Ferguson's "anti-politics machine" (1990) may have become an "iteration machine" perpetually adapting while unfolding in the bounds of short-term project and funding cycles. Within these limits, ToC allows to meaningfully ask and operationalize "what works?" through adaptation to real world

---

[84] Lessons learned are even applied to the very use of ToC, as the latest PRIME publication reflecting on its own experience with the technique proves. It is entitled, "Theory of change for complex mental health interventions: 10 lessons learned." (Breuer, De Silva, & Lund, 2018)

[85] A colleague working in the realm of global health security remarked to me: "Entire careers are being built on the failure of the Ebola response. Literally, gazillions of publications."

contingencies (including the “political”). Yet, as the ceiling of accountability reminds us, ToC pathways map but barely ever reach long-term impact – also, by design.

c) Reading outcomes in terms of process

The perhaps most exhilarating, and perhaps most challenging epistemic effect of ToC is what I would call the collapse of outcome and process analysis. Traditionally, evaluation practices were either a post-hoc practice or ran alongside standalone interventions. Now, evaluation logics are pervasive, they are the start and endpoint of any action or intervention. With this shift, the arm-length relationship between interventionists and evaluators disappeared, and the production of knowledge and reflection on knowledge production collapsed into the same role. Interventionists are effectively in charge of evaluating themselves, often in interdisciplinary collectives using multiple methods. They routinely inhabit a reflexive position in which they produce and question their own knowledge; individually and collectively within their teams. ToC is an epistemic device that formalizes this dual role. The approach systematically allows for outcomes to be interpreted in terms of process - combining two ways of reasoning formerly kept neatly apart.[86] Interpreting also collapses what is often imprecisely mapped onto a divide between “applied” and “critical” engagements. In a curious, if incomplete way, ToC’s openness and continued reflection suggest that an outside vantage for evaluation and critique may be obsolete.

---

[86] Mary De Silva makes this explicit when she writes: “A key intended benefit of using a ToC framework for the evaluation of complex interventions, particularly in trials, is that it breaks down the barriers between evaluations of interventions effectiveness and process evaluation by combining them into one framework.” [This merger is] “enabling interpretation of the outcome data in light of the process data” (De Silva et al., 2014, 10).

d) The universal's vanishing edge and the dangers of do-able difference

So far, I have approached "contingent universals" and iterative knowledge practices in GMH on their own terms. Zooming out from this close-up I would like to situate them in a broader lineage of how the "universal" has been crafted, mobilized and critiqued.

Many scholars have pointed out that claims to universality harbor and enable mechanisms of exclusion and oppression - at times as part of overt projects of colonization and domination, at others woven into the practices of science, philosophy, and religion, each producing the universal's edge in their own situated and historically specific ways. Enlightenment thinkers and humanists, for example, found Man's universal feature in *reason;* a shared trait put forth to be inclusive but simultaneously demarcating its Other: be it animals (D. J. Haraway, 2013), women and children (De Beauvoir & Parshley, 1953), the savage (Fanon, 2008; Trouillot, 2003), and, of course, madness/insanity as the inversion of reason (Foucault, 1988). Such epistemic cuts made in the name of universal Man produced not merely nominal differences but also, as Frantz Fanon poignantly wrote, brutal violence grounding in the devaluation of the so marked Other in the context of colonialism. He writes:

> "Leave this Europe where they are never done talking of Man, yet murder men everywhere they find them, at the corner of every one of their own streets, in all the corners of the globe"(Fanon et al., 1963, 311-312).

Taking a rather giant leap towards the contemporary, today's Global (Mental) Health and humanitarianism craft the universal human and their needs around the imaginary of a shared biology and human rights (Bemme & D'souza, 2014; Moyn, 2010; Rabinow, Marcus, Faubion, & Rees, 2008; Rees, 2014). It may seem as if the universal human here has lost its discrete and discernible Other as all men, women, and children are construed as equally deserving of care and saving. However, the excess falling outside the epistemic boundaries of medicine, science and the psy-ences, the Other to formalized and experimental knowledge, is encoded in the notions of “context,” “bias,” or “confounding factors.” With Berg and Timmerman (2000), but also with Mary Douglas (2003) in a way, it is helpful to think of such orders as simultaneously producing the disorder they delimit themselves from. Berg and Timmerman suggest that the universal and the contingent are not inherently different orders but emerging properties of an actor-network engaged in practices of standardization. They are two sides of the same coin with neither preceding the other temporally (2000). My empirical work among GMH actors, however, complicates this image of a two-sided coin somewhat further because ToC disrupts the very stability the materially bound object suggests. While the two sides of the coin still come into being simultaneously, they now also seem to be able to swap places and change denomination while in circulation.

The violent edge of universal, reasonable Man as it was drafted by predominantly white, male aristocrats and scientists is also at the center of feminist scholarship which shows how the absence and subjugation of women in and through expert knowledges has perpetuated not only the larger patriarchal system but also practices of objectivity that establish a “view from nowhere” (D. Haraway, 2003, 589). Calling attention to the ways in which objectivity is always fundamentally partial, situated and historically contingent (Daston, 2007; Harding, 1992, 2015), feminist philosophers of science have since the 1980 proposed alternative epistemologies and practices of objectivity that are neither beholden to radical constructivism nor to naïve empiricism (D. Haraway, 2003). And curiously, while observing ToC knowledge practices in GMH it was like encountering a distant echo of these critiques, which seemed to have moved from the toolbox of the critic to those of the practitioner, reverberating in the call for grounded "views from somewhere," all the while here also unapologetically embracing the optimism of progress, achievable outcomes, evidence, and the possibility of truth. Analytically, this put me in a similar situation to what Annelise Riles encountered in her fieldwork among NGO actor, who had adopted the concepts and critiques of social sciences and left her searching for a new vocabulary to capture this difference between her concepts and theirs (Riles, 2001). In this spirit, I too, want to outline and problematize new questions arising from the flexible knowledge practices of ToC for anthropology.

What puzzles me about ToC is what I would call the *vanishing, or receding edge* of the universal as an effect of its adaptability. Since contingent universals present themselves as fluid, flexible, and tied to fast-paced iterations, they do not posit themselves against the contours of a static Other. Instead, the edge of universality, its *cutting* edge as outlined above, appears dissolved and folded into the perpetual promise of movement and further adaptation. Hence, when the universal becomes imperceptible, not least to anthropology's critical tools, we might require different ways of engaging a universality that emerges from participatory and open-ended design processes and embraces and works through, rather than eliminates, difference.

However, in exploring this idea I want to take very seriously what Lisa Stevenson has offered as a note of caution in response to this chapter. Is the difference Theory of Change encodes in its meandering pathways ultimately merely "do-able difference"?, she asked me to consider. By do-able difference she referred to the kind of difference that does not offend and ultimately remains faithful to the interest of the colonizer, of patriarchy, and the structures of dominance already in place. Is ToC really equipped to engage with fundamental alterity? Pointing to the efforts of the Canadian government in the 1960s that sought to educate and integrate Inuit children, she points out that certain difference in their behavior could be rendered acceptable within the settler colonial society, while others had to be repressed.[87] In this sense, do-able difference might have its own form of violence that forecloses more possibilities than it opens. Her commentary is well taken. ToC may assemble more diverse collectives around shifting tables and processes, however, the depth of possibility and the spaces for alterity remain at all times sanctioned, circumscribed and controlled by those who can *convene* such workshops. One therefore must take a step back and ask: Whose interests and desires are pursued in projects of commensuration to begin with? Elizabeth Povinelli has powerfully shown how the practices of commensuration and recognition of Aboriginal people in Australia, while validating some forms of alterity, erased those deemed in conflict with the liberal state's projects of assimilation. Stevenson (2014), Povinelli (2001, 2002) and especially Audra Simpson in "Mohawk Interruptus" therefore remind us of the ambiguity of consent and the importance of practices of refusal vis-à-vis commensuration projects (2014, 2016). Contingent universals as they emerge from techniques such as ToC while imbued with the seductive promise of reflexivity and inclusion may render the edge of universality less visible, but not less powerful.

***

---

[87] See also the documentary *Experimental Eskimo* by Barry Greenwald.

Interlude – the Bench

I am shadowing the weekly supervision meeting of a project in which lay health workers assess the psychosocial needs of people who encountered interpersonal violence – victims and perpetrators alike. We stop at a primary care clinic in Heideveld, a neighborhood in the Cape Flats, a notorious gang area. The clinic's dark and crowded hallways in the front give way to a shiny new building in the back, which also houses the emergency unit. It is here where the lay counselors approach the injured on their beds, on stretchers, or in the waiting area; some of them handcuffed to the bed, awaiting police questioning. It is here where the lay health workers administer a short questionnaire, where they ask them about their struggle with Tik (the local name for meth) and alcohol, and where they offer those who qualify to come back for problem solving counseling; a conversation on how to turn one's life around.

The lay counselors themselves have little space. A former isolation cell the size of a larger closet serves as their office. The steel enforced door opens to a room that fits a desk and two chairs. A small window slits lets in some daylight. The tiled floor is covered with a piece of cardboard under which a drain hints at past uses of this space. Six of us squeeze into it now, leaning against the wall, sitting on the chairs, squatting on the floor, and standing in the doorframe. Banter and updates go back and forth. The questionnaires and audio recordings of counseling sessions are collected and numbers entered into excel sheets. A laptop hovers precariously on someone's knee. For the supervision meeting we wiggle out of the "office" and walk past the emergency floor, down the hallway and, to my surprise, out through the emergency exit into the chilly winter air of the backyard. It is mid-July and the winter winds are relentless at that time. A picnic table with a bench serves as the point of care for the carers within the "task-shifting" infrastructure. We huddle together, our shoulders in fleece sweaters rub against each other. Giggles ward off the chills. The supervisor asks about incidents of the past week and tells the women their work T-shirts will soon be ready; the uniform they have all been waiting for to mark them as professionals on the emergency floor. During the car ride she had told me that the three different NGOs in charge of paying the lay counselors' salaries were squabbling over the cost for the T-shirts, which led to the delay in the order. Fragmented threads or responsibility.

These benches, like the lay counselors they accommodate, sit uncomfortably outside the clinic. It is here where the women receive their slice of care; an ear to listen to their problems encountered on the emergency floor and in their counseling sessions. Benches are the space the clinic could spare for this. They replaced a tent that too often was blown away. The informality of this fragile space is its most important feature; liminality made virtuous and turned into a treatment model by the Friendship Bench; ready to travel from Zimbabwe, to New York, and London. These benches' legitimacy and place-ness are derived from, and are lodged into, windy yards of global care.

***

Chapter 4 – Knowing Nepal

This chapter is an experiment. It is an experiment in that it may produce something genuinely new and interesting (as experimental systems should)[88], but also simply in that it may fail. At its core sits an article I was tasked to write during my time at the Center in Cape Town concerning the experiences of "mental health and poverty in Chitwan, Nepal" – a region I had never visited and a topic I, admittedly, knew little about. I produced this article based on the analysis of a qualitative data set produced by PRIME, a multi-country research consortium with the goal of integrating mental health care into the primary care systems of five countries (South Africa, Nepal, India, Uganda, Ethiopia). At the time of my fieldwork, PRIME was coming to an end, and the team was struggling with what some called a data deluge. People who could "write up" data were in demand. As an anthropologist, I seemed suitable enough to analyze a qualitative data set from Nepal.[89]

This chapter tells the story of how I came to know Nepal. It is about how I came to write an article about the experience of villagers in the Chitwan region, without ever having been to Nepal. Working remotely as part of an interdisciplinary team is, in itself, not unusual in Global Health, yet rarely has such a complicated, collaborative, epistemic space been made visible empirically. Writing this article felt intellectually somewhat risky – its concepts, assumptions, style and convention – were "not me," placing me squarely outside my comfort zone. Yet I entered into the production of the Nepal article in an honest attempt at "speaking in tongues" (see chapter two) and a desire to participate, rather than merely observe.[90] Willing to

---

[88] (Hans-Jörg Rheinberger, 2015).

[89] I do in fact have experience in qualitative health research from a project I worked on before my PhD. I had, however, only ever analyzed interview material that I had planned and conducted myself.

[90] While I could immerse myself in meetings, conference calls, and face-to-face conversations, important aspects concerning the workflow across the many project sites remained inaccessible to me as an anthropologist; namely

put myself at stake, I let go of my existing, albeit fragile, disciplinary vantage point, and engaged an interdisciplinary episteme, while meticulously recording the process of getting lost in it. Could I perform, produce, and distribute knowledge that remains partially foreign to my own epistemic inclinations? Would I become yet another "reluctant anthropologist" sheepishly doing "applied work" while experiencing a profound sense of disciplinary betrayal[91]? In the best case, this chapter will produce a better understanding of the texture of globally assembled knowledge as I came to inhabit and produce it. At worst, it will make for an awkward piece of auto-ethnography.

a) Give her a paper…

"That's how we do it, we make you one of us by giving you a paper," one of PRIME's principle investigators said with a big laugh. Everyone around her, including myself, joined in. Her joke was one of the rare moments in which the ambiguity about my presence and intentions made itself explicit; even if in a friendly, inclusive, and cheerful manner. It was a scorching hot day and we were all lounging on benches or on the grass during a break between sessions at the annual meeting of PRIME consortium. Idyllically nestled high into the Helderberg mountain range, the conference center was surrounded by a pristine landscape. The outlines of the mountain ridges broke crisp against the bluest skies and just below the barren rock formations, a

---

those behind computer screens (e.g. email chains, spreadsheet-scapes, or data environments such as Mobenzi); however, being the lead author of an article made me part of these processes.

[91] During my fieldwork, I have frequently encountered colleagues that I would call "reluctant anthropologists," who were engaging in applied qualitative health research all the while bemoaning the betrayal of their "actual" craft and methodological allegiance to anthropology. This ambiguity could be found among GMH most prestigious institutions and projects, as well as by authors of influential signature publications (e.g. the World Mental Health Report, 1995). In discussions with these colleagues or at conferences on the topic, the rising popularity of "mixed methods" in Global Health was seen as laudable validation of qualitative knowledge, but it also caused profound unease as it was seen to be mostly employed in piloting, or as exploratory research for quantitative interventions and evaluations.

carpet of dark green fynbos flora covered the rolling hills towards the horizon. Sitting on the lush grass in the courtyard of the conference center, the water crisis in the Western Cape seemed distant, and so did Cape Town's sprawling urban scape an hour's drive away.

I joined the annual meeting during the third day as I was not allowed into the main sessions but was welcome to a film screening, writing workshops, and dinner on the penultimate day, and to a concluding session the next morning. Excited to finally meet some of the country team members in person, I found the atmosphere much more stifled and hierarchical than I had imagined. In this corner of the afternoon lawn, however, guards came down a bit. The summer heat combined with the impending end of the project had changed the social dynamics, as somebody commented. "Finally," she said, "one gets to know each other as people. It only took us five years!" Several layers of yearlong formality, of email and conference-call etiquette came peeling off. Last night's social event, I heard, produced hidden talents. A guitar was brought out and a project song composed, as evidenced by the cell phone video passed around. I missed all the fun, as well as many meetings. In the hallway I collected a lonely printout of the song and the pang of social exclusion reminded me that access to global networks is always partial, selective, and a rolling process, impossible to stabilize with finitude.

b) On (never) "being there"

My presence at the Alan Flisher Center for Public Mental Health had paradoxically both become normal and remained self-conscious during my eight months stay. When I gave my final talk at the Center before my departure, the director introduced me by saying: "Somehow Dörte has become part of the furniture here." And indeed, I had been rather present in a place with little workspace to spare. I came in almost every day, happily hot-desking across various offices, and shared spaces with numerous people over time. This allowed me to build trading zones of friendship and collegiality with most people at the research unit, guarded on the one hand by research ethics protocols, and elaborate consenting procedures, and on the other, enshrined tacitly through lunch errands, smoke breaks, after-work-drinks, weekend road trips, and birthday celebrations involving an enormous trifle. Curiously, however, even in our drunkest moments, my colleagues at times went "on and off the record." The procedural hold of informed consent and research ethics never lost its importance among these public health researchers who were used to working within its rule themselves.[92] Despite our everyday closeness, at every meeting or conference call my presence was meticulously announced to all attendants ahead of time (via email) and verbally consented before the call. I introduced myself to the intercom numerous times; it never got old. While I had initially hoped to achieve a more blanket access to my field site, I soon realized that these rituals of perpetual consent and consensus were part and parcel of this globally networked knowledge production. No bound and guarded community could be entered here; trust and access were never definitively won. Instead, porous and ever changing team compositions required constant, short, and repeatable forms of initiation. When every call and every meeting is a new assemblage of actors, trust and access remain partial and particular to each instantiation and conversation.

In this context, leading a paper and the being part of the discussions around its production in a small group mattered immensely. It plugged me right into the consortium's academic assembly line, their division of labor, and their public displays of accountability and progress. I became a legitimate line item in an Excel publication tracker, which was pulled up on a large screen every month and reported against. During the annual meeting in 2017, when the final

---

[92] Honoring this sensitivity, this chapter's reflection seeks to respect the confidentiality of all work meetings by focusing predominantly on my own process and practices rather than those of my co-workers.

update wound its way around the large conference table, I inserted my slice of work with the Nepal team into the public display of workflow and accountability.

Yet even when physically sitting among the people I had spent eight months with, “being there,” and the epistemological legitimacy anthropology derives from it (Borneman & Hammoudi, 2009), remained elusive in peculiar ways. This was not simply due to my own multi-sited engagement and mobility, but derived from the architectures of partial affiliation in a constantly re-assembling team with tight schedules, and little face-to-face interaction. Within PRIME’s knowledge production nobody was ever really “there;” but everyone was “somewhere.” That being said, the core group of GMH actors did indeed constantly re-assemble in different corners of the world; they were a “flying circus,” as one researcher called it. The boundedness of the community was held together by project proposals, funding streams, institutional legacies, friendships, and most of all – by shared collaborative projects and working styles. The spatial or social groundedness of teams and their local knowledge, while sometimes important, was not essential to the project’s modus operandus.[93] The coeval-ness of its actors extended often to the needs of time zones and call scheduling.

This introduction serves as a backdrop to my work on the Nepal poverty paper. It also sets the stage for the profound disciplinary discomfort I experienced, because “being there”, obviously, matters greatly to anthropologists. In this chapter, I want to explore the edges of anthropology epistemological foundation through “being there” vis-à-vis the transient and collaborative epistemic space I shared with my interlocutors. The immediate templates at hand

---

[93] Even core members of the data management team told me that they did not spend much time in the project sites they were monitoring; their interpretation and follow-up of problems was predominantly informed by the incoming data (which showed when there was a problem in a clinic, or something unlikely happening in a site). Remoteness and distance were perceived to be the norm, even within the country. My own attempt to visit the South African implementation site in the Kenneth Kaunda district failed, because everyone was only ever a visitor in these sites, especially in primary care settings where research teams were already struggling for space and legitimacy themselves. Without a purpose or the company of an equally mobile contact person, the latter who also only ever visits, these “places” are rather impenetrable.

are, of course, the figure of the 19th century armchair anthropologist who produces knowledge from the vantage point of the colonial library or veranda, and the contemporary figure of the multi-sited anthropologist whose limited engagement makes for shallow inquiry. Yet, while these familiar tropes offer themselves as immediate templates for my discomfort, I found that neither ultimately fit with what could perhaps be called the *globally networked production of local knowledge*.

Focusing solely on the anthropologist's location - and my lack of locally grounded engagement with Nepal – would too easily obscure the hermeneutic labor and infrastructures that enabled me to produce knowledge about Nepal. Knowing Nepal involved a complex set of actors, planning activities, conferences calls, a central data server, weekly Skype calls with the Nepal team, lonesome hours spent reading transcripts and coding documents (unilaterally conversing with the faraway villagers and health workers), and an interpretative process that unfolded across many spatial and temporal orders. Along the gossamer strands of guess work, crackling conference calls, patterns of interview coding, and through emails and manuscript drafts reaching across different collaborative distances, countries, and desks, knowledge about Nepal was produced.

c) Entering Nepal - from (a networked) somewhere

The Nepal paper initially emerged from the intersection of three independent factors: 1) Me offering my labor to the Center as part of the fieldwork arrangement in Cape Town, 2) the early upload of Nepal's qualitative interview data, 3) and the director's longstanding interest in the relationship between mental health and poverty.[94] In short, I entered into existing curiosities,

---

[94] Based on an extensive meta-review, he had narrowed their relationship down to two hypothesized causal mechanisms: a) social causation, in which the conditions of poverty lead to the onset of mental health problems, and

workflows, and material infrastructures, adding my skillset and intellectual inclination to an existing space of possibility, wondering if and how we would adapt to each other.

After an initial discussion with the director, I agreed to familiarize myself with the interview material. One of the data managers gave me access to a server located at the University of Cape Town – the central but also contested "place" where most PRIME country data were stored.[95] I found the Nepal data in the country folder tree, and downloaded about fifty interview transcripts, divided into "service users," "caregivers," and "health professionals," onto a USB key.

As I walk home that evening from the Center, which is located in Cape Town's suburban neighborhood Rosebank, I pass the bank of the Liesbeek River where neighbors let their dogs run free before dawn. Even dogs, I was repeatedly told, are racist in South Africa; they only bark at black people. And sure enough, dogs inhabit an ambivalent place in pre-dominantly white, middle class neighborhoods. They are loved and cared for as family members, but are also weaponized creatures, embodying and defending the very boundary of that belonging. They are security features of homes and lives. Together with barbed wired fences, high metal gates, cameras, and private security firms, they maintain a fragile state of security; an elusive always-already racialized frontier.[96] Dogs are ambiguous creatures deeply entangled, and sometimes synonymous, with apartheid oppression. In this post-apartheid moment they are used to articulate

---

b) the mechanism of social drift, in which mental health problems and their loss of social and economic functioning lead people to drift into poverty (Lund et al., 2011). This conceptual architecture provided the guiding grid through which this material was to be approached.

[95] All country data are centrally located on the University of Cape Town server. Guarded by ethics protocols and passwords, the UCT server was also a somewhat controversial "place" for the project's data and not all countries agreed to use it. Nepal, however, sits right in this folder. Of all countries, Nepal had been the fastest in transcribing its qualitative interviews, which is why I developed country, rather than a cross-country article.

[96] When the police questioned me after I was once robbed in my bedroom at 5am, I was asked one repetitive question over and over again: "Was he black or colored? Black or colored?" I had just been in SA for about two weeks, and barely knew the difference and was simply mortified to be asked this question repeatedly by different black officers. "I don't know," I said, "it was dark in my room." Only later, when I understood the ubiquity of racial interpretations, I came to understand that to them this was an innocuous, pragmatic question relating to the particular gangs operating in the area.

tensions around race and inequality through questions of lifestyle. A few years back, President Zuma called owning dogs as pets "not African," and a part of "white culture" not to be emulated by the growing black and colored middle-class. The immorality of "treating dogs better than humans" became a common trope to express deep seated grievances.[97] When I reach my gate, I am enthusiastically greeted by Battersea, the border collie belonging to my hosts. My easy love for her guiltily nods to the anguish I know many of my friends feel when they approach the same gate. After a chat with my host over a glass of sparkling wine, I go upstairs to my room to settle in for work on Nepal.

d) Reading vertically: along the integrity of person, context & time

I arrive in Nepal reading. More precisely, reading through interview manuscripts from top to bottom; reading vertically. This may seem obvious, but soon I will realize this distinction is important. Reading vertically affords a precious integrity of narrative and units such as persons, time, and place, all of which will soon disappear when the work of coding carves out rather different units and similarities.

But first things first.

Reading vertically, I synchronize myself with the progression of each interview. I see respondents and interviewers grow tired or impatient with repetitive questions and indulge the contradictions and ambiguities within their stories, the shifting and slipping of perspectives, hesitations and decisions to share or withhold. The free mental health treatment people receive at the health post through PRIME is often experienced as effective and brings about many changes.

---

[97] For example, a recent article on land reform cites a woman from the townships during a consultation process: "This discussion [on expropriation without compensation] is eye-opening. We live like rats. That is why we *toyi-toyi*. Hence we need to get back the land. … Why is it that people who have land respect dogs more than humans? We need our land back," said Swebe."(Luhanga, 2018). *Toyi-toyi* refers to a war dance used by the anti-apartheid resistance, which is commonly associated with protesting or putting up a fight.

But a few paragraphs down, it may also have side effects, create the need for distant travel, delay planting the fields, or it may simply stop working. Savings from free care, while always highly appreciated, also emerge as meaningless in the bigger picture of a person's "economic condition." Lives, illness, loss and relations unfold through and beyond the questions asked; they often exceed them despite considerable steering by the interviewer.[98]

Reading vertically, I marvel at the things I do not understand. And there are many. There is, for example: [laughter]. Inserted into the flow of sentences, I find myself repeating the lines out loud to find the humor - to no avail. Often it sits in stories of former alcohol users, recounting the damage they inflicted. Then there are relational descriptors that puzzle me – people call each other mother, father, sister, or brother independently of "real" kinship. Am I looking at degrees of seniority, reverence, or intimacy? I do not know. I marvel at the many layers of removal and translation through which these narratives reach me. Somebody – who I do not know – journeyed into these villages, sat down with patients and their caregivers, and placed a recorder in front of them, urging them to talk of their experiences. Perhaps somebody else then transcribed the interviews in Nepali, and yet another may have translated them into English. Each researcher shaped what I am looking at. Yet, just like the participants, their background, names, gender, or incentives – it all eludes me and remains partial.

Distances removed, but encounters nonetheless.

Reading vertically, I stumble over – rope. A man with epilepsy, who has been treating his condition with various medications, procured from distant hospitals at a high cost, has most recently received a new medicine from a friend. It turned out to be effective and left him free of seizures for eight months. He had therefore not returned to the health post; he is a drop-out for

---

[98] A person's persistent "I don't know" stems against a tide of questions. An empty phrase, it will vanish soon during the coding process. Yet, hidden in the vertical order I find a half-sentence explaining that she is illiterate and not used to speaking expertly.

PRIME. Throughout most of the interview he does not say what his new treatment is, until eventually he confides in the interviewer that he has acquired a piece of rope used in a recent suicide. He ground it up, burnt and ingested it with food, three times, over three months. Now the seizures have stopped. He promises that when the seizures return he will come back to the health post for treatment. I am intrigued by this entanglement. One kind of suffering becomes the remedy for another - while the only thing that seems certain for him is the uncertainty of any treatment.

I do not really understand what I am looking at, what it all means, and how it is relevant to the relationship between mental health and poverty. I feel naïve and mostly, lack. A lack of contextual and relational insight, body language, genealogies and histories to hold on to. Will I ultimately get comfortable with this state of partial blindness, or will I grow able to see? All I have are multiply mediated interview data, a downloaded fieldsite on a USB key; a Malinowskian arrival scene of sorts. He, who famously asked us to…

> "imagine yourself suddenly set down surrounded by all your gear, alone on a tropical beach close to a native village, while the launch or dinghy which has brought you sails away out of sight…Imagine further that you are a beginner, without previous experience, with nothing to guide you and no one to help you." (Malinowski, 1922, 4)

I do find myself stranded on an unfamiliar shore, in the middle of my suburban bedroom in Cape Town. My open window overlooks a swimming pool and a small lizard enjoys running along the ridges of my keyboard. Much like Malinowski, I am inexperienced and clueless, but also much less heroic, lacking a "native," and certainly not isolated. My team members – in Kathmandu, Addis Ababa, and Amsterdam – are a mere keystroke away.

e) Conference call: connected confusion

A few weeks later *my* conference call has finally been scheduled to discuss the Nepal data. Six people are calling in from Amsterdam, Kabul, Addis Ababa, and Kathmandu. Doodle polling for a time took us weeks and I initially miscalculated the time zones - but finally we are all "here." The director and I meet in his small corner office and as organizers we set up Skype to call everyone in. Yet, the researcher from Amsterdam has difficulties joining. We switch everyone over to my computer. But now Nepal cannot hear us despite being dialed in. Everyone is calm and graceful, obviously experienced in troubleshooting. Our next attempt is to Skype two parties in on separate computers, but the sound is not good enough to be picked up across the room. I now need an extension cord, as I am low on battery. I dash to the public relations officer and we pull a cord from behind her shelf, which begins tipping over. My nerves are fraying. The precious hour scheduled for this call is dripping away. Cable in hand, I run back, where I find it is no longer needed because the call has been routed through Amsterdam.
We are finally all "there."

Introductions and call small talk ensue. Inquiries into the "situation" in Ethiopia and Kabul are made, where one of the researchers has been on lock-down in his hotel for a few days. We are three PhD researchers and three PIs. Hierarchies abound but unclear to me. One by one, we explain our interest in the Nepal data, each delineating an article idea. The director sketches his interest in poverty and mental health while another PhD researcher proposes to write on "access to care, and bottlenecks in the health system." They then turn to me asking if there is enough richness in the material to cover these questions. I am a little bit bewildered as I thought we all had read the material and would discuss what we found; yet their ideas – full fledged paper outlines, really – do not resonate with what I have been reading over the past days. I give a summary of my first impression of the interviews, a few examples on the poverty theme: narratives in which people are able to repay debt or re-enter work after treatment, narratives of rekindled relationships leading to regaining access to shared resources, savings due to free treatment, and how mental health problems affect marriage prospects. We are running out of time. The director looks at the agenda and says “Emergent themes from the material, we’ve got that covered.” I silently gasp in disbelief. Our colleague in Kabul had dropped out, his internet connection disrupted. We move on to the practicalities of coding and I learn that three researchers in Nepal, who are not on the call, have already been tasked with coding. Ten percent should be cross-coded by me as the lead author.

We are now out of time, but Kabul has just come back on. The director needs to get onto his next call. He pulls out the intercom and starts dialing into the other call. We mute the microphone on Skype because the new call’s automated voice gives frequent updates on the attendance status. In the background, Amsterdam patiently repeats the coding instructions to Kabul, word by word. The director begins talking to the new conference call organizer - introductions are made and small talk ensues. I pack up my laptop and silently mouth goodbye, leaving the layers of this sound-scape behind.

Disjoints multiplied. The unsettling feeling of not knowing, or not knowing how to know, expands. I am gleaning, guessing, listening, and marveling all over again. This time to the crackling voices of the five researchers – strewn all over the world – speaking with confidence about material only I had read. I understand this meeting as little as the man who ingested the rope. How do they connect? I cannot see.

f) Coding: learning to think in new units

The three researchers in Nepal and I set up weekly coding calls. In order to synchronize our interpretative practice, we must reliably interpret the same things when reading the material. First, however, we have to become technically aligned. The coding software is not immediately compatible between Mac and Microsoft computers. We spend the first week figuring out how to convert our files into each other's programs.

Seeing like a codebook. A codebook exists already developed to be applicable to all PRIME country sites. Its terms become the common conceptual denominators we huddle around: illness attribution (by service users and others), decision to seek care, acceptability of services, access to care, barriers, caregiver burden, stigma, medication, psychosocial, financial challenges, but also the category called "good quotes." The codebook serves as a conceptual tunnel that narrows and synchronizes my gaze as we begin to comb through the vertical order of each interview, cutting out new units. The mechanics of running my mouse across text, grabbing words, marking them, dragging them into relevance, and letting others sink into an unmarked silence – become rather automatic. Applying conceptual lenses narrows my visual field, so to speak, and yet I strangely begin to see *more* rather than less. Both the exuberance of the stories and my own spotty blindness are tamed at once. Things fall into place. The questions and answers match with the codes applied to them forming a circle of mutual confirmation. Hacking's "self-vindicating structure" of science comes to mind: theories, techniques, and observations all holding each other up (1992). Surprisingly, they are really there. The themes discussed during the conference call rise to the surface; each interview *can* be disaggregated into the interests put forward by the call attendants. How did I not see this before? Unsurprisingly, I am beginning to feel more competent.

As the three Nepali researchers and I learn to code together, we mutually discipline each other. Over emails and in calls, we discuss our misalignments. We laugh when it is far off, and haggle over examples. Sometimes our compromises resemble trawling nets as we agree to cover contentious cases with a range of acceptable codes to make sure it will be caught (and later found) somewhere. NVivo produces automated verdicts on our overlap, revealing our differences with humanly impossible precision. I am not surprised I often emerge as the outlier. I receive our overlap analysis from one of the researchers: “ST, SP and NH's coding are quite similar compared to DB. DB 's coding is mostly on financing aspect.” A selfish coder I am, alright, losing sight of the many futures this material will have. I must have gotten caught up in my own interests. “NH, SP and ST have coded, specific lines of the transcripts in the sub-themes whereas DB seems to be a lump coder, which is also fine.” A lump coder. My reluctance to break the narrative flow into miniscule units, shows. I am too attached to the vertical order.

At times, we realize the codebook may be the problem and not only our differential use of it. So we tinker on both ends. We involve others in this conversation. The cross-country team PIs in Amsterdam and Addis Ababa agree that the codebook’s “current version is a bit too rigid and detailed.” Adjusting for that, we are instructed to decrease the conceptual resolution; two levels of sub-codes are suspended. In addition, rather than changing the nominal codes, we agree to only adjust their *description and use*; an interesting de-coupling. We stop worrying about messing up the codebook for the other countries, and create our islands of specificity. From here everything becomes easier.

We work continuously on cross-coding until I leave Cape Town, and with it this routine. It will be months before Nepal re-enters my life. In the meantime, I transition along academic affiliations, follow-up fieldwork trips, conferences through Nairobi, Geneva, Paris, Berlin, Florence - before I settle back into Montreal in June 2017. I prioritize my dissertation and re-connect with the questions of my own discipline. The epistemological discomfort with the Nepal paper grows again. Yet, the guilt of an unreciprocated gift hangs over me. While I may have forgotten Nepal for a while, Nepal never forgot me. My line item in the publication tracker keeps popping up reliably in project meetings around the world, leading to friendly follow-up reminders and equally friendly postponing emails from me. By the time I start writing the Nepal article it is March 2018, and I am nearing the end of my dissertation. Montreal's winter grips life and the city firmly during that time, making the daily commute to campus treacherous and my overheated basement office a treat. Pickled in this winter routine that knows no outside or end, I settle into long working days. I comb through my fieldnotes, draft chapters and hunches, and grapple with how best to produce knowledge about knowledge. Skype gathers my writing group from many corners of the world, along with chats with my supervisor. It also sometimes streams my South African friend's living room into my basement for passive company, just hanging out. It is from here that I also re-connect with the Nepal team and ask for the coded data set.

g) Reading horizontally: along the unit of code

The team in Nepal completed the coding months ago and I receive the material in my inbox. Each code is now separated, its material compiled in a single word document. Some code documents are nearly eighty pages. Some codes create pithy paragraphs (i.e. financial challenges); others create page-long narratives each (i.e. caregiver burden). Lifted from their vertical order, their crafted similarity makes for a rather different kind of repetitive, and interpretative routine. I call it "reading horizontally," as I move from purified code document to the next. My cursor runs over its paragraphs quickly. I skim, group, and rearrange paragraphs, like sorting uni-colored Lego bricks. I am learning to think in units of code rather than those of biography, history, place, and temporality.

The writing process extends seamlessly from these practices of reading horizontally. Another layer of sorting distinguishes the narratives on “social drift” from those of “social causation”; a common ground exercise unfolding within the therapeutic imagination of gains and losses, assessed “before” and “after” receiving free treatment at the local health post. Mental health and poverty, however, the two main organizing concepts, are never employed directly. They are made up, and aggregated from a great number of stories nested within the codes – for example, I find myself drawing on illness attribution, different notions recovery, stories on household functioning, on earning an income, on the state of relationships, on food and education, and on marriage prospects for the service user, or their children. Most narratives fall into gains or losses, but I routinely create a third space for the “otherwise” that do not appear to fit. Here, I collect stories of stagnation and those that resist linearity, adding new pockets to the space of possibility within this article. Yet, I also appreciate the regularity and patterned knowledge the process gives rise to, even though most methodological and conceptual choices were initially not mine.

During this fast-paced sorting routine, I stumble again, this time over – wind. A bracketed note within a quotation stops me in my tracks: [Due to the blowing of the wind, the recorder sound is different in the time of recording]. This gust of wind escaped the removal of all contextual information in the coding process. It gets through to me and anchors me back in Nepal. It restores the singularity of the interview in time and space; we are somewhere, listening to somebody. It draws attention to the fragility of the infrastructures and the many actors participating in it, and their choices, incentives and interpretations. The materiality of the recorder and the sensory engagement of the person adding this note to the transcript, perhaps to explain its missing clarity, become tangible. Touching me discursively but not on my skin, this gust of wind, reminds me again that I am "not there" - and yet right in the middle of it.

While initially frustrated with the partiality of my insight and agency, I begin to accept such limitations as the new norm and enjoy being part of a knowledge process that squarely betrays the 19th century myth of authorship and singularity (Foucault, 2001), but also that of experimental systems reliably producing knowledge true to nature or their own set-up (Hacking, 1992; Hans-Jorg Rheinberger, 1997). Rather than feeling paralyzed by what I cannot know and see from my questionable position of "not being there," I develop a tentative trust in the *knowledge-producing assemblage as a whole*, in the interpretative iterations that lie in the past, and those that will occur in the future. I begin to trust that they may be able to fill in the blind spots – both those I am able to flag and those I cannot even see. Thinking in this collaborative space is both restrictive and generative. Will it be possible for me to operate within the confines of the social drift and causation binary, point out cases that do not fit, *and* add a short genealogy of poverty to the discussion, that situates this very paper at a particular moment in the history of development?[99]

In search of context, ambiguity, and genealogy

Loosening disciplinary habits does not make for a "truer" or "better" way of knowing. There are dilemmas that I cannot solve within this epistemic space: stories that force me to return to a vertical reading and restore the little bit of context at my disposal; stories rescued from the thousand cuts of coding that demand to be understood through the lens of personhood, biography, and relationships.

---

[99] The jury is still out on that question, as the current draft of the paper is awaiting feedback from everyone involved. A summary of the Nepal article as if now is appended (appendix one).

Let me give you an example of a woman's story that I struggled to produce differently through this epistemic practice: she is the wife of a man with psychosis, visible in our material as a "caregiver" to him. She shows up on my radar recounting how both her family and her church community refused to give her money for her husband's treatment – a paragraph that is coded as "financial challenge." In it she also recounts how she received free treatment from the health post, which, combined with her intense prayer practice, improved her husband's condition. She takes pride in doing it all on her own. It is an empowerment story in which PRIME's services gave her agency outside her traditional support systems. This is how I will write it up.

However, over the coming weeks, as I am reading horizontally, her story keeps showing up in other code documents, presenting me with contradicting snippets that prompt me to revisit her vertical world. Here, I find that her husband has for a long time threatened to kill her and insisted on marrying a new wife. She had asked her family to intervene because she could not take the abuse anymore. The family had scolded the man and ordered him to treat her better and reminded him of his duties of being a good husband - to no avail. They eventually withdrew their support and refused to give money for his treatment because they thought she would be safer without him. (this is paragraph I initially found). Yet, she stayed, driven by her Christian devotion to being a good wife. While his health improved, her situation did not. He continued to be abusive and her most effective strategy was spousal submission. She narrates a pivotal moment in their relationship when he again threatened to kill her. She tells him to go ahead, but only after she gives him her savings – he will need the money for the children when she is dead. He then broke down crying, she recalls, and apologized for being a bad husband. Now, he is back at work but not sharing his earnings with her and the children.

I cannot represent her story in therapeutic gains and losses as they occur along a mental health recovery trajectory. Within the logics of my article, the husband's health improvement and return to work are gains, yet her economic or emotional situation has not changed. Her role as a "caregiver" renders her experience only relevant in relation to his health status. My article's way of knowing clearly forecloses another; it has its own edge and violence. Ambiguity, context, and relational insight into a person's "point of view" are betrayed. Yet, while the disaggregation of a person's experience into coded data points can easily be described as reductionist or de-contextualizing, this critique assumes an underlying ontological wholesomeness of personhood and context. It speaks merely to what is lost in the process of taking things apart, but not to what is generated when putting them back together, in different terms.

What is generated in this process of collaborative epistemic labor are two things: patterns and composite knowledge objects. Patterns exceed the singular units of person, place and time; they produce obviousness through frequency.[100] This is how we see that relatives of alcohol users often experience violence and financial distress, and that free treatment makes life for everyone more predictable in some shape or form. Patterns also make the singular newly relevant. For example, they allow me to revisit the man who ingested the suicide rope. I still struggle to understand what the rope is about, even as I find two caregivers who speak of the same treatment. Between the three, they share the difficulties in procuring the rope, and the high social and financial costs of this endeavor. While one found it effective, two called it a sham. The rope becomes relevant to my composite knowledge object – poverty – as it is now becoming a treatment that is draining scarce resources.

---

[100] This could either lead us back into the earlier discussions between "thinking in cases" and "thinking in populations." or, as Venturini and Latour suggest, to the problem of connecting the micro and the macro, with its choices of precision versus scope (Venturini & Latour, 2010, 90). However, I wonder if those really are the stakes in constructing "mental health and poverty" through different units, or if it is preserving the possibility of imagining poverty as a countable item, while simultaneously holding that it depends on villagers' own ideas of scarcity and well-being. There is no geometrical continuity of scale – only juxtaposition or "speaking in tongues."

This brings me to the second generative effect, composite knowledge objects such as "mental health" and "poverty."[101] Neither are simply given, but both are assembled through choices from at least four different modes of thought: 1) epidemiological ideas around symptoms, functioning, and resource scarcity; 2) the contours of the interviewees' understanding of scarcity and well-being in Nepal; 3) the conceptual "common ground" required by PRIME's cross-country framework; and 4) my epistemological inclination to reflect on the very objects of "poverty" and "mental health" in history and in this project. In other words, the article on Nepal was brought into being through collaborative epistemic labor that partly drew on pre-existing methodological conventions, but also produced spaces for new questions to emerge at the interstices of different disciplinary logics, actors, work styles, technologies, and curiosities. In the absence of disciplinary enforcement, this process was shaped along iterations that stayed open: My conceptual inclination met a pre-existing data set and coding scheme that was originally developed by a multi-country team with an eye to project evaluation and cross-country comparison. Added into the mix was the director's specific interest in the relationship between mental health and poverty, nested within which is a concern for social justice issues emerging from South Africa's historic and contemporary texture of extreme inequality. Through the disaggregation of the Nepal interviews, this flexible assemblage answered questions posed from different geographical but also epistemological places. Participating in this process, I was

---

[101] Here, I am also taking inspiration from my colleague Fiona Gedeon Achi's work on the concept of poverty in international development, especially on how RCT practices reconfigure poverty as an object of knowledge. Her preliminary findings from fieldwork India show that "poverty" is never a directly measurable category. It does not exist on its own but is replete with philosophies of the human and their needs. As such, it is made up and measured through nested elements such as education, housing, food security, etc. From my own observation, I would add to her finding that composite knowledge objects such as poverty or mental health remain rather flexible and open to re-assemblage within the space of globally networked knowledge production. They are re-assembled from many elements and data points, depending on the trial, program, or policy collective targeted for funding. They are not hardened into universals but remain modularized – a phenomena that the epilogue of this dissertation will discuss as the emergence of an "aggregate human."

.

certainly uncomfortable, and experienced disciplinary phantom pain. But despite the ubiquitous "lack" of disciplinary familiarity, this process produced a flexible common ground, and a shifting vantage point from where to re-think anthropology's own mode of knowledge production.

One of the important features of anthropology's ethos of "being there" relates to its emic epistemological attachments, or to its theorizing from and through the field and its actors. Ideally, its categories are from the field. Within the PRIME collective, it may be easy to say that since concepts such as the codebook are imported, they are external to each country. But then, not quite. They were developed in collaboration between country teams and are perpetually tinkered with in all arms of the project. These categories are neither coming from the "outside," nor the "inside," – they are neither global nor local knowledge. They emerge from a networked "somewhere." As such, they may not be from the field, but they are *of* the field.

I would like to end this chapter with a broader reflection that neither reconciles nor evaluates different ways of knowing, but seeks to open a space of questioning and exposure towards anthropology's methodology. While this first part of the chapter was broadly concerned with the question of how Nepal can be known within collaborative epistemic space (or, what is valid knowledge?), the second part ventures to wonder about the possibility of an ethics of "not being there" (or, how should we come to know?). The idea of "being there" is not only the title of a seminal edited volume (Borneman & Hammoudi, 2009), it is also a shorthand for the discipline's most significant epistemological grounding: its relational and long-term modes of engagement that "produce knowledge that can acknowledge its relationality and still aim for truth" (2009, 8).

In defense of "not being there"

During my time in South Africa, I found myself agonizing over two inverse questions that only began to intertwine fully when I was working on this chapter. The first one is by now familiar: "How will I ever possibly be able to write about Nepal without having been there?" The second one pertained to my fieldwork in Cape Town: "How will I possibly be able to write about South Africa when many black people I know conceive of my "being here" as wrong?" Both of these questions now lead me to formulate a gentle provocation – to venture a defense of "not being there" by drawing on the texture of my experience of "being there" in South Africa, and in Global Mental Health.

(An experiment, remember? It may fail.)

In Cape Town, I was immersed in – and in fact confronted with - the problematic historical lineages of anthropology's subject matter and its practices, on a daily basis. While my presence as a white German/Canadian researcher was at the Center entirely normalized as an international collaboration, it was perceived as a perpetuation of a racial violence outside of these immediate academic networks.[102] Three more or less separate communities shaped my understanding of this conundrum: my academic community at the Center that included predominantly white, colored, and Indian researchers from South Africa and Europe. My white host family, a British couple in

---

[102] Not a single interaction occurs outside the grid of racial interpretations. At work, the grocery store, streets, restaurants, hospitals, in homes, or in parking lots; not once and nowhere does this all-encompassing interpretative grip loosen. Conflicts around race and racism erupt quickly and intensely; interactions rupture, accusations fly, speeches are made, as well as formal complaints. Sometimes physical violence erupts. Confrontations – big, small, awkward, joking, angry, or self-deprecating - play out between friends, colleagues, strangers everyday. I could fill pages with moments in which I observed and absorbed the all-consuming textures of race. Just like this tension was pervasive, so were the choices one had to make in the face of it, every day; where to sit on a train, when to change the side of the street, when to offer help to a friend – and most of all, when to become silent and give space, when to support through absence and when with words, when and how to be an ally and also when to be eviscerated as such. Other questions that emerged were, how to conduct once research: whether to work in the townships or not, or whether to seek out therapeutic spaces for observation, or not. How best to do this, when one's whiteness and observing gaze is nothing but glaring and offensive to many?

their seventies, had been living in Cape Town for more than forty years. She worked as a radio host, freelance journalist, and literature critic, and he is a retired graphic designer and painter. Through them I learned about the longue duree changes in the country as they had experienced them and became immersed in an artsy, white middle class community and their forms of social engagements with the pervasive texture of poverty and race. My closest social group of friends was a group of black and colored lesbian activists working in the precarious, but upwardly mobile NGOs sector. Their work and daily concerns focused on the legalization of sex work, environmental issues, HIV and human rights, and children's empowerment through art. Despite their precarious membership in an aspiring black middle-class, most of them had grown-up in the townships of Cape Town, or Johannesburg. Not quite yet "born free," as the post 1994 generation is called, but having come of age during the transition to democracy, they were intimately familiar with poverty and violence. Stories of their violent upbringing, reflections on the pervasive topics of rape, femicide and hate crimes, but also personal stories of heroic confrontation of racists and homophobes, were frequent topics of conversation. Some had blogs reflecting on the changes in their country through their own life trajectories. My friends also never hid their disdain for the many visiting foreign researchers that circled through their NGOs; the "hit and run" kind of researchers who "never stuck around long enough to see things through, who ultimately were seen to care little beyond their own academic careers. They never asked me about my research, but I believe it was an intentional omission for our friendship's sake. They did, however, confront my international academic friends from the Center whenever I brought them together socially. "Being there" and "giving voice" were highly offensive epistemological grounds to stand on.

My own research choice to focus strictly on GMH experts but not on disadvantaged communities, or therapeutic spaces in the townships were certainly informed by my growing sensitivity towards these issues. Typically, the linkages between anthropological practice and existing colonial legacies are acknowledged and neutralized through gestures of reflexive awareness (Marcus, 1998) before moving on to speak in "expert" registers nonetheless. In South Africa, however, I was never convinced that this genre of reflexivity would lend sufficient legitimacy. Others faced with similiar conundrums took to more radical solutions. A young German filmmaker, for example, who came to Cape Town to produce a documentary about the "fees must fall" student protests was met with hostility for being a white person trying to tell the story of black people's struggle. She inadvertently produced so much vivid footage of people confronting her, that she changed the focus of her documentary and made the film called "Fuck white tears" (Boros, 2016) about being part of the problem – effectively "giving voice" to those who objected to her giving voice; to her "being there." She carved out a space that preserved her voice, while giving it up.[103]

As I was threaded into the workflows of the Global Mental Health assemblage in Cape Town, and many other places thereafter, I came to think that in fact perhaps, "not being there" could be an acceptable, albeit uncomfortable, epistemological vantage point of anthropological knowledge production. In a leap that may seem geographically far but collaboratively quite close, I wondered: Perhaps I was never meant to be that person planting a recorder before a villager in Nepal. Perhaps my skills could be put to use differently within this collaborative space. Perhaps my "not being there" offers a new kind of presence that is partial but therefore

---

[103] Similarly, queer performance artist Dean Hutton's work called "Fuck white people," in which she is wearing a suit that has this sentence printed all over it, is pointing to a similar space of possibility for white voices in contemporary South Africa (see photograph Appendix 2). Notably, she had to perform her piece virtually, projected onto a statute – which was not planed, but a security measure in response to death threats she received for this piece.

always shared. Shared, for example, with the three researchers in Nepal, and everyone else involved in the production of this article; a dispersed kind of presence that could tell stories with me and through me instead of asking me to achieve the anthropological authority to speak "about" Nepal by means of "being there."[104]

Yet, you might ask: Did she just leverage South Africa's post-apartheid, racial tension against grounded ethnographic work in the entirely different context of Nepal? Did she just mix-up a social justice argument with an epistemological one? Did she blindly jump into the cesspool of comparison, of false equivalency? If that is what I have left you with, this experiment may indeed have failed. Let me scrape the bottom of this cauldron one more time: What I have been trying to make tangible here is how the milieu of a global network makes "not being there" a possible – and I suggest perhaps even an ethical – place of knowledge production. I offer these thoughts on the possibility of "not being there" from the inside of this specific assemblage, not only from the vantage point of South Africa and its post-colonial ethical dilemma, nor from a generalized critique of "being there" as an anthropological method and modality of truth. Instead, I have followed my own journey along the empirical edges of my specific field, and through the process of my disciplinary undoing, to marvel out loud if perhaps Nepal – or anything else for that matter – could be known differently; a kind of knowledge production that does not rival or foreclose "being there," but opens up an additional space of possibility.

---

[104] My emphasis on a collaborative practice here does not suggest the absence of power dynamics, or some kind of flattened network. It is certainly fraught with uneven mechanisms of inclusion and exclusion, and what Wenzel Geissler has called the "unknowing" of structural and professional differences in Global Public Health (Geissler, 2013). Another problematization is that dispersed presence is also always dispersed accountability.

Chapter 5 – Conclusion & Epilogue

By way of ending my dissertation, I would like to take the opportunity to think about a couple of larger currents running through its chapters; its connective tissue, so to speak. Arguments linger at the interstices, inchoate until now perhaps, but full of future curiosities. In this epilogue, I bring two such elements to the fore, one concerning the contours of the figure of the human, and the other concerning the question of evidence in its relation to truth.

The aggregate human

Let me begin with the particular conception of the human built into, and emerging from, Global Mental Health. Michel Foucault contended that "man" (sic) as a figure is not only a relatively recent invention but also a figure that may be erased again through changes in the arrangement of knowledge; the famous "face drawn in the sand at the edge of the sea" (Foucault, 2002). My observations of GMH interventions certainly do not go that far, but allow me to venture a proposition nonetheless. The figure of the human may have taken a novel shape, especially in the practices of data design, management, and analysis: it comes into view as perpetually aggregated and disaggregated within what I have called a functional understanding of truth (chapters two and three). Erica Bornstein and Peter Redfield, describing the features of humanitarianism, make a related, but also different, observation. They write:

> "Humanitarianism in this sense is several things at once: a structure of feeling, a cluster of moral principles, a basis for ethical claims and political strategies, and a call for action. […] Moreover, in both nominal and operational terms it defines itself around the collective figure of the human, measured through basic needs and dignity. However stabilized in conceptual and rhetorical terms, this figure proves less stable in practice." (Bornstein & Redfield, 2011, 18)

Bornstein and Redfield here distinguish between a stabilized discursive construct of the human and one that is “less stable in practice.” I found this shared observation reassuring, yet could not discern such a clear division in my fieldsite: the human in GMH seemed to be unstable in theory *and* in practice, and quite deliberately so. Its boundaries, needs, and the actions mobilized in the name of mental health were flexibly assembled out of a number of data points and conceptual scripts. No singular theory of mind, psyche, or conception of mental health or illness would hold the human together; no finite horizon of wholesomeness could be achieved. Instead, it seemed perfectly normal that each problematization of mental health would only ever be partial, and constrained by the methods, resources, and real world idiosyncrasies of specific projects, platforms, or health care systems. Each project gave rise to a new aggregation of traits, factors, and scores pertaining to such things as diagnosis, symptoms improvement, social determinants of health, functioning scores, stigma, risk factors, and economic indicators, at times using flexible conceptual boundaries, as described in chapter three on Theory of Change. Similarly diverse were the actors in charge of aggregation – be they data managers, PIs, lay health workers, ToC workshop attendants, the visiting anthropologist, or experts skilled in speaking multiple disciplinary registers.

Chapter one, on the emergence of GMH, sought to contrast this finding with a disciplinarily structured past, when the psy-ences produced a figure of the human equipped with a psyche, interiority, and subjectivity, which later transformed into a list of fixed and specific mental disorders undergirded by the assumption of a universal biology that is knowable through quantifiable symptoms that can be compared globally. When I began this work, I expected to arrive at a story about how some of these elements vanished, and how others became validated within the rule of evidence-based medicine. But what I found instead was that within the bounds of evidence, many ways of knowing mental health co-existed, or were managed in the space designated for the "absence of evidence" (Knaapen, 2013). The elements constitutive of "mental health" could be juxtaposed and assembled in ways that did not lend themselves to a fixed ontology, not even when multiplied (Mol, 2002).

The aggregate human, I contend, exceeds and destabilizes a number of ordering principles such as the dichotomy between "global" and "local" knowledge systems; it is not confined to either but exists on a continuum between the universal and the specific. Depending on how and by whom its data points are chosen, the aggregate human can be produced through the specificity of place, or outside of it. By way of an example, let me return to the article on "poverty and mental health in Nepal," which aggregated its narrative in local terms, but also around the composite notion of "poverty." If you recall, I described the result of this collaborative, networked labor a *global production of local knowledge.* It assembled disaggregated interview data into knowledge about Nepalese villagers, their social networks, forms of reciprocity, and the uncertainty introduced by a fuel blockade interrupting the drug supply to the health post. And yet, what I also showed was that the coded data used in this article had many futures and stories to tell (or foreclose). It was equally imaginable to produce knowledge on the "caregiver burden" across the five PRIME countries, or a subgroup analysis on how gender affects the experience of mental illness, in relation to place, or factors such as educational or marital status. Within different collaborative teams, these interviews could produce local knowledge about Nepal, or cross-country comparisons of singular elements, depending on how one chose to aggregate components.

The aggregate human in GMH is assembled in a strangely post-disciplinary world – governed by rules I tried to glean through my fieldwork. These rules challenged much of what I knew about the organizing principles of knowledge – be they paradigms, thought styles, boundary objects, discursive apparatuses, or experimental systems – and in my attempt to capture the divergences from my expectations, I arrived at a tentative formulation of the epistemic flexibility I observed in terms of aggregation and disaggregation. Nevertheless, the figure of the human – including their various outgrowths and dissolutions (Rees, 2018) – is not the main stake of this thesis. The stakes of aggregation and disaggregation of knowledge are bigger than any particular epistemic object they shape. Thus, I would like to return to GMH to describe the implications and effects of knowledge aggregation and disaggregation within the specifics of this field's practice. What if the global imaginary of GMH, for example, is much less a space than an aggregate problematization?

a) Why the "global" is not a space

Even though GMH uses the common icon of the "globe" in many of its project logos, brochures, and publications — often in combination with a range of circular arrows, hand-holding chains of people, or hands cupping the planet — one quickly realizes that the "global" in GMH is not a place.

I outlined in the introduction and in chapter one how the global aspiration within GMH is a project of the inclusion of the poor, and how global scaling imagines the integration of low-resource settings into a shared infrastructure of evidence-based care. The idea of the global as low-resource setting, however, is itself an aggregated set of challenges that can be found in the North of Canada, in rural Ethiopia, or in the South of Chicago – their unifying aspect is their lack of resources, trained staff, political will, and infrastructures of care. Vikram Patel, in many of his talks, rebuts arguments about the "cultural" differences in mental health by highlighting the commonalities a poor person in Delhi shares with a poor person in London. The “global” here is an aggregate experience of scarcity and the accompanying operational challenges in healthcare delivery. It is built from common denominators that do not ontologically map onto countries, culture, gender, or disease categories – even while any of these elements can be used to aggregate a global problem and its solutions. Stating the obvious perhaps, aggregation carves out a *common ground* to stand on and to act from at a given time.

The “global” as a common, but always shifting ground is not a place; it is not a simple orientation towards the totality of the globe. Let me illustrate this through a little anecdote: Unbeknownst to many, GMH does have a commercial arm in London, a consulting company called “Maudsley International”, which has recently been renamed to “Implemental.” It is located at the Institute of Psychiatry (IoP) at KCL and offers its services – such as mental health system building, implementation, and policy advice – for a fee, while drawing on the same academic networks that make up the GMH community in London. During my interview with the managing director of Maudsley International, she told me that at times it was quite difficult to recruit experts because many GMH scholars felt conflicted about working for higher-income countries and monetizing their expertise. They preferred to apply their skills and devote their time to low-income settings. The “global” understood as an aggregate set of operational challenges around scarcity and care delivery, as well as its moral orientation towards the poor, here created its own selective cartography. As observers, we cannot begin to understand this kind of globality with recourse to substantive, spatial references; our only recourse is to seek the techniques that allow for such common ground to emerge, as I sought to do in my dissertation.

Evidence ≠ Truth

While this first set of reflections about the aggregate human and the global speak to the productive effects of aggregation, I also want to attend to those of disaggregation. My dissertation described "evidence" as an organizing principle of knowledge, showing how it was produced, used, and scaled in practice. Yet, my thesis in different ways also speaks of the biggest surprise of my fieldwork, which could be summed up as the realization that: evidence ≠ truth. This realization grounds in the practices of disaggregation and iterative evidence-production, which I would like to bring into even sharper relief now.

On "active ingredients" in complex interventions

A frequent preoccupation of interventionists is to find the so-called "active ingredients" in complex community interventions. This notion undoubtedly evokes the pharmacological drug testing model in which a singular chemical compound is seen as responsible for the drug's overall effect. When applied to complex interventions, the idea of an "active ingredient" similarly expresses hope for the existence of effective elements that can be isolated, and ideally transferred to a different context. But this is where the similarity ends. Despite the pharmacological metaphor, the effect is not one of medicalization, strictly speaking. Talk of "active ingredients" in complex GMH interventions first and foremost acknowledges that evidence is never *wholly* reproducible; evidence does not travel well.

Evidence, as I have shown in chapters two and three, is generally recognized as grounded in a particular place, methodological protocol, and the specific circumstances of each clinical trial. It is not viewed as independent from the multiplicity of components and their interactions with each other. The transferability of evidence – and with it the very idea of scaling – therefore crucially depends on the ability to disaggregate this complexity into a number of "active ingredients" that can travel across differences. Ingredients that become mobile and transferable, not because they are uniform and unchanging, but because they are generic, broad and hyper-changeable, as they are expected to be realized, fleshed out, and made effective within a new complex situation upon arrival. Let me give you two examples. One such active ingredient mobilized in anti-stigma interventions is called "social contact with a moderately ill service user." Senior GMH psychiatrist Graham Thornicroft elaborated on this concept during the GMH summer school in London as follows:

> "What is the active ingredient in reducing stigma? It is social contact. But not any social contact - the effective stigma changing ingredient is dependent on the condition that a person with a mental illness moderately disconfirms a common stereotype."

As Thornicroft's example shows, active ingredients are formulations that are both generic and specific at the same time. They bind a singular element, such as "social contact," with a discernible mechanism, such as "disconfirming a common stereotype." But this formulation remains broad and generic, and so it does not prescribe the setting in which this encounter takes place, how it is framed, or what is being talked about; all of that can be variable. But there is also specificity to the formulation: "social contact with a moderately ill person" says something about the necessity of face-to-face interaction, relationality, and alludes to a ceiling of "too much otherness." It speaks about the existence of stereotypes without spelling them out. In this sense, active ingredients are what I have called contingent universals in my thesis. And it is precisely their flexibility and openness that makes them universally applicable, not their standardization.

Another example of active ingredients emerges from what is called "problem solving therapy." In recent years, problem-solving therapy has become the most popular psychological approach for low-resource settings. It seeks to teach people new skills for how to cognitively process, reflect, and act on their problems.[105] The approach is remarkable because its only "universal" assumptions are that humans have problems, and that all humans problem solve. In case of mental illness, this capacity might be inhibited. The Friendship Bench in Zimbabwe, for example, draws on problem solving therapy and has identified its "active ingredient" as – list-making. Listing one's problems is considered to be the technique that leads to a cognitive re-structuring needed to act differently, and feel better in life. It is a generic practice, a skeleton of a practice, really, which I have seen applied, modified, and taught in a number of different settings. While the Friendship Bench integrates list-making into the counseling sessions delivered by elder community members on benches in front of primary care centers, I also witnessed training sessions in which list-making was advocated for managing tasks as diverse as "cleaning your pool filter" and "changing your baby's diapers," as was suggested to new mothers with depression during one workshop. This may seem absurd in this clipped presentation, but the reasoning behind the practice – that list-making is a technique that restructures routines and cognitive processes – is proposed in all seriousness. Such lists are imagined to activate reward cycles and produce new relationships with others, oneself, time, and a person's life world. List-making is also, crucially, a technique for "breaking down" problems into actionable, do-able items. Nevertheless, the act of making lists, as an active ingredient, is not in itself seen as meaningful. Active ingredients only become effective when integrated and embedded in other care practices – whether that be a conversation on a bench, a counseling session, or a cell phone app rewarding its user with smiley face icon when a list item is resolved.

Active ingredients, also sometimes called "common elements," could be described as new universals emerging from GMH. But I suggest that rather than cataloguing them as new

---

[105] WHO has developed a program for problem solving therapy called PM+ (problem management plus), but see also (Chibanda et al., 2011; Dawson et al., 2015) for the most prominent models and GMH interventions based on the approach.

bounded, specific units, their importance and generative power may lie in their flexibility. The main characteristic of active ingredients is their propensity to adapt, to dis- and re-aggregate when needed; to become something else. Mary De Silva expresses this simultaneous belief in common elements and active ingredients, while also maintaining that things need to be fundamentally changeable in order to "work" in new contexts:

> "Well, I am not sure there are interventions that are globally applicable. I don't think there are any interventions that you could apply in any country and it would work, but there would be universal features to such interventions. And I think the trick is to understand what the fundamental elements of interventions are and why they work. Say, well if you take the analogy of drugs then, well we are all humans with the same biology, so…there is no reason to think that a drug wouldn't work in one population or another, you know, generally speaking. And there will be more differences between some groups within a population than there will be between populations. So you can say the same thing, for example, that elements must speak to some kind of common cognition of humans. That we all have the ability to problem solve and therefore having some kind of therapy based on problem solving is, uhm, has universal appeal. Same for mindfulness, you know. The kind of human ability to calm the mind and focus on one thing at the time must be some kind of universal. I am not a neuroscientist or a psychologist but I am assuming experiments have been done that across cultures people have the ability to problem solve and focus, so therefore those kind of interventions have a…basically a new logic on a human basis, across cultures. And then you adapt them to the relevant frame of the context, the culture that people are living in – but that fundamentally is still problem solving."

Problem-solving and focusing are two features she singles out as both universally human *and* as techniques/skills that become active ingredients in interventions, while also maintaining that there is never a one-size-fits-all type of intervention. In other words, "active ingredients" as a modality of thought allow GMH actors to safely take things apart, and put them back together, often in new terms. This disaggregation, however, is not random. It maintains a lineage, a degree of identity between the active ingredient (as a flexible model) and its realization (or adaptation) in a complex interventions. Conceptually and operationally this is captured in the measure of "fidelity," which can – perhaps unsurprisingly – also be quantified.

In the light of my findings I began wondering more generally: what if evidence harbors a rather different ethos and politics than commonly ascribed to it? I was accustomed to viewing evidence-based practices as rigid, limiting, and as exerting power through epistemologically guarded truth claims – famously represented as a hierarchy of knowledge, a pyramid, that prioritizes trial evidence and meta-analysis over expert opinions, case studies, and observational knowledge. But if one understands evidence as a practice of aggregation, disaggregation, and iteration, then the politics of that very same pyramid appear in a different light. The meta-review at the pinnacle of the pyramid elevates a transient form of knowledge to the top: a truth announcing itself as iterative and summative. Evidence expires, just as any guideline or meta-review might; evidence never achieves the "truth," *unchanging*. Produced and validated in large collectives it remains forever suspended in the space that Vikram Patel called imperfect "but the best we have."

To conclude, my thesis ended up pursuing a question posed to me by the field: how is evidence different from truth? In the simplest terms, after working through my observations, I propose the following tenuous answers, which are themselves bound up with the knowledge infrastructure of GMH:

> Evidence is actionable – it is oriented towards changing the "real world."
> Evidence is flexible – it requires dis/aggregation in order to "work."
> Evidence has an open epistemic horizon – it works through updates and iteration.
> Evidence ≠ truth – it cannot ever be achieved once and for all.

Epilogue: Evidence in a post-truth world

I want to end this thesis on a more somber note, with concern rather than a merry embrace of novelty. The open-ended knowledge practices of GMH, over the course of my fieldwork, began resonating with a more unsettling reality. While I grappled with GMH's shifting messages, their alignments with collaborative currents and a functional notion of truth, the world saw facticity and its experts – scientists and journalists – come under attack after the election of Donald Trump. Scholars raised new questions regarding the "crisis of expertise" and the role of evidence in the "post-truth moment" (Gross, 2017; Kelly & McGoey, 2018) acutely amplifying what Latour had already begun to articulate vis-à-vis anthropocentric climate change (Latour, 2014). In the context of contemporary US American political discourse, journalist Megan Garber captures the embattled fragility of truth, when she writes:

> "The logic of the battlefield wins out, and the assigned teams face off, and it becomes clear, if you watch for long enough, that the thing being fought for is reality itself: facts, truths, common knowledge. The content and the contours of the world as we agree to understand it."(Garber, 2018)

I want to use Garber's quote here to articulate the difference I see between what my work has called a shifting horizon of functional truth in a collaborative episteme, and the receding ground of "common knowledge" Garber diagnoses on the partisan battlefield. GMH, sure enough, is acting politically as well. After all, the field seeks to convince a great number of actors that investment in mental health care in low-resource settings is a good idea; its knowledge practices, as my thesis has shown, are built around advocacy as much as around science. Yet, while the post-truth conundrum points to the dissolution of "common knowledge," GMH devises techniques that work towards the opposite effect: the expansion and stabilization of "common" epistemic ground, albeit temporarily, through collaboration, integration, and shifting conceptual boundaries. That is to say that a functional notion of truth, in Cassirer's sense, remains as fundamentally married to "getting it right" as substantive truth; the aspirational endpoint of "truth" never disappears. What marks perhaps the greatest difference is that functional knowledge perpetually examines itself; it knows its position within a field of knowledge through reflexive self-inspection.[106] It is this iterative, open-ended quest towards more, rather than less, truthful claims about mental health that my thesis sought to bring into relief.

***

---

[106] For example, knowing outcomes in terms of process (see chapter three).

Appendix

Appendix 1: Abbreviated summary of Nepal manuscript

Poverty and Mental Health - Nepal

Summary

This article discusses the relationship between mental health and poverty, based on qualitative interviews with mental health service users, caregivers, and primary health care workers in Chitwan, Nepal. The poverty and mental-health nexus will be explored in five thematic sections:

1.) Social causation: how poverty leads to mental health problems
2.) Social drift: how mental health problems lead to poverty
3.) The cost of care: how free treatment impacts economic condition
4.) Narratives beyond the causal binary
5.) The concept of poverty: empirically and historically (in epidemiology, development)

The binary: Social drift and causation. In recent years, the relationship between mental health and poverty has been discussed within the binary of the "social drift" hypothesis, which sees poverty as a result of mental illness, and the "social causation" hypothesis, which sees poverty as the cause of mental illness (Lund et al., 2011). Crucially, these two interpretative templates suggest different strategies for intervention. Despite their dichotomous formulation, however, these mechanisms are not mutually exclusive. Recent studies have found that both mechanisms can be at play at once, compounding the burden people experience (Lund & Cois, 2018). Overall, the interviews interview material confirms the simultaneity of both mechanisms.

1) Social causation.

Narratives of social causation are most commonly found among people with depression, but also among those suffering from alcohol use disorder, epilepsy, and psychosis. They describe day-to-day economic hardship, the hopelessness of being unemployed, and the economic impact of adverse life events as causing 'tension' and 'stress', which are subsequently seen as causing the mental health issues they face.

2) Social drift.

Narratives supporting the social-drift hypothesis illustrate how mental health problems are accompanied by a significant loss in social and economic functioning and a substantial caregiver burden. At the same time, recovery narratives show that after receiving free mental health treatment through PRIME, many service users and their caregivers experienced significant gains in economic and social functioning Economic recovery might take the form of a return to household duties, paid labor, formal education, or increased social participation. However, many other participants report no economic improvement despite their improved mental health status, pointing to the multi-factorial nature of poverty.

3) Cost of care.

A third thematic complex concerns the cost of care. It showcases the economic effects of free mental health care on service users and caregivers. This section is divided into two parts. Part one showcases the strong appreciation and the associated financial benefits of free mental health care. Across all cohorts, service users and caregivers report saving money and time commonly spent on medication and transportation. They also speak to the ways in which these savings are redirected – for instance, towards necessities like food and education. Some report the avoidance of new loans and the alleviation of emotional stress associated with finding and affording care. Part two attends to more ambiguous narratives surrounding the cost of care. Narratives of economic barriers to accessing free care, strategies of coping with medication stock-outs, and people's concerns regarding the lack of choice in their treatment will be discussed (e.g. the "one drug" seen as care for the poor).

4) Beyond the binary.

After discussing the material along the causation and drift framework, the analysis will turn to empirical nuances that reveal the complexity of the calculative choices people make in the face of combined adversity from mental illness and material scarcity. Narratives that cannot be subsumed in the binary causation logic, and that may complicate the linear, causal assumptions will be discussed. Examples include instances in which service users and caregivers insist that savings never materialize despite free treatment or improvements to their health –; a logic pointing perhaps to a zero-sum economy in which needs always exceed resources. For many people, the alternative scenario to receiving free care was not out-of-pocket treatment, but foregoing treatment altogether (a logic that clashed with the interviewer's intent on eliciting stories on "savings").

5) The concept of poverty – empirically & genealogically.

One important finding from these narratives is the profound entanglement of social and economic functioning: economic pressure and relief are experienced by and within interdependent social networks. As the interviews show, resources may be best conceived of as both relational and material – they circulate in extended networks of obligation and reciprocity. Social and material wellbeing are intertwined to such an extent that a notion of poverty focused solely on material resources may limit an analysis of how poverty and mental health problems are related. Both unfold and find a response in social networks that do not map onto the individual, household, or spatially bound family units (e.g. migrant labor). This warrants a genealogical reflection on the concept of poverty commonly used in epidemiology (S. Cooper, Lund, & Kakuma, 2012), development (Best, 2013; Ravallion, 2015), and anthropology (Green, 2006; Han, 2012).

Appendix 2, Dean Hutton performing “Fuck white people,” Cape Town 2016

Image by Doerte Bemme

Literature

Adams, V. (2016). *Metrics: what counts in Global Health*: Duke University Press.

Alexander, G. C., Gallagher, S. A., Mascola, A., Moloney, R. M., & Stafford, R. S. (2011). Increasing off-label use of antipsychotic medications in the United States, 1995–2008. *Pharmacoepidemiology and drug safety, 20*(2), 177-184.

Alkin, M. C. (2004). *Evaluation roots: Tracing theorists' views and influences*: Sage.

Anderson, A. A. (2006). *The community builder's approach to theory of change: A practical guide to theory development*: Aspen Institute Roundtable on Community Change.

Anderson, W. (2014). Making global health history: the postcolonial worldliness of biomedicine. *Social history of medicine, 27*(2), 372-384.

Appadurai, A. (1996). *Modernity al large: cultural dimensions of globalization* (Vol. 1): U of Minnesota Press.

Bains, J. (2005). Race, culture and psychiatry: A history of transcultural psychiatry. *History of psychiatry, 16*(2), 139-154.

Barnet, R. J., & Muller, R. E. (1976). Global Reach. The power of multi-national corporations: New York: Simon and Schuster.

Bartlett, N., Garriott, W., & Raikhel, E. (2014). What's in the 'treatment gap'? Ethnographic perspectives on addiction and global mental health from China, Russia, and the United States. *Medical anthropology, 33*(6), 457-477.

Basaglia, F., Scheper-Hughes, N. E., Lovell, A. M., & Shtob, T. T. (1987). *Psychiatry inside out: Selected writings of Franco Basaglia*: Columbia University Press.

Bashford, A. (2006). Global biopolitics and the history of world health. *History of the human sciences, 19*(1), 67-88.

Bashford, A. (2014). *Global population: history, geopolitics, and life on earth*: Columbia University Press.

Becker, A., & Kleinman, A. (2013). Mental health and the global agenda. *New England Journal of Medicine, 369*(1), 66-73.

Becker, G. S. (1967). *Human capital and the personal distribution of income: An analytical approach*: Institute of Public Administration.

Bemme, D., & D'souza, N. (2012). Global mental health and its discontents. *Somatosphere. Science, Medicine, and Anthropology.* Retrieved from http://somatosphere.net/2012/07/global-mental-health-and-its-discontents.html

Bemme, D., & D'souza, N. A. (2014). Global mental health and its discontents: An inquiry into the making of global and local scale. *Transcultural Psychiatry, 51*(6), 850-874.

Berg, M., & Timmermans, S. (2000). Orders and their others: on the constitution of universalities in medical work. *Configurations, 8*(1), 31-61.

Berlivet, L. (2005). " Association or causation?" The debate on the scientific status of risk factor epidemiology, 1947-c. 1965. *Clio medica (Amsterdam, Netherlands), 75*, 39-74.

Best, J. (2013). Redefining Poverty as Risk and Vulnerability: shifting strategies of liberal economic governance. *Third World Quarterly, 34*(1), 109-129.

Blamey, A., & Mackenzie, M. (2007). Theories of change and realistic evaluation: peas in a pod or apples and oranges? *Evaluation, 13*(4), 439-455.

Bolton, P., Lee, C., Haroz, E. E., Murray, L., Dorsey, S., Robinson, C., . . . Bass, J. (2014). A transdiagnostic community-based mental health treatment for comorbid disorders: development and outcomes of a randomized controlled trial among Burmese refugees in Thailand. *PLoS medicine, 11*(11), e1001757.

Borneman, J., & Hammoudi, A. (2009). *Being there: the fieldwork encounter and the making of truth*: Univ of California Press.

Bornstein, E., & Redfield, P. (2011). *Forces of compassion: humanitarianism between ethics and politics*: School for Advanced Research Press.

Boros, A. (Writer). (2016). Fuck white tears.

Bowker, G. C., Baker, K., Millerand, F., & Ribes, D. (2009). Toward information infrastructure studies: Ways of knowing in a networked environment *International handbook of internet research* (pp. 97-117): Springer.

Bracken, P., Giller, J., & Summerfield, D. (2016). Primum non nocere. The case for a critical approach to global mental health. *Epidemiology and Psychiatric Sciences*, 1-5.

Brada, B. (2011). "Not here": making the spaces and subjects of "Global health" in Botswana. *Culture, Medicine, and Psychiatry, 35*(2), 285-312.

Breuer, E., De Silva, M., & Lund, C. (2018). Theory of change for complex mental health interventions: 10 lessons from the programme for improving mental healthcare. *Global Mental Health, 5*.

Breuer, E., De Silva, M. J., Fekadu, A., Luitel, N. P., Murhar, V., Nakku, J., . . . Lund, C. (2014). Using workshops to develop theories of change in five low and middle income countries: lessons from the programme for improving mental health care (PRIME). *International Journal of Mental Health Systems, 8*(1), 15.

Brody, E. B. (2004). The World Federation for Mental Health: its origins and contemporary relevance to WHO and WPA policies. *World Psychiatry, 3*(1), 54-55.

Brown, T. M., Cueto, M., & Fee, E. (2006). The World Health Organization and the transition from “international” to “global” public health. *American journal of public health, 96*(1), 62-72.

Campbell, C., & Burgess, R. (2012). The role of communities in advancing the goals of the Movement for Global Mental Health: SAGE Publications Sage UK: London, England.

Carothers, J. C., & Organization, W. H. (1953). The African mind in health and disease: A study in ethnopsychiatry.

Cassirer, E., Swabey, W. C., & Swabey, M. C. (2004). *Substance and function and Einstein's theory of relativity*: Courier Corporation.

Castells, M. (1996). The information age: Economy, society, and culture. Volume I: The rise of the network society.

Castells, M. (2011). *The rise of the network society: The information age: Economy, society, and culture* (Vol. 1): John Wiley & Sons.

Center for Theory of Change, C. (2017). ToC Origins. Retrieved from http://www.theoryofchange.org/what-is-theory-of-change/toc-background/toc-origins/

Chase, L., & Sapkota, R. P. (2017). “In our community, a friend is a psychologist”: An ethnographic study of informal care in two Bhutanese refugee communities. *Transcultural Psychiatry, 54*(3), 400-422.

Chen, H. T. (1990). *Theory-driven evaluations*: Sage.

Chibanda, D., Bowers, T., Verhey, R., Rusakaniko, S., Abas, M., Weiss, H. A., & Araya, R. (2015). The Friendship Bench programme: a cluster randomised controlled trial of a brief psychological intervention for common mental disorders delivered by lay health workers in Zimbabwe. *International Journal of Mental Health Systems, 9*(1), 21.

Chibanda, D., Cowan, F., Verhey, R., Machando, D., Abas, M., & Lund, C. (2017). Lay health workers’ experience of delivering a problem solving therapy intervention for common mental disorders among people living with HIV: a qualitative study from Zimbabwe. *Community mental health journal, 53*(2), 143-153.

Chibanda, D., Mesu, P., Kajawu, L., Cowan, F., Araya, R., & Abas, M. A. (2011). Problem-solving therapy for depression and common mental disorders in Zimbabwe: piloting a task-shifting primary mental health care intervention in a population with a high prevalence of people living with HIV. *BMC public health, 11*(1), 828.

Chibanda, D., Verhey, R., Munetsi, E., Cowan, F. M., & Lund, C. (2016). Using a theory driven approach to develop and evaluate a complex mental health intervention: the friendship bench project in Zimbabwe. *International Journal of Mental Health Systems, 10*(1), 16.

Chisholm, B. (1950). The World Health Organization. *British Medical Journal, 1*(4661), 1021.

Chisholm, D., Sweeny, K., Sheehan, P., Rasmussen, B., Smit, F., Cuijpers, P., & Saxena, S. (2016). Scaling-up treatment of depression and anxiety: a global return on investment analysis. *The Lancet Psychiatry, 3*(5), 415-424.

Cieza, A., & Stucki, G. (2008). The International Classification of Functioning Disability and Health: its development process and content validity. *Eur J Phys Rehabil Med, 44*(3), 303-313.

Cohen, A., Eaton, J., Radtke, B., George, C., Manuel, B. V., De Silva, M., & Patel, V. (2011). Three models of community mental health services in low-income countries. *International Journal of Mental Health Systems, 5*(1), 3.

Cohen, A., Kleinman, A., & Saraceno, B. (2002). *World mental health casebook*: Springer.

Cohen, A., Patel, V., Minas, H., Patel, V., Minas, H., Cohen, A., & Prince, M. (2014). A brief history of global mental health. *Global Mental Health: principles and practice*.

Coleman, E. G. (2010). Ethnographic approaches to digital media. *Annual Review of Anthropology, 39*, 487-505.

Collier, S. J. (2006). Global assemblages. *Theory, Culture & Society, 23*(2-3), 399-401.

Collier, S. J., & Ong, A. (2005). Global assemblages, anthropological problems. *Global assemblages: Technology, politics, and ethics as anthropological problems*, 3-21.

Collins, P. Y., Patel, V., Joestl, S. S., March, D., Insel, T. R., Daar, A. S., . . . Fairburn, C. (2011). Grand challenges in global mental health. *Nature, 475*(7354), 27.

Cooke, B., & Kothari, U. (2001). *Participation: The new tyranny?* : Zed books.

Cooper, J. E., & Sartorius, N. (2013). *A companion to the classification of mental disorders*: OUP Oxford.

Cooper, S., Lund, C., & Kakuma, R. (2012). The measurement of poverty in psychiatric epidemiology in LMICs: critical review and recommendations. *Social psychiatry and psychiatric epidemiology, 47*(9), 1499-1516.

Coryn, C. L., Noakes, L. A., Westine, C. D., & Schröter, D. C. (2011). A systematic review of theory-driven evaluation practice from 1990 to 2009. *American journal of Evaluation, 32*(2), 199-226.

Crane, J. T. (2013). *Scrambling for Africa: AIDS, expertise, and the rise of American global health science*: Cornell University Press.

Daly, J. (2005). *Evidence-based medicine and the search for a science of clinical care* (Vol. 12): Univ of California Press.

Das, A., & Rao, M. (2012). Universal mental health: Re-evaluating the call for global mental health: Taylor & Francis.

Das, V. (2007). *Life and Words: Violence and the Descent into the Ordinary*: Univ of California Press.

Daston, L. (2000). *Biographies of scientific objects*: University of Chicago Press.

Daston, L. (2007). *Objectivity*: The MIT Press.

Dawson, K. S., Bryant, R. A., Harper, M., Kuowei Tay, A., Rahman, A., Schafer, A., & van Ommeren, M. (2015). Problem Management Plus (PM+): a WHO transdiagnostic psychological intervention for common mental health problems. *World Psychiatry, 14*(3), 354-357.

De Beauvoir, S., & Parshley, H. M. (1953). The second sex.

De Laet, M., & Mol, A. (2000). The Zimbabwe bush pump: Mechanics of a fluid technology. *Social Studies of Science, 30*(2), 225-263.

De Silva, M. J., Breuer, E., Lee, L., Asher, L., Chowdhary, N., Lund, C., & Patel, V. (2014). Theory of Change: a theory-driven approach to enhance the Medical Research Council's framework for complex interventions. *Trials, 15*(1), 267.

De Silva, M. J., & Ryan, G. (2016). Global mental health in 2015: 95% implementation. *The Lancet Psychiatry, 3*(1), 15-17.

DeLanda, M. (2006). *A new philosophy of society: Assemblage theory and social complexity*: Bloomsbury Publishing.

Deleuze, G., & Guattari, F. (1988). *A thousand plateaus: Capitalism and schizophrenia*: Bloomsbury Publishing.

Delille, E. (2018). Eric Wittkower and the foundation of Montréal's Transcultural Psychiatry Research Unit after World War II. *History of psychiatry*, 0957154X18765417.

Delille, E., & Crozier, I. (2018). Historicizing transcultural psychiatry: people, epistemic objects, networks, and practices: SAGE Publications Sage UK: London, England.

Demazeux, S. (2014). Psychiatric epidemiology, or the story of a divided discipline. *International Journal of Epidemiology, 43*(suppl_1), i53-i66.

Desjarlais, R. (1995). *World mental health: Problems and priorities in low-income countries*: Oxford University Press, USA.

Desjarlais, R., Eisenberg, L., Good, B., & Kleinman, A. (Eds.). (1995). *World mental health: Problems and priorities in low-income countries*: Oxford University Press, USA.

Desrosières, A. (2002). *The politics of large numbers: A history of statistical reasoning*: Harvard University Press.

Dokumaci, A. (2018). Disabilitisation of Medicine: The Emergence of "Quality of Life" as a Place to Interrogate the Medical Model. *The History of the Human Sciences, (forthcoming)*.

Douglas, M. (2003). *Purity and danger: An analysis of concepts of pollution and taboo*: Routledge.

Duclos, V. (2015). Designing spaces of care in the era of global connectivity. *Medicine Anthropological Theory, 2*(1), 154-164.

Ehrenstein, V., & Neyland, D. (2018). On scale work: evidential practices and global health interventions. *Economy and Society, 47*(1), 59-82. doi:10.1080/03085147.2018.1432154

Elyachar, J. (2010). Phatic labor, infrastructure, and the question of empowerment in Cairo. *American Ethnologist, 37*(3), 452-464.

Fanon, F. (2008). *Black skin, white masks*: Grove press.

Fanon, F., Sartre, J.-P., & Farrington, C. (1963). *The wretched of the earth* (Vol. 36): Grove Press New York.

Fassin, D. (2012). *Humanitarian reason: a moral history of the present*: University of California Press.

Federici, S., Meloni, F., & Lo Presti, A. (2009). International literature review on WHODAS II. *Life Span and Disability, 12*(1), 83-110.

Ferguson, J. (1990). *The anti-politics machine:'development', depoliticization and bureaucratic power in Lesotho*: CUP Archive.

Ferguson, J. (2014). Transnational topographies of power: beyond" the State" and" civil society" in the study of African politics. *Occasional paper*(19), 45-71.

Ferguson, J., & Gupta, A. (2002). Spatializing states: toward an ethnography of neoliberal governmentality. *American Ethnologist, 29*(4), 981-1002.

Ferguson, N., Maier, C. S., Manela, E., & Sargent, D. J. (2010). *The shock of the global: the 1970s in perspective*: Harvard University Press.

Fernando, S. (2014). *Mental health worldwide: Culture, globalization and development*: Springer.

Fleck, L. (2012). *Genesis and development of a scientific fact*: University of Chicago Press.

Forrester, J. (1996). If p, then what? Thinking in cases. *History of the human sciences, 9*(3), 1-25.

Foucault, M. (1988). *Madness and civilization: A history of insanity in the age of reason*: Vintage.

Foucault, M. (2001). What is an Author? *Contributions in Philosophy, 83*, 9-22.

Foucault, M. (2002). *The order of things: An archaeology of the human sciences*: Psychology Press.

Foucault, M. (2008). *The Birth of Biopolitics. Lectures at the College de France 1978-1970* (G. Burchell, Trans. M. Senellart, F. Ewald, & A. Fontana Eds.). New York: Palgrave.

Foucault, M. (2012). *Discipline & punish: The birth of the prison*: Vintage.

Foucault, M., Davidson, A. I., & Burchell, G. (2008). *The birth of biopolitics: lectures at the Collège de France, 1978-1979*: Springer.

Francis. (2018). Retrieved from https://www.mettle.com/francis-vr-film-world-bank-fugitives/

Freeman, M. (2016). Global mental health in low and middle income, especially African countries. *Epidemiology and Psychiatric Sciences*, 1-3.

Friedman, M. (2008). Ernst Cassirer and Thomas Kuhn: The neo-Kantian tradition in history and philosophy of science. *The Philosophical Forum, 39*(2), 239-252.

Galatzer-Levy, I. R., & Galatzer-Levy, R. M. (2007). The revolution in psychiatric diagnosis: Problems at the foundations. *Perspectives in biology and medicine, 50*(2), 161-180.

Garber, M. (2018, 19. July 2018). The World Burns. Sarah Sanders Says This Is Fine, The White House press secretary has set a new precedent: Partisanship over patriotism. Victory over truth. *The Atlantic*.

Garcia, A. (2010). *The pastoral clinic: Addiction and dispossession along the Rio Grande*: Univ of California Press.

Geissler, P. W. (2013). Public secrets in public health: Knowing not to know while making scientific knowledge. *American Ethnologist, 40*(1), 13-34.

Giordano, C. (2014). *Migrants in translation: Caring and the logics of difference in contemporary Italy*: Univ of California Press.

Green, M. (2006). Representing poverty and attacking representations: Perspectives on poverty from social anthropology. *The Journal of Development Studies, 42*(7), 1108-1129.

Green, M. (2010). Making development agents: Participation as boundary object in international development. *The Journal of Development Studies, 46*(7), 1240-1263.

Gross, M. (2017). The dangers of a post-truth world: Elsevier.

Hacking, I. (1990). *The taming of chance* (Vol. 17): Cambridge University Press.

Hacking, I. (1992). The self-vindication of the laboratory sciences. In A. Pickering (Ed.), *Science as Practice and Culture* (pp. 29-64): University of Chicago Press.

Hacking, I. (1998a). *Mad travelers: Reflections on the reality of transient mental illnesses*: University of Virginia Press.

Hacking, I. (1998b). *Rewriting the soul: Multiple personality and the sciences of memory*: Princeton University Press.

Hacking, I. (2002). Historical ontology *In the Scope of Logic, Methodology and Philosophy of Science* (pp. 583-600): Springer.

Hacking, I. (2006). *The emergence of probability: A philosophical study of early ideas about probability, induction and statistical inference*: Cambridge University Press.

Han, C. (2012). *Life in debt: Times of care and violence in neoliberal Chile*: Univ of California Press.

Hanlon, C., Fekadu, A., Jordans, M., Kigozi, F., Petersen, I., Shidhaye, R., . . . Raja, S. (2015). District mental healthcare plans for five low-and middle-income countries: commonalities, variations and evidence gaps. *The British Journal of Psychiatry*, bjp. bp. 114.153767.

Haraway, D. (2003). Situated knowledges: The science question in feminism and the privilege of partial perspective. *Turning points in qualitative research: Tying knots in a handkerchief, 2003*, 21-46.

Haraway, D. (2006). A cyborg manifesto: Science, technology, and socialist-feminism in the late 20th century. *The international handbook of virtual learning environments*, 117-158.

Haraway, D. J. (2013). *When species meet* (Vol. 3): U of Minnesota Press.

Harding, S. (1992). Rethinking standpoint epistemology: What is" strong objectivity?". *The Centennial Review, 36*(3), 437-470.

Harding, S. (2015). *Objectivity and diversity: Another logic of scientific research*: University of Chicago Press.

Healy, D. (2009). *The creation of psychopharmacology*: Harvard University Press.

Heaton, M. M. (2013). *Black skin, white coats: Nigerian psychiatrists, decolonization, and the globalization of psychiatry*: Ohio University Press.

Heaton, M. M. (forthcoming). The politics and practice of Thomas Adeoye Lambo: towards a post-colonial history of transcultural psychiatry. *History of psychiatry*, 1-16.

Heis, J. (2011). Ernst Cassirer's neo-Kantian philosophy of geometry. *British Journal for the history of philosophy, 19*(4), 759-794.

Hickling, F. W., Gibson, R. C., & Hutchinson, G. (2013). Current research on transcultural psychiatry in the Anglophone Caribbean: Epistemological, public policy, and epidemiological challenges. *Transcultural Psychiatry, 50*(6), 858-875. doi:10.1177/1363461513508806

Hill, A. B. (1965). The environment and disease: association or causation? : SAGE Publications.

Hyde, S. T. (2011). Migrations in humanistic therapy: Turning drug users into patients and patients into healthy citizens in Southwest China. *Body & Society, 17*(2-3), 183-204.

Inda, J. X., & Rosaldo, R. (2002). Introduction: a world in motion. *The anthropology of globalization: A reader*, 1-34.

Isaac, M., Janca, A., & Costa e Silva, J. (1995). A review of the World Health Organization's work on primary care psychiatry. *Primary Care Psychiatry, 1*, 179-185.

Jain, S., & Jadhav, S. (2009). Pills that swallow policy: Clinical ethnography of a community mental health program in Northern India. *Transcultural Psychiatry, 46*(1), 60-85.

James, C. (2011). Theory of change review. *a report commissioned by Comic Relief, London*.

Jenkins, R. (1997). Nations for Mental Health. *Social psychiatry and psychiatric epidemiology, 32*(6), 309-311. doi:10.1007/bf00805433

Jensen, N. (2017). 8 A genealogy of evidence at the WHO. *Global Health and Geographical Imaginaries*, 135.

Jerven, M. (2013). *Poor numbers: how we are misled by African development statistics and what to do about it*: Cornell University Press.

Kelly, A. H., & McGoey, L. (2018). Facts, power and global evidence: a new empire of truth. *Economy and Society, 47*(1), 1-26.

Kelty, C. M. (2017). Too much democracy in all the wrong places: toward a grammar of participation. *Current Anthropology, 58*(S15), S77-S90.

Kirmayer, L. (2012). Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism. *Social science & medicine, 75*(2), 249-256.

Kirmayer, L., & Pedersen, D. (2014). Toward a new architecture for global mental health.

Kirmayer, L., & Swartz, L. (2013). Culture and global mental health. In V. Patel, H. Minas, A. Cohen, & M. Prince (Eds.), *Global Mental Health: principles and practice*. Oxford: Oxford University Press.

Kirmayer, L. J. (2007). Cultural psychiatry in historical perspective. *Textbook of cultural psychiatry*, 3-19.

Kleinman, A. (2009). Global mental health: a failure of humanity. *The lancet, 374*(9690), 603-604.

Kleinman, A. (2012). Rebalancing academic psychiatry: why it needs to happen–and soon: RCP.

Knaapen, L. (2013). Being 'evidence-based'in the absence of evidence: The management of non-evidence in guideline development. *Social Studies of Science, 43*(5), 681-706.

Kohrt, B. A., & Mendenhall, E. (2016). *Global mental health: Anthropological perspectives* (Vol. 2): Routledge.

Krajewski, M. (2005). Restlosigkeit. Weltprojekte um 1900.

Kuhn, T. S. (1970). *The Structure of Scientific Revolutions, 2nd enl. ed*: University of Chicago Press.

Larkin, B. (2013). The politics and poetics of infrastructure. *Annual Review of Anthropology, 42*, 327-343.

Latour, B. (1983). Give me a laboratory and I will raise the world. *Science observed, 141*, 170.

Latour, B. (1987). *Science in action: How to follow scientists and engineers through society*: Harvard university press.

Latour, B. (1993). *The pasteurization of France*: Harvard University Press.

Latour, B. (1999a). Give me a laboratory and I will raise the world. *The science studies reader*, 258-275.

Latour, B. (1999b). *Pandora's hope: essays on the reality of science studies*: Harvard university press.

Latour, B. (2009). Spheres and Networks. Two ways to reinterpret globalization. *Harvard Design Magazine*(30), 138-144.

Latour, B. (2014). AIME. An Inquiry into Modes of Existence. An Anthropology of the Moderns. Retrieved from http://www.modesofexistence.org/aime

Lee, C. W. (2014). *Do-it-yourself democracy: The rise of the public engagement industry*: Oxford University Press.

Lee, K. (2003). *Globalization and health: an introduction*: Springer.

Lezaun, J., & Soneryd, L. (2007). Consulting citizens: technologies of elicitation and the mobility of publics. *Public understanding of science, 16*(3), 279-297.

Lovell, A. M. (2014). The World Health Organization and the contested beginnings of psychiatric epidemiology as an international discipline: one rope, many strands. *International Journal of Epidemiology, 43*(suppl 1), i6-i18.

Lovell, A. M., & Susser, E. (2014). What might be a history of psychiatric epidemiology? Towards a social history and conceptual account: Oxford University Press.

Luhanga, P. (2018). Expropriating land without compensation: shack-dwellers have their say *Ground Up*. Retrieved from https://www.groundup.org.za/article/informal-settlement-residents-give-their-views-expropriation-without-compensation/

Lund, C. (2017). Balancing the Local and the Global: Commentary on 'Globalizing Mental Health: Challenges and New Visions' Section *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health* (pp. 429-441): Springer.

Lund, C., & Cois, A. (2018). Simultaneous social causation and social drift: Longitudinal analysis of depression and poverty in South Africa. *Journal of affective disorders, 229*, 396-402.

Lund, C., De Silva, M., Plagerson, S., Cooper, S., Chisholm, D., Das, J., . . . Patel, V. (2011). Poverty and mental disorders: breaking the cycle in low-income and middle-income countries. *The lancet, 378*(9801), 1502-1514.

Maier, C. (2010). 'Malaise': The Crisis of Capitalism in the 1970s. *The Shock of the Global: The 1970s in Perspective*, 25-48.

Malinowski, B. (1922). Argonauts of the Pacific. *Holt, Rinehart and Winston, New York, NY.*

March, D., & Oppenheimer, G. M. (2014). Social disorder and diagnostic order: the US Mental Hygiene Movement, the Midtown Manhattan study and the development of psychiatric epidemiology in the 20th century. *International Journal of Epidemiology, 43*(suppl_1), i29-i42.

Marcus, G. E. (1995). Ethnography in/of the world system: The emergence of multi-sited ethnography. *Annual Review of Anthropology, 24*(1), 95-117.

Marcus, G. E. (1998). *Ethnography through thick and thin*: Princeton University Press.

Marcus, G. E., & Saka, E. (2006). Assemblage. *Theory, Culture & Society, 23*(2-3), 101-106.

Matza, T. (2018). *Shock Therapy: Psychology, Precarity, and Well-Being in Postsocialist Russia*: Duke University Press.

Mayes, R., & Horwitz, A. V. (2005). DSM-III and the revolution in the classification of mental illness. *Journal of the History of the Behavioral Sciences, 41*(3), 249-267.

McCoy, D., Jensen, N., Kranzer, K., Ferrand, R. A., & Korenromp, E. L. (2013). Methodological and policy limitations of quantifying the saving of lives: a case study of the Global Fund's approach. *PLoS medicine, 10*(10), e1001522.

Mendenhall, E., De Silva, M. J., Hanlon, C., Petersen, I., Shidhaye, R., Jordans, M., . . . Patel, V. (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.

Merry, S. E. (2016). *The seductions of quantification: Measuring human rights, gender violence, and sex trafficking*: University of Chicago Press.

Merry, S. E., & Conley, J. M. (2011). Measuring the world: Indicators, human rights, and global governance. *Current Anthropology, 52*(S3), 000-000.

Merton, R. K. (1973). The normative structure of science. In idem, The sociology of science. Theoretical and empirical investigations (pp. 267–278): Chicago: University of Chicago Press.

Mills, C. (2014). Decolonizing global mental health: The psychiatrization of the majority world. *London and New York: Routledge*.

Moats, D. (2016). Of Stories and Numbers: Rethinking the Settlement between Anthropology and Metrics in Global Health: Taylor & Francis.

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

Moncrieff, J. (2013). Magic bullets for mental disorders: the emergence of the concept of an “antipsychotic” drug. *Journal of the History of the Neurosciences, 22*(1), 30-46.

Moyn, S. (2010). *The last utopia: human rights in history*: Harvard University Press.

Moyn, S. (2012). *The last utopia*: Harvard University Press.

Muller, R. E. (1975). Globalization and the failure of economic policy. *Challenge, 18*(2), 57-61.

Murray, C. J., & Lopez, A. D. (1996). The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020: summary.

Mykhalovskiy, E., & Weir, L. (2004). The problem of evidence-based medicine: directions for social science. *Social science & medicine, 59*(5), 1059-1069.

Nguyen, V.-K. (2010). *The republic of therapy: Triage and sovereignty in West Africa’s time of AIDS*: Duke University Press.

Nutley, S. M., Smith, P. C., & Davies, H. T. (2000). *What works?: Evidence-based policy and practice in public services*: Policy Press.

Okpaku, S. O., & Biswas, S. (2014). History of global mental health. *Essentials of global mental health*, 1-10.

Padma, T. (2014). Developing countries: The outcomes paradox. *Nature, 508*(7494), S14-S15.

Pandolfo, S. (2018). *Knot of the Soul: Madness, Psychoanalysis, Islam*: University of Chicago Press.

Patel, V. (2014). Why mental health matters to global health. *Transcultural Psychiatry, 51*(6), 777-789.

Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, M., . . . van Ommeren, M. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *The lancet, 370*(9591), 991-1005.

Pinch, T. J. (1992). Opening black boxes: Science, technology and society. *Social Studies of Science, 22*(3), 487-510.

Porter, T. M. (1996). *Trust in numbers: The pursuit of objectivity in science and public life*: Princeton University Press.

Povinelli, E. A. (2001). Radical worlds: the anthropology of incommensurability and inconceivability. *Annual Review of Anthropology, 30*(1), 319-334.

Povinelli, E. A. (2002). *The cunning of recognition: Indigenous alterities and the making of Australian multiculturalism*: Duke University Press.

Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R., & Rahman, A. (2007). No health without mental health. *The lancet, 370*(9590), 859-877.

Prince, R. H. (2000). Transcultural psychiatry: personal experiences and Canadian perspectives. *The Canadian Journal of Psychiatry, 45*(5), 431-437.

Rabinow, P. (1995). *French modern: Norms and forms of the social environment*: University of Chicago Press.

Rabinow, P. (2003). Anthropos today. *Reflections on Modern Equipment. Princeton, NT: Princeton University Press*.

Rabinow, P., Marcus, G. E., Faubion, J. D., & Rees, T. (2008). *Designs for an Anthropology of the Contemporary*: Duke University Press.

Raikhel, E. (2010). Post-Soviet placebos: Epistemology and authority in Russian treatments for alcoholism. *Culture, Medicine, and Psychiatry, 34*(1), 132-168.

Raikhel, E., & Bemme, D. (2016). Postsocialism, the psy-ences and mental health. *Transcultural Psychiatry, 53*(2), 151-175.

Ravallion, M. (2015). *The economics of poverty: history, measurement, and policy*: Oxford University Press.

Read, U. M., Adiibokah, E., & Nyame, S. (2009). Local suffering and the global discourse of mental health and human rights: An ethnographic study of responses to mental illness in rural Ghana. *Globalization and Health, 5*(1), 13.

Redfield, P. (2000). *Space in the tropics: from convicts to rockets in French Guiana*: Univ of California Press.

Redfield, P. (2008). Vital mobility and the humanitarian kit. *Biosecurity Interventions*, 147-172.

Redfield, P. (2013). *Life in crisis: The ethical journey of doctors without borders*: Univ of California Press.

Redfield, P. (2016). Fluid technologies: The Bush Pump, the LifeStraw® and microworlds of humanitarian design. *Social Studies of Science, 46*(2), 159-183.

Rees, T. (2014). Humanity/Plan; or, On the" Stateless" Today (Also Being an Anthropology of Global Health). *Cultural Anthropology, 29*(3), 457-478.

Rees, T. (2018). *After Ethnos*: Duke University Press.

Reubi, D. (2018a). Epidemiological accountability: Philanthropists, global health and the audit of saving lives. *Economy and Society*, 1-28.

Reubi, D. (2018b). A genealogy of epidemiological reason: Saving lives, social surveys and global population. *BioSocieties, 13*(1), 81-102.

Rheinberger, H.-J. (1997). Toward a history of epistemic things: Synthesizing proteins in the test tube.

Rheinberger, H.-J. (2015). Difference Machines: Time in Experimental Systems. *Configurations, 23*(2), 165-176.

Rigillo, N. (2010). *Investing in Women for Development: Human Capital, the New Home Economics, and the World Bank*. Bibliographic Essay (unpublished).

Riles, A. (2001). *The network inside out*: University of Michigan Press.

Robins, L. N., Wing, J., Wittchen, H. U., Helzer, J. E., Babor, T. F., Burke, J., . . . Regier, D. A. (1988). The Composite International Diagnostic Interview: an epidemiologic instrument suitable for use in conjunction with different diagnostic systems and in different cultures. *Archives of general psychiatry, 45*(12), 1069-1077.

Rose, N. (1990). *Governing the soul: the shaping of the private self*: Taylor & Frances/Routledge.

Rose, N. (1998). *Inventing our selves: Psychology, power, and personhood*: Cambridge University Press.

Rose, N. (2006). Disorders without borders? The expanding scope of psychiatric practice. *BioSocieties, 1*(4), 465-484.

Rothstein, W. G. (2003). *Public health and the risk factor: a history of an uneven medical revolution* (Vol. 3): Boydell & Brewer.

Sartorius, N. (1993). WHO's work on the epidemiology of mental disorders. *Social psychiatry and psychiatric epidemiology, 28*(4), 147-155.

Sassen, S. (2006). *Territory, authority, rights: From medieval to global assemblages* (Vol. 7): Cambridge Univ Press.

Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: scarcity, inequity, and inefficiency. *The lancet, 370*(9590), 878-889. doi:10.1016/S0140-6736(07)61239-2

Schmidt, J. C. (2008). Towards a philosophy of interdisciplinarity. *Poiesis & Praxis, 5*(1), 53-69.

Scull, A. (2015). *Madness in Civilizatio*. Princeton: Princeton University Press.

Shore, C., & Wright, S. (2000). Coercive accountability. *Audit cultures: Anthropological studies in accountability, ethics and the academy*, 57-89.

Shore, C., & Wright, S. (2015). Governing by numbers: audit culture, rankings and the new world order. *Social Anthropology, 23*(1), 22-28.

Shukla, A., Philip, A., Zachariah, A. Z., Phadke, A., Suneetha, A., Davar, B., . . . Kalathil, J. (2012). Critical perspectives on the NIMH initiative “Grand Challenges to Global Mental Health”.

Siddiqi, J. (1995). *World health and world politics: the World Health Organization and the UN system*: Univ of South Carolina Press.

Simone, A. (2004). People as infrastructure: intersecting fragments in Johannesburg. *Public Culture, 16*(3), 407-429.

Simpson, A. (2014). *Mohawk interruptus: Political life across the borders of settler states*: Duke University Press.

Simpson, A. (2016). Consent's Revenge. *Cultural Anthropology, 31*(3), 326-333.

Sobel, I. (1978). The human capital revolution in economic development: its current history and status. *Comparative Education Review, 22*(2), 278-308.

Stein, J. G. (2008). Humanitarian organizations: Accountable—why, to whom, for what, and how? *Humanitarianism in question: Politics, power, ethics*, 124-142.

Stengel, E. (1959). Classification of mental disorders. *Bulletin of the World Health Organization, 21*(4-5), 601-663.

Stevenson, L. (2014). *Life beside itself: Imagining care in the Canadian Arctic*: Univ of California Press.

Stone, D. A. (1986). *The disabled state*: Temple University Press.

Storeng, K. T., & Béhague, D. P. (2014). "Playing the Numbers Game": Evidence-based Advocacy and the Technocratic Narrowing of the Safe Motherhood Initiative. *Medical Anthropology Quarterly, 28*(2), 260-279.

Strand, M. (2011). Where do classifications come from? The DSM-III, the transformation of American psychiatry, and the problem of origins in the sociology of knowledge. *Theory and Society, 40*(3), 273-313.

Strathern, M. (1995). *Relation*: Prickly Pear Pamphlets (North America).

Street, A. (2014). *Biomedicine in an unstable place: Infrastructure and personhood in a Papua New Guinean hospital*: Duke University Press.

Sturdy, S., Freeman, R., & Smith-Merry, J. (2013). Making knowledge for international policy: WHO Europe and mental health policy, 1970–2008. *Social history of medicine, 26*(3), 532-554.

Sullivan, H., & Stewart, M. (2006). Who owns the theory of change? *Evaluation, 12*(2), 179-199.

Summerfield, D. (2008). How scientifically valid is the knowledge base of global mental health? *BMJ: British Medical Journal, 336*(7651), 992-994.

Summerfield, D. (2012). Afterword: against "global mental health". *Transcultural Psychiatry, 49*(3-4), 519-530.

Summerfield, D. (2013). "Global mental health" is an oxymoron and medical imperialism. *Bmj, 346*, f3509.

Swartz, L., Kilian, S., Twesigye, J., Attah, D., & Chiliza, B. (2014). Language, culture, and task shifting–an emerging challenge for global mental health. *Global health action, 7*(1), 23433.

Ticktin, M. I. (2011). *Casualties of care: Immigration and the politics of humanitarianism in France*: Univ of California Press.

Timimi, S., Salie, M., Shatrunga, V., & Fernando, S. (2011). A reply to "Grand Challenges in Global Mental Health". Retrieved from http://somatosphere.net/2011/10/a-reply-to-grand-challenges-in-mental-health.html

Timmermans, S., & Berg, M. (2010). *The gold standard: The challenge of evidence-based medicine and standardization in health care*: Temple University Press.

Tousignant, N. (2013). Insects-as-infrastructure: Indicating, project Locustox and the Sahelization of ecotoxicology. *Science as culture, 22*(1), 108-131.

Trouillot, M.-R. (2003). Anthropology and the savage slot: The poetics and politics of otherness *Global Transformations* (pp. 7-28): Springer.

Tsing, A. (2000). The global situation. *Cultural Anthropology, 15*(3), 327-360.

Tsing, A. L. (2012). On nonscalability: The living world is not amenable to precision-nested scales. *Common Knowledge, 18*(3), 505-524.

Tsing, A. L. (2015). *The mushroom at the end of the world: On the possibility of life in capitalist ruins*: Princeton University Press.

Valters, C. (2015). Theories of change. Time for a radical approach to learning in development.

Venturini, T., & Latour, B. (2010). The social fabric: Digital traces and quali-quantitative methods. *Proceedings of future en seine, 2009*, 87-101.

Vogel, I. (2012). Review of the use of 'Theory of Change'in international development. *UK: Department for International Development (DFID)*.

Wahlberg, A. (2018). The Vitality of Disease *The Palgrave Handbook of Biology and Society* (pp. 727-748): Springer.

Wahlberg, A., & Rose, N. (2015). The governmentalization of living: calculating global health. *Economy and Society, 44*(1), 60-90.

Watters, E. (2010). *Crazy like us: The globalization of the American psyche*: Simon and Schuster.

Weart, S. R. (2008). *The discovery of global warming*: Harvard University Press.

Weiss, C. H. (1995a). New approaches to evaluating comprehensive community initiatives. *Washington, DC: The Aspen Institute. Retrieved from* http://files*. eric. ed. gov/fulltext/ED383817. pdf.*

Weiss, C. H. (1995b). Nothing as practical as good theory: Exploring theory-based evaluation for comprehensive community initiatives for children and families. *New approaches to evaluating community initiatives: Concepts, methods, and contexts, 1*, 65-92.

Weisz, G., Cambrosio, A., Keating, P., Knaapen, L., Schlich, T., & Tournay, V. J. (2007). The emergence of clinical practice guidelines. *The Milbank Quarterly, 85*(4), 691-727.

Wendland, C. (2012). Moral Maps and Medical Imaginaries: Clinical Tourism at Malawi's College of Medicine. *American Anthropologist, 114*(1), 108-122. doi:doi:10.1111/j.1548-1433.2011.01400.x

White, R., Jain, S., Orr, D. M. R., & Read, U. (Eds.). (2017). *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health*: Palgrave Macmillan.

Whiteford, H. A., Degenhardt, L., Rehm, J., Baxter, A. J., Ferrari, A. J., Erskine, H. E., . . . Johns, N. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *The lancet, 382*(9904), 1575-1586.

WHO. (1973). Report of the international pilot study of schizophrenia.

WHO. (1975). Organization of Mental Health Services in the Health Services in the Developing Countries: Technical Report Series 564. *Geneva, WHO.*

WHO. (1978). *The Declaration of Alma Ata. Presented at.* Paper presented at the International Conference on Primary Health Care. Alma Ata.

WHO. (1998). Mental disorders in primary care: a WHO education package.

WHO. (2001a). *Atlas of mental health resources in the world 2001.*

WHO. (2001b). *The World Health Report 2001: Mental health: new understanding, new hope.* (9241562013). World Health Organization.

WHO. (2008). Integrating mental health into primary care: a global perspective.

WHO. (2010). *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP)*: Geneva: World Health Organization.

WHO, & Unicef. (1978). Primary health care: report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

Wing, J. K., Babor, T., Brugha, T., Burke, J., Cooper, J., Giel, R., . . . Sartorius, N. (1990). Scan: Schedules fonr clinical assessment in neuropsychiatry. *Archives of general psychiatry, 47*(6), 589-593.

Wing, J. K., Cooper, J. E., & Sartorius, N. (1974). *Present state examination*: Medical Research Council London.

Wu, H. Y.-J. (2015). World citizenship and the emergence of the social psychiatry project of the World Health Organization, 1948–c. 1965. *History of psychiatry, 26*(2), 166-181.

Wu, H. Y.-J. (2016). From racialization to world citizenship: The transnationality of taiwan and the early psychiatric epidemiological studies of the world health organization. *East Asian Science, Technology and Society: An International Journal, 10*(2), 183-205.

Young, A. (1997). *The harmony of illusions: Inventing post-traumatic stress disorder*: Princeton University Press.