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Engaging culture and context in mhGAP implementation: fostering reflexive deliberation in practice

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ABSTRACT

In 2002, WHO launched the Mental Health Gap Action Programme (mhGAP) as a strategy to help member states scale up services to address the growing burden of mental, neurological and substance use disorders globally, especially in countries with limited resources. Since then, the mhGAP program has been widely implemented but also criticised for insufficient attention to cultural and social context and ethical issues. To address this issue and help overcome related barriers to scale-up, we outline a framework of questions exploring key cultural and ethical dimensions of mhGAP planning, adaptation, training, and implementation. This framework is meant to guide mhGAP activity taking place around the world. Our approach is informed by recent research on cultural formulation and adaptation, and aligned with key components of the WHO implementation research guide (Peters, D. H., Tran, N. T., & Adam, T. (2013). Implementation research in health: a practical guide. *Implementation research in health: a practical guide*.). The framework covers three broad domains: (1) *Concepts of wellness and illness*—how to examine cultural norms, knowledge, values and attitudes in relation to the "culture of the mhGAP"; (2) *Systems of care*—identifying formal and informal systems of care in the cultural context of practice.; and (3) *Ethical space*: examining issues related to power dynamics, communication, and decision-making. Systematic consideration of these issues can guide integration of cultural knowledge, structural competence, and ethics in implementation efforts.

Summary box

- There is continued debate about efforts to provide standardized mental health care across cultures and contexts with concerns about: (1) inadequate identification and integration of local modes of expression of distress and healing practices; (2) risks of medicalizing everyday forms of distress; and (3) broader ethical questions about the effects of imposing of biomedical frameworks.
- The need for better understanding of culture in global mental health care has long been recognized. However, there is a need to develop approaches to guide the process of integration of culture and context in local adaptation and implementation of mental health protocols and interventions like mhGAP.
- This framework outlines points of entry to engage with culture and context by presenting a series of questions that can guide critical reflexive deliberation at all stages of mhGAP implementation as well as other efforts to address culture and context in global health work.
- The questions are organized around three key domains: concepts of wellness, systems of care, and ethical space. They focus on participants' knowledge, attitudes and assumptions about mental health, as well as local social and cultural context of mental health care, specific cultural and contextual issues relevant to the mhGAP intervention guide, and key ethical issues related to the power dynamics of health service implementation and delivery.
- Engagement with these questions creates opportunities for diverse voices to be heard, to promote knowledge exchange and allow key ethical questions to be addressed, whether for implementation, policy or practice. This framework can guide efforts to promote power-sharing and co-construction of knowledge in ways that are beneficial to diverse populations and communities and has the potential to improve implementation, uptake, and sustainability of global mental health programs.

BACKGROUND

In 2002, WHO launched the Mental Health Gap Action Programme (mhGAP) to address the growing burden of mental, neurological and substance use disorders. Globally, there is a significant gap between individuals in need of mental healthcare and those receiving it.[1–4] The expressed aim of mhGAP is to provide health planners, policy-makers and donors with programmes and tools to support implementation and scale-up of mental health services and care, especially in low-income and middle-income countries (LMICs).[5] The most recent iteration of this programme is presented in the WHO's Comprehensive Mental Health Action Plan 2013–2020 with the objectives of: (1) strengthening effective leadership and governance for mental health;

(2) providing comprehensive, integrated and responsive mental health and social care services in community-based settings; (3) implementing strategies for promotion and prevention in mental health and (4) strengthening information systems, evidence and research for mental health.[6 7] A key component of mhGAP involves training non-specialised health professionals, and other service providers to address mental health needs in their practice. The mhGAP Intervention Guide (mhGAP-IG) was launched in 2010 to support this training initiative and has been used in more than 90 countries.[8] The guide aims to equip service providers with clinical algorithms to diagnose and treat common mental and neurological disorders.

The mhGAP initiative and the broader global mental health (GMH) movement[9 10] have been engaged in a debate about the appropriateness of globalising standardised mental healthcare across cultures and contexts.[11–13] Critiques of GMH include concerns about: (1) inadequate identification and integration of local modes of expression of distress and related healing practices; (2) risks of medicalisation or psychiatrisation of everyday forms of distress and (3) broader ethical concerns about the imposition of biomedical frameworks.[14–16] Despite efforts to acknowledge culture and context in recent mhGAP materials, critics have argued that in practice mhGAP implementation tends to prioritise a biomedical approach to the relative exclusion of alternative, locally grounded, approaches to care.[14 17 18] These and other critiques have spurred discussion of alternative approaches to GMH emphasising greater engagement with social and cultural context.[13 14 16] Notwithstanding these conceptual critiques and practical challenges, the mhGAP programme continues to be implemented in varied settings. The programme has been used to train a range of groups including primary healthcare staff, physicians, schoolteachers and others, and the diagnostic algorithms have been adopted by healthcare workers and traditional healers in countries in Africa, Asia and South America.[4]

The need to address culture and context stems from assumptions that are embedded in mhGAP tools and approaches about what constitutes a mental health problem and what counts as relevant knowledge for evidence-based practice.[19] The urgent task of better understanding and addressing culture, care and mental health has long been recognised.[20] Prior to the development of the cultural formulation framework,[21] constructs like ‘cultural competence’,[22] ‘cultural responsiveness’,[23] ‘cultural safety’[24] and ‘cultural humility’[25] had been advanced as a way of drawing attention to the importance of differences in interpreting the causes of distress and illness and approaches to care. Recent Lancet commissions have argued that engaging with the unique features of social contexts is necessary to adequately prevent, diagnose or treat disease, attain high-quality health systems by improving user experience and trust, foster collaboration across sectors, facilitate access and increase use of care to reduce preventable disease, and overcome barriers and errors encountered in programme scale-up.[26–29]

Like many approaches aimed at standardising and systematising practice across contexts, there is a risk that conceptual constructs oversimplify or neglect crucial factors in healthcare including such as local belief systems, patterns of care and support, and subjective experiences. Simplistic approaches to ‘culture’ as stereotyped individual traits are common. Implicit assumptions about the meaning of symptoms and appropriate treatments often result in barriers to implementation when they come into conflict with local values or ways of knowing and doing. Our premise is that when these assumptions are made explicit, they can inform the process of local adaptation of interventions through dialogue, planning and action research, enhancing the ability to integrate local idioms of distress, ways of coping, and approaches to care. Our aim in this paper is to outline and operationalise meaningful engagement with culture and context through a series of critically reflexive questions organised around three key domains: concepts of wellness, systems of care and ethical space.

Our framework introduces a series of questions meant to guide reflexive deliberation at all stages of implementation. Reflexivity is a practice rooted in the critical theory tradition that ‘goes beyond pragmatic reflection to embrace a critical dimension and to carefully interrogate the very conditions under which knowledge claims are accepted and constructed’.[30] Reflexivity is a justice-oriented practice that attends to the ways that power reproduces modes of thinking and doing and, importantly, points to the ways that this reproduction can neglect alternatives, both deliberately and inadvertently.[31] While some questions in our framework can yield crucial information for specific stages of mhGAP implementation, the questions are meant to drive enquiry, exploration, discussion, reflection and introspection throughout the implementation process by attending to local ways of thinking and doing. Knowledge of local systems and of one’s role in the process of implementation are basic to training. Implementers and trainers function within multicultural spaces and contexts, each with their own unique personal and national culture. An explicit understanding of how one’s own implicit ways of knowing and presumptions can affect mhGAP implementation will serve to enrich all aspects of mhGAP programming.

QUESTIONS TO GUIDE ETHICAL AND CULTURALLY SENSITIVE DELIBERATION

The framework and questions presented here are based on recent work in cultural psychiatry,[32] including the Diagnostic and Statistical Manual of Mental Disorders-5 Outline for Cultural Formulation and the Cultural Formulation Interview,[21] work on structural competence[33] and cultural competence,[34] as well as insights from work on cultural safety in Indigenous healthcare.[35–38] The questions are organised around three key domains that focus

on participants' knowledge, attitudes and assumptions about mental health, as well as local social and cultural context of mental healthcare, specific cultural and contextual issues regarding the mhGAP-IG, and key ethical issues related to the power dynamics of health service implementation and delivery box 1. Domain 1 (Concepts of Wellness and Illness) considers how cultural knowledge, practice and values influence expectations about the nature, causes, and course of wellness, illness and recovery.[39] Domain 2 (Systems of care) invites participants to identify formal (Formal health systems are comprised of practices, institutions and professionals regulated by laws) and informal systems of care (Informal systems of care are those operating outside health systems regulations including in some cases traditional healers, but also supports provided by social and spiritual networks, neighbours, friends and family members) in the cultural context of their practice, including specific spiritual, family, kinship-based and gendered dynamics of access to care.[36 40–43] Having highlighted importance of culture and context and suggested ways to start considering these in a more systematic manner, Domain 3 (Ethical Space) provides a guidance to examine potential tensions and challenges in implementation related to gaps between the cultural assumptions of mhGAP and those of local cultures and systems of care.[44–46] These questions should be viewed as a starting point for dialogue and reflection—to be adapted, tested and refined in local contexts. Ultimately, the focus here is on the process of engagement with these questions rather than on finding specific answers or acquiring specific skills.

1. Concepts of wellness and illness

While the mhGAP-IG V.2.0[47 48] addresses adaptation in more detail than previous versions and includes attention to local terms to improve communication with users and service providers as well the recommendation to include all stakeholders in the process (although it makes no mention of traditional healers), it does not consider many of the assumptions of western psychiatric nosology that are built into mhGAP and, in consequence, may foreground certain symptoms or problems while failing to recognise others.[45] Reflection on the taken-for-granted aspects of culture is particularly important in the area of mental health because concepts of mind, self and personhood vary across cultures with consequences for the experience and expression of illness as well as for definitions and thresholds of normality and pathology.[34 45] The epistemic critique of the GMH movement, namely that interpretations of distress and responses to this distress are varied across culture emphasises that the evidence base that supports biomedical modes of care is limited and of uncertain generalisability.[19 49] In box 2, we illustrate this point by using examples from work on the idiom 'thinking too much'.[50–52] These examples illustrate the often socially rooted ways that distress is interpreted, quite distinct from strictly biomedical categories of pathology.

The examples presented in box 2 point to the importance of understanding local idioms of distress to ensure cultural and contextual fit in diagnostic assessment and intervention.[53] In this case, a narrowly biological or psychological assessment of pathology may fail to identity the social origins of suffering or distress.[20 54] There are numerous examples of the ways that culture shapes experience and interpretative frames for individual and collective suffering. For example, Pedersen *et al*[55] mapped the multiple forms and expressions of distress of an indigenous community in the Peruvian highlands in relation to political violence experienced in the 1980s and concluded that, although the diagnostic category of Post-traumatic Stress Disorder (PTSD) had some utility, 'no intervention or rehabilitation programme can neglect the reconstruction of the social fabric as its primary concern' (p. 214). Critical examination of the relationship between mhGAP and local concepts of wellness and illness is essential to develop appropriate and effective systems of care.

2. Systems of care

Most healthcare interventions implemented in LMIC, including the mhGAP-IG,[48] were developed largely in European and North American contexts.[56] The literature on mental health services in LMIC suggests that interventions developed and evaluated in one context may not yield the same results in another setting.[12 13 43 49 57 58] However, despite more than 50 years of research on cultural variations in mental health and illness, there have been few practical tools to integrate culture in a systematic way in the routine implementation of evidence-based interventions in GMH.[12 13 43] As we noted above, failing to consider the role of culture and context when training local non-professionals as part of task-shifting approach can lead to a loss of opportunity to incorporate local explanatory models and idioms into regular clinical practice and may risk imposing inappropriate, ineffective and insufficient models of care.[46 48] Local or indigenous healthcare systems have their own resources and modes of intervention. One of the major risks of neglecting locally meaningful cultural idioms and social systems that frame the experience of distress and wellness, and expectations for care, is that effective local processes of healing, coping and recovery may be missed or discounted.[12–14] Delivering interventions in context involves engaging the formal, traditional and informal healthcare systems, which may have their own pathways to care and diagnostic and treatment practices, including culturally grounded interventions as well as culturally adopted and adapted interventions.[59]

Inadequate attention to culture can create situations in which individuals in need of support are unable or reluctant to access services. If they do access services, these services may fail to recognise the core issues or to address appropriately for example by medicalising social suffering or offering alienating medical solutions.[60] Studies on palliative care, for example, have found that

Box 1 Three key domains to support context-sensitive Mental Health Gap Action Programme (mhGAP) implementation and practice

These questions invite policy-makers, planners and mhGAP implementers, trainers and trainees to consider the importance of culture, context and power in the implementation of mental health services. This supports the process of implementation as well as contributing to research studies.

To ensure that diverse perspectives are recognised, the questions can be considered individually and then discussed in small groups of participants with relevant knowledge and experience. A member of the mhGAP operations team can promote discussion, summarise knowledge gathered through the process, and provide clarification and additional examples as needed.

The mhGAP adaptation is an iterative process with administrative directives that guide the principal mhGAP implementation plan. The primary plan is drawn up by the implementing organisations in consultation with ministries of health and their representatives. WHO mhGAP implementation guidelines require that at least one local health professional be appointed as a member of the training team. The local health professionals' knowledge of the local cultures, languages and health system is imperative to the design and development of the adaptations.

In the field, plans may undergo further modifications to adjust to local realities. These secondary modifications are based on cultural and contextual factors which are adjusted throughout the implementation to address issues as they arise and the practicalities of the environment. Often, the requirements are unpredictable, demanding swift reactions under challenging conditions, time-constraints and low resource-settings. Most guidelines focus on system level adaptation, practicalities and bureaucracies (for more details see mhGAP operations manual[8] section 2.1 page 17). We suggest that familiarity with our framework and reflective consideration of its questions can support mhGAP implementation through the full range of the adaptation processes including the formal and the ad hoc.

Introduction

The initial questions ask participants to locate themselves in the mhGAP process.

i. What is your role in the mhGAP (or other) programme being implemented?
ii. How might your knowledge, professional training, experience, positionality (Positionality is the social, cultural and political context that shapes your identity in terms of ethnicity, gender, sexuality, socioeconomic and ability status vis-à-vis another person. It also describes how your identity influences and biases your perspectives, understanding and experience of the world) and values influence the ways that you approach the implementation?

1. Concepts of wellness and illness

This section focuses on local concepts of wellness and illness, beginning with a general invitation to consider how cultural knowledge and values influence expectations about the nature, causes, and course of wellness, illness and recovery. Practitioners are encouraged to examine their own knowledge, values and attitudes in relation to the taken-for-granted assumptions and knowledge structures behind mental health models and interventions, including mhGAP—what can be termed 'the implicit culture' of the mhGAP—as well as potentially relevant culturally specific knowledge, values, and norms in the context of their practice. The mhGAP diagnostic approach acknowledges the concepts of wellness and illness are culturally determined and may be distinct among populations. This domain encourages the reader/implementer to explore, discuss and consider whether their conceptualisations of wellness and illness differs from those of local colleagues and stakeholders. It also invites the reader/implementer to seek out answers explicitly and to review the content of the mhGAP and their own views accordingly. As a result, the guide adaptation and the diagnostic approach in mhGAP can be guided by culturally-informed adaptations that result in locally meaningful health service provision.

1a. Recognise your own knowledge, values and attitudes in context

i. What knowledge, values and experiences (including your personal and professional background) influence the ways you think about mental health and illness?
ii. In your view, how do specific factors (eg, biological, psychological, social, cultural, spiritual, etc) contribute to mental illness and recovery?
iii. Where might your views (or those expressed in the mhGAP materials) align or misalign with the social and cultural context where you plan to use mhGAP?

1b. Identify local knowledge, values and attitudes

i. What are local cultural models of how to be a healthy person? (eg, maintaining family, kinship or other social norms and expectations, religious or spiritual practices, individual goals and aspirations, etc).
ii. What cultural and contextual factors influence local concepts of illness, including the causes and course of illness and the process of healing and recovery (eg, biological, psychological, social, moral, spiritual, etc)?
iii. What are common local ways of expressing distress that may be related to mental health problems? How do these modes of experiencing, expressing and explaining distress influence coping and help seeking?

2. Systems of care

This section invites participants to identify formal (formal health systems are composed of practices, institutions and professionals regulated by laws) and informal systems of care (Informal systems of care are those operating outside health systems regulations including in some cases traditional healers, but also supports provided by social and spiritual networks, neighbours, friends and family members) for self and others in the cultural context of their practice, including specific spiritual, family, kinship-based and gendered dynamics of access to care.

i. What are the local cultures and systems of care and how are they accessed by different groups of people?

Continued

Box 1 Continued

ii. Where is care locally provided for mental health problems? In addition to the formal healthcare system, what is the role of families, communities, and institutions including indigenous healers, religious or spiritual groups?
iii. What local cultural knowledge, values, practices and institutions influence help seeking, access to and provision of healthcare?

3. Ethical space

This section focuses on the processes involved in integrating culture into mhGAP training and other programme or policy development. These issues should be considered at each stage of care, illness experience and healing systems.

i. Who identified the need for implementing the mhGAP and what are the explicitly stated objectives? What are the mechanisms to identify the needs on the ground? To what extent are the objectives aligned with local needs and is there a mechanism for reconfiguring the objectives if needed?
ii. At what stage in the process of mhGAP implementation was the local community invited to participate? How was the engagement negotiated? What individuals, institutions, interests or other factors may be influencing or constraining this engagement?
iii. Which local stakeholders were invited to participate, and which ones may have been excluded? Was there adequate representation of local, regional and/or ethnocultural and socioeconomic groups, genders and sexualities in participants. How were differences in power and perspectives between these groups taken into account?
iv. How have local cultural knowledge, values and assumptions underlying the process of wellness, illness experience and healing been explored and integrated into the training?
v. What are the potential synergies or tensions with other locally available pathways of care? What are the mechanisms to address these tensions?
vi. What power relations may be changed by the implementation? What are the health and social implications of these changes?

hospital policies that prevent families from gathering with a dying family member, or conducting ceremony with the family member lead to a decrease utilisation of such services in Indigenous communities.[61] In many Western contexts those experiencing mental illness often feel isolated from the wider society, leading to a renewed emphasis on fostering social inclusion through recovery-based models.[62]

Integrating local systems of care in mhGAP implementation can begin by ensuring those involved have opportunities to explore and clarify: (1) the local systems of healthcare and their cultural practices, as well as how they are accessed by different groups of people; (2) where or to whom people tend to go locally when experiencing distress specifically related to mental health problems; (3) the role of families, communities and institutions including indigenous healers, religious or spiritual groups; (4) how local cultural knowledge, values, practices and institutions influence help seeking, access to and provision of healthcare.

3. Ethical space

Critical reflexivity can begin by identifying and interrogating the social, institutional and administrative structures that shape participation in mhGAP implementation. This involves an examination of who is participating, for what reason and, crucially, who is being excluded and why. Asking the group to 'take note of who is invited to the training and why', helps consider local power dynamics and hierarchies within the healthcare system. It may also help clarify what role the training process plays in the larger strategy of implementation and to what extent the wider context of existing models of care have been considered and respected. The responses to this question may also provide insight into the decision-making process at various steps of implementation. The process of participant selection may reflect planners' and administrators' views of mental health and can also influence participants' response to the trainer and the programme. For example, in Kenya, Musyimi, Mutiso, Ndetei and their team of colleagues have engaged faith healers and traditional healers in the mhGAP training and monitoring the impact of this training on service delivery.[63–65] By bringing together different groups of providers and creating a space for dialogue across approaches, they were able to encourage mutual recognition and greater willingness to work together for service delivery.[66]

Although challenging, this reflection is important because the knowledge produced in mental health settings is shaped by the power dynamics of the clinical encounter and the healthcare system, as well as the larger institutional agendas of Non-Governmental Organizations (NGOs), governments, and international agencies. This kind of reflection requires what Indigenous scholars have called 'ethical space'[35] and 'cultural safety',[37 38] in which past structures of silencing and oppression associated with colonial regimes and other institutions, are recognised and deliberate efforts are made to ensure that diverse perspectives can be articulated and considered. This begins with determining that key stakeholders and community representatives are included and that the working group has a shared understanding of history, culture and context. Research with Indigenous persons in Western healthcare settings continues to undercover ways that colonialism and systemic racism shape healthcare experiences, underscoring the need to create space to share, listen and respond to these forms of structural violence.[67] The notion of ethical space starts with the explicit aim of understanding 'what the other is thinking', by acknowledging the different histories, experiences, cultures and subjectivities of the particular groups and individuals involved.[68] This orientation then extends to a collective process of identifying and interrogating the structural barriers to recognising and integrating local knowledge and experience. For example, Brunger *et al*[69]

Box 2

Kaiser *et al*[50] conducted a systematic review to establish the cross-cultural applicability and variability of the idiom 'thinking too much'. In a qualitative synthesis of 138 publications (from 1979 to 2014), they assessed descriptive epidemiology, phenomenology, aetiology and course of the idiom and contrasted them to psychiatric constructs. They found that 'thinking too much' did not map onto any one single psychiatric construct and warn against reducing these idioms to a single psychiatric diagnosis. Instead, they consider the idioms of distress as 'heterogeneous lay categories' with a complexity within and across contexts that should be recognised and preserved. Across contexts 'Thinking too much' idioms were more saliently used to communicate distress with reference to locally meaningful ethnopsychological constructs, value systems and social structures. Instead of displacing these idioms with psychiatric constructs, which is often the case, they propose that these idioms may have a role for stigma reduction, clinical communication and therapeutic intervention. They propose this as a starting point to incorporate lessons learnt in other cultural contexts into European/North American psychiatry.

Below are two concrete examples from work reviewed by Kaiser *et al*[50] that indicate the ethics of insufficiently or inappropriately attending to culture and context, and concretely reinforce the need to systematically avoid the blurring of social suffering and psychiatric care, even though deeply related:

In Nicaragua, Yarris'[73] analysis of 'pensando mucho' (thinking too much) suggests that the idiom 'communicates a certain moral ambivalence in the context of transformed social lives and its embodiment as 'dolor de cerebro' (brainache) reflects failure to achieve moral ideals of unity and solidarity within the family' (Kaiser *et al*, p.17).[50]

Sakti's[52] ethnographic work in East Timor on the idiom 'hanoin barak' ('thinking too much') exposes how this idiom—interpreted by biomedical practitioners as a psychological reaction to traumatic experiences—is better understood as a reaction to disruptions in typical communication and reconciliation practices with ongoing implications for the everyday social fabric of communities.

The consequences of these findings for diagnosis and interventions go beyond the dilemmas of inaccurate diagnosis and potentially inappropriate treatment. The failure to comprehend local modes of expressing distress may lead care providers to miss essential aspects of the problem.

drew from the idea of ethical space to bring together representatives from Indigenous communities in Eastern Canada and stakeholders from government and other relevant institutions to 'critically interrogate' how research in these indigenous communities is governed. The workshop involved presentations, case-based discussion and dialogue on key concepts and logistics. Importantly, the workshop created opportunities to recognise and discuss different viewpoints, resulting in immediate changes in the governance of research work.[69]

CONCLUSION

We have outlined a framework to support cultural and contextual adaptation in mhGAP implementation. This framework can serve as a starting point for fostering critical reflexivity and dialogue among stakeholders on key ethical, cultural and pragmatic challenges relevant to the local adaptation and implementation of the WHO mhGAP in LMICs.

The questions we have introduced can guide mhGAP programme planning and implementation, including team development and functioning; situation analysis and needs assessment; implementation planning; training and supervision; and monitoring and evaluations. In each of these different aspects of implementation, a different approach to using these questions can be taken. For example, during the phase of situation analysis these questions may simply be used as a planning guide to help orient the team to questions of inclusion and participation. Another example may be for an individual in charge of say developing an implementation plan to go through the questions by themselves to considering their relevance and impact for the activity planned. Alternatively, as part of the training and supervision process dyads or small teams could be asked to engage with the questions to guide their practice. Finally, during the initial stages of an mhGAP adaptation process, these questions could be used in a more in-depth manner as part of an adaptation workshop. These questions can also be applied beyond mhGAP to other interventions. For example, in the adaptation process of other mental health intervention programmes such as Problem Management Plus or even as part development of mental health awareness and prevention strategies within public health initiatives.

We believe the resultant process of reflexive discussion and knowledge exchange has the potential to improve implementation, uptake, and sustainability of the programme and to advance the goals of GMH equity. This reflexive approach and framework can also contribute to broader global health initiatives. This framework is being presented at a time when the assumptions underpinning global health initiatives are being questioned and the direction of knowledge generation and implementation is being critiqued,[70] where scholars are increasingly drawing on postcolonial theory to reconfigure how we think about global health.[71 72]

As noted, one common critique of GMH programmes has been the lack of sufficient attention to local knowledge, values and practices. In part, this stems from emphasising an evidence-based approach that may discount local knowledge. A more inclusive and sustainable approach to mental health system development and service delivery begins by recognising the diverse knowledges of stakeholders and the hierarchies of power that may privilege some voices while silencing others. Facilitating knowledge exchange requires cultural safety and 'ethical space' to establish a framework in which difference and diversity are respected. The questions proposed here can guide implementers to consider available alternatives. The aim is to move from unidirectional knowledge translation or mobilisation, to knowledge exchange or coproduction and dialogic decision making. The process of dialogue that we advocate encourages interrogation of structural barriers to recognising and integrating local knowledge

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and experience. Systematic approaches like the one we propose can support research on cultural and contextual adaptation of interventions and the process of reflexivity essential to advance efforts to develop culturally appropriate mental health interventions globally.

In most settings, mental healthcare involves multiple institutions, actors and practices that extend well beyond biomedical and psychological treatment modalities fostered by the mhGAP programme. These practices include care outside formal health systems, including extended family, community support or healing rituals and ceremonial religious or spiritual practices. Given the diversity of contexts in which mental health services are needed, implementing a generic or standardised training programme must include place and time for safe and inclusive dialogue with local communities. This dialogue aims to create opportunities for diverse voices to be heard, to promote knowledge exchange, and allow key ethical questions to be addressed. In this way, the implementation process itself can begin a process of power-sharing and co-construction of knowledge beneficial to diverse populations and communities.

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