Context and Coordination in Complex Implementation

On WHO's role and recommendation on access to mental health services in Nepal - a case study

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Abbreviations

CSO – civil society organisation

CMC – Centre for Mental Health and Counselling

DPO – disabled people organisation

HIC – High income countries

LMIC – Low- and middle-income countries

mhGAP – mental health Gap action Program intervention guide for mental, neurological and substance use disorders in non-specialized settings.

MHPSS – Mental Health and Psycho-Social Support,

MoHP – Ministry of Health and Population

NCD – Non-Communicable Disease

NGO – non-governmental organisations

PHCRD – Primary Health Care Revitalization Division

TPO – Transcultural Psychosocial Organisation

UMN – United Mission to Nepal

WHA – WHO World Health Asssemby

WHO – World Health Organisation

Abstract

Mental health has been a neglected subject globally, despite the fact that 1 billion people live with mental disorders, that a treatment gap exists where ¾ of people in need do not have access to mental health services, and that a suicide is committed every 4 seconds. The Nepali health ministry and WHO have increased their involvement only after the 2015 earthquake. Sub-cluster meetings were then initiated as a regular mechanism for interaction within the mental health care community in Nepal.

This inductive case study was conducted based on interviews with nine informants from the mental health care community in Nepal and from WHO. Its overarching theme has been how to implement a mental health care system in a low-resourced country. As this has been the part of WHO's mission, the research question of this qualitative study is: "How is WHO's role and recommendations on access to mental health perceived by main actors in Nepal?".

From the findings, a model (see fig. 4) emerged, showing implementation of a mental health care system in Nepal as a 'complex' system of implementation. The perception is that WHO and their recommendations have played an important role on both a 'policy' level and a 'program' level, but also as a facilitator for 'coordination', including a wider range of mental health 'entrepreneurial' and 'project' initiatives in Nepal. The study discusses, with reference to implementation science, how this coordination and interaction has contributed to both the specific contextualization process of WHO tools and recommendations towards national 'programs', but also how the continued technical discussions taking place contribute to contextualisation on all levels, ensuring further quality assurance.

Based on discussions in Nilsen and Birken (2020) about 'context' and 'complexity' in implementation science, the study suggests to include perspectives from 'translation theory' from Rørvik (2016) and 'values work' from Gehman (2013) and the concept of 'samhandling' instead of 'coordination' (Torgersen, 2019) into the categorization by Nilsen (2015) of theories, models, and frameworks in implementation science. The discussion indicates that these additions would increase the understanding of context identified as a shortcoming in implementation science.

Preamble

On 25 April 2015, I was awakened by SMS from a colleague in Nepal: "We have just experienced the earthquake we have been preparing for!" I was a director of a Norwegian organisation working in Nepal since the 1950ies. The earthquake had struck with a magnitude of 7.8 at 10 am on a Saturday. 8.800 lives were lost, thousands more were injured and over 800.000 buildings and monuments were destroyed or damaged. But it could have been even worse – people were awake, children were not in schools and many were in the fields. The epicentre was 50 km from the capital of Kathmandu, but brought terror to people at large, as most live in non-earthquake-resistant housings. Everyone from all walks of life lived under tarps - together, some for weeks. After-shocks felt like the grass had waves. Smaller ones continued for months and up to a year. But the worst were the big aftershocks the following day and on 12 May when everyone thought it was over for this decade. As one said: "That was when the earthquake moved into the minds of people".

Mental health is all about emotions. By introducing you as a reader to the earthquake, I want to start this thesis by bringing you into the emotions that is an important context for both myself as a researcher and for the informants and politicians in Nepal responsible to ensure access to mental health for their population. The need to understanding the deeper context has been a theme in my work experience in developing countries, and has also guided this study, both in terms of theme, research question, scientific approach, and thematic approach. It has been an inspiring and humbling journey as my preconceptions about the area of mental health in Nepal and its actors have been widened in respect for the work in progress.

I want to start by giving thanks to you who have been my informants. You have shared your experience, knowledge, perspectives, worries and involvement. This has emphasized to me the capability of the Nepali people in ways that bring hope. I therefore hope this thesis shows respect to each of you and your perspectives and will be perceived as a useful input to the area of mental health in Nepal.

Thanks also to VID Specialized University for the perspectives that I have been given – especially on the respect for the practice area, including values and ethics. Especially a big thanks to my supervisor Gry Espedal, for believing in my scribbles and asking the basic questions, assisting me to go deeper and ensure more clarity.

I also want to thank some mentors on the way. Ellen Hagemo for initial talks when the research question was still very broad. You gave important perspectives from your experience as a psychiatrist top management in Norway that I have brought with me along the way. To Ane-Marthe Skar-Solheim and Anastasia Fedotova for introducing me to the field of implementation science. And to Ragnhild Dybdahl for being my kind opposer, pushing me to argue better and clearer and assisting me to land the research question that has been my safe guideline through the main parts of the process. I value equally our common grounds and our different perspectives. Both have been crucial for me personally and for this study.

Warm thanks also to Elin Ersdal for proofreading on a sunny weekend day and to my daughter Ingeborg Steel for making the models for me. And last, but not least, thanks to my fantastic and kind husband, who has been there all along. As a nature scientist with deep understanding of philosophy, you have been my important discussion partner during all these master's years. Not to speak that you have given of your valuable time to proofread at all hours of the day minding the details – and made dinners and listened to my strange singing while in my writing bubble.

1. Introduction

1.000.000.000 people live with mental health disorders
3.000.000 people die of substance abuse
There is one suicide every 4 seconds
3 of 4 living with mental, neurological and substance abuse get no treatment
Less than 2 % of budget allocation on mental health

Mental health has been a neglected area in global health.

It was only as late as in 2007 that *the Lancet* series on Global Mental Health (Lancet, 2007) launched six reviews formulating a clear call of action. A group of professionals stated: *"Despite the great attention western countries pay to the mind and human consciousness in philosophy and the arts, disturbances of mental health remain not only neglected but also deeply stigmatised across our societies. Mental health disorders represent a largely hidden, if not substantial proportion of the world's disease burden. They can often be neglected, especially in low and middle-income countries, many of which have no resources to tackle mental-health concerns."* This was indeed the start of a global movement, though at a slower pace than envisioned.

The WHO World Health Assembly, comprising all WHO member states, ratified in 2012 a resolution on "The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level" (WHO, 2012). The Mental Health Action Plan 2013-2020/2013 (WHO, 2013) paved the way for a comprehensive, but low key movement in several low- and middle-income countries (LMIC) through intensive research, civil society movements, disabled people organisations, academic exchange, some donor agencies, trainings, interventions and collaborations. A new *Lancet* series was launched in 2018 (Lancet, 2018), inspired by the Sustainable Development Goals (SDG) (UN, 2015) *"expanding from a focus on reducing the treatment gap to improving the mental health of whole populations and reducing the global burden of mental disorders by addressing gaps in prevention and quality of care"*.

The overarching theme behind this master study in value-based leadership, follows the Lancet 2007 call, looking for the mechanisms on how to implement a mental health care system in a low- and middle-income (LMIC) country when such countries basically start from

scratch. This was also the underlying mission of WHO since the 2012 resolution (WHO, 2012), and the base for WHO's recommendations and tools. The aim has been to assist low- and middle- income member countries in their macro level implementation of mental health services in their nations, based in their Action Plan (WHO, 2013). It was therefore natural to look at WHO's role and recommendation in the specific research question of this study, assuming that a study of the efforts of the multinational body of WHO could shed light on the huge question of implementation mechanisms. A study could also assess how the implementation of such recommendations is perceived in a country like Nepal, after a decade of intensive implementation and strategy development meet the needs of their people. The hope is that this inductive approach might be useful also in other contexts.

Implementation is an everyday phenomenon, and we all acknowledge the need to plan well. We have to some extent become good at it at a limited scale. But even though we plan well, we all know that plans seldom work fully in practice. It is common knowledge how difficult it is to implement plans, and in particular programs and policies, with success. Implementing a new 'area of expertise' based on a foreign idea is even more difficult. Implementation science looks at what factors might affect success and failure. This constitutes the base of this study.

1.1 Research question

Based in the main theme of mechanisms behind implementation of mental health care system in a low and middle income (LMIC) country, the background of my main research question is: "How are the WHO's role and recommendations on access to mental health services perceived by main actors in Nepal?". I will assess this question through the following underlying questions:

1. How do the mental health actors perceive that WHO recommendations on access to mental health have been contextualized in Nepal?
2. What role do the mental health actors perceive that WHO has played in the development of mental health services in Nepal?
3. What future role would the key mental health actors like WHO to play?

This study is limited to covering the dimension of 'access to mental health treatment' and does not cover the whole area of mental health and psycho-social support (MHPSS) that include 'promotion of mental wellbeing' and 'prevention of mental disorders', the way WHO define mental health in the Mental Health Action Plan (WHO, 2013).

This focus is chosen, as this has been a priority in the upscale of mental health services in Nepal during the past decade. Hence, this can stand as a case for learning and interpretation. This does, however, not disregard the call in the Lancet (2018) to "expand the focus from reducing the treatment-gap to improving the mental health of whole populations (…) by addressing gaps in prevention and quality of care". On the contrary, I hope this study of implementation and perception, can shed light on learnings that can benefit the further expansion to the whole area of MHPSS. This has been an empirical inductive and iterative study, attempting to draw perspectives from empirical findings that might shed light on relevant theoretical approaches.

1.2 Mental health in Nepal

Nepal is a republic, federal nation landlocked between India and China. It is ethnically diverse, with 125 ethnic groups and approximately 123 languages (Khanal, 2019) spoken as mother tongues. The country has emerged from a civil war (1996-2006), a massive earthquake (2015), a political transition after the promulgation of the constitution (2015-) and is now in the midst of the Covid19 crisis. The current healthcare delivery system is organised as a tiered referral system with community health units, health posts, urban health clinics and primary hospitals. More complex and serious cases are referred to secondary level hospitals, tertiary level hospitals (provincial and above) and eight specialised hospitals (Rai et al., 2020).

Nepal's vision in mental health is to "enable all Nepalese to lead a productive and quality life by improving their mental health and psychosocial wellbeing". This is stated in the not-yet-endorsed National Mental Health Strategy and Action Plan 2021-2025 (Government of Nepal, not yet published). The mission in the strategy is further "to ensure quality mental health services through optimum utilization of available resources, continuous coordination, and collaboration with concerned individuals, institutions, and bodies".

A recent pilot study of the National Mental Health Survey reported the prevalence of mental disorders to be 12.9%. Suicide (16%) was the leading cause of death among women of reproductive age, with 21% of suicide occurring below the age of 18 years (Jha et al., 2018). As opposed to other countries, suicide among women (20 per 100 000) is higher than among men in Nepal (3rd highest cause of death among women versus 17th highest among men). A pilot study reported that substance use disorder, dissociative conversion disorder, major depressive disorder, alcohol use disorder and psychotic disorder were common among adults. Similarly, psychotic disorder, agoraphobia, major depressive disorder, and anxiety disorders were common among children. Current suicidality was present among 10.9 % of adults and 8.7 % of children. The National Mental Health Survey is just completed but not yet published in seven provinces for both adults and adolescents.

The history of the development of mental health care service in Nepal shows the engagement since the 1960ies, a special focus in the 1980ies, a new lift during the 2000s, before the devastating earthquake in 2015 formally shook Nepal to internalize that there is 'no health without mental health', the way WHO have been promoting for many years.

This timeline is based on articles on the history of mental health in Nepal by Upadhyaya, (2015) and Rai et al. (2020), in addition to information provided by the informants of this study. Dr Upadhyaya (2015:60) describes how the first two psychiatrists, Dr Sharma and Dr Kunwar, came to Nepal in the 1960ies. An out-patient treatment was started at Bir Hospital in 1961, and the first mental hospital was established in 1984. A pioneer community mental health program from 1987 (Wright et al., 1989) was initiated and funded by United Mission to Nepal (UMN) and Save the Children, Norway ('Redd Barna'), led by psychiatrist Chris Wright from the United Kingdom and Dr Nepal (Upadhyaya (2015:62). UMN also supported the development of the studies on psychiatry and psychology at Tribuvan University Teaching Hospital (TUTH). Only three peer-reviewed papers are found in an online search from the period before 1990 with 'mental health' and 'Nepal' in the title. It should be noted that both research and manuals were produced but have not been digitalized.

From 2000, local mental health civil society organisations were established (Rai et al. 2020). In 2003, Centre for Mental Health and Counselling Nepal (CMC Nepal) was formed as a hand

over from UMN during their nationalization process as agreed with the Nepali government. Transcultural Psychosocial Organization Nepal (TPO Nepal) was established in 2005, and Koshish Nepal was formally founded in 2008 by and for persons living with mental health issues.

After 2010, these and other more community-based organisations, in addition to academicians from TUTH, continued to pioneer mental health efforts on different levels supported by global funding and academic exchange. In 2012, Nepal, led by TPO, was included as one of five countries in the eight year-long PRIME study (De Silva et al., 2016) with the aim to generate high quality evidence on the scaling up of WHO intervention program of mhGAP (Mental Health Gap Action Programme Intervention Guide) (WHO, 2010). CMC, UMN and Koshish Nepal have also implemented or been trained in mhGAP implementation during this decade. An online search between 2000 and 2010 shows nine peer-reviewed papers.

It is during the latest decade from 2010 until today that the area of mental health has received increased attention in Nepal. The increase in activity and priority can be shown by the number of documents since 2010, now counting 118 peer-reviewed papers with mental health and Nepal in the title. There has also been an increase in the number of actors, in the establishment of different networks, and number of conferences. However, the informants point to the earthquakes of 2015 as the real turning point. It was then, as a response to the earthquakes that hit Nepal 25 April, 26 April, and 12 May 2015, that both the WHO and later the Nepali government recruited a focal person on mental health. As part of the UN OCHA (WHO, 2012), health response to the earthquake, WHO co-lead the mental health sub-cluster together with the Ministry of Health and Population (MoHP). These sub-cluster meetings continued after the earthquake response, and again more frequently with as a Covid-19 response.

1.3 The structure of the thesis

The structure of this thesis is that I will build a theoretical argument in chapter 2 based on aspects within implementation science. The theories are chosen to discuss relevant aspects of this discipline based on the three aggregated dimensions that have evolved in this study.

In chapter 3 the scientific and methodological approach is described and discussed. Here I have also included a description of the institutional context of WHO (3.3) and similarly a description of my own background and preconception (3.4). Chapter 4 presents the findings based around a discussion of the aggregated dimensions that have come out of analysis. Chapter 5 a hermeneutic discussion of the findings against the theoretical approach, before the conclusion in chapter 6.

2. Theoretical approach

The base of this study is an implementation theoretical approach. I will lean on Nilsen (2015;1) who categorizes implementation theories, models, and frameworks with the aim to facilitate appropriate selection of tools and to foster cross-disciplinary dialogue. Relevant to discussions in articles in the recently published Handbook on Implementation Science by Nilsen and Birken (2020), I will attempt to contribute to broadening the original approach in traditional implementation science. The main theoretical discussions will be based on a discussion about policy implementation research in relation to implementation science by Nilsen and Cairney (in: Nilsen and Birken, 2020:368-389) and similarly perspectives on context in implementation science by Nilsen and Bernhardsson (in: Nilsen and Birken, 2020:259-275).

I will present translation theory (Røvik, 2016) as a mechanism for contextualisation, complexity theory through Bjartveit and Roos (2005) as a base for understanding and the theory of 'values works' (Gehman et al., 2013 and Aadland et al., 2019) as an understanding of values in context and the conceptualisation of "samhandling" or interaction (Torgersen, 2018) as an alternative to the notions of coordination or collaboration.

Implementation is an everyday phenomenon, and people in general acknowledge the need to plan well. Most people are to some extent good at this at a limited scale. But even though we plan well we, it is common knowledge that plans seldom work out accordingly in practice. It is often difficult to implement programs and plans with success. Implementation science looks at which barriers and factors that can contribute positively.

2.1 Level of complexity in implementation

Implementation science has, according to Nilsen (2015:1), progressed towards increased use of theoretical approaches to provide better understanding and explanation of how and why implementation succeeds or fails.

In the area of policy implementation science has for the past four decades covered the policy level (Nilsen, 2020;368), while implementation scientists have been developing the evidence-based practice intervention level for only the past decade. Even though there are

many parallels between these two research traditions, minimal transfer of knowledge have taken place between these two fields has according to Nilsen and Birken (2020:368).

In this study I am leaning on reviews of implementation science by Nilsen (2015) and Nilsen and Birken (2020). In this review Nilsen and Birken (2020) attempts to link to a broader understanding of implementation science. I will in my presentation focus on the implementation dimension rather than the research dimension of implementation.

Both implementation science and policy implementation research emphasize according to Nilsen and Cairney (in: Nilsen and Birken (2020: 380), the importance of interdisciplinary research. They both have roots to disciplines such as the spread and adoption of innovation from Roger's ground-breaking diffusion theory from 1962. Implementation science has in addition pragmatically borrowed from sciences such as psychology, sociology, and organisational theory. According to Nilsen and Cairney (in: Nilsen and Birken, 2020:368) the similarities between the two areas calls upon implementation science to learn from the four decades older field of political intervention research.

The birth of implementation science is usually linked to the emergence of the evidence-based movement in the 1990s (Nilsen and Birke in: Nilsen and Birken, 2020:1). An often-used definition has been delivered by Proctor et al. (2013) (in: Nilsen and Birken, 2020:265) which defines implementation science as *"methods or techniques used to enhance the adoption, implementation and sustainability of clinical program and practice"*. However, Nilsen and Birken (2020:1) opens for a broader definition of implementation science; *"The scientific inquiry into questions concerning how to carry intentions into effect"*. Nilsen (in: Nilsen and Birken, 2020:8) describes how early implementation research was empirically driven, not paying attention to the theoretical underpinnings of implementation, which has made it difficult to understand why implementation succeeds or fails and identify explanatory factors systematically.

Policy implementation studies is on the other hand an older trait, found in the intersection of public administration, organisational theory, public management research and political science studies. This science was born already in the 1970ies in the United States with the concern of the effectiveness of public policy (Nilsen and Cairney (in: Nilsen and Birken

(2020:369-370)). The first-generation studies were explorative, seeking to position implementation within the policy cycle based on a more top-down approach, attempting to ensure clear goals, fewer actors and limited amount of necessary change. Later 'bottom-uppers' argued the need to understand factors that caused difficulty. Their recommendation were mostly flexible strategies allowing for adaption to local difficulties and contextual factors. The debate between the top-downers versus bottom-uppers had many facets, intertwining normative, methodological and theoretical issues and to a large extent ignoring the portion of the reality explained by the other (Nilsen and Cairney (in: Nilsen and Birken (2020:370)). Some years later the two schools of thought tried to reconcile and developed synthesized models and frameworks, before policy implementation science stagnated in the 1990s with the change in state-society relations, and was later in some ways replayed by the advent of New Public Management (Nilsen and Cairney (in: Nilsen and Birken (2020:371)).

One of the main differences between implementation science and policy implementation research is the difference in the potential complexity of the phenomena studied in the two fields (Nilsen and Cairny in: Nilsen and Birken, 2020:380). In policy implementation, the subjects of study can be both relatively easily defined, but more often they are long-term political developments over time that can be described as "extremely complex set of elements that interact over time". In contrast, implementation science focuses on specific clinical practices described in research and their adoption in a relatively short time perspective by health care practitioners in health care settings. This, and the strong influence of medical sciences, has according to Nilsen and Cairney (in: Nilsen and Birken, 2020:380) allowed for a more reductionist approach to the study of implementation. As experienced from the early days of policy implementation research can show, this could easily result in a more top-down rationale. Policy implementation researchers have also over time more often stressed the inherent interdependency between various factors as well as the crucial importance of the context, making it difficult to generalize findings on the relative importance of individual determinates.

The similarities between the two fields, suggest that policy implementation science can in fact be included in Nilsen's categorization of theories, models, frameworks (see figure 1) developed for implementation science. This would require that the model is based on a

broader definition of implementation science as above (Nilsen and Birken in: Nilsen and Birken, 2020;1). Nilsen (2015:1) describes five categories of theories, models and frameworks used in implementation science; process models, determinant frameworks, classic theories, implementation theories and evaluation frameworks. Nilsen also describes the differences between a 'theory'; a set of analytical principles designed to structure our observations and understanding the world, a 'model'; a deliberate simplification of a phenomenon, and a 'framework'; a structure, system or plan consisting of various descriptive categories or variables and the relationship between them. Nilsen developed this model to ensure the appropriate selection of relevant approaches and to promote a cross-disciplinary dialogue among implementation researchers (Nilsen, 2015, Nilsen and Birken, 2020).

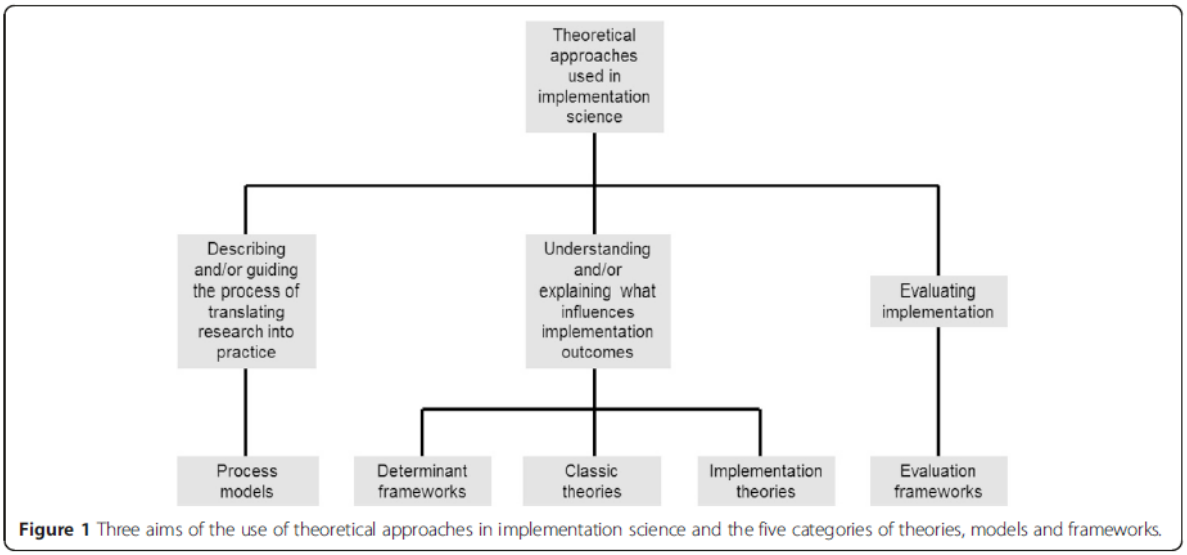

Figure 1 Three aims of the use of theoretical approaches in implementation science and the five categories of theories, models and frameworks.

In figure 1, Nilsen (2015) separates the following: 1) 'process models' that have the objective of describing and guiding a process of translating research into practice, 2) determinant frameworks, 3) classic theories and 4) implementation theories that have the intention to understand what influences implementation outcomes, and lastly 5) evaluation frameworks developed specifically for evaluation purpose.

Early 'process models' (Nilsen 2015:3) tended to depict rational, linear processes from producers to users. Implementation as a multidimensional phenomenon receive increased attention, while determinants are, however, still often assessed individually. This assumes a

linear relationship between the determinants, ignoring that individual barriers and enablers may interact in various ways that can be difficult to predict.

The 'classical theories' (Nilsen 2015:7) are based on theories from psychology, sociology and organizational theory, and are considered to be more passive as they primarily describe without having ambitions to bring about change. There is an increased interest in theories on organizational culture and leadership, such as situation change theory (Jacobsen and Thorsvik, 2019:417), complexity theory (e.g. Bjartveit and Roos, 2005, Stacey and Mowles, 2016), economic theories, theories about innovative organisations. Other relevant theories could be transformational leadership (Jacobsen and Thorsvik, 2019:429) and theory of reframing organisations (Bolman and Deal 2017). I will argue in this thesis that also theories of values-for, values-in or values work (Askeland and Aadland, 2017, Askeland et al., 2019) are relevant.

The determinants frameworks (Nilsen 2015:5) tries to describe what has influenced the implementation outcomes by describing general classes where each determinant typically comprises of a number of individual barriers and/or enablers. Some frameworks hypothesize relationships between these determinants whereas others recognize without clarifying them. Integrative frameworks recognize that implementation is a multidimensional phenomenon, with multiple interacting influences. The most often referred to determinants are organisational support, financial resources and social relations and support, leadership and organisational culture and climate, and Nilsen and Bernhardsson (in: Nilsen and Birken, 2020: 267) point out that patient related determinants should also be included.

A weakness in the reviews of Nilsen (2015) and Nilsen and Birken (2020) is that they continue to present an unclear definition of implementation science, not clearly taking a stand on a narrow or broad definition. Further the original model of categories (2015), suggests that the categorization will assist in choosing the appropriate amongst the theories/models/frameworks, seemingly encouraging to make a choice, while in fact a search for appropriate combinations should be encouraged.

Including political intervention research models, theories and framework into Nilsen's categorization in figure 1, might be a relevant integration of the two fields, opening up for

perspectives that include both the higher level of complexity such as national policies, together with e.g. clinical interventions of more limited complexity, as relevant to this study. This implies that this study will be leaning on the broader definition of implementation science of Nilsen and Birken (2020:1): *"The scientific inquiry into questions concerning how to carry intentions into effect".* In addition, to suggesting the possibility of combining different tools from within this categorization.

Nilsen and Cairney (in: Nilsen and Birken (2020:382) do however make reference to researchers who warn against uncritical combination of theories that may be based on different assumptions, although there are researchers who advocate increased use of exogenous theories in policy implementation research. Askeland (2013:5) also indicates that in an interdisciplinary research area such as organisation science, or as here, implementation science, the basic thinking of the researcher constitutes an important base for research, theory or model. Because this forms basic assumptions, he emphasizes the need to be aware of such background and for researches to make them explicit.

Implementation science has during the latest decade become an important scientific field in the health sector settings. As this scientific branch is introduced to a global context, the understanding of strengths and weakness of implementations science will be important, including combining traditional implementation science with the wider thinking and learnings from e.g. an area such as policy implementation, can assist this new area of expertise to avoid pitfalls of reductionism and one-dimensional assessments suggested by Nilsen and Bernhardsson (in: Nilsen and Birken, 2020:265) and thus as the next chapter will show contribute to increase the understanding of complexity (Nilsen and Bernhardsson in: Nilsen and Birken, 2020: 259-276).

2.2 Context in implementation

Diffusion is, as described by Rogers (1995), a process where innovation is communicated amongst members in a social system through specific channels over time. Diffusion applies the spread of a new idea or innovation and includes a process of creation based on a common understanding. The theory of diffusion and organisational 'recipes that travel fast and

far' Røvik (1998) is based on the assumption that ideas that travel both geographically and conceptually and become popular are based on common traits.

The review by Nilsen (2015:7-8) of implementation science points to the lack of a unifying understanding and definition of the concept of context. He shows that implementation science researchers agree that context is critically important to understand and explain implementation, but there is a lack of consensus on how this concept should be interpreted. Nilsen and Bernhardsson (in: Nilsen and Birken, 2020:259) emphasizes that this may hinder implementation actors to identify the most relevant context dimensions in their implementation project. Generally, context would be understood as surroundings in which something exists, typically referring to an analytical unit that is higher up in the system than the phenomena directly under investigation. However, the role afforded to context varies. In some studies context is essentially the physical 'setting in which the proposed change is to be implemented'. In others, it is assumed that context is something more active and dynamic that greatly affects the implementation process and outcomes. As the need to understand context is becoming more evident amongst the scientist, Nilsen (2015:7) points out that there has also been an increasing interest in assessing the organisational level such as organisational culture, complexity science or theories on innovative organisations.

Nilsen and Bernhardsson (in: Nilsen and Birken, 2020:265) points to the importance of viewing context in holistic terms, because successful implementation depends, in their view, on combinations of different contextual determinants and avoid taking an overly reductionist approach. Studying the impact of different dimensions in isolation, neglects the fact that two or more seemingly unimportant contextual determinants may combine to create either not-according-to-plan powerful or weak effects. Stressing a holistic view, organisational behaviour theorist Johns (2006, in: Nilsen and Birken, 2020) has referred to context as a "bundle of stimuli" and talked about "deadly combinations" of otherwise effective determinants that can yield unfavourable outcomes. As a social construction, it can be shown that context can be difficult to manipulate or manage (Nilsen and Bernhardsson in: Nilsen and Birken, 2020:269). This emphasizes the challenge if the underlying assumption is that one can break down context into its constituent parts and influence them in cause-

and effect manner, or even quantify various aspect of the context. This would illustrate an objectivist's understanding of context.

Røvik (2016) has attempted to adapt translation theory to the process of taking knowledge from one setting to another the way diffusion terms it (Rogers, 1995, Rvik, 1995). This points to the process before the actual implementation, emphasizing the need to detangle the context of where the idea came from (the source) and the context of were the idea is meant to be implemented (the recipient setting) (se fig. 2).

This translation theory Røvik (2016) could with advantage be included into Nilsen's categorization. Røvik (2016) outlines the possibility to use translation theory to conduct translations of practices and ideas to achieve various organizational ends. Røvik (2016:294) argues that the way a translation is performed may explain outcomes of knowledge-transfer processes as knowledge transfers between a source and recipient. This can be conceptualized as acts of translation, based on translation-rules.

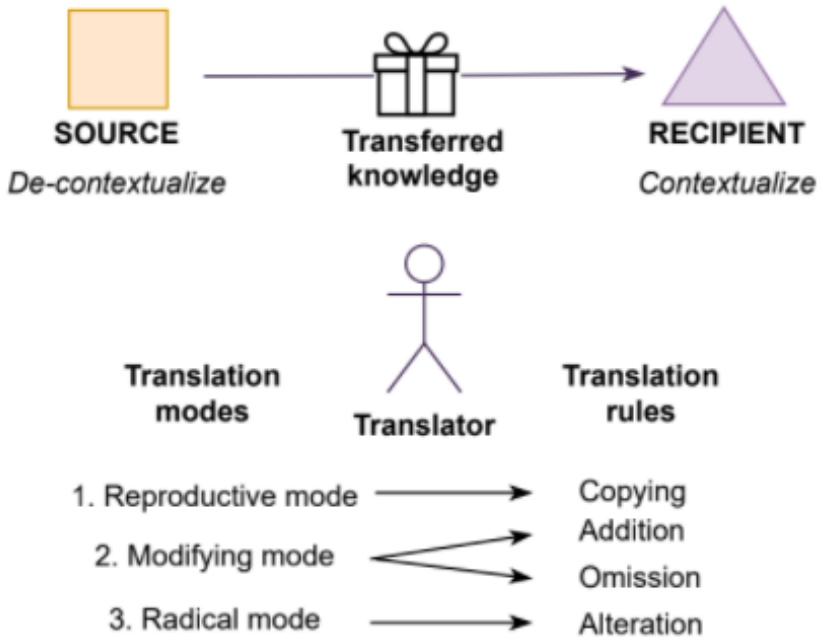

Figure 2: Simplified model of Translation theory based on Røvik (2016)

As the simplified model of the translation theory by Røvik (2016), shows that transferring knowledge from a source to a recipient organizational unit, can be described as a process of translation as first the task of de-contextualizing the knowledge of a source practice, before

contextualizing it into the recipient context. This happens according to Røvik (2016) as translating of a practice from a context into abstract of images, words and texts, then through translation it is developed into specific, materialized practices in another context. This translation can be done according to Røvik in different 'translation modes'. A translation can either be done in a 'reproducing mode', where the translation rule often is to 'copy'. An alternative is the 'modifying mode' where translation means 'addition' or 'omission' of the original knowledge base. Finally, the radical mode, is where the translation rule would be an 'alteration', and thus it can be argued that we are in fact not faced with a translation, but innovation.

When de-conceptualizing, Røvik (2016:294) has through a literature review identified three variables that seem to be decisive for the translatability of a desired practice. These are 'complexity' (e.g. practices that depend on a strong human component are more complex and harder to model), 'embeddedness, (to what extent the knowledge in a desired practice is anchored in the recipient setting) and 'explicitness' (if knowledge is easily thought in formulas or manuals or if it is tacit which often underlies a skilful performance). Røvik describes that the more complex and embedded a source practice is, the harder it may be to explicate.

In the contextualization phase a translator according to Røvik (2016:295-296) faces two main contradictory hazards: missing the essentials of the desired practice in the source context, and missing the essentials of the recipient context and not making the necessary adaptions that would enable the knowledge construct to fit into this context. A recipient setting is not a tabula rasa, but a context with distinctive structures, cultures and actors with various interests and powerbases. Thus, a successful implementation will relate to the extent of the new knowledge replacing existing practices and meeting resistance. If the new practice is only loosely coupled to old practices, the conceptualization may be relatively uncomplicated. The translators clearly need to know established practices in the recipient context to determine how the new knowledge relates to already existing practices. Translators do not necessarily possess such knowledge.

The role of the translator is a key and according to Røvik (2016:291) one can empirically identify skilled and less skilled translators in knowledge transfers. This brings the attention to 'translation competence', e.g. knowledge about how to translate practices and ideas between organizational contexts to achieve desired ends. Røvik (2016:296) points out the process of translation by the translator happens more informal and implicit, than as following explicit guidelines

Røvik (2016:304) emphasizes that one of the limitations of his paper is that there is a need to increase empirical research to support the theoretical approach. The reframing of knowledge transfer as a translation process also merges underlying assumptions that one should be aware of. Røvik also points out that translators shape and reshape knowledge throughout a transfer, and has indeed the potential to translate 'sticky', or mismatching, knowledge into matches.

This brings the attention to the fact that Røvik (2016) refers to "translator" in a singular term, giving an impression that it is a one man show to translate. The more complex the translation process, the less would one "translator" be able to understand the context based on only simple translation rules. Even though this is meant only as a model, in a social constructivist view words like "translator" in singular term, and translation "rules" do in fact give associations to a more reductionistic view of the translation process.

This tendency is also a pitfall by Nilsen and Bernhardsson (in: Nilsen and Birken, 2020). Nilsen and Birken (2020) generally opens for reflections on a more open view on implementation science. However, there is a thought in Nilsen and Bernhardsson (in: Nilsen and Birken, 2020:261) suggesting that a greater conceptual clarity and consistency would enhance transparency and improve communication. Theories or simplified models are indeed useful and might very well bring clarity and improve communication but should not be mistaken to give the real picture of a complex context.

Bjartveit in (Bjartveit and Ross, 2005) suggest another approach based more on complexity science.

Bjartveit and Roos (2005) criticism to the consultant as posed in Scandinavian perspectives on management consulting. Bjartveit in: Bjartveit and Roos, 2005 refer to Henry Mintzberg critic of strategic thinking the way it is according to Mintzberg in 1994 as carried out in most organisations; saying that strategic thinking has not produced the desired results because it has developed into a bureaucratic planning system. With reference to complexity theory they suggest a thinking of three states of existence. First order and stability compared to chaos and unpredictability. But between these is a third state of existence with limited stability where order and chaos coexist. He argues that "patterns may look similar, but you cannot count on them to be identical and political agendas and irrational elements make things even worse", making it difficult to predict and understand context over time, also because it changes. Bjartveit in (Bjartveit and Roos, 2005) argue this perspective for consultants and emphasize the need for consultants to constant search for meaning and understanding and propose 'interpretation' as a method or tool referring to the hermeneutic analysis. Bjartveit and Roos (2005) include in their arguments using classic philosophical literature such as Platon, Aristotle, Kierkegaard, Machiavelli, and Shakespeare as such tools.

2.3 Values in context

As shown above, Nilsen and Bernhardsson (in: Nilsen and Birken, 2020;259-275) conclude that context is recognized in implementation science but that it also can be seen to have a tendency (:265) toward a more reductionistic approach to context. Nilsen and Bernhardsson (:269) refers to the view from organisational behaviour science, where context is typically understood as influences that are external to and/or "above" (at a higher aggregation level than) the individual. This also resembles, according to Nilsen and Bernhardsson (:269), the view in the determinant frameworks on barriers and facilitators shown to influence implementation outcomes in Nilsen (2015) original categorization.

The term "value" is not mentioned by Nilsen and Bernhardsson (2020) and assumably not by any of the 17 determinant frameworks they have reviewed, and it is also not mentioned by Røvik (2016). But Nilsen and Bernhardsson's reference to context as "influence on a higher aggregation level", brings the attention to the values that any given context comprises of and an understanding of how they evolve.

There has been a renewed interest in values and values work - both in public policy discourses, and in organisational research (Espedal in: Askeland and Aadland, 2019:49). There has also been an increased attention on the notion of context as taken for granted and seldom specified (Sirris in: Askeland and Aadland, 2019:56). Scholars note that values play a role in the interaction between actions and institutions and in the social order that influences activities. A central question in current research is how institutional complexity triggers values work. This could also count for the concept of 'values in contexts' from an implementation science perspective.

Social anthropologist Clyde Kluckhohn (in: Askeland in: Askeland and Aadland (2019;21) formulated an understanding of the concept of value: "*A value is a conception, implicit or explicit, distinctive of an individual or characteristic of a group, of the desirable, which influences the selection from available modes, means and ends of action*."

Values can according to Askeland and Aadland (in: Askeland and Aadland, 2017) be categorized as either 'inherent qualities that can be specifically identified', or they are perceived as 'constructions that are given meaning in a social space that catches the attention at a given time and affects practice, and is later replaced by other concerns'. Values develop through dialog and interpretation. Each actor brings their own experience, assessments, and interests into the meaning-creation process.

The latter of the two perception of how values work, indicates that in a given context, values will evolve and change over time. This by itself shows the challenge of attempting to even identify determinants and rely on these to understand a context as assumed in the determinant frameworks (Nilsen and Bernhardsson in: Nilsen and Birken (2020:269).

Context comprises of values and because they are less tangible, we tend to just take them for granted (Espedal in: Askeland et al., 2019). If we refer to the perception of values as "constructions that are given meaning in a social space and catches the attention at a given time and affects practice, and is later replaced by other concerns" (Askeland and Aadland in: Askeland and Aadland, 2017), it shows that values develop through dialog and interpretation. This means that each actor brings their own experience, assessments, and interests into the meaning-creation process. Thus values work, indicates that in any given

context, values will evolve and change over time. Given their importance, it is critical to understand how values are practiced in an organisation (Gehman et al., 2013;1) – or a context. In particular: how do such practices emerge, and how are they performed over time? This study is not a study to identify these values, but rather to identify a possible theory or method that could compliment implementation science.

By looking through the lenses of Gehman et al. (2013), I propose to include the theory of values work into the classification system devised by Nilsen et al. (2015), not so much as an implementation theory/model/framework on its own, but as tools to assess some of the more messy factors and values that influence context that are 'external', 'above' and 'complex' - and might even as shown, 'change over time'. Values are intractably connected to norms and morals: they signify worth, preferences and priorities and separate the desirable from the undesirable (Askeland and Aadland et al. (2019:3). This makes context both muddled and difficult to catch.

Given their importance, it is critical to understand how values are practiced in organizations (Gehman et al., 2013;1). In particular: how do such practices emerge, and how are they performed over time? The review by Gehman et al., (2013) of the diverse literatures on values, revealed that literature stop short of fully developing a dynamic understanding of what we call values practices, that is "sayings and doings in organizations that articulate and accomplish what is normatively right or wrong, good or bad, for its own sake". Gehman points out that we perceive values practices as ends in themselves, and thus analytically distinct them from organizational practices driven by technical or efficiency considerations. Gehman emphasizes that values practices include normative concerns in e.g. areas such as ethics, diversity, and sustainability, that can be crucial to outcome of interventions that we try to put forward.

Gehman et al. (2013) operationalised the work in values into four mechanisms. These are described as (1) pockets of concern, (2) knotting of concerns into networks, (3) performing value practice, and (4) circulating values (Gehman et al., 2013). As any set of acts in everyday work according to Espedal, Askeland et al. (2019:4) is value-driven, "values work" can be defined as a particular set of actions that enhance the ongoing knowledge and reflection-

creating processes that infuse an organization with value-related actions. This definition also comprises the broader setting of ‘context’ relevant for this study.

Klive (in: Askeland et al., 2019:4) shows in practice how values work starts with the unstructured and loosely linked identification of concerns; the ‘pockets of concern’. and how these can be constructed into patterns, connecting the pockets together in wider networks of key persons, named ‘knotting of concerns’. Klive points out that generators for “knotting concerns” could be e.g. formal meetings, informal talks and other forums where key persons present concerns and promote new trust practices. The knotting enables the formulation of new value practices and eventually ‘ends’ in new patterns of value practices. When values are practised in specific contexts, they are confronted by practical possibilities and obstacles, such as competing value practices (Gehman et al., 2013). Underneath this movement, from isolated concerns into new patterns and practices, the semiotic tools for communicating values are present. In the circulation of values, a value practice can be said to be addressed and legitimised by metaphors, signs, and symbols, implicitly representing frameworks of institutional logics. Such practices can be tools for values work as they aid value transfer across contexts.

It should also be noted in the interpretation of contexts that values are in fact often contradicting institutional logics that show that value can be, and often are, interpreted and handled differently by different actors.

Nilsen and Bernhardsson (in: Nilsen and Birken, 2020:260) suggest that greater conceptual and terminological clarity and consistency in ‘context’ could enhance transparency and improve communication among researchers. However, an important question that arrives from the above, is if such clarity is in fact possible and thus if the attempt to seek it would assist in predicting the outcome of an implementation. This chapter shows that context cannot easily be understood and that this fact counts for the need to rather include mechanisms of interpretive nature, to understand the complexity and messiness of any given context, than seeking conceptual clarity as such.

2.4 Concept of 'samhandling'/'interaction'

Gehman's (2013) concept of identifying 'pockets of concern' and 'knotting them in networks' show how values develop in interaction with others. This shows the possibilities that are, in utilizing such mechanisms to understand a given context and the values in it. Using Gehman's (2013) terminology, one can say that by promoting networks, increase communication, stimulate collaboration, ensure coordination, and develop partnership, one can contribute to 'knotting of concerns' that can become 'value practices' that again can be 'explicitly or implicitly' 'circulated'.

Røvik's concept of translator can be regarded as contrary to 'coordination', 'collaboration' and 'partnership' because he indicates "one" translator and by that gives an impression that it is a one man show to translate. The more complex the translation process is, the less would one "translator" be able to understand the context based on only simple translation rules. I will in this study look at translators in plural, defining the translators as networks.

This brings me to the final theory. I will include is the notion of interaction/samhandling as described by Torgersen et al. (2018). He argues that the Norwegian word "samhandling" covers more than English translations such as 'collaboration', 'cooperation' or 'coordination'. "Samhandling" which according to Torgersen et al. (2018:25) is closer to the English 'interaction', can be defined as "an open and mutual communication and development between participants, who develop skills and complement each other in terms of expertise, either directly, face-to-face, or mediated by technology or manually. It involves working towards common goals. The relationship between participants at any given time relies on trust, involvement, rationality and industry knowledge." The notion of samhandling is based in the cultural and social aspects of the Nordic welfare model, where trust, rights and care are put in an interactive relation to equality, participation and "samhandling". Samhandling is distinguished from cooperation/teamwork by three core attributes which we can call the identity of samhandling: focus on complementarity, exchange and utilization of the participants' various skills, experiences, backgrounds and cultures, and coordination of these factors in efforts towards a common goal. The following competencies were identified in order for good samhandling to occur trust, assurance, well-being, belonging, clarity, time

and tolerance. Samhandling is, according to Torgersen et al., a skill that every complex community system has to possess to meet and avoid crises and conflicts.

3. Method

3.1 Selection of scientific and methodological approach

> *The hermeneutic thinking is when the diversity of interpretation and understanding collides, leading to inspiration»* (Ricoeur i Alvesson og Skjöldberg, 2008)

3.1.1 Scientific approach

The selection of scientific approach has been important in this study. I have chosen to base my study mainly on a hermeneutic approach leaning on the systematic framework from Alvesson and Skjöldberg (2008). I considered including what Alvesson og Skjöldberg (2008:349) have termed 'triple hermeneutic' or Ricoeur's 'hermeneutic suspicion' but realized that I was not seeking to uncover hidden truths in this study. The intention has instead been closer to a milder version of social constructivism (Thomassen, 2006:182), the way Kenneth Gergens (1985 in Aadland in Aadland and Askeland, 2017:97-98) phrases as "to have a critical attitude towards taken-for-granted knowledge". This approach has been aimed mainly at theoretical approaches of this study, but also when the findings revealed some discrepancies.

A hermeneutic approach emphasizes that a phenomenon can be interpreted at several levels. Hermeneutics is built on the principle that meaning can only be understood as part of its context. We understand each individual 'part' based on the 'whole' (Thagaard, 2013:41). Neither the whole nor each part can be understood without reference to one another. This becomes a circle, and the approach stresses that the meaning of a text or action has to be found within its cultural, historical, and literary context. This also appears to be a fruitful and respectful approach in a foreign cultural setting, as this study aspires to be. Another reason for the choice of scientific approach also comes from a perception that the area of implementation science would benefit from more interpretive understanding of especially 'context' (Nilsen and Bernhardsson, in: Nilsen and Birken, 2020) or the 'whole' as the hermeneutic approach would word it.

The social constructivism approach, on the other hand, claims that social phenomena are not eternal and unchangeable, but created through historical and social processes (Rasborg,

2013:403). Social constructivism has been much discussed but has over the years also gained ground (Rasborg, 2013, 403). One of the door openers was Thomas Kuhn's perspective on paradigms (Thomassen, 2006. pp. 178-198). Kuhn, who was himself a nature scientist, claimed that all science is governed by paradigms that develop in fractures and stages. This shows that science is determined by context and by human influence.

The systematic framework of Alvesson and Skjölberg (2008) is an approach where pre-understanding is made explicit in the research, using it as a positive input in research, alongside formal data and theory. I have in this study drawn on a dialogue between data and theory. The objective of this study has been to mobilize my pre-understanding as an interpretation-enhancer and horizon-expander throughout the research process, including explicitly stimulating imagination and idea generation, broadening the empirical base, and evaluating what empirical material and theoretical ideas are interesting. This iterative process has been going on from start till end.

3.1.2 Methodological approach

To answer the overall research question, I have chosen to conduct a qualitative analysis. This to give a deeper understanding of how 'WHO's role and recommendations' are perceived as a social phenomenon in Nepal. My focus is to draw out the essence and find patterns in the interpretations of the informant's perceptions and concerns. This will give rich data with large quantities of text about the phenomenon, the context, and the informants interpretations. This will then be used to inductively draw out an understanding of what role WHO and their recommendations have played in the development of a future system for mental health care in Nepal.

Qualitative research is based on a rather interpretative philosophy of science (Thaggard, 2012:14). One seeks less causation and more understanding and interpretation, while assuming general connections based on observations of individual cases. In qualitative research the researcher needs to balance between a systematic approach and a more emphatic or intuitive approach (Thagaard, 2012:15). The latter ensures that the researcher is open and accepting towards impressions coming from the people or institutions that are being studied. The systematic approach is however crucial for it to be called research.

I will be basing the analysis on Gioia (2012:15) who argues the need for good methods of analysis in the inductive research. He emphasizes that the prime motivators for qualitative researchers is not just "to train our attention on refining the existing ideas we use to navigate the theoretical world" the way he perceives research to do. However appropriate and important, this dominating approach does not, according to Gioia, encourage the kind of originality that inductive research has the potential for, surfacing new concepts and generating persuasive new theories. I originally set out just to interpret what was already in theory of findings, but as the data talked to me, they clarified patterns and connection that I have tried to bring forward with humbleness.

I have chosen to conduct this study as an intrinsic case study in an inductive approach (Thagaard, 2013:56-57,214). A case study is an assessment of one or few units, where the objective is to analyse the phenomena in its natural context, based on several sources of data. This produces rich data about the unit in question, which in this case is 'Nepal's overall mental health system'. As an intrinsic study, the focus is on that Nepal might represent a unique case that could be interesting to understand. The study has been undertaken in a highly inductive way, where the theoretical approach was chosen mostly inspired by the findings. The findings in this study would later benefit from more deductive theoretical research, and a possible comparative case study of WHO's role and recommendation in other WHO member countries within global mental health.

A challenge with qualitative methods is, however, that when we interpret social phenomena, there will always be several interpretations. According to Gadamer, all understanding will assume a preconception (Krogh, 2014. 47-51). The researcher's preconception is both an important resource, but can also be a liability. It is especially important to separate one's own perspective from the presentation of the informants understanding, so that the presentation is not perceived as abuse (Thagaard, 2013). It is important that the informants feel that they are understood by the researcher and that their statements are not used to support other basic views than their own.

A researcher will always be embossed by your own background and theoretical perspective that you bring into your research. My own background, as described more thoroughly in 3.4,

is that I have been involved in the area of mental health for the past 20 years, 10 years in Nepal.

3.2 Selection of data collection and analysis method

The data has been collected through what Giogi (2012:19) refers to as the heart of the qualitative research, namely the semi-structured interviews. But I have also included a multiple data source with documents and articles covering relevant aspects of the study. The objective has been to obtain rich material about WHO and mental health in Nepal as the studied unit through the informants' thoughts and perspectives (Johannesen et al., 2016).

3.2.1 Selection of informants

I decided to interview nine informants for this data collection in a strategic selection process (Johannessen et al.,2016:117). These are all key actors within the mental health field in either Nepal or within WHO, be that authorities, civil society, and academia. They are picked to ensure a representative selection as far as possible with respect to gender, age, professional background and views. The majority are, however, men and psychiatrists, which by itself is representative in the field in Nepal. The most important criteria for selection was however that they have held a central position within the area of mental health in relation to Nepal, and that they have had natural contact with WHO from their positions.

The base for the selection was mainly a snow-ball method (Johannessen et al.,2016:117) based on my own network after working in Nepal for 10 years in the area of mental health. It was therefore important to ensure that I chose informants that also were less known to me. I therefore required with some of the informants and other key resource people on how who could be considered helpful informants. These were assessed against my knowledge of the dynamics between the actors to ensure representation.

It seems that, I after the interviews, reached a saturation point in understanding the research question itself (Johannessen et al., 2016:114), which means that I assume that more interviews would not bring significant new information that would influence the findings noteworthy. I base this perception on the fact that there are relatively few leading actors in this new area of expertise in Nepal.

The focus in this project has also been more 'access to mental health services' than promotion of mental well-being and prevention of mental illnesses. This has also contributed to reducing the number of actors and potential informants.

To ensure anonymity (Giogi, 2013:19), but also to show objective patterns in the answers by the informants, the informants are presented in the findings with numbers but also divided into groups based on common denominators. The groups are divided according to where they come from. Some will be part of different groups. One set of groups are the central, civil society organisations (CSO)/non-governmental organisations (NGO) and academicians.

All approached informants agreed to participate in the study.

3.2.2 The interviews

Using the overall research question and the underlying support questions, an interview guide based on open questions with follow-up questions was developed (see appendix 1). I developed the guide based on a model close to a 'tree with branches' model according to classification by Rubin and Rubin (in: Thagaard, 2012:102). The research question constituted the base from early in the process and was the base of the interview, guiding the informants on the two main questions on WHO role and recommendations. The interview guide was not designed around theory and terminology, as the perception was that I would have missed out on key aspects of the informants sensemaking by imposing my preordained understandings on their experience (Gioia et al., 2012: 17).

The objective of the interviews was rather to develop a dialogue than bouncing direct questions and answers (Johannessen, 2016, s. 145ff). Even though my main research question was quite specific, a lot of the interviews gave in-dept understanding of the concerns and issues in the entire field of mental health in Nepal. It was through the involvement that came up during these discussions, that the understanding of the specific research questions evolved. This gave possibility of a wide and deeper hermeneutic understanding and interpretation.

Generally, the informants will always be perceived experts on both their own experiences. In this study, the informants are also experts in the main theme of the study. Literature emphasizes challenges with interviews in asymmetric relations and cross-cultural settings

(Kvale and Brinkmann, 2019). These concerns are to a lesser degree applicable in this study. In terms of asymmetry, the informants' background are more 'experts' in the main theme than me as the researcher, and in terms of cross-cultural understanding, my background and understanding of both Nepal and the institutional setting of mental health in Nepal assisted my understanding of dialects, relationships, organisational context, cultural context, geographic understanding, health system understanding and so on (Thagaard, 2013:96). The informants could thus describe more in-depth, as basic explanation was not necessary. This does, however, require that I am particularly careful not to mix my own preconceptions with the concerns voiced, and the informants need to be reassured that their statements are not taken into account for other basic views than their own.

All the informants were contacted by e-mail, accepted to be interviewed and signed the consent form (see appendix 2). The interviews were conducted from December 2020 to February 2021. The interviews ran parallel with the more intensive period for the selection of the theoretical approach. All interviews were conducted on Zoom, lasted from 45 minutes to 1 hour and 30 minutes, and were recorded upon consent. All the interviews went according to plan and with a fairly good technical connection. As an interviewer I made conscious attempt to develop a connection in the beginning of the meetings and was also mindful of how we used the camera. In addition to the recording, I took notes. Sometimes taking notes could be disturbing but was also a base to sharpen relevant follow-up questions that would bring more clarity towards the research question.

The interviews started off quite specifically on the research question, which the informants had been prepared for in the letter of consent. The main questions were basically posed to all informants, but some of the follow-up questions were altered and skipped based on the involvement and information the informants gave. Questions such as a description of each informant's perception of history, or what discussions went on in mental health, were e.g. meant rather as background. But the findings show that the patterns coming out of these parts of the interview gave a wider understanding of the phenomena, including confidence to develop a model from the findings.

In the consent form, the informants were promised anonymity (Thagaard, 2013: 229). This is to ensure that crucial information is in fact shared. All interviews and recordings were anonymised.

After the interviews, the interviews were electronically transcribed.

3.2.3 Analysis

Qualitative data does not speak for itself, but need interpretation (Johannessen, 2016:161). The method of analysis depends on what scientific approach the study is based on. In this study, the approach is a combination of a hermeneutic and social constructivistic, and both of them can be classified as philosophies, research design and method of analysis (Thomassen, 2006:157).

Even though collecting and analysing data are intertwined, the differentiation of the two is important to secure a systematic approach in order to call it science (Thomassen, 2006:71). It is therefore important that the methods of analysis are well thought through and planned before the data collection starts. At the same time, there must be room for flexibility in order to adapt the process to experiences along the way (Thagaard, 2015:18).

In inductive research, a researcher's background needs to be made explicit. This includes a researcher's preconceptions, but also scientific and professional platform and other relevant assumptions. One's own theoretical base controls to some extent the researcher (Johannessen, 2016:181, Askeland, 2013:5). My background and preconception are described in 3.4.

The data in this study has been analysed using the methodology of analysis from Gioia et al. (2012:15), which was developed in a "search for qualitative rigor in inductive research, while still retaining the creative potential for generating new concepts and ideas". The method is based on the assumption that informants are "knowledgeable agents", but Gioia et al., (2012:17) also point out "that researchers are pretty knowledgeable people too", having the ability to find patterns in the data, surface concepts and relationships that might be hidden, and formulate concepts theoretically.

The methodology by Gioia et al. (2012) is a structured method to interpret the rich material coming from data collection using codes. The analysis of all this data goes through different phases of coding, termed by Gioia et al. as 'orders'. I have in this study moved back and forth in an iterative process being cautious to take what Gioia et al. (2012) calls a 'semi-ignorant approach'. I did not decide on theory before the findings spoke to me. I had a couple of thoughts on themes that might come up. However, these were not mentioned, and few regarded them as important even when asked.

After each interview, the interviews were electronically transcribed. The quality was surprisingly good, but it was important to do a thorough quality assurance of the transcriptions. I have read, listened and transcribed all the data at least five times. The first was quality assurance of the digital transcription. Thereafter I read through to get an overall impression. The next stage was doing a 1st order analysis according to Gioia et al. (2012:19-20x) looking for concepts in the data that would be faithful to the informant's terms. This was done by marking the text in each interview. The next stage was seeking similarities and differences that evolved in the data in a 2nd order analysis, using labels. This phase continued over time, going back and forth between the informants, but also moving between interpretations. When the thesis writing started, and as part of doing the 3rd-order analysis pulling out the aggregated dimensions, I made it a point to listen through all the interviews once more while walking. This turned out to be very useful, going back to the essence of the informants concerns before drawing on a bigger picture.

The entire analysis process started during the interviews, but to hold a strict scientific approach, I was cautious trying to parse the interview phase from the analysis. As my personal liability is to interpret quickly, this was a challenging phase. And going through the interviews several times, was a humbling experience in how much one overlooks at the first glance when interpreting only though one's own preconceptions. The richness in the answers came across again and again.

In order to meeting a scientific criterion, Gioia (2013) stresses that evidence must be presented systematically, and Gioia has over the years not only worked out procedures to conduct research more rigorously, but found that also the presentation should demonstrate

the connections among data, the emerging concepts, and the resulting theory. The data structure of my study can be presented as the following:

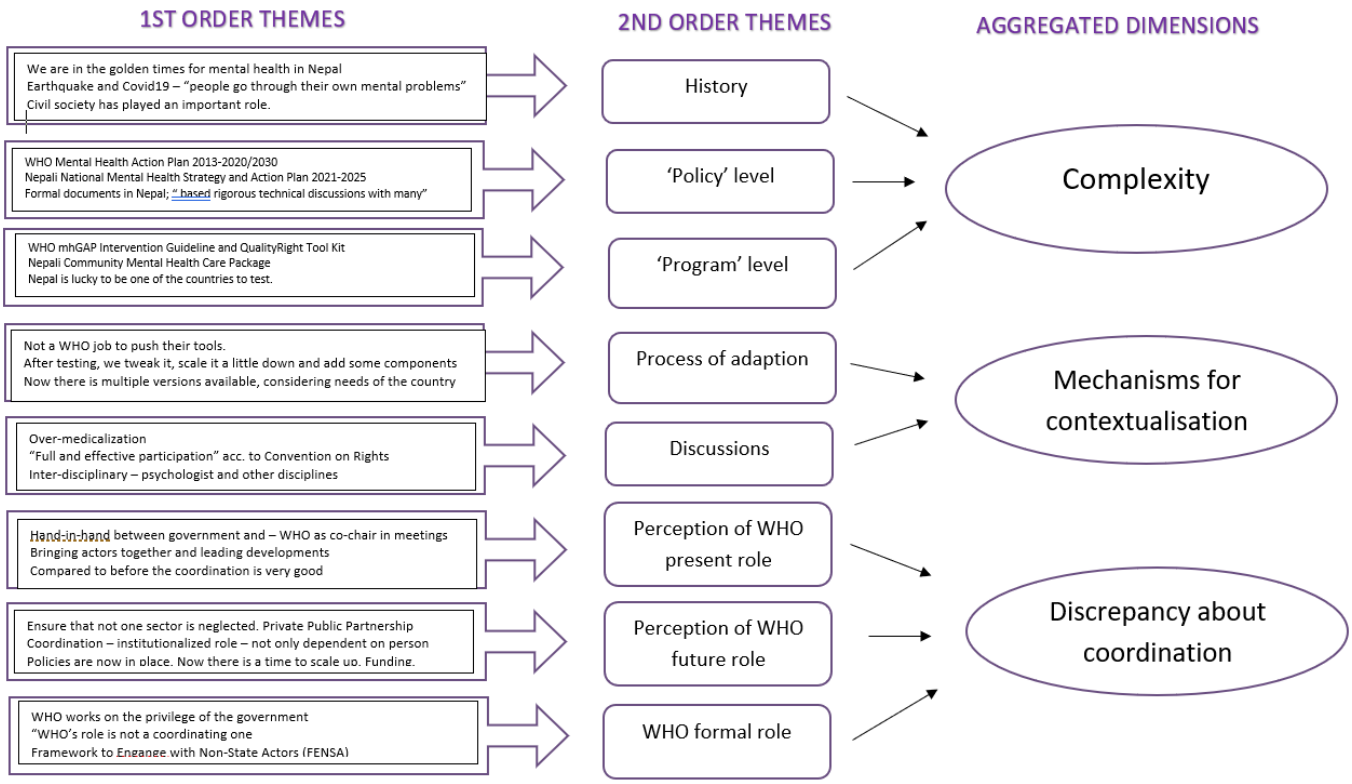

Figure 3: Data structure based on Gioia's method of analysis (2013)

Based in the three C's in the aggregated dimensions, a model evolved (see fig. 4) from the findings and the processes. It was based in an attempt to try to make a pattern that could be presented in a structured manner, but also as a response to the need to look at implementation not just as parts, but as parts of a whole. Having worked with entrepreneurial thinking earlier, this model evolved based on the findings and as an answer to the questions posed by Nilsen and Bernhardsson (in: Nilsen and Birken, 2020), questioning how information science thinks about 'context' and 'complexity'. The issue of 'coordination' in the model came out of the interviews more directly.

3.3 Institutional context

I will present a more in-depth understanding of the institutional WHO, WHO globally and in Nepal here. In addition, a short introduction to the main actors in Nepal working in the area of mental health is presented.

Seventy years ago, on 7 April 1948, the World Health Organization (WHO) was founded on the principle that health is a human right and all people should enjoy the highest standard of health. This aspiration towards better health for everyone everywhere has guided the organization's work ever since, in partnership with its member countries, making impressive progress in many areas to promote the world's population health and well-being.

A break-through in the area of global mental health within WHO came with the Mental health resolution in 2012 (WHO, 2012).

WHO has had access to knowledge from around the world and has based their recommendations and tools partially on knowledge from high income countries. WHO has, however, had to adapt recommendations and tools to totally different contexts.

The main documents I have assessed for this presentation are; the WHO Constitution (WHO, 1946), the Thirteenth General Works Program (GWP13) (WHO, 2013), the Framework for the Engagement of Non-state Actors (WHO, 2016), the Country Cooperation Strategy for Nepal (CSS) (WHO, 2018) and the Mental Health Action Plan 2013-2020/2030 (WHO, 2012). I have also reviewed the OCHA Sub-cluster approach (WHO, 2020).

The formal role of WHO as stated in WHO Constitution (WHO, 1946) article 2(c) is to assist Governments, upon request, in strengthening health services; and (d) to furnish appropriate technical assistance and, in emergencies, necessary aid *upon the request or acceptance* of Governments. The current strategy, the Thirteenth Global Working Programme (GWP13) (WHO, 2013), emphasizes four areas of involvement a) engaging in policy dialogue, b) providing strategic support, c) technical assistance and d) coordinating service delivery, depending on the country context' (WHO, 2019:5). This is also emphasized in the specific area of mental health, in the objectives in the Mental Health Action Plan 2013-2020/2030 (WHO, 2013).

At country level, the Country Cooperation Strategy (CSS) for Nepal (WHO, 2018:2) states that "WHO will support the Government of Nepal to effectively manage this federalisation transition period…" And further: "WHO's specific role in addressing such needs, and the re-

prioritization of activities that goes with it, will be determined through ongoing dialogue with the government and partners".

On the specific area of mental health, the Mental Health Action Plan 2013-2020/2030 (WHO, 2013:11), suggest more specific action points for both member countries, WHO secretariate and international and national partners. The plan states that all parties are needed for "effective implementation of the global mental health action plan", including specifically 'academic and research institutions' and 'civil society', including rightsholder organisations. The Action Plan finally emphasises that "country-based assessments of the needs and capacity of different partners will be essential to clarify the roles and actions of key stakeholder groups".

3.4 Preconception

A researcher will always be embossed by your own background and theoretical perspective that you bring into your research (Krogh, 2014. 47-51).

My own background in global mental health, is that I have followed this young field of expertise since 2000, the past 10 years in Nepal. My involvement has been linked to overall political questions, but more importantly through supporting local civil society organisations on project implementation. My background has been in the area of substance abuse in Africa, through the civil society organisations Blue Cross Norway and Blue Cross Lesotho from 2002 till 2009. Then, with HimalPartner in Nepal and China from 2010 till 2020. I have in addition been involved with advocacy towards Norwegian governmental involvement on the global scene. This has materialized in the Norwegian strategy on non-communicable diseases, including mental health (Utenriksdepartementet and Helse- og omsorgsdepartementet, 2019)

My personal background also count as relevant as it forms my pre a researcher using an hermeneutical interpretive approach, living in South Asia and Africa, including Nepal as a child, and having the privilege to work with Nepal the past 10 years shapes me and thus also me as a researcher. My professional background is organisational development and social geography, working on a policy level in the diaconical area of health related work.

My preconception of the research question of this study, has been that WHO's recommendations enjoy high respect, even though I was unsure how well know or specific the knowledge was. From a donor perspective, based outside Nepal, my preconception has been that WHO after the 2015 earthquake played an important role of convening actors from across the whole range of mental health professional contributors. My perception has been that the role of civil society organisations where important, and that through them, Nepal pioneered community based mental health initiatives. I was also personally an active part in the history of collective efforts by civil society organisations. After the earthquake, these organisations have changed focus toward advocating and supporting the Government of Nepal towards a sustainable national implementation, rather than only case-based project implementation. As for WHO's recommendations and tools, I was as a donor representative familiar with the Mental Health Action Plan 2013-2020/2030 (WHO, 2013) and the mhGAP Intervention Guide (WHO, 2010), but was less familiar with the details of WHO recommendations. I was aware that TPO was in fact the lead in the PRIME project. It was as a starting point unclear to me what role WHO has had in relation to this process and in relation to other actors in Nepal.

3.5 Discussion on reliability and validity

For an assessment to have the status of research and not just the opinion of the researcher, one must be able to evaluate the assessment based on questions on reliability and validity (Johannesen et al., 2016:231). Such transparency has been ensured provided through the discussions above.

Reliability and validity in qualitative studies show what and how data is collected and how it is processed. When the data is "heavier", less systematic and the number of informants is smaller, the findings will be more dependent on the context and based on interpretation. To reduce uncertainty, one needs to be able to give an open and detailed description of the research process (Johannseen et al.,2016). A choice has to be made if the objective is that the reader should be able to make their own assessments, if the researcher's objective is to draw out central patterns or if you want to emphasize that transferability is limited. As shown in the methodology so far, I seek in this thesis to draw out central patterns, while still holding high that the findings as far as possible can be verified.

Validity shows, on the other hand, how you assess what you want to assess, that is whether the procedures reflect the objective of the study (Johannsessen et al., 2016: 232). To be able to separate between relevant and not relevant information, it is important to understand the context well. This can be done through continuous observation or triangulation (Johannessen et al., 2016:232) and requires that the researcher reflects the trade-offs and shows the steps explicitly. In addition, a researcher in qualitative interpretive processes as mentioned has to include a degree of spontaneity and creativity (Thagaard, 2013:15). This will of course make it more demanding to explain in detail, especially in the analysis process.

For this assessment to be transferable to, in this case, WHO in other countries, I have sought to systematize the findings and make the analysis open, in my seeking towards new theories, terms and interpretations (Johannessen et al., 2016:233). This can give possibilities for transferability without having the objective of ensuring statistical generalisation the way one seeks in quantitative studies.

3.6 Research ethical reflections

It is important to consider the research ethical elements of such a project (Johannessen et al., 2016:83). This includes ensuring the notification and licensing obligation in the personal security, that has become even more strict through the new General Data Protection Regulation (GDPR guidelines for personal security.

At a higher level, privacy must be ensured through the notification and licensing obligation in the Personal Data Act, which is also strengthened by the GDPR guidelines. The researcher's duty is to respect the informants' privacy and to avoid harm (Johannessen et al., 2016:85). This project has been approved by the Norwegian Center for Research Data (NSD). The informants have read, signed and submitted consent letters before taking part in this project.

The researcher should be aware of possible negative effects of the research. The Helsinki Declaration, which summarizes ethical principles in research ethics, states that the population in which the research is conducted must experience the benefits of completed research (WMA, 2004: 3, item 19). Minding the negative effects is the base for the

discussions in this chapter and I sincerely hope that the experience informants find both the interview and the thesis beneficial to the time spent.

As this project seeks to assess overall political themes, there are few personal sensitive questions for the informants. But as there are not that many actors in this field in Nepal, it has been a dilemma to ensure both anonymity and transparency when trying to develop a setting of openness in an interview setting. The results should also be traceable, so that the informants recognize themselves in the generated data. It is a question how open each informant feel they can be if their connection to an institution or role makes it difficult to express clear views. My own involvement in the area in Nepal has, as mentioned above, been an important theme, also explicitly during the interviews. The selection of informants was important. It is important to be cautious about the close contact between the interviewer and the informants that can influence the interpretations, as termed by Thagaard (2013) 'going native'.

Myself being a former donor representative could also have influenced the answers given. Just after the interviews were conducted, it became clear that the Norwegian government would in fact fund WHO to support Nepal as a so-called Special Initiative on mental health (WHO, 2019). There is no formal connection to me as a researcher, but if information about this were known, it could have had implication for the answers given. I was aware of this myself but did not voice it before the interview was over.

4. Findings

This case study revealed a generally positive perception of WHO's role and recommendations in the development of access to mental health services in Nepal. The findings of this case study can therefore count as learnings for implementation of a system for mental health services in a low- and middle-income country (LMIC).

Based on the research question, the following main findings, can be drawn from the interviews and document search of the study:

1) A complex implementation system on access to mental health care has evolved in Nepal and is generally well perceived locally (4.1)
2) There has been a comprehensive contextualisation process of WHO recommendations and tools to a Nepali context (4.2)
3) There is a discrepancy between the informants about whether 'coordination' should be and actually is a WHO role in practice (4.3)

Nepal is slowly building up a mental health care system (see 1.2). The above three main findings will be presented more thoroughly under, but an overview of the findings show that the Nepali government has been in lead of the development of mental health care services since the earthquake in 2015, with WHO as a technical advisor, including a broad involvement from civil society and academicians. Further Nepal was fortunate to be part of global research initiatives that has pushed forward the contextualisation process of some of WHO's main tools and recommendations into a Nepali context. This has included both program intervention- and training level, but also in developing a national strategy on mental health. The earthquake and the Covid19 crisis have brought about a deeper understanding of mental health issues in the population. Together with, historical elements, this has contributed to a diversity of mental health actors and discussions between them, that seems to have become an interesting contextualisation process. The voice of the informants from civil society, academicians and government, appreciate what they term as WHO's coordinating role and emphasize this role for the future. However, there are dilemmas as WHO central level and steering documents on the one hand promote building

partnerships with non-state actors, but on the other hand stresses the need to protect WHO from unfit interests.

4.1 Complex implementation – a model

The empirical findings from this study will be presented in relation to a constructed model (fig. 4) describing complexity, context and coordination in implementation. The model evolved from the findings as will be described in relation to the finding in the presentation below. The process of how it was developed is described in 3.2.3.

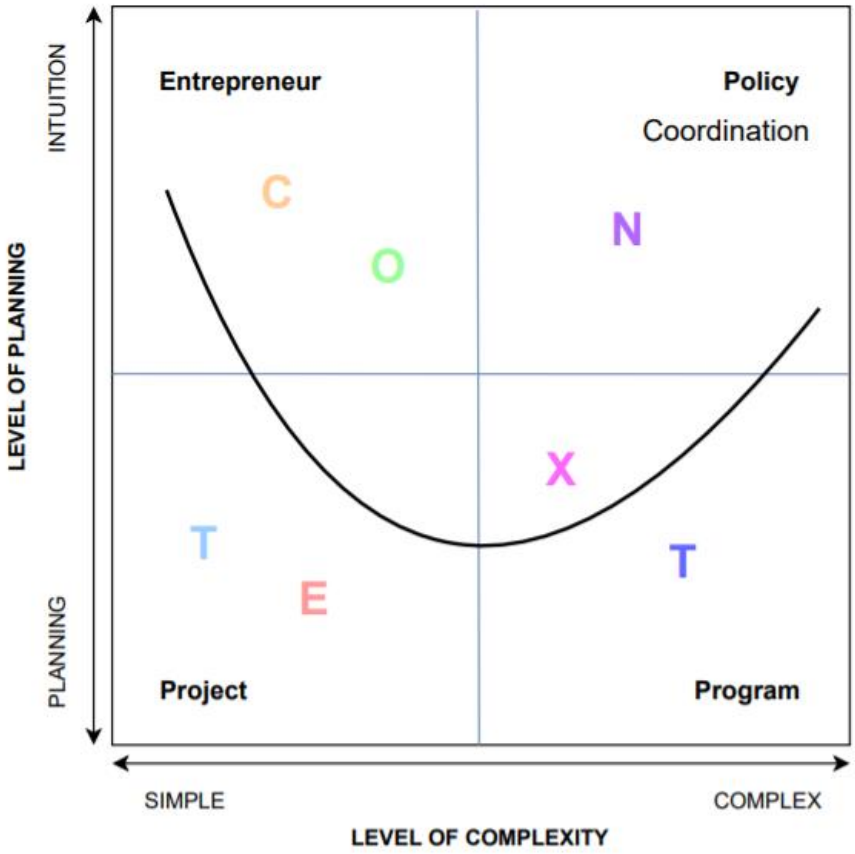

Figure 4: Complexity, context and coordination in implementation

The model shows the 'level of complexity' as one dimension and the 'level of planning' as the other. Complexity from 'simple' to 'complex', and planning from a high level of 'planning' to increased amount of 'intuition'. The background is the 'context'. Through these dimensions, four 'ways of implementation' comes forward. The first based on high level of intuition in a more limited setting with less complexity is the 'entrepreneur' or the 'entrepreneurial initiatives'. The second with higher level of planning, but still in a more limited setting and thus less complex is a 'project'. The third way of implementation where

the level of complexity increases, demanding high level of planning, is the ‘program’. The fourth way of implementation is on an aggregated level the level where the level of complexity is high consisting not of singular programmes, but of multiple programs like implementation on the level of big institutions or nations there is a need for ‘policy’. On this level more ‘intuition’ is needed and can be termed as ‘trust’, The findings in this study show here how the role of what the informants termed as ‘coordination’ comes out. By ‘coordinating’ all the different programs and might as the case of this study include ‘project’ and ‘entrepreneurial initiative levels’, the policy can be implemented. Behind all this lies the context illustrated in the letters ‘C-O-N-T-E-X-T’. They are shown in the background in a messy order and thus difficult to see, interpret and understand, pointing to the complexity <and giving a notion that context requires interpretation and is not possible to understand through a reductionistic view.

The findings show how actors in Nepal over the years, have evolved a complex implementation system on all levels; ‘policy and strategy’, ‘program’, ‘project’ and ‘entrepreneurial initiative’ in a quest towards increasing access to mental health care for the people in Nepal. The findings below also showed how WHO has been involved and how this role has been perceived.

Nepal has in the not yet published National Mental Health Strategy and Action Plan 2021-2025 put forward an ambitious vision for its people (Government of Nepal, 2021, not yet published); “to enable all Nepalese to lead a productive and quality life by improving their mental health and psychosocial wellbeing”. This is a huge task for a country with limited financial and human resources (Rai et al., 2020). The actors are few, with only 200 psychiatrists and 33 pscyologists . The need is huge (Rai et al., 2020) and will be shown in the not yet published National Mental Health Survey. The perception of mental health in the population is challenging. E.g. as phrased by Rai et al., (2020); “Mental illness is perceived as a ‘spiritual dysfunction’ or ‘weak mind’ and attributed to spirit possession, black magic, divine wrath and misdeeds committed in previous lives.”

It is also a new area for Nepal as a nation the way a central informant (9, 24.02.21) puts it "MoHP recognized this as a public health problem since only around four years ago", adding to the perception of high level of complexity in implementation in Nepal (fig. 4).

The findings show how important initiatives were taken in Nepal to increase the knowledge and understanding on mental health over the years. These (see 1.2) came as 'entrepreneurial initiatives', 'projects', 'programs', and some 'coordination' (fig. 4) by civil society and academicians. A comprehensive 'policy' was even endorsed already in 1997 (Government of Nepal, 1997). But it was never put into action until recently. Findings will show how all these initiatives were the start of a broad knowledge base that can be shown in today's comprehensive technical discussions (4.2.4) between actors in the area of mental health.

As a response to the devastating earthquake in 2015, WHO recruited a mental health focal person and after advocacy from main mental health care actors, the government recruited a focal person and later a focus unit in 2018. Together these initiated sub-cluster meetings on mental health for a broad number of mental health care actors, as part of the UN earthquake response (OCHA in: WHO, 2020). This initiative was led by Ministry of Health and Population and co-chaired by WHO. This again was the start of a coordination of all levels (fig. 4), increasing the position of mental health in Nepal on a 'policy and strategy level', first through the Multi-Sector Action Plan (Government of Nepal, 2014), before the 'soon-to-be-approved' separate National Mental Health Strategy and Action Plan 2021-2025 (Government of Nepal, 2021, not yet published).

On a 'program level', Nepal was chosen to be one of five countries in the PRIME research initiative, testing the evidence-based intervention program mhGAP (WHO, 2010). This was later contextualized into the Nepali context as the "Community Mental Health Care Package" (Government of Nepal, 2017) based on the evidence brought out in the PRIME research (De Silva et al., 2016).

The sub-cluster meetings also became an area to "sit together and discuss" (1, 21.12.20) for mutual information about 'project' and 'entrepreneurial initiatives' within civil society and the academic arena.

Working on the levels of 'policy' and 'program' correspond with WHO's mandate in the WHO Constitution (WHO, 1946) and their strategy as in the General Working Program GWP13 (WHO, 2013) (see 1.2). This is however both more unclear and comes with more dilemmas.

There is an explicit, general respect by the informants for the work done by WHO in Nepal. One informant (3, 20.01.21) points out that "WHO has become better, clearer and more transparent". There is, however, a pattern that those who are more familiar with the WHO documents and most involved, are also the informants that voice most respect. These are mostly the 'technical mental health civil society organisations (CSO) informants', more than the 'general community based CSO informants'. The academians seem to feel that they are the furthest away from the processes. One informant (3, 20.01.21) describes positive informal interactions with WHO, but still describes the formal contact as "good, but not meaningful". When asked to elaborate, the informant explains that the reason for this discrepancy is that the positive contact is perceived to be "individual, not institutional".

4.2 Contextualization of WHO tools and recommendation in Nepal

The second main finding is that there has been a comprehensive contextualisation process of WHO recommendations and tools to a Nepali context. The findings show that the developed national 'policies' and 'program' have to a large extent been based on WHO tools and recommendation, but that this has not been that clear for the informants. The informants mention different aspects that have contributed to the adaption process through the years. The issues bring focus to the informant's perception of the underlying 'context' in fig. 4. It shows both external and internal factors, planned and unplanned processes.

The informants are to a varying degree aware of specific WHO tools and recommendations, but they all describe involvement in the development of national intervention packages and strategies that are in fact based on WHO's tool and recommendations. This can be interpreted that regardless of where the inspiration came from the informant feels that the strategies and packages are developed locally. The findings show further different internal and external factors and processes of what has contributed to the adaption process.

The main tools that the informants knew of, were the following:

- All the informants know of mhGAP intervention guide (WHO, 2018), couple after being reminded. This intervention and training 'program' to increase the access to mental health in the primary health care has been tested in Nepal as part of the PRIME study (De Silva et al, 2018).
- Surprisingly few, apart from some of the central informants themself and a couple of the technical mental health civil society informants, were well acquainted with the WHO Mental Health Action Plan 2013-2020/2030 (WHO, 2013). This has been one of the main inspirations behind Nepal's now National Mental Health Strategy and Action Plan (Government of Nepal, 2021, not yet published).
- Some mention other WHO intervention tools such as the QualityRight Tool Kit (WHO, 2012) and Problem Management Plus (PM+) (WHO, 2016). PM+ is being tested and QualityRight Tool Kit was by several mention as hugely important but difficult to implement.

An important background is also that a central informant (9, 24.02.21) describes that "it is not a WHO job to push their tools" and that "WHO makes the tools for those who want to use them". It was also pointed out that even though mhGAP was very popular, it should be known that it is in fact also "an extremely difficult strategy" – especially for Nepal where the clinicians move regularly, making it difficult to ensure quality control supervision.

4.2.1 External factors – Critical national events

The informants describe how the two crises' have brought about an awareness and deeper understanding of mental health issues in the public.

The informants convey the felt effect of the earthquake as "that's when the government and other people realized that mental health is real, like something had to be done to address these mental health problems" (3, 20.01.21). Another (5, 25.01.21) voiced "… when people themselves are scared, they're going through their own mental health issues in some way, I think that has helped to highlight mental health in general…". Or as another informant (7, 29.01.21) said, that "people felt the need - and lot of it takes a lot of space in people's talks and in the media talks…". This effect can be summed up by the fact that the Ministry of

Health and Population (MoHP) recruited a focal person and later a focal unit in MoHP on mental health after the earthquake.

As one informant (6, 28.01.21) explains: “it is after this event (…) that we got a number of guidelines, protocols and also the work on mental health strategy and action plan, the development of various mental health care package started so and furthermore”. Also, the present covid pandemic has contributed to increased understanding of the issue of mental health for people in general – also addressing the silent pandemic of suicide (3, 20.01.21).

4.2.2 Internal factors – Rooted in the history of the mental health care community in Nepal

The findings also show that this is again rooted in where the mental health community came from historically (see 1.2). Different aspects of contextualisation can be drawn from the informants’ descriptions of the historical line of events; from the first psychiatrists, to the first community-based mental health program by United Mission to Nepal in the 1980ies, including building up the academic disciplines of psychiatry and psychology at Tribuvan University Teaching Hospital (TUTH) before the technical mental health civil society organisations were established. This included a couple of rights holder organisations voicing rights, dignity, access to mental health treatment and care, highlighting the resources in people living with mental illnesses. All these organisations have been run by local expertise, champions and advocates - only getting funding and input from foreign expertise. At the same time, the academic faculties developed exchange and collaboration with universities globally.

During this period there were a couple of attempts to develop networks, at first based amongst the civil society organisations, but later including academic groups and government officials – for joint events and advocacy. A side effect was joint project-collaboration between organisations. After the earthquake, the UN crisis response system, OCHA’s, sub-cluster system (WHO, 2020) however came into play, getting everyone on board in sub-clusters that became the new arena for networking with the MoHP as head, co-chaired by WHO. The interaction amongst the mental health actors continued also after the earthquake.

4.2.3 Planned processes – Pilot testing

Nepal was in 2012 included as one of five countries into the PRIME (Programme for Improving Mental health care), which was a program with the aim "to generate high quality evidence on the implementation and scaling up of integrated packages of care for priority mental disorders in primary and maternal health care settings in low resource settings in Ethiopia, India, Nepal, South Africa, and Uganda" (Lund et al., 2012). In Nepal, modules from the mhGAP Intervention Guide (WHO, 2010,2018) were selected, translated into Nepali, implemented in some districts, and rigorously evaluated in the primary health care system in Chitwan district (De Silva et al., 2016). The primary results showed effectiveness in reducing mental health symptoms and improving functioning of people with mental illness.

As a central informant (1, 21.12.20) voiced: "While many of these manuals are being tested, one of the countries has luckily become Nepal", which means that "by the time it is adapted, all we need to do is tweak it a little bit and get it reviewed from the health administrator perspective to see if it is feasible to administer". "So, most of the time we need to scale it a little down, then we do a lot of negotiation to make it practical (…) include also other disorders like anxiety that is not included in mhGAP, which is a very popular criticism". The mhGAP was also implemented on a project level by several civil society organisations.

Guided by the PRIME study, the Ministry of Health and Population (MoHP), Primary Health Care Revitalization Division (PHCRD) with the assistance of WHO, started a process of developing a Nepali specific 'Community Mental Health Care Package' (Government of Nepal, 2017). In the preface, the MoHP formulates the following adaption process: "The package took an overview of the PRIME community mental health model at the beginning and underwent a series of reforms through rigorous technical discussions within a team of experts and representatives from government and non-governmental organisations, academicians and mental health professionals, to give the final structure" (Government of Nepal, 2017).

All these discussions resulted in several adaptions to the Nepali context. Some disorders were added to the original mhGAP listing of mental disorders, such as anxiety and compulsion disorder. The Community Mental Health Care Package now includes 10 mental

disorders. In addition, the symptomatology was improved. As an informant (explained: “Our patients express symptoms differently with more somatic complaints, rather than clear cut modes of worry, anxiety and hopelessness. People have a lot of indirect symptoms”. In addition, the secondary and tertiary strategies were strengthened, including getting one psychiatrist and one psychologist as authorized position in all governmental hospital. As one informant (1, 21.12.20) stressed “the government has not employed not even a single psychologist in the government system” In addition, special programs for children, homeless and for the prevention of suicide were developed. As described academics, UNICEF and WHO collaborated in Nepal to develop an mhGAP adapted to children and adolescents, as the first in the world. Informant (1, 21.12.20) described “so we walked together and adapted to the needs of children and adolescents”.

The result of all these processes according to the informant (1, 21.12.20) is that “now there is multiple versions of the training manuals available, with each considering needs of the country.” As the ‘Community Mental Health Care Package’ (Nepali government, 2017) is based on the three principles of evidence-based practices and international standards, dignity and rights-based approach, and Public Private Partnership (PPP) approach, it is designed to be “used by government, but also by other civil society and private organizations for similar purpose without distorting the substance and standards of the package”.

4.2.4 Unplanned processes – Technical discussions

The informants present a variety of discussions themes that are up for discussion in the mental health care community in Nepal. They were partly linked to the informant’s speciality, but there was also interesting coherence between the informants listing of important discussion. Some of the themes indicate disagreements, but the main impression is that these discussion areas represented additional perspectives.

The main themes that were voiced when the informants were asked what discussions were present within the mental health care community. These are presented in tab. 1 below.

The role of medicine	*General concern*: Discussion if medicine should play a small or dominating role. Worry about mhGAP's effect towards over-medicalization of mental health services *Voices*: *"So my understanding is that mhGAP is more diagnostic labelling of people. That the approach is medication and diagnosis more – less psychosocial support" (3, 20.01.21)* *"The Kind of mindset that we have developed that probably medicines only. But now things are changing. More recently people are opening up" (2, 28.12.20)*
QualityRight	*General concern*: QualityRight Tool Kit (QRTK) would lift the importance of quality of services for the service users, putting the person as a subject. *One voice: "It should be that people with mental health problems. That their rights and needs be recognized and needs to develop activities to create enabling environment people with psychosocial disability". (7, 29.01.21)*
Inter-disciplinary	*General concern*: The main influencers in Nepal were identified as men and psychiatrists. There are only 33 psychologist and no authorized governmental positions for this profession. There is still no education for e.g occupational therapist or special educators. *One voice*: "But in near future we are planning to adapt this and post clinical psychologist in our government system as well" (8. 2.2.21)
Funding	*General concern*: Now that the policies are in place, there is need to roll out funding. *One voice*: "*So I think if WHO so has adequate funding and then working together with all these government and non-government stakeholders in various provinces and regions of the country would definitely be contributory to scaling up mental programs and bringing all the stakeholders together." (6, 28.1.21)*
Sustainability	*General concern*: There have been several projects, but when the project period ends, what then? *One voice*: *"The projects that have been done in different areas only few components are being continued in some places. So the sustainability is another issue, so I guess the political ownership is really, really important in order to continue these services" (4, 22.01.21)*
Secondary and tertiary care	*General concern:* only going towards the primary care, but at the same time strengthening secondary care services and tertiary care service on mental health services. *One voice*: *"When there is not that much developed secondary care services, the support to primary care services couldn't happen actually" (1. 21.12.20)*

'Full and effective participation'	*General concern*: Convention on Rights for people with disability (UN, 2006) voices "full and effective participation" *One voice*: "*There are ways of either 'listening' or 'meaningful listening' or 'just including'. That is when they invite in but it doesn't influence anything"* (3, 20.01.21)
Local inclusion	*General concern*: More participation of local people and hearing from local people and they can identify gap and how they can further work on. One voice: "I see that the decision-making is more limited to technical expertise Maybe the WHO team can be more inclusive of people from different backgrounds, *different contexts that would help influence decisions, and then maybe that could be more applicable to different context" (*4, 22.01.21)
Specific areas	*General concern*: Child and adolescent mental health, suicide as the 'silent pandemic' and care for the homeless. *One voice*: "*Few years ago, nobody talked about children having any mental health issues. So I think now the children mental health is also being at least being recognize, but at least we are In their radar and people are talking about it. (5, 25.01.21)*
Many different psychosocial centres	*General concern*: Concern about the quality and seriousness of many mediation centre and for-profit centres. *One voice*: "*The need has increased and then we have these psychosocial counsellor – a concept of counsellor is developed, and some courses have been developed to building capacity of the people with 12 year schooling" (7.29.01.21).*
Private Public Partnership (PPP)	*General concern*: PPP is a principle in the new national strategy. *One voice*: "*The government is not fully equipped and is not empowered with the human resource and all these things. We are planning in the coming days, but at present other NGOs are also supporting to the government to give us to deliver the service to the people. So you know there is a definitely role for NGOs and INGOs in the field of mental health, for more yearsI think so" (6, 29.01.21)*
Deinstitutionalization	*General concern*: Was still a quite low priority theme, only voiced by a couple.

Table 1: Discussion areas in the mental health care community according to the informants

The list of discussion themes shows a strong and broad internal technically discussion, that is also emphasized in the Community Mental Health Care Package (Government of Nepal, 20xx) and can be argued to be an indicator of a good processes of contextualisation. Many of the themes are also included in the newly endorsed National Mental Health Strategy and

Action Plan (Government of Nepal, not yet published) show a broad willingness from the government's side to listen to what is actually happening on the ground voiced through different stakeholders, concerns and expertise.

These issues have been discussed during the development of the Nepali Mental Health Strategy and Action Plan 2021 -2025 (Government of Nepal, 2021. Not yet published). The plan has recently been endorsed by the Ministry of Health but is yet to be endorsed by Cabinet. Some of the informants were not acquainted with the final version get. The main areas of the strategy are 1) Service extension, 2) Ensure the resources and structures, 3) Increase public awareness, 4) Address the rights and needs of a person living with mental conditions and taking legal and policy action, *5*) Work on resource information systems and research. In several of these the concerns from the list above will find its place in the strategy. However one of the informants (3, 20.01.21) voice that strategy can become a "do,do,do" document that will not be implemented. Another informant (5, 25.01.21) voiced "we need to put our foot where our mouth is. We are still talking. But the biggest problem is budgetary issues."

4.3 Coordination as a WHO role?

One of the clearest findings in this study, is the call for WHO's coordinating role. All the informants have understood that WHO role is to work close to government, and most are aware that their formal role. All the informants however acknowledge the coordination role WHO in Nepal has had since the earthquake, and most of them call for this role also in the future. This intention is confirmed in WHO steering documents and by practice. However, the findings show a discrepancy when central informants describe the consequences of WHO's needs to protect itself WHO from inappropriate situations, influence, or lobbying. The informants also relate to the term 'coordination' differently.

4.3.1 Perception of WHO's formal role

All informants are aware that WHO first and foremost is responsible towards government. One informant (3, 20.01.21) voice this as "WHO is 100 % obligated to government" and "listens only to government". The informant was unsure about the structure within WHO but still voiced that WHO should be neutral and listen equally to both health ministry and civil

society. Another informant (5, 25.01.21) voice that “WHO is usually always present, but a lot of their work is focused primary with the government, and not necessarily sharing that with the greater community”. Yet another (2, 28.12.20) says that “WHO is really working close with the Health Ministry and try to guide the Ministry”.

Central informants (9, 24.02.21) confirm this; “WHO’s role is setting norms and standards and supporting countries, upon their request, with implementation and technical assistance” (9, 24.02.21). Similarly by another (8, 02.02.21) describing that WHO and the government “go hand-in -hand” and that it is the government that heads the sub-cluster meetings on mental health, with WHO as co-chair, and that they e.g. “develop training together”. As a central informant (9, 24.02.21) describes WHO has a complicated role and is in fact the only of the UN agencies where the Director is appointed by the Member States. He emphasizes how this affects the dynamics of the relationship between WHO and the member states as “going in different directions”. On the one hand member states are WHO’s “board”, “recruit their boss” and thus “tells WHO what to do” on the other hand WHO is an entity on its own.

This role is confirmed in steering documents as the WHO mandate and strategy is stated in e.g. the Constitution (WHO, 1946: Article 2c) “to assist Governments, upon request, in strengthening health services

4.3.2 Perception of WHO having a coordinating role

As for WHO having a coordinating role the findings show discrepancies, dilemmas and unclarity. The role is guided by mandates and steering documents that to some degree signals internal discrepancies that can count for dilemmas and unclarity.

The informants describe how WHO’s influence has increased the role of mental health in Nepal the past years. WHO has according to one informant (6, 28.01.21) been “bringing together all the actors and stakeholders engaged in mental health and psychosocial support responsive mechanisms, and also leading development of various care packages and protocols”. His view was that “So I find WHO doing a good job and should really appreciate the endeavours that they have done during this last decade”. Or another (2, 28.12.20) with long time experience in the field, who describes the change the past four year as “the coordination is really good now and we see how we have been all linked in subcluster

meetings. (…) We now know what WHO is doing, what strategies the government is looking at; from technical, trained manpower and from hospitals, psychiatrists, or psychologists. Now we can see the effects and the work has become more transparent. (…) So, I think the coordination is working very good than what it was. And with the Covid crisis, I see that really well". Or 3, (20.01.21) who said that WHO used to be silent, and that it is better now.

The informants describe that WHO have the following roles; co-chair role in the sub-clusters meetings, technical advice as they prepare and present at the sub-cluster meetings, being an influencer or advocate, bringing the actors together and being a bridge between government and civil society.

The informants see the coordinating activity as an important role for WHO the future as voiced as "as we lack resources (…), it has a lot to do with coordination" (2, 28.12.29). The informants emphasize the need to ensure an inter-disciplinary approach to avoid that one sector is neglected (2, 28.12.20), to keep updated about all actors work to avoid duplications (4, 22.01.21), to continue to advocate for mental health care, including government's ownership (4, 22.01.21). To become more inclusive to ensure the involvement of e.g. "service-users" also outside Kathmandu and include a broader number om common counsellors into the work (4, 22.01.21).

In practice WHO in Nepal is perceived as "coordinating", with the government as lead. As a central informant (1, 21.12.20) describes; "So we kind of synthesize, listen to them and synthesize based on the experience. (…) The process starts with the need. Then based on the field visits, based on the experience, based on the interaction with the colleagues, we kind of feel what is important now. When we feel the need, then we look around what's already available, and then, more often than not, we find some WHO publication related to this. And then this becomes the basis for discussion. It's reviewed, it's translated, and different clauses in the document is discussed, based mostly on feasibility than on effectiveness. In WHO publications there's a lot of effectiveness being proven, but then feasibility in our context is challenged"

4.3.3 WHO and non-state actors

The voices of central informants however show an internal discrepancy. One of a central informant (9, 24.02.21) emphasizes that "WHO in the country is under the privilege of the government", so he voices that he would not say that WHO "has a coordinating role". In country work, we are absolutely supporting governments. We can support the government in coordination." Another (1, 21.12.20) describes that ""one major limitation is that WHO exclusively engages with the government" (1, 21.12.20), but this also has an "advantage because most of the time with knowledge of what government is doing, but then we can't freely engage with the private sector and NGOs effectively". The same informant describes that WHO has to "convince government before doing a government program through private sector", but it has "certain advantages and disadvantages". And continues; "If we make it as a government program, there is a lot of ownership issues. It obviously becomes the common. But government doesn't have a technical capacity."

There is however according to the central informant a difference during an emergency and the government falls apart. That is when UN comes in and coordinates. But even during the Nepal earthquake, WHO/UNICEF are only co-chairing the coordination group in support of the ministry. We didn't take over the coordination.

There is also a discrepancy in documents between the documents that call for increased interaction and the documents that regulate the need for WHO to protect itself. On the one hand the documents promote the need to work with civil society and rights holders, but on the other hand the bureaucracy in engaging is so ridged creating a challenging role for the country office representative, afraid of bending rules and even voicing that the contextualisation was not "perceived positively globally".

WHO steering documents promote working with civil society. At the same time steering documents promote working with civil society and disable people organisations and rights holders. WHO's steering documents emphasizes that outreach to non-State actors is "critical for WHO's work" (WHO, 2019:33).

However, there is a challenge when WHO has to protect itself from inappropriate situations, influence or lobbying. At the same time, there is a challenge as "WHO's sets of norms and

standards can differentiate from other actors in global health". This called for the need for WHO to develop a 'Framework of Engagement with Non-state Actors' (FENSA) (WHO, 2016) to provide the "guidance needed to engage in partnerships with all types of non-State actors while the need to maintain 'WHO's integrity and independence from interests detrimental to health". The FENSA regulates the engagement with nongovernmental organizations, philanthropic foundations, and private sector entities.

FENSA (WHO, 2016:97) is a thirty-page document that mentions some benefits (:97), but the main focus of the document is on regulating the interaction. The framework voices that an effective engagement calls for due diligence and transparency measures. Thus, the objective according to GWP13 to "identify risks, balancing them against the expected benefits, while protecting and preserving WHO's integrity, reputation and public health mandate" (WHO, 2019:34).

The rationale in FENSA pkt. 2 (WHO, 2016) is that "*WHO is the directing and coordinating authority in global health in line with its constitutional mandate. The global health landscape has become more complex in many respects; among other things, there has been an increase in the number of players including non-State actors. WHO engages with non-State actors in view of their significant role in global health for the advancement and promotion of public health and to encourage non-State actors to use their own activities to protect and promote public health".* Still when FENSA later mentions benefits in engaging with non-state actors (pkt. 6), of the five benefits mentioned four are formulated on how WHO can influence the non-state actor, and only one that the non-state actor can contribute to WHO's work.

These protection mechanisms become a dilemma. As voiced by a central informant (9, 24.02.21) "the bureaucratic rules that protect from inappropriate situations, whether it's corruption or influence or lobbying (…) with the goal to protect the WHO from external influence, (…) are quite good because, even though, I offensively struggle with it every day, but I do think it's leading to choices that are quite wise". However, the same informant also confirms that "FENSA is a huge barrier in terms of fluid interaction with civil society" and "that it is complicated, so the role of civil society gets affected by all these complications". Another informant (1, 21.12.20) voices that "one of the feedbacks is for WHO to engage more with civil society. At the headquarters level, they have created a platform to engage

with civil society organisations, and at the country level they are now gradually very cautiously opening up". The informant describes the FENSA assessment "before we engage, give some money or ask for technical support" as 'tedious'.

But also working with civil society organization is voiced by an informant (1, 21.12.20) as "sometimes gets a little tricky. (…) There is understandably some competition. Some issues around who is the more visible, but generally people agree. (…) Earlier there was competition that is OK, but now they all go for the government's banner. (…) But some of them have different approach. The mix would be ideal, so so we kind of synthesize, listen to them and synthesize based on the experience, and try to find the best model".

One informant (3, 20.01.20) claim that this collaborative way of working is due to individuals and is not institutionalized. This tallies with a central informant who rejects WHO's coordinating role and addresses their role more as partnership. In documents such as the GWP13 (WHO, 2013) and even more clearly in the Mental Health Action Plan 2012-2020/2030 (WHO, 2013), civil society and specifically rights holder organisations are emphasized as important collaboration partners. However, this becomes a dilemma when the formal demands to such collaboration partners need to be subject to ridged analysis according to the Framework of Engagement with non-State Actors (FENSA). This applies to all private actors that WHO wishes to collaboration or work with. Centrally this is assessed as an important tool to avoid unwanted intervention of WHO by actors such as the tobacco- and weapon industry. WHO also have the same restrictions toward the alcohol and pharmaceutical industry. It was also said sometimes even actors with the best intention, tried to influence in ways that was challenging to the role as WHO.

5. Discussion

I will be using the empirical findings of this this case study, to discuss the implementation theoretical approach as chosen for this study. As I have described in the methodological chapter, I will use a hermeneutical approach, as that gives the opportunity to go deeper and deeper into understanding the issue in a tango-like process (Thomassen, 2006:157).

The findings on 'complexity', including the model in fig. 4, will be discussed in relation to the review by Nilsen and Birkens (2020) of implementation theory in a first hermeneutic circle (Alvesson and Schölberg, 2008) in 5.1. Thereafter, based on the discussions of 'context' in Nilsen and Birken (2020), I will take a second hermeneutic circle (5.2) of understanding, looking at the process of contextualising WHO tools and recommendations in relation to the translation theory by Rørvik (2016). In a third circle (5.3), I will go further in the discussion on 'context' by Nilsen and Birken (2020). And inspired by Bjartveit and Roos (2005) notion of a toolkit, and the 'values work' by Gehman (2013) and Askeland et al. (2019), discuss which mechanisms that can increase the understanding of 'context'. In the last circle (5.4), based on the main concern as voiced by the informants in this study, and in relation to the presented model, I will discuss 'coordination as a WHO role' in relation to the theories of "samhandling" or "interaction" as conceptualized by Torgersen (2018).

The entire discussion will be based on answering the research questions and assess the relevance of fig. 4 in relation to the review by Nilsen (2015) and Nilsen and Birken (2020) of implementation science.

A researcher's preconception is important in a hermeneutical approach, as it is both the asset and the liability of researcher and should be transparent. My preconception constitutes, as described under 3.4, a base of pre-supposed understanding of the area of global mental health, of the context, and of the group of informants.

The overarching question behind this study has been how to implement a mental health care system in a low-resource setting, when such countries basically start from scratch. As this can be said to correspond with WHO's mission since the 2012-resolution on global mental health (WHO, 2012), the research question of this study has been how the WHO's

recommendation and role are perceived by main actors in Nepal. This is not a study to evaluate WHO, but to understand their role as part of the bigger implementation process of mental health in Nepal.

5.1 Complexity changes implementation determinants

Based on Nilsen (2015) and Nilsen and Birken (2020) (see 2.1) and the findings in 4.1, I will here discuss how the model in fig. 4 might shed light on the discussions in the review by Nilsen and Birken (2020) of theories, models and frameworks as described.

The assumption in the model in fig. 4 is supported by Nilsen and Cairny (in Nilsen and Birken, 2020:380), where they suggest that the differences between implementation science and policy implementation research is the level of complexity. As suggested in fig. 4 a move from 'program' level to 'policy' level is an increase in complexity.

Implementation of mhGAP is identified as an intervention of an evidence-based practice on a 'program' level. As based in both WHO recommendations and Nepali steering documents, the study further identifies the need to develop national contextual 'policy and strategies' as fig. 4 shows. In addition, even though the focus of this study was the WHO role, this study shed light on the role of smaller 'entrepreneurial initiatives' and 'project'. The findings show how the learnings from these smaller initiatives, in the case of Nepal, were important also on the national up-scale. The findings show how entrepreneurial and project participation actively gave inputs and tested 'programs' such as the mhGAP (WHO, 2010), including contributing to the national 'policies and strategies'.

By including policy implementation theories, models, and frameworks into the categorization by Nilsen (2015) (fig. 1), this could bring broader perspectives on implementation to our attention. This could then also contribute to both of the objectives put forward by Nilsen (2015): "appropriate selection of relevant approaches" and "promote a cross-disciplinary dialogue". This could inspire dialogue among traditional implementation researchers, but also in relation to policy implementation scientists and other political science groups, and by that lift the contextual understanding to a higher level.

The Nepal case shows that improving the communication between the fields of implementation science and policy implementation science could increase communication and understanding between the strategy and intervention level, be that in a nation like Nepal or in an organisation.

In the first hermeneutic circle, the findings showed a combination of implementation initiatives within mental health in Nepal, and thus confirm the broadening of the perspective presented in fig. 4 on implementation from primarily a 'program' level to four different levels of implementation based on the degree of complexity and planning. This adds to the categorization of implementation tools by Nilsen (2015) and ensure even more relevant selection of approaches and add perspectives to a cross-disciplinary dialogue. By that, the model enables going further into the understanding and explaining of how and why implementation succeeds or fails.

5.2 Contextualization as a translation process from WHO to Nepal

Based on translation theory as described by Røvik (2016) in 2.2 and the findings in 4.2, I will here go further in the hermeneutic circle and discuss the relevance of this theory in relation to the understanding of context when implementing an idea from one context to another. I will with reference to fig. 4 look at how the translation process took place on a 'policy or strategy' level and on a 'program' level in mental health in Nepal. I will argue that translation theory can contribute to increasing the understanding of context, and thus improve the contextualization through focus on the implementation process.

Nilsen and Bernhardsson (in: Nilsen and Birken, 2020) describes a discrepancy within implementation science between how context is in fact perceived as critically important. There is, however, also according to Nilsen and Bernhardsson no unified understanding of what context is. When implementing a new idea or tool from one context to another, diffusion theory (Røvik, 1998, Rogers, 1995) describes it as 'the spread of new ideas', where information is shared amongst the members of a social system in a creative process, developing a common understanding of the new idea. In this study the 'idea' that is spread is the 'idea of mental health', being disseminated by WHO between two very different contexts; from a high-resource setting to a low-resource setting. The knowledge that is

transferred can be said to be in one of the more complicated areas, as mental health goes to the core of how people 'tick', which is both personal, but also culturally determined.

I will in this discussion take the stand that 'context', as Nilsen and Bernhardsson (in Nilsen and Birken, 2020:265-269) point to, is something more active and dynamic that greatly affects the implementation process and outcomes. I will argue that ensuring a holistic approach hence means not studying the determinants in isolation. As Nilsen and Bernhardsson emphasizes seemingly unimportant or combinations of determinants can play out very differently than assumed. They are also not easily manipulated. Hence, context cannot be assumed to be broken down and influenced in a cause and effect manner.

As a background to the context of Nepal, it should be pointed out that in the area of development aid this diffusion process has turned out to be extremely challenging, as the notion of translating ideas from one context to another has proven more difficult than was believed in the childhood of development aid after the second world war. Examples of unwanted effects and direct failures are unfortunately many, such as the Norad's Kerala fishery project in the 1970ies (Norad, 2012). Thiessen (2013:3) points to local ownership as demanding for both theoreticians and practitioners. However, the ideal is that people take better care of themselves when we own a problem our self. This has been an important backdrop in all development aid and translating a program or an idea from one context to another, is usually based on the ideal of "local ownership". This experience has indirectly implied that there has been a scepticism towards any "copying", as it has been perceived as equivalent to not taking the context into account. However, it appears that the rate of diffusion of ideas is now increasing, and the rate of diffusion is more rapid when an idea is initiated/promoted in the policy or popular realms than in the academic realm. The most successful ideas are also not those that are most analytically rigorous, but those that are most malleable, achieving consensus by conveying different meanings to different audiences (McNeill, 2006).

If we assess the findings in relation to the three critical variables in the translation theory of Røvik (2016), we see that WHO have pursued extensive processes for many years in translating recommendations and tools from a source practice being the western context.

There is no doubt that the differences between the source context, the westen as high-income context, and the recipient context, Nepal as a low- and middle-income (LMIC) context is huge and the possibility of a good translation to an LMIC context is demanding in the area of mental health. It is also not made easier by the third critical variable, according to Røvik (2016), which is if the knowledge is easily transformable. Mental health touches the soul of people's existence and universality of basic psychological perceptions is obviously a continuous discussion where we know that culture plays an important part, but research in LMIC settings is still scarce. This was the base for the start of the area of mental health in the book "Where there is no psychiatrist", first published in 2003 (Patel and Hanlon, 2017).

The Lancet 2007 call for action has later produced results slower than what one envisioned, but this might also have given time for the 'de-conceptualization' process according to Røvik (2016). The low-key movement gave time for WHO as the 'translator', to include a multiple of actors in global movements with focus on networks around the world such as the Movement for global mental health (Ref?) or the Global community of mental health innovators. The actors are from civil society, disabled people organisations, research institutions, academicians, some donor agencies, and networks.

I will first use the translation theory as described by Røvik (2016) to describe the translation of the mhGAP (WHO, 2018) to a Nepali context, where the program was expanded and named "Community mental health care package". This is placed in fig. 4 at a 'program level'. The 'deconceptualization' process was part of this study. This confirms the point made by Røvik (2016:290) that expanded translation of general ideas into recipient units to also include translations from source units. But since the process of developing WHO's tool and recommendations took time, based in different worldwide networks and in WHO initiated forums like the annual mhGAP Forum, this might have been the reason for the thorough and rooted process, however unintended.

In "the conceptualization" of the mhGAP as an evidence-based program, Nepal was, as the informant (1, 21.12.20) voiced, "lucky" to be chosen to take part in the PRIME study and thus receive funding and expertise for quality implementation, which in turn meant that Nepal only needed to "tweak" and "modify" it to the Nepali context. This means that the

'translation mode' used in the theory by Røvik (2016) was a 'modifying mode' where they 'added' new elements from the Nepali context and discussion.

As for the 'policy' level (fig. 4) the Mental Health Action Plan 2013-2020/2030 (WHO, 2013) was 'decontextualized' from a high-income source in the same broad contextual manner as with mhGAP. As for the contextualization process toward the Nepali "National Mental Health Strategy 2021-2025", findings show how they "tweaked and sat together and walked together with UNICEF". The process was perceived by the informant as a national process. The mode of translation was a more radical translation, however not altering the message completely, but focusing more on the context and inputs from on national actors than using the Action Plan 2013-2020/2030 as a base, while still listening in on all the discussions as described under 4.2.

I have here shown how the translation theory by Røvik (2016) can be used to understand not only the contextualization process of tools and recommendations from WHO, but also the de-contextualisation from a western context that WHO has undertaken. The findings show how the 'program' and 'policy' level in my model (fig. 4) might call for different modes of translation. In none of these cases, the translator is not term in singular but is more perceived a network of translators.

5.3 Mechanism for increased understanding of context

As shown above, context is not straight-forward. It is often messy, difficult to understand and can as Nilsen points out easily be manipulated (Nilsen and Bernhardsson in: Nilsen and Birken, 2020; 259-275). This is very much the case in this study, as mental health is a new area of expertise in Nepal, a complex society comprised of 123 languages (Khanal, 2019) and over 100 ethnic cast groups, and with small resources both in terms of financial means and expertise in an area such as mental health.

And if we, as Nilsen and Bernhardsson (in: Nilsen and Birken, 2020), refer to an understanding of context as influences that are "above" or 'at a higher aggregation level' than the individual, it brings the attention to the complexity and values that any given context is comprised by, including an understanding of how values evolve.

In this chapter, I will go further in the hermeneutic circles, arguing that context needs more than identification of clearer determinants to be understood. Based in the findings, I will introduce relevant aspects of complexity theory (Bjartveit and Roos, 2005) and argue the need for different tools in a toolkit. I will later in the chapter, based on Gehman (2013) and Askeland et al. (2019), show how the theory 'values work' can be used as one such tool for 'translators' (Røvik, 2016) to understand a context. In the next chapter (5.4) I will go further to the main concern as voiced by the informants in this study, being 'coordination as a WHO role'. This can be seen as one 'pocket of concern' according to Gehman (2013).

As described in 4.1 and in fig. 4, context is illustrated in the letters 'C-O-N-T-E-X-T', which are difficult to see and thus similar to real life contexts that are difficult to discover and interpret. As Nilsen and Bernhardsson (in: Nilsen and Birken, 2020:265) points out, context will often turn out to be either "bundles of stimuli" and "deadly combinations" of otherwise effective determinants that can yield unfavourable outcomes, thus making context difficult to manipulate. Nilsen and Bernhardsson proposes the need for a "greater conceptual clarity and consistency" of context (:261)". I would claim that this will miss out on the points they themselves have argued about the dynamics of context. This study brings attention to the complexity in context, and sheds light on the difficulty of understanding a context. As an example, in Nepal one of the informants (4, 22.01.21) points out "there is a need to include the local view, as the main actors today are mostly living in Kathmandu". Here yet another dimension is needed to understand the context of Nepal and there will always be other dimensions coming in. It is obviously quite challenging to shape or translate an intervention to a context in a country with 123 language groups (Khanal, 2019) etc. If you include dimensions such as traditional versus modern, rural versus urban, public versus private, hill versus terrain, as well as religious background and each person's individual history and understanding of life, it becomes clear that defining determinants that are meant to assist a 'translator' to understand context will never be justifiable. This shows that it might be useful to identify some guiding determinants, but these should always be followed by a clear inductive approach, developing and using a wider range of mechanisms for interpretation.

How then understand 'context'? Nilsen and Birken (2020) mention complexity theory as one theory that has caught interest within implementation science. This has also inspired the

criticism by Bjartveit and Roos (2005) of the consultancy world. A consultant has a similar role to Røvik's (2016) 'translator' in spreading ideas from one place to another, be that management ideas or implementation interventions. With reference to complexity theory, Bjartveit (in: Bjartveit and Roos, 2005:197) argues that theories or models assume predictability, when real life experience shows that order and chaos coexist. Bjartveit claims that things might look similar, but you can never count on two contexts to be identical. In addition, political agendas or irrational elements will come and interfere. This would be true for most contexts, not least to a complex context country like Nepal just experienced civil war and an earthquake, and no undergoing a federalisation restructuring, and is in the midst of the covid crisis.

Thus, based on Bjartveit and Roos (2005) general perspectives, I argue that for a 'translator' like WHO to understand 'context', it would need an arsenal of appropriate interpretation mechanisms, rather than attempts to develop a clear set of determinants to assess context the way it seems that Nilsen and Bernhardsson (in Nilsen and Birken, 2020) envisions. This is evident in the extreme complexity of a nation, but it also applies the way Bjartveit (in: Bjartveit and Roos, 2005) shows to individual organisations. They emphasise that a 'consultant' or 'translator' has to develop a mode of the constant search for understanding and to use 'interpretation' as a method the way hermeneutic analysis calls for. This 'toolkit' could also contain the traditional implementation theories, models and frameworks as Nilsen (2015) describes. Including other theories and models the way this study proposes. Bjartveit and Roos (2005), have even gone further and developed classic philosophy literature from Platon, Aristotle, Kierkegaard, Machiavelli and Shakespeare as tools to assist a 'translator' in interpretation . These could find parallels in other cultural settings, such as Nepali classic literature.

Context is comprised of values, and because values are not so tangible, we tend to just take them for granted (Espedal in: Askeland et al., 2019). My perspective is, as mentioned under 2.x, that "values are constructions that are given meaning in a social space, catching the attention at a given time and affecting practice, and is later replaced by other concerns" (Askeland and Aadland in: Askeland and Aadland, 2017). This again calls for the

understanding of context as comprised by values that emerge through dialogue and interpretation.

Based on Gehman et al. (2013) and Klive (in: Askeland et al., 2013), I will in this discussion identify which 'pockets of concern' were voiced by the informants in the study. The most important was the concern for 'coordination' as a WHO role. This will be covered separately in 5.4. Other concerns are those listed as discussion items under 4.2.x. These show underlying values and ethics about whom to include, what perspectives are viewed as important, what dignity is all about, and so on. Such 'values' can be put in documents, but they are even more a sign of ethics in a given context (Gehman et al., 2013). The 'pockets of concern' that are voiced by the informants and represent discussions in the mental health field in Nepal, can be said to be loosely linked together, based on where each actor or informant come from. These links have over time been 'knotted together' in e.g. the formal sub cluster meetings and most probably through informal communication. In such settings the different concerns voiced will influence each other, and 'new practices' will be formulated and "end" up in new patterns of 'values practice', before they again will be confronted by other views and competing value practices (Gehman et al., 2013). And so, the circle goes. The processes of sharing or circulating the values take place, according to Gehman (2013), often through metaphors, signs, symbols, and stories that emphasize or give legitimacy to a value or 'values practice'.

I will exemplify this by using the concern voiced by several of the informants that the focus on access to mental health through the mhGAP program alone could lead to an "over-medicalization" of mental health issues in Nepal. This can be said to be a 'pocket of concern' that seems to have been 'knotted' at so-called sub-cluster meetings. It seems to have influenced other concerns under 5.3, such as the need to increase psycho-social support and ensure an interdisciplinary approach to mental health, developing a knotted concern based on values such as 'dignity' and 'diversity'. This will then be formulated into new 'value practices' in an up-coming Strategy 2021 (Government of Nepal, 20xx, not yet published) where many of these concerns are in fact included. These concerns most probably have roots also in the global community like from the Lancet 2018. When circulating the values,

Gehman (2013) describes how the values are legitimised by metaphors, signs and symbols that can be shown in a quote such as this one by informant.

Before going deeper into coordination as a concern, I will though the theory of values work assess how this concern emerged. During the interviews, the issue of coordination or similar notions of networking etc. were not posed as a question on its own. The concern still came up independently, but quite unanimously. The concern was voiced when questions of WHO's present and future role came up, but also when the informants were asked about the discussion themes under 4.2. It came up in relation to concern about "meaningful participation…" (3, 20.01.21), in relation to inclusive and local participation (2, 28.12.20), in relation interdisciplinary approach and some others. The concern was raised irrespective of professional background. This shows how the issue of "coordination" was a 'knotted concern' and had developed into a pattern of 'values practice' that came across during the interview. The informants described that the present coordinating role of WHO had become something they saw the value of, but they also voiced or circulated as a concern whether it would continue in the future.

5.4 Coordination/interaction/"samhandling" as a WHO role

During the data collection, it became evident that the role of WHO is unclear. The findings show that WHO role is respected. However there seems to be different perceptions of the specific role voiced as 'coordination'. As shown, the steering documents and the informant's perceptions correspond to that WHO's important roles is within the areas of policy dialogue, strategy xx, technical advice and implementation xx as described in the present five year strategy (GWP13) (WHO, 2013). All parties also seem to be aware that WHO first and foremost are responsible towards government.

I choose to remove this discussion from the general discussion of mechanisms in order to understand context, as I regard the issue of 'coordination' as an important finding of this study. As described under 4.3, the issue of coordination came out strongly among the informants. As shown in 5.3, this concern can be viewed as a 'values practice' that has evolved over the years based on 'pockets of concern' and has been 'knotted' together at sub-cluster meetings. This 'values practice' can be said to have guided the interaction

between actors in Nepal based in intention of WHO documents and other documents such as the Convention of Rights of People with Disability (UN, 2006)

The voiced discrepancy between the informants is confirmed in the internal value discrepancy between strategy documents like the Action Plan (WHO, 2012) and the protective framework of FENSA (WHO, 2016). These documents are all based on documents like the Convention of rights of People with Disability or the Sustainable Development Goals (UN, 2015) which voice values such as 'meaningful participation' and 'leave no one behind'. However, the strategy documents have clearer action points to include civil society, while the FENSA frameworks objective is to protect WHO.

This discrepancy can be seen as a dilemma based on WHO's complex role. With FENSA, the weight is put on control, thus making it challenging in relation to "the interaction with civil society" as the central informant (9.24.02.21) voiced. This study will not try to conclude on this discrepancy, but point to the dilemmas, and suggest ways to look into the voiced value of 'coordination'.

FENSA is, as informant (9, 24.02.21) pointed to, crucial for WHO and has "led to choices that have been important". The world is increasingly complex, with influence from money, other nations, ideologies that easily result in conflicts of interest or improper influence (WHO, 2016). In the specific context of Nepal this is no easier. Industries such as tobacco, alcohol and pharmaceutical industry will obviously try to influence in an area of non-communicable diseases, including mental health. And as the informant (9, 24.02.21) pointed out "they may have good intentions, but their influence is still undue compared to WHO priority". Understanding the context of a country like Nepal, in terms of e.g. political groups and ethnic cast-groups, is crucial for conveying implementation and interventions to the right people. In this regard, FENSA, becomes a crucial mechanism to ensure that WHO efforts are based on the right intentions, "to avoid negative impact on WHO's integrity, independence, reputation and public health mandate" (WHO, 2016).

However, as another informant (1, 21.12.20) describes, this dilemma looks quite different on the ground close to the actual implementation. Here stakeholders hold up rights according to the Convention of Rights of People with Disability for "meaningful participation". National

steering documents emphasises private-public-partnership (PPP) as it acknowledges that government “does not have capacity”. The Community Mental Health Care package (Government of Nepal, 20) states directly that: “the package realizes the concept of PPP in community mental health programs, and hence forces on collaboration with other government non-health sectors, non-government organisations and volunteer in various areas such as awareness raising, training, research, rehabilitation and reintegration”.

So, as Gehman (2013) points out, “in interpretation of contexts, values are in fact often contradicting institutional logics that show that value can be, and often are, interpreted and handled differently by different actors”. This seems to be the case in implementing mental health schemes in Nepal. The ‘values practice’ of ‘coordination’ is felt as important and is appreciated on all levels by the informants, but is made difficult through the WHO FENSA frameworks that requires a rigid system of assessment for WHO to be able to work with civil society and academics.

The different ways of interpreting coordination, such as when a central informant claims that “coordination is not seen to be a task for WHO” (9, 24.02.21), adds to the dilemma. The base for this statement seems to be a definition that coordination is “distribution and transfer of duties to the right place, with the right skills” (Torgersen, 2019:47). The informant felt that the term ‘partnership’ might cover the role better. Torgersen (2019:41) shows that there are many definitions for words like “cooperation”, “collaboration”, or “join forces with”. A definition of “collaboration” is e.g.: “The collective work of two or more individuals where the work is undertaken with a sense of shared purpose and direction that is attentive, responsive, and adaptive to the environment.”

However, the way the civil society and academic informants seem to interpret the value of ‘coordination’ is however closer to the Norwegian concept of ‘samhandling’, such as Torgersen (2019) conceptualizes it. Torgersen (2019) shows that there is no direct equivalent in the English language. The closest translation of ‘samhandling’ is “interaction” or “joint action”, although not covering the meaning of ‘samhandling’ precisely.

Torgersen (2019:26) defines ‘samhandling’ as “an open and mutual communication and development between participants, who develop skills and complement each other in terms

of expertise, either directly, face-to-face, or mediated by technology or manually. It involves working towards common goals. The relationship between participants at any given time relies on trust, involvement, rationality and industry knowledge". Torgersen refers to 15 key underlying processes that are important for effective 'samhandling'/interaction, based on the experiences of a variety of businesses and theoretical approaches.

Based in this definition, it seems that the dilemmas with FENSA could be looked at by discussing the notion of 'coordination' the way that the informants in this study have voiced it, and using the Norwegian concept of 'samhandling' according to Torgersen (2019) to assist in mitigating the dilemmas. In a social constructive perspective (see 3.1), words are important (Thagaard, 2013), and thus a discussion on the concept of 'coordination'/'samhandling'/'interaction' would both draw attention to dilemmas, elaborate for all parties how one best can manoeuvre within the given dilemmas, and help choosing what word would in fact resolve the 'pocket of concern' that was named 'coordination' by the informants.

One of the most important reasons to look into this dilemma is that interaction/samhandling/coordination is also an important mechanism to understand context as voiced by Nilsen and Bernhardsson (in Nilsen and Birken, 2020). It is also implicit in Gehman et al. (2013) notion of 'knotting concerns', and it has been argued that Røvik's 'translator' should be a network of translators, not just one single person.

6. Conclusion

Implementation science is a branch of science only a decade old, having progressed, according to Nilsen (2015:1), towards an increased use of theoretical approaches to provide better understanding and explanation of how and why implementation succeeds or fails. Nilsen and Birkens (2020) review is an interesting and close-to-practice endeavour to discuss different dimensions of traditional implementation science.

This study has attempted to elaborated on a couple of these discussions, namely themes related to 'context' and indirectly to 'complexity'. The theoretical discussions have been based on the interpretive empirical data from a case study where we have seen the a 'complex' implementation of mental health care on country level in Nepal. The focus being on WHO's role and recommendations on access to mental health.

My preconception that has been in an hermeneutic tradition fairly explicit (Alvesson og Skjöldberg, 2008), has partly changed during this study based on the new knowledge that I have acquired listening to the perceptions of the informants. It has confirmed the high respect I assumed WHO had. I have got an broader understanding of the challenging task that Nepal is collectively undertaking in scaling up mental health in Nepal through multiple stakeholders. WHO and government's respect towards civil society and inter-disciplinary academicians, have been more evident than my original preconception. Likewise, civil society's and academicians' have a clearer strategic focus on supporting their government and call for WHO to assist MoHP to be part of facilitating this. WHO's global role as a promoter of contextualization, based on high technical advice, has also been evident, and the complexity in their role including the dilemmas they stand in when having to protect themselves from inappropriate situations and influence.

The findings gave birth to a model (fig. 4) of different levels of complexity and planning that contribute to four ways of implementation. Behind all these lie the 'context' that is always difficult to interpret. I agree with Nilsen and Bernhardsson (in: Nilsen and Birken, 2020) that implementation science may have had a more reductionistic approach to e.g. context. I would, however, go further and suggest not only a need for clearer determinants, but the

need for a tool-kit comprising different approaches of interpretation the way Bjartveit and Roos (2005) argues for consultants. This study proposes tools, or in reality theories and concepts like the translation theory (Røvik, 2016), as mechanisms for contextualisation, and the theory of 'values works' (Gehman et al., 2013 and Aadland et al., 2019) as an understanding of values in context. The findings also revealed the importance of 'coordination', or rather 'samhandling/interaction (Torgersen, 2018), as a mechanism for contextualisation or good translations.

Limitations of this study is that it was not set forward to assess the impact of the tools and recommendation of WHO, but only look at the mechanisms of implementation. It is also not an evaluation of neither WHO nor the implementation and up-scaling on access to mental health service in Nepal. Another limitation is that the role of external donors has not been discussed. This issue only came up from one central informant (8, 2.2.21) that voiced the need to work together globally.

There are many options for future research. This study, including both its findings and its suggested implication on implementation science, would benefit from further empirical research. Similarly, a comparative study from another country would be interesting to assess if this integrated methodology is a Nepali phenomenon or if one could find similar mechanism in other countries. Also, an overall impact study would be beneficial. This inductive study might furthermore inspire a more deductive approach, using the findings in this study as the base for a hypothesis. Finally, an effect study of the FENSA framework, to assess the framework for un-intended outcomes and internal dilemmas and ways to mitigate them, could find new answers that would both benefit those working within WHO, but also ensure that WHO's coordinated mechanisms are understood as institutionalized.

With that, I will end my thesis with the humbleness of interpretation and understanding of knowledge: *"For we know in part, and we prophesy in part." 1 Corinthians 9.*

Literature list

Alvesson, Mats og Sköldberg, Kaj 2008. *Tolkning och reflection: Vetenskapsfilosofi och kvalitativ metod.* 2. opplag. Lund: Studentlitteratur

Askeland, Harald, Espedal, Gry, Løvaas, Beate Jelstad og Sirris, Stephen, 2020. *Understanding Values Work in Organisations and Leadership* in: Askeland, Harald, Espedal, Gry, Jelstad, Løvaas, Beate og Sirris, Stephen (red.). 2020. Switzerland: Palgrave Macmillan.

Askeland, Harald, 2013. *Hvordan forstå organisasjoner og ledelse av organisasjoner? Faglige grunnlagsspørsmål av betydning for organisering og ledelse.* Rapport 2013/10. Diakonhjemmets Høgskole.

Bjartveit, Steinar og Roos, Göran (red.). 2005. *Scandinavian perspectives on management consulting*. Oslo: Cappelen Akademisk

Bolman, Lee G. and Deal, E. Terrence, 2017. *Reframing Organizations: Artistry, Choice, and Leadership*, Sixth Edition

De Silva, Mary J., Rathod, Sujit D., Hanlon, Charlotte, Breuer, Erica, Chisholm, Dan, Fekadu, Abebaw, Jordans, Mark, Kigozi, Fred, Petersen, Shidhaye, Inge, Girmay Rahul, Medhin, Ssebunnya, Joshua, Prince, Martin, Thornicroft, Graham, Tomlinson, Mark, Lund, Crick and Patel Vikram, 2016. *Evaluation of district mental healthcare plans: the PRIME consortium methodology.* The British Journal of Psychiatry: 208

Espedal, Gry, 2020. *What Is Values Work? A Review of Values Work in Organisations* in: Askeland, Harald, Espedal, Gry, Jelstad Løvaas, Beate og Sirris, Stephen (red.). 2020. Switzerland: This Palgrave Macmillan

Gehman, Joel, Treviño, Linda K. and Garud, Raghu, 2013. *Values work: A process study of the emergence and performance of organisational values practices.* Academy of Management Journal 2013, Vol. 56, No. 1, 84–112.

Government of Nepal, Ministry of Health, 1997. *Mental Health Policy*. Kathmandu

Government of Nepal, Ministry of Health 2014-2020, 2014. *Multi-Sector Action Plan*. Kathmandu

Government of Nepal, Ministry of Health, 2017. *Community Mental Health Care Package*. Kathmandu

Government of Nepal, Ministry of Health, 2018. *Public Health Act Nepal*. Kathmandu

Government of Nepal, Ministry of Health, 2021. *National Mental Health Strategy Action Plan 2021-2005*. Not published.

National Mental Health Team, 2020. Nepal Health Research Council, *National Mental Health Survey, Nepal-2020, Factsheet.* Kathmandu

Jacobsen, Dag Ivar and Thorsvik, Jan. 2019. *Hvordan organisasjoner fungerer.* 5. utgave. Oslo: Fagforlaget.

Khanal, Rajendra, 2019. *Linguistic Geography of Nepalese Languages.* The Third Pole: Journal of Geography Education. 18, 45-54.

Klive, Benedikte Tveter, 2020. *Work on Values When Shaping Public Institutions: "What's Trust Got to Do with It?" — Experiences from Scandinavia* in: Askeland, Harald, Espedal, Gry, Jelstad Løvaas, Beate og Sirris, Stephen Switzerland: This Palgrave Macmillan

Krogh, Thomas, 2014. *Hermeneutikk. Om å forstå og fortolke.* 2. utg. Oslo: Gyldendal Akademisk

Kvale, Steinar og Brinkmann Svend. 2009. *Det kvalitative forskningsintervju*. 3. utgave. Oslo: Gyldendal

Lancet Global Mental Health Group, 2007. *Scale up services for mental disorders: a call for action*, Lancet 2007; 370: 1241–52.

Lund, C, Tomlinson, M, De Silva, M, Fekadu, A, Shidhaye, R. (2012) PRIME: A Programme to Reduce the Treatment Gap for Mental Disorders in Five Low- and Middle-Income Countries. PLoS Med 9(12): e1001359. doi:10.1371/journal.pmed.1001359

McNeill, Desmond 2006. *The Diffusion of Ideas in Development Theory and Policy.* Global Social Policy 1468-0181 vol. 6(3): 334–354

Nilsen, Per, 2015. *Making sense of implementation theories, models and frameworks*. Implementation Science

Nilsen, Per, 2020. *Overview of theories, models and frameworks in implementation science.* in: Nilsen, Per and Birken, Sara A, 2020. *Handbook on Implementation Science*. Cheltenham, Elgar

Nilsen, Per and Cairny, Paul, 2020. *Policy implementation research.* in: Nilsen, Per and Birken, Sara A, 2020. *Handbook on Implementation Science*. Cheltenham, Elgar

Nilsen, Per and Bernhardsson, Susanne, 2020. *Context.* in: Nilsen, Per and Birken, Sara A, 2020. *Handbook on Implementation Science*. Cheltenham, Elgar

Norad, (2012). *Fiskeribistand i Kerala førte til overfiske.* Artikkel. https://norad.no/resultater/resultatportal/2012/fiskeribistand-i-kerala-forte-til-overfiske-/

Patel, Vikram and Hanlon, Charlotte, 2017. *Where there is No Psychiatrist: A Mental Health Care Manual.* Cambridge: Royal College of Psychiatrist.

Patel, Vikram, et al., 2018. *The Lancet Commission on global mental health and sustainable development.* The Lancet, Vol. 392, No. 10157; 392: 1553–98.

Rogers, E. M. 1995. Lessons for guidelines from the diffusion of innovations. *The Joint Commission journal on quality improvement*, *21*(7), 324-328.

Rai, Yugesh, Gurung, Deoman and Gautam, Kamal, 2020. Insight and challenges: mental health services in Nepal. BJPSYCH International, Cambridge University Press

Røvik, K. A. 1998. *Morderne organisasjoner. Trender i organisasjonstenkningen ved tusenårsskiftet*. Bergen: Fagbokforlaget.

Røvik, K. A. 2016. *Knowledge Transfer as Translation: Review and Elements of an Instrumental Theory*. International Journal of Management Reviews, 18: 290-310.

Stacey, Ralph D. and Mowles Chris. 2016.*Stratetic Management and organisational dynamics. The challenge of complexity to ways of thinking about organisations.* Harlow, UK: Pearson

Thagaard Tove, 2013. *Systematikk og innlevelse: en innføring i kvalitativ metode*. 4. utg. Bergen: Fagbokforlag

Thomassen, Magdelena 2006. *Vitenskap, Kunnskap og Praksis. Innføring i vitenskapsfilosofi for helse- og sosialfag.* Oslo: Gyldendal Akademisk

Torgersen, Glenn Egil (ed.), 2018. *Interaction: 'Samhandling' Under Risk*. A Step ahead of the forseen. Cappelen Damm Akademisk

United Nation, 2006. *Convention on the Rights of Persons with Disabilities.* UN

United Nation, 2012. *Operation OCHA.* UN

United Nations, 2015. *Sustainable Development Goals.* UN

Upadhyaya, Kapil Dev, 2015. *Mental Health & Community Mental Health in Nepal: Major Milestones in the development of Modern Mental Health Care.* Journal Psychiatrists Association of Nepal Vol .4, No.1, 2015

Utenriksdepartementet og Helse og Omsorgsdepartementet. 2019. *Bedre helse, bedre liv – Innsats i norsk utviklingspolitikk for å bekjempe ikke-smittsomme sykdommer (2020 – 2024).*

WHO, 1946. *Constitution of the World Health Organisation.* In *Basic Documents Forty Ninth Edition, 2020*. Geneva: World Health Organisation

WHO, 2010. *mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings.* Geneva: World Health Organisation.

WHO, 2012. WHA 65.4. *The global burden of mental disorders and the need for a bcomprehensive, coordinated response from health and social sectors at the country level.* Geneva: World Health Organisation.

WHO, 2012. *WHO QualityRight Tool Kit.* World Health Organisation

WHO, 2013. *Mental health Action Plan 2013 – 2020/2030.* Geneva: World Health Organisation

WHO, 2016. *mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings, Version 2.* Geneva: World Health Organisation.

WHO, 2016. *Framework on Engagement with Non-State Actors.* Resolution WHA69.10 In *Basic Documents Forty Ninth Edition, 2020*. Geneva: World Health Organisation

WHO, 2016. *Problem Management Plus (PM+). Individual psychological help for adults impaired by distress in communities exposed to adversity*. Geneva: World Health Organisation

WHO, 2018. *Nepal–WHO Country Cooperation Strategy (CCS)* 2018–2022. Nepal: World Health Organisation.

WHO, 2019. *Thirteenth General Program of Work 2019-2023. "Promote Health. Keep the* World Safe". Serve the Vulnerable. Geneva: World Health Organisation.

WHO, 2019. *The WHO Special Initiative for Mental Health (2019-2023): Universal Health Coverage for Mental Health.* Geneva. MSD/19.1.

WHO, 2020. *Health cluster guide. A practical handbook. Serve the Vulnerable. Integrated programming for better health outcomes: a multisectoral approach.* Geneva: World Health Organisation.

World Medical Association, 2001. *World Medical Association Declaration of Helsinki. Ethical principles for medical research involving human subjects.* Bulletin of the World Health Organization*, 79* (4), 373 - 374. World Health Organization.

Wright, C, Nepal, MK and Bruce-Jones WDA, 1989. *Mental Health Patients in Primary Health Care Services in Nepal*. Asia Pacific Journal of Public Health, Vol. 3, No. 3 (1989), pp. 224-230. Sage Publications, Inc.

Aadland, Einar and Askeland, Harald, 2017. *Verdibevisst ledelse.* Oslo: Cappelen Damm as.

Figures and tables

Appendix

Appendix 1: Interview Guide

Semi-structured interview guide

How are WHO's recommendations to increase access to mental health services perceived by main actors in Nepal?

The main research question is; *How are WHO's recommendations to increase access to mental health services perceived by main actors in Nepal?*

This research question will be assessed through the following questions:

1. Is the content of WHO recommendations to Nepal in the area of mental health and access to mental health services generally known to key people in the professional mental health field in Nepal?
2. What is the history of mental health and access to mental health services in Nepal?
3. What role have been perceived that WHO's recommendations have played, positively and negatively, in the development of mental health services in Nepal?
4. What role could/should WHO's recommendations have?

Interview guide

Personalia

Name:
Organisation/unit:
Position:

Number of years in the area of mental health in Nepal:
Elements in your own story:

Reasearch question	Interview questions	Follow-up questions	Key words
1. Is the content of WHO recommendations to Nepal in the area of mental health and access to mental health services generally known to main actors in the professional mental health field in Nepal?	How are you familiar with the fact that WHO has recommendations to member states in upscaling access to mh services? Normative?	What are the WHO's recommendations to member states in general and to Nepal specifically? What documents guide these recommendations? Are there specific recommendations to each member state? How are they developed? How are the recommendations communicated to government? How are the recommendations communicated to other sectors? What is WHO's objective with the recommendations? ~~How long have you known about these?~~ ~~And/or what thoughts do you have after reading the documents sent you?~~	Universal health coverage (UHC), mhGap, deinstitustionalization, peer programs, people with mental health, task shift, Intervention guidelines training/app etc
2. What is the history of mental health and access to mh services in Nepal?	Could you describe the history of mh in Nepal?	From the start? How was mh perceived?	

		• What are the main documents?	How were they developed? And what authority do they bring?	
		• Who have been the main actors?	What do they do?	
		• What are the main achievements?		
		• What are the main discussions?	How do they implement in relation to the mhGap recommendations?	Effect? Not effect? Gjøre mer av hva?
3. What role is it perceived that WHO's recommendations have positively and negatively had in the development of mental health services in Nepal		Are you familiar with the mental health act in Nepal (2018). What role has WHO recommendations played in the development of this law? Or: What role do you perceive that WHO had?		
		Want role do you think that WHO has towards government, towards universities, towards NGO sector? How do you perceive this role in your sector?		Active? Passive? Specific? Networking? Encouraging? Promoting?
		Are there any specific areas where they have played a more significant role – positively or negatively?		Earth quake, deinstitutionalization, mh Gap trainings,
		What are the main discussions between professional in Nepal on the upscaling of mental health services?	What stand does WHO take? Do they facilitate such discussions? How is this done?	
4. What role could/should WHO's recommendations play?		What role would, in your view, be the most beneficial for Nepal that WHO tok in developing access to mh		Implementation theory? Theory of roles?

		services in accordance with the visions?			
5. Who are the main actors in Nepal?					

Appendix 2: Invitation letter and consent form

Request to take part in a master research project

I hereby request for your participation in this master research project about how WHO's recommendations to increase access to mental health services are perceived by main actors in Nepal?

The main theme of this research project is mental health in low- and middle-income countries. It is an area where WHO through mhGAP have developed a framework on recommendations to its members counties. This research projects will assess how the area of mental health has developed in Nepal – specifically access to mental health services and how the WHO recommendations are perceived by the main actors in Nepal. Documents and interviews with main stakeholder will be the base for the analysis and discussion around the projects main question.

VID Specialized University www.vid.no is responsible for this research project. The project has been approved by Norwegian Centre for Research Data (NSD).

You are invited to participate because you have played a role in the area of mental health in Nepal either directly or indirectly through NGOs, academics, government or WHO. You will be asked together with up to 10 other colleagues. We believe that you will have insight and experience and information that is relevant to this project.

The interview will be conducted based on a semi-structured guide conducted by the responsible researcher who is Heidi Westborg Steel. The main questions will be followed up by follow-up questions. We will allocate approximately 1,5 hour for the whole session and assume an hour's interview.

You will be invited by zoom where the interview will recorded ensuring the privacy data collection regulations (GDPR) in line with general research ethics and approved by the Norwegian Centre for Research Data (NSD). The recordings will be transcripted and used as the base for the analysis.

After the project both the oral and written interviews will be deleted.

It is optional to take part in this project, and if you choose to participate, you can withdraw your consent without giving any reason. All personal data will then be deleted.

We will only use the personal data about you for the objective as described. We will treat the information confidentially and in light of the privacy data collection regulations (GDPR). During the project the thesis will be discussed with the supervisor at VID Specialized University.

The personal data will be protected as the answers will not be linked to each informant and name and the contact information will be replaced by a code that will be saved separately. As stakeholders in this area are few and easily identified caution will be taken to ensure anonymity, including loyalty to the informants integrity.

The anonymised information will at the end of the project when the thesis is approved be deleted. This is planned within August 2021.

You have the right to:

- insight into the personal data that is registered about you, and get a copy of this information
- to get the right to the information about you and get it deleted.
- to send a complaint to The Norwegian Data Protection Authority about how your personal data has been used.

We will treat the information based on your concent, the approvement by VID and Norwegian Centre for Research Data (NSD), and is in accordance with the privacy data collection regulations (GDPR).

If you have questions about this study, or wish to use your rights you can contact:

- VID Specialized University with professor Gry Espedal gry.espedal@vid.no and master student Heidi Westborg Steel heidi@steel.no tlf.: 93208465
- Our data protection officer: Nancy Yue Liu nancy.yue.liu@diakonhjemmet.no Tlf.: +4793856277

If you have questions to Norwegian Centre for Research Data, they can be contacted on personverntjenester@nsd.no or on +47 55582117.

Oslo, 4.12.2020

With regards,

Gry Espedal

Researcher/supervisor VID Høyskole

Heidi Westborg Steel

Master student VID Høyskole

Consent form

I have received and accepted the information about the project "WHO's recommendations to increase access to mental health services are perceived by main actors in Nepal?" and have been given the possibility to ask questions. I consent to:

- ☐ take part in the interview
- ☐ that the information about me is anonymised as far as possible.

I consent that my information is being used until the end of the project

Place/date:

(Signed by the participant in the project)

Appendix 3: Application to NSD

NSD NORSK SENTER FOR FORSKNINGSDATA

Meldeskjema 587198

Sist oppdatert

01.12.2020

Hvilke personopplysninger skal du behandle?

- Navn (også ved signatur/samtykke)
- Fødselsdato
- Adresse eller telefonnummer
- E-postadresse, IP-adresse eller annen nettidentifikator
- Lydopptak av personer
- Bakgrunnsopplysninger som vil kunne identifisere en person

Type opplysninger

Du har svart ja til at du skal behandle bakgrunnsopplysninger, beskriv hvilke

Stilling og arbeidssted

Skal du behandle særlige kategorier personopplysninger eller personopplysninger om straffedommer eller lovovertredelser?

Nei

Prosjektinformasjon

Prosjekttittel

How are WHO's recommendations perceived in member countries - a study on WHO recommendations to Nepal on how increase access to mental health services"

Prosjektbeskrivelse

Mental health is a stigmatized health issue around the world. During the past 20 years WHO have been developing a set of normative frameworks worldwide. However, these initiatives have not been followed by funding, so mental health has continued to be a neglected area for national health authorities in developing countries. In a country such as Nepal civil society and academics thus took the lead to develop services, to educate and to advocate towards the government on the need to address this area of ignorance and ensure the rights of people who so far had had no voice.
My research question is linked to what role WHO's normative recommendations played in this process in Nepal: "How are WHO's recommendations to increase access to mental health services perceived by the main actors in Nepal?"

I will be assessing this through a qualitative research design. As this is a young area, with limited numbers of actors, I will strategically choose up to ten informants to interview.

Dersom opplysningene skal behandles til andre formål enn behandlingen for dette prosjektet, beskriv hvilke

Det skal de ikke.

Begrunn behovet for å behandle personopplysningene

Del av en master.

Ekstern finansiering

Type prosjekt

Studentprosjekt, masterstudium

Kontaktinformasjon, student

Heidi Westborg Steel, heidi@steel.no, tlf: 93208465

Behandlingsansvar

Behandlingsansvarlig institusjon

VID vitenskapelige høgskole / Fakultet for teologi, diakoni og ledelsesfag / Fakultet for teologi, diakoni og ledelsesfag Oslo

Prosjektansvarlig (vitenskapelig ansatt/veileder eller stipendiat)

Gry Espedal, Gry.Espedal@vid.no, tlf: 99090005

Skal behandlingsansvaret deles med andre institusjoner (felles behandlingsansvarlige)?

Nei

Utvalg 1

Beskriv utvalget

Fagpersoner som arbeider innenfor mental helse feltet hos frivillig sektor i Nepal, hos nepalske myndigheter eller hos WHO.

Rekruttering eller trekking av utvalget

Strategisk utvalg

Alder

35 - 65

Inngår det voksne (18 år +) i utvalget som ikke kan samtykke selv?

Nei

Personopplysninger for utvalg 1

- Navn (også ved signatur/samtykke)
- Fødselsdato
- Adresse eller telefonnummer
- E-postadresse, IP-adresse eller annen nettidentifikator
- Lydopptak av personer
- Bakgrunnsopplysninger som vil kunne identifisere en person

Hvordan samler du inn data fra utvalg 1?

Personlig intervju

Grunnlag for å behandle alminnelige kategorier av personopplysninger

Samtykke (art. 6 nr. 1 bokstav a)

Informasjon for utvalg 1

Informerer du utvalget om behandlingen av opplysningene?

Ja

Hvordan?

Skriftlig informasjon (papir eller elektronisk)

Tredjepersoner

Skal du behandle personopplysninger om tredjepersoner?

Nei

Dokumentasjon

Hvordan dokumenteres samtykkene?

- Elektronisk (e-post, e-skjema, digital signatur)

Hvordan kan samtykket trekkes tilbake?

Ved e-post

Hvordan kan de registrerte få innsyn, rettet eller slettet opplysninger om seg selv?

Ved e-post

Totalt antall registrerte i prosjektet

1-99

Tillatelser

Skal du innhente følgende godkjenninger eller tillatelser for prosjektet?

Behandling

Hvor behandles opplysningene?

- Mobile enheter tilhørende behandlingsansvarlig institusjon

Hvem behandler/har tilgang til opplysningene?

- Student (studentprosjekt)

Tilgjengeliggjøres opplysningene utenfor EU/EOS til en tredjestat eller internasjonal organisasjon?

Nei

Sikkerhet

Oppbevares personopplysningene atskilt fra øvrige data (koblingsnøkkel)?

Ja

Hvilke tekniske og fysiske tiltak sikrer personopplysningene?

- Opplysningene anonymiseres fortløpende
- Adgangsbegrensning

Varighet

Prosjektperiode

01.09.2020 - 30.06.2021

Skal data med personopplysninger oppbevares utover prosjektperioden?

Nei, data vil bli oppbevart uten personopplysninger (anonymisering)

Hvilke anonymiseringstiltak vil bli foretatt?

- Lyd- eller bildeopptak slettes
- Koblingsnøkkelen slettes

Vil de registrerte kunne identifiseres (direkte eller indirekte) i oppgave/avhandling/øvrige publikasjoner fra prosjektet?

Ja

Begrunn

De er strategisk utplukket i et lite fagfelt. Det er derimot lite sensitive opplysninger annet enn det at de vil kunne holde tilbake informasjon som er ufordelaktig for dem selv og dermed få effekt på oppgaven. Det må jeg finne løsninger på å unngå så langt som mulig.

Tilleggsopplysninger
