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Publication Date

2021-12-01

DOI

10.1016/j.ssmmh.2021.100036

Peer reviewed

HHS Public Access

Author manuscript

SSM Ment Health. Author manuscript; available in PMC 2022 February 23.

Flexible protocols and paused audio recorders: The limitations and possibilities for technologies of care in two global mental health interventions

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Abstract

Lay-counselors have become a key human resource in the field of global mental health, aiming to address the estimated one-million-person shortage of mental healthcare providers. However, the role of lay-counselors is ambiguous and in tension: their role is quasi-professional, with specific training and skills that set them apart within communities, yet their role is also defined in contrast to professional mental healthcare providers. We explore how these tensions manifest through the material technologies for protocolizing and evaluating lay-counselor roles. We draw on our ethnographic fieldwork within two global mental health interventions that represent different ends of the spectrum of lay-counselor involvement, in order to explore the possibilities and limitations of such material technologies. Thinking Healthy Program-Peer delivered is a cognitive behavioral therapy-based intervention for women with perinatal depression delivered in Goa, India, and Tuko Pamoja (Swahili: "We are Together") is a family therapy intervention to improve mental health and family functioning in Eldoret, Kenya. First, we explore how intervention manuals – the step-by-step protocols that guide therapy delivery – can both constrain counselors to a script and enable their novel contributions to therapeutic encounters. Then, we examine assessment tools used to evaluate interventions writ large and lay-counselors specifically. We describe how, even where lay-counselors are encouraged to bring their own expertise into therapy delivery, this expertise is not often reflected in evaluation tools. Instead, the focus tends toward fidelity checklists, which require adherence to the manualized intervention and can penalize counselors for "going off book." Even though lay-counselors are often recruited specifically because of their existing roles and "local expertise," we argue that the material technologies of interventions can at times limit how their expertise is enabled and valued. We offer recommendations for global mental health programs to facilitate greater recognition and valuing of lay-counselor expertise.

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1. Introduction

Lay-counselors are a key human resource in the field of global mental health, aiming to address the estimated one-million-person shortage of mental healthcare providers (Kakuma et al., 2011). Task-sharing has become an increasingly prevalent practice for three critical reasons: (1) The shortage of mental health specialists in low-and-middle-income countries (LMICs) does not meet population demands for mental healthcare; (2) With training and supervision, non-specialists can perform a variety of important services; and (3) The development of comprehensive health systems demands a multi-sectoral approach that includes the involvement of non-specialist workers (Kakuma, Minas, & Dal Poz, 2014).

The precise *role* of the lay-counselor, however, often remains ambiguous. Commonly assigned to the "routine" dimensions of mental healthcare, lay-counselors can be responsible for a wide range of tasks, including detection and diagnosis, prevention and treatment, and education and awareness across a range of common and severe conditions (Kakuma, Minas, & Dal Poz, 2014). Lay-counselors are often expected to bridge the services of the health program to their community, ensuring culturally and contextually appropriate delivery (see, for example, Brodwin, 2013; Genat & Bushby, 2006; Myers, 2015). In evaluations of interventions, lay-counselors are assigned the additional task of being a study subject, with unique sets of expectations, including protocols, supervisions, and participation in interviews and focus group discussions. Participating in caregiving, yet often subjected to evaluation; responding to a community in which they are often part, but are marked distinct from; providing a range of tasks across the breadth of the "routine" dimensions of mental healthcare, lay-counselors frequently engage multiple roles that, at times, are in tension.

Recognizing the ambiguities inherent in the conceptualization of lay-counselor roles, we explore how these are reflected in the materials of interventions. Drawing on our ethnographic fieldwork with the Thinking Healthy Program-Peer delivered (THPP) - a cognitive behavioral therapy-based intervention for mothers with perinatal depression delivered in Goa, India - and Tuko Pamoja (Swahili: "We are together") - a family therapy intervention to improve mental health and family functioning in Eldoret, Kenya - we examine how lay-counselors' roles are operationalized and enacted through techniques of documentation, protocolization, and evaluation in global mental health interventions. Our focus is the material technologies that encapsulate processes of intervention delivery and evaluation, from intervention manuals to assessment tools. We argue that such material enactments are useful for revealing the ways that lay-counselor roles are conceptualized, valued, and placed in tension, as well as suggesting avenues for more active shaping of these roles by lay-counselors themselves.

1.1. Task-sharing in global mental health

A 2011 study estimated that globally, there is a one-million-person shortage of mental healthcare providers needed to address the global burden of mental health disorders, with the need being greatest in LMICs (Kakuma et al., 2011). This report was part of a general push to commit greater attention, funding, and political will to expanding mental healthcare, beginning with the 2007 Lancet Series on Global Mental Health and soon followed by the launch of the Movement for Global Mental Health and publication of the World Health Organization's Mental Health Gap Action Program (mhGAP). The crux of mhGAP's approach is responding to the "human resource shortage" through task-sharing, with non-professionals (e.g., lay-counselors) or non-specialists (e.g., primary care providers) trained to deliver mental healthcare. In the ensuing years, hundreds of mental health task-sharing programs have been implemented, informed by approaches to task-sharing used in programs focused on HIV, TB, and maternal health. As with these programs, global mental health interventions face a tension regarding whether lay-counselors represent volunteers or workers who should be paid (Maes, 2016).

In many ways, these lay-counselors - and the tensions and ambiguity inherent in their roles - have paralleled the history of the broader community health worker (CHW) role. Early conceptualizations of community member participation in psychiatry emphasized the promise of "indigenous personnel drawn from low-income communities" in "developing rapport with low-income clients" by way of "the fact that they are similar to the clients in terms of background, language, ethnicity, and interests" (Pearl & Riessman, 1965, p. 78). While community members were initially sought due to an absence of professionals and limited funds, their "lack of professional qualification" became seen as an "asset, as one expression of the lack of distance between these workers and the people they serve" (Frankel & Doggett, 1992, 3). The 1978 Alma-Ata Declaration's call for broadening the concept of primary health care emphasized the CHW as an entry-point for influencing what are now imagined as social determinants of health, as long as they were "immersed in their cultural context" (Frankel & Doggett, 1992, 4). Emerging out of the 1986 Yaoundé Conference, the term "community health worker" was described as: "members of the community where they work; should be selected by the communities; should be answerable to the communities for their activities; should be supported by the health system but not necessarily a part of its organization; and have a shorter training than professional workers" (Frankel & Doggett, 1992, 2). In representing a health system, CHWs were expected to "be answerable" to communities and hold a knowledge and skill-set that distinguished them from other community members. Yet, they were also given "shorter training" than providers of the healthcare system in positions that were "*supported…*but *not* necessarily a part of its organization" (emphasis added).

1.2. Technologies of care

In recognizing how these tensions regarding lay-counselors are manifest, one useful lens is to focus on material technologies in caregiving. Care is often situated by medical anthropologists as a deeply interpersonal or intersubjective process that is influential for the recipient of care and caregiver themselves (Kleinman, 2012). Care is grounded in and shaped by the historical and sociocultural (Jenkins, 2015). Often, these dimensions are

examined and integrated in the development of global health programs (Patel, Minas, Cohen, and Prince 2013).

Medical anthropology has engaged technologies of care in a variety forms: from pharmaceuticals and machines to community health programming manuals and mood rating tools. Materials of global mental health interventions can function as technologies that, as Biehl and Moran-Thomas write, "enabl[e] new types of exchanges" and facilitate care among lay-counselors and program participants (Biehl & Moran-Thomas, 2009, p. 269). Medical anthropologists and other social scientists have remained interested in the possibilities of technologies for inner and social dimensions of illness experience. DelVecchio Good, for instance, grounds these concerns in her theory of the "biotechnical embrace," or how the introduction of technologies shapes the subjectivities of patients and clinicians by generating an "enthusiasm" accumulating in, she writes, what "sparks the medical imagination" and "drives the political economy of hope" (DelVecchio Good 2001, 399). Biehl (2013) examines the function of psychiatric drugs to both situate and break his interlocutor Catarina from her subjective experience and social world. The past decade of anthropology has examined medical technologies themselves, including pharmaceuticals, medical machines, and facilities, with "our ways of being human […] increasingly dependent on technological devices - from prosthetic eyes and virtual avatars to dialysis apparatuses and gambling machines" (Biehl and Moran-Thomas, 2009, p. 280).

While less readily apparent as forms of technology than machines or devices, technologies of care extend to include protocols and instruction manuals. Situated in community mental health, anthropologists have been especially interested in such intervention materials in mental healthcare, from instruction manuals to protocols, to constitute technologies of care. In his ethnography on community psychiatry among marginalized U.S. populations, Brodwin (2013) observes how histories of deinstitutionalization and reform ignited "blueprints" of care that could be standardized as treatment models and used in other settings. Within this context of "manualized" care, frontline providers confront technical restrictions with "tasks […] spelled out in minute detail, routinized, and audited from above" (Brodwin, 2013, 37). Myers, in an ethnography of a mental health center in the Midwest of the U.S., describes the conflict between the program's recovery-oriented curriculum and the counselors' understandings of patient needs (2015). Myers engages the tensions between and among lived experiences of peer healthcare workers and the technical regulations to which they are prescribed.

As technologies, intervention materials can enable a structure and, as Biehl and Moran-Thomas (2009) have framed, an exchange, for lay-counselors and patients to map their subjective engagements and create a framework for discourse. Yet, in their standardization of care, program materials can also impose a limitation on that very exchange. Technologies at times constrain, and in other moments generate, care among patients and lay-counselors. Material technologies of global mental health interventions, we find, often encapsulate the tensions that are embedded in the history of the lay-counselor role itself.

1.3. Aims

Among the myriad global mental health interventions that exist, we present examples from two programs that represent different ends of the spectrum of lay-counselor interventions. Thinking Healthy Program-Peer delivered and Tuko Pamoja ("We are Together") use different therapeutic approaches and structures (individual cognitive behavioral therapy vs. family therapy) and provide different levels of flexibility to lay-counselors in delivering therapy. In these ways, they reflect the variability that exists in design and delivery of lay-counselor programs. Yet, we argue that these two examples also highlight similarities in underlying logics and technologies of lay-counselor programs. By bringing the material technologies of these interventions into conversation, we explore the limits and possibilities of lay-counselor roles, expertise, and agency in global mental health, as well as the ways they are valued and evaluated.

First, we explore how intervention manuals – the step-by-step protocols that guide therapy delivery – at times constrain counselors to a script and in other moments enable their novel contributions to therapeutic encounters. Then, we examine assessment tools used to evaluate interventions writ large (e.g., client outcomes) and lay-counselors specifically. Finally, we offer recommendations for global mental health programs to facilitate greater recognition and valuing of lay-counselor expertise.

2. Interventions

Thinking Healthy Program-Peer delivered (THPP) is a brief psychological intervention based on cognitive behavioral principles for mothers with perinatal depression. THPP was initially delivered by CHWs in Pakistan and was shown to be effective in reducing the prevalence of perinatal depression (Rahman, 2007). From 2014 to 2017, the intervention was tested in Goa, India to assess its effectiveness when peer-delivered. The trial sought to understand whether the use of peers, who represent a broader sector than CHWs, would be feasible and effective. Fuhr et al. found that the intervention had "moderate effects on clinical, social, and functional outcomes during the 6 months after birth" (2019, 124). The intervention also improved the perceived social support of mothers within the 6 months after childbirth (Fuhr et al., 2019).

THPP peers are not called counselors but *sakhis*, or 'friends' in Hindi. The intervention asks sakhis to share their own experiences with pregnancy. The twenty-six sakhis were selected because of their shared position as mothers and shared sociodemographic background as the participants. They were trained for 25–40 h on intervention content and counseling skills through discussion and role-plays. The sakhis were closely supervised for two months post-training as they counseled smaller caseloads. They were then assessed via role plays before participating as sakhis in intervention delivery.

Tuko Pamoja (Swahili: "We are Together") is a family-therapy intervention that is being iteratively developed and tested in Eldoret, Kenya (Puffer et al., 2020; Puffer, Friis-Healy, Giusto, Stafford, & Ayuku, 2021). It draws on multiple evidence-based therapies, including family-systems, solution-focused, and cognitive behavioral approaches. Families are eligible if they experience significant conflict or dysfunction and have an adolescent exhibiting

distress or behavioral issues. Therapy is not time-limited in that length is based on goal completion, and session length is also flexible; in general, about 12 weekly sessions are expected. In the first pilot study, there was an average of 9 contact hours but over higher numbers of shorter sessions (Puffer et al., 2020). The intervention is delivered by lay-counselors, who are initially trained for 60 h over 10 days, followed by ongoing supervision including training review and skills practice throughout intervention delivery. A 5-day refresher training was provided in the pilot due to intervention revisions. Tuko Pamoja lay-counselors are more varied than THPP sakhis, with about half men and half women, education levels ranging from some primary to one university-educated individual, and various roles in the community, including church leaders and local "policymakers" who work in partnership with the police.

Our analyses of these programs arise from collaborations with the intervention teams. AL conducted an ethnographic study of THPP, with a focus on interviews with lay-counselors to understand their experiences of the intervention. BK has collaborated with the developer of Tuko Pamoja (EP) since 2017, contributing to non-clinical aspects of intervention planning and evaluation. While my[1] fieldwork was less ethnographic in nature, my insight into the program derives from team planning meetings, transcripts of therapy sessions, interviews with lay-counselors and families, and quantitative data collected from family members and lay-counselors.

2.1.   Lay counselors

THPP is delivered by peers who are mothers from the same community and of similar sociodemographic background as the program participants. The program's field guide, a manual by which counseling sessions are structured, asks the sakhi to share her experiences with pregnancy with inserted spaces in the text to represent the integration of her own narrative. Requiring the sakhi to narrate her personal engagements with pregnancy, THPP depends on sakhi experience as part of the intervention. Yet, sakhis are asked to share their experiences through the technical format of the field guide. The intervention depends on lists, manuals, and questionnaires to consider perinatal depression: an illness experience that is conceptualized nationally and considered locally through frameworks of the everyday (see, for example, (Addlakha, 2008; Pinto, 2014; Van Hollen, 2003).

A key challenge for sakhis is navigating the extent to which the guide is just that: a guide. THPP is intended to be flexible. This is evident in the selection of lay-counselors and their roles as "sakhis" or "friends." Supervisors, who evaluate the sakhis with the Therapy Quality Scale, a questionnaire of criteria specific to the field guide curriculum assessed on a three-point rating, encouraged, particularly early in the trial, sakhis to adhere to the guide. Beyond fidelity, adherence to the guide is critical for developing evidence for the intervention's effectiveness and for the larger hope of scaling-up. Sakhis are asked to navigate the guide as *both* an invitation to share personal experience *and* a script to structure that experience.

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[1]Although we use first-person plural when discussing our arguments, we switch to first person singular when discussing specific projects to reflect the ethnographic perspective of the author engaged in that project. When discussing Thinking Healthy Program – Peer delivered, "I" refers to AL, and in the context of Tuko Pamoja, "I" refers to BK.

Tuko Pamoja is delivered by "natural counselors," or individuals who are identified as already providing support and counseling to neighbors and community members. Sometimes this counseling is part of a formal role such as pastor or youth group leader, but often it is informal. In focus group discussions with pastors prior to Tuko Pamoja trainings beginning, they described their counseling as centering spiritual needs, including biblical counseling, as well as visiting people in the hospital, praying with them, and addressing material needs, for example:

> Participant 1: "You know I am a pastor, most of the time we don't do Tuko Pamoja. When you get into a family, you will find that a family has a problem, and one of them is poverty. So what we do as a pastor, I first educate them on what they have as a family, then we ask what the mother can do to sustain the family and father can do what." […]

> Participant 2: "When you saw a family that had conflicts every now and then, you go and find out what is the problem. One will tell you that they slept without food. One will say that they don't even have money to buy soap; if they ask the father, he refuses to give them. So sometimes you can find out that the father takes a lot of alcohol and the mother doesn't take alcohol. So we ask him, you, can you weed? Can you wash clothes? Yes, I can. So I tell her that [name 1] wants someone who can wash for her clothes. So you come tomorrow, you will wash the clothes and get your a hundred shillings. Already you have got the food. Now tomorrow, come to [name 2], [name 2] has some small garden which needs to be attended to, you do it. […] Then we go to the father, we tell him, where do you get the money you used to buy alcohol with? Maybe he tells you that he gets some casual jobs. Then you tell him to reduce the or cut down the amount he is taking. Use fifty shillings and bring the other fifty shillings back at home. If you give the mother that money, all shall be well. So the family realizes that if they do these activities one at a time, slowly they will get through it."

As in the above example, lay-counselors largely describe their prior activities as focused on advice-giving or providing concrete support to alleviate economic problems, rather than using the kinds of therapeutic strategies that Tuko Pamoja imparts. Through Tuko Pamoja, people engage in counseling for complex family problems that take months or years to resolve, such as marital conflict or concerns about children's behavior. Thus, although the natural counselors had previously been sought out by - and provided concrete support to - families, their specific skillset and forms of support changed significantly through Tuko Pamoja.

While THPP and Tuko Pamoja are both delivered by lay-counselors and are evaluated using similar technologies of assessment, they also differ in important ways, including the flexibility granted to counselors in delivering care. These differences allow us to speak to the continuities, differences, and possibilities in lay-counselor programs more broadly and to consider the limits and potentialities of technologies of care.

3. Field guides and manuals: scripted vs flexible therapy

3.1. Field guide as script vs flexible manual

For sakhis working in Goa, India, the THPP field guide is central to their experiences and evaluations of intervention delivery. A two-inch thick manual for the four phases of the program, it includes a script for the sakhi to read from, a curriculum for her to instruct, and examples to provide. The guide is heavy. It is carried by the sakhis to the office, to their regular meetings with the intervention team, and to the counseling sessions. Each has a waterproof bag for storage. Collectively, the guide and the bag become part of the counselor's standard presentation for infield visits to the mothers.

More than a material, the guide provides a structure for the intervention. The text itself follows the story of "Lakshmi," an exemplary mother from India, who herself suffers from perinatal depression. Lakshmi puts on a colorful sari and often a glum face. With baby in arms, she is depicted in different contexts, from a lush park, to her in-laws' house, to the corner of a crowded kitchen, an overboiled kettle in front of her. Each session features Lakshmi as she struggles with a different issue related to her illness. Examples include her difficulty in communicating with new in-laws, her disinterest in attending festivities, and her fear of how neighbors perceive her mothering abilities. The next section of the manual asks the counselor to provide an example of when she endured an experience similar to that of Lakshmi. Finally, the counselor is given a script of the "healthy actions" that the mother should practice when she encounters a similar experience (see Fig. 1).

In contrast to THPP, one of the distinctive features of Tuko Pamoja is that it provides flexibility in delivery from the on-set (see Fig. 2). Tuko Pamoja is modular, including sections that are parent-child, couple, or family focused. Each family receives only those modules that are relevant to them, and they can be delivered in a different order by family, depending on what families select as the area of greatest need. Each module is structured around 10 core steps, with some overlap between modules. Additionally, Tuko Pamoja is manualized but not scripted: Each session includes specific steps (activities and topics) to cover but typically does not specify how those steps must be accomplished and communicated. Although similar in overall length to the THPP field guide (70 pages), the Tuko Pamoja manual is broken up into modules that are less detailed, more open-ended, and not all used for every family. For example, a family might complete therapy based on only about 25 pages of the manual if they did two modules—a common course of treatment.

At the same time, not all sessions have equal flexibility. Some sessions – particularly at the beginning of modules – include instructional videos and role plays that counselors play on their phones, such as introducing specific communication strategies. This means that some content is delivered in not only a scripted but pre-recorded way. However, only a few minutes (5–10) of session time is accounted for by such videos, and the process of *applying* those concepts is flexible: counselors sometimes restate concepts in new ways throughout sessions, and they guide families in applying the lessons to their own lives and practicing key strategies. Fig. 3 provides an example of a video transcript alongside an excerpt from a session transcript in which the lay-counselor expands and applies lessons from the video.

3.2. Desiring and enacting flexibility

Guided by a manual, sakhis in THPP expressed the lived difficulty of responding to issues that fell outside of the guide, particularly in the early stages of the trial. For instance, across the THPP cohort, sakhis identified sex education as a key experience of participants that remained absent from the content of the guide. Yvonne,[2] a lay-counselor of three years past, invited me into her bedroom. "It will be quieter in here," she motioned, the closed door separating us from her mother-in-law standing in the kitchen preparing *Amul* (a milk product) for Yvonne's toddler. "Tell me," she said, patting the edge of the bed for me to sit on. "Alright," I responded, picking up on the conversation. "You were going to tell me about the experiences that were common across the mothers you counseled?" "Right," Yvonne said. "Okay, and so, I could not relate to this experience, but many mothers are sharing experiences regarding sex. I didn't experience it myself, but often, the husband wants the mother to come into contact with him but she is very tired at the end of the day, and she is scared. I mean by like the third-month, the fourth-month she feels something might happen, miscarriage might happen. So, she is scared. So, she doesn't know how sex can be performed during pregnancy. Even the husband doesn't know. So, it is very important, at least for the mother to know what the husband can do and what the mother can do during pregnancy to satisfy each other." I nod. "And it's not in the field guide," she reminded me.

> "So what do you do?" I asked. "You said that you haven't experienced that personally, and it's not in any of the materials you were given, so how do you respond to these moms who are telling you about this?" "Uhh… about their personal life? It is really difficult because that part was not recorded at any time, and I didn't know what to answer because I am also not so much having sexual education. So, I did not know what to say. Sometimes I used to just pat them and console them regarding that."

> "Right. And so, when the moms are telling you about this, this is the point where the recorder is usually off?" I asked. "Yeah," Yvonne responded. "So, were you able to receive feedback from your supervisors about this?"

> "I never told them about this part because the mom told me not to tell anybody, and when that part is not in our field guide, then I did not feel like telling them. It was really very important, but I didn't know how to express myself in front of the supervisors because it was out of the track or out of the field guide or out of the project, and maybe the supervisors didn't know that this would come up from the mothers." "There should be a book," she concluded.

Technical rationales, shaped by the text of the manual, can pervade into the understandings of lay-counselors. In her telling of patient experience, Yvonne refers to the materials in more than one instance. After explaining the shared uncertainty of sex during pregnancy, she concludes with, "there should be a book." When I asked her to further explain the mothers' uncertainties, she acknowledged the materials again with, "It's not in the field guide." In emphasizing that there "should be" a book for an encounter that is "not" in scope of "the field guide," Yvonne affirms meaning in her peers' experiences: a meaning she understands

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[2]A pseudonym, as are all names in this manuscript.

as existing outside of, and in precedence of, what exists in the guide, so much so that she asserts its presence as needed within the guide.

As the encounter is not in the field guide, Yvonne does not bring it to her supervisors. Here we can observe the influence of material technologies on lay-counselor expertise: the sensibilities and experiences for which lay-counselors are recruited and those in which they deepen across their caregiving. While Yvonne finds meaning from the experience, she does not present it, as it is off "track or out of the field guide or out of the [scope of the] project."

The topic matter is intimate. A topic that would be better discussed in the privacy of her closed doored bedroom than a shared space with her mother-in-law, the experience is one that the mothers desired to remain unrecorded and one in which Yvonne "didn't know how to express [her] self in front of the supervisors."

Not listed in the field guide, and thus not recorded by the portable audio device during the counseling session, the experience remained uncaptured by the recorder and unknown to the supervisors and to the study. This takes on particular significance in THPP's context as part of a randomized controlled trial. What is recorded, and what remains unrecorded, has critical implications for what becomes evidence toward care for new mothers across the subcontinent.

Technologies, then, often shape what is said in and of intervention delivery. In their limitations, they can constrain the sensibilities for which lay-counselors are selected and limit what becomes evidence in evaluations of evidence-based care. In manualizing responses to experiences that are often conceptualized and expressed through the everyday, technologies can penetrate into the understandings and responses of lay-counselors, selected *because of* their knowledge and experience of that everyday.

Lay-counselors who were part of the Tuko Pamoja project in Kenya had a different relationship with the manual, as they were specifically given greater flexibility in delivering the intervention. This flexibility in therapy delivery is what drew me to study the program: I was interested in examining what practices, pedagogies, and approaches lay-counselors spontaneously introduced into their therapy, given the flexibility to do so. Through analyzing transcripts of therapy sessions, I identified such novel practices, which fall outside of the scope of the intervention manual. Practices included the incorporation of metaphors and proverbs, religious content, self-disclosure, examples and role models, and community dynamics and resources. I also analyzed whether these practices were used in ways that aligned with and promoted the manualized intervention, contrasted with or interrupted therapeutic practices, or were neutral. For the most part, counselors' novel practices aligned with intervention goals far more often than they countered intervention goals (Kaiser et al., 2019). Indeed, some of them seemed so effective that they are being incorporated into intervention trainings to promote their use by future counselors.

The practice introduced by counselors that most often aligned with intervention goals was self-disclosure, or sharing one's own experiences that are similar to what the family or individual is going through. For example, counselors described specific ways they struggle with familial conflict, as a way to validate challenges and frustrations of families they

were counseling. They also described using skills learned from the Tuko Pamoja program in their own lives: "Do not think we do not have problems; we also have problems. I also love this program because it has helped me; when I pass through such challenges, I know that I need to do this and this." Some counselors also discussed their experiences overcoming substance abuse. This was particularly relevant for families whose conflict was largely driven by fathers' substance use, which was fairly common. While self-disclosure is explicitly included in the THPP field guide, with spaces for sakhis to insert their own stories, Tuko Pamoja does not specify when, how, or even *that* counselors should share their own stories. When Tuko Pamoja counselors incorporate self-disclosure in ways that illustrate the material well, it is encouraged by trainers and supervisors, but it is not explicitly taught or modeled in training. Despite the differences in scripted vs. flexible manuals, counselors in both programs converged on this practice.

For the most part, the flexibility provided for lay-counselors by Tuko Pamoja resulted in effective counseling practices (Puffer et al., 2020). It is important to note, however, that this was not always the case. Some of the ways that counselors introduced new material and practices were potentially harmful. These instances were fairly uncommon but are important to recognize as a potential consequence of the flexibility provided in the intervention design and training model. For example, when one woman described that she sleeps in her children's room when her husband comes home drunk, the counselor began a long lecture on the importance of sleeping with her husband, couched in biblical justifications: "Paul says well in Corinthians that when a wife and husband marry each other, you become the reason for your wife and the reason for your husband, do you see? You are no longer two, you are one body [… Wife], are you fulfilling what God wanted you to do?" After the wife pushed back, explaining that the smell due to her husband's drinking can be overwhelming, the counselor continued, "Why did God want a wife and a husband to live together? He wanted to live together to be happy together and the happiness of the married is sex. Paul said do not deny your wife her right and the wife do not deny the husband his right, and the style that you are talking, I have discovered that you may not be… do you have the marriage relationship?"

Although a rare occurrence, such lectures were problematic in several ways and in opposition to the foundational principles of Tuko Pamoja. They were focused on demands, rather than promoting clients' development of their own solutions — the central focus of the intervention. Additionally, they encouraged the woman to put herself into a situation in which violence might occur. This particular counselor was also a pastor, and in this situation, his roles became somewhat confused, drawing on both the authority of his church role and biblical authority in ways that seem coercive.

While there were examples of particularly productive new practices, these tended to be most aligned with therapeutic goals when incorporated early in therapy to promote psychoeducation. In contrast, those who introduced the fewest adaptations might have been most effective at the key aspect of therapy: that is, stepping back to let the family lead in developing solutions. Such counselors did much less talking than those who readily incorporated new material, with the former mostly asking guiding questions to support

families in developing their own solutions. Of course, such practices are closely aligned with the general goals of counseling.

4. Desire for script: what global mental health materials generate

While in cases like that of sex education, the THPP field guide's structure constrained sakhis' senses of their intervention delivery, in other moments the guide was described as generative to the exchange of care. In moments, the technical, external nature of the guide was perceived as generating an engagement with the intimate and internal.

An example of the utility of the guide across ethnographic interviews was its role in facilitating discussion across family networks. Sakhis explained that husbands of participants would occasionally attempt to sit in during their counseling sessions. The guide opened a framework for them to speak directly to husbands about their participation in pregnancy and postpartum.

Shreya described: "When I used to hear what the mothers are facing, I used to sometimes feel like going and talking to their family. Like when they used to share with me how their family members used to trouble them, I used to feel sometimes like going to talk to those members of the family."

I questioned, "And did you ever speak with them?"

> "With the husbands, sometimes. When I used to visit the mothers, sometimes the husband would be concerned, like 'Why is this lady coming? What is she actually telling?' So, they used to come and sit in front of us. So, at that time I, when I'd explain to the mother with the guide, the field guide, then I used to tell through the guide. If the husband troubles you during pregnancy, this is what happens. Through that I used to explain to the husband also."

Shreya communicates with the husband not through her own words, but "through the guide." The guide provides a script to describe the role of the husband during pregnancy. When confronted with a husband antagonized over her presence in the house, Shreya calls upon the guide to respond to not only his concern for Shreya, but Shreya's concern for his wife. Shreya identifies the guide as the reason for her entrance into their home and, furthermore, reads from the guide to explain the role of the husband during pregnancy.

The script affords an external explanation for an internal event, or a technical response outside and distinct from the everyday. The engagement is a departure from frameworks of medicalization or that which would consider such a script as limiting to illness experience. In this case, the script *is* what generates a dialogue of illness experience. Returning to the case of Yvonne, she begs for there to be just that: a script, or framework, for the intimate and interior.

The generative potential of the field guide was discussed across other dimensions of the THPP intervention. Sunita explained that before becoming a sakhi, she would sometimes discuss her experience of pregnancy with her sisters.

> "What makes this different then?" I asked. "Again, it is the guide. Before when I was a housewife talking to my sisters and all, at that time they used to just say their problems, what difficulties they'd face. Now being a counselor, I came to know I can actually guide people."

"And before?" I questioned.

> "Before that I did not. If any of my friends told me about their problems and all, then it was not that easy to guide. We used to just say to not pay attention to what other people, your mother-in-law and such, say to you. To ignore because it will hurt you badly."

I nodded.

> "But I was not able to guide like now what I do. Now this guide, it reminds us of our experiences, of what we have in common."

For Sunita, the guide functions to "remind" her of her experience. As a technology, it provides a structure for her to consider her engagement with pregnancy and, via its material recommendations, give care that "before [she] was not able to." Sunita slips to and from her caring with the guide and her position as a guide. The introduction of a technology generates the recollection of experience. The script of the guide, with its questions, examples, and spaces for lived experience, acts as a framework to engage subjectivity. The program materials, like symptoms, categories, and technologies, can create space for mothers to map their subjective engagements with perinatal depression onto a framework to consider among and between themselves. As Turkle (2008) positions, and Biehl and Moran-Thomas (2009) emphasize, technologies do not necessarily limit human engagements but can liberate them.

For counselors from both programs, various technologies of care generated experiences and positionalities beyond the straightforward client-counselor interaction. For example, the manuals – and in the case of Tuko Pamoja, the phones that facilitated sharing videos – contributed to counselors' credibility as trained experts. In Goa, the field guide often encouraged skeptical husbands to accept sakhis into their homes, the technology serving to legitimize the encounter. Tuko Pamoja counselors frequently requested material 'proof' of their new role in the community, from ID cards on lanyards to Tuko Pamoja t-shirts. Their descriptions of the experience of becoming a Tuko Pamoja counselor reflect being professionalized into a new role, which made them reconfigure their self-assessments of the work they had done previously as natural counselors. In interviews asking them to compare their experiences pre-training and post-intervention, lay-counselors contrast their prior approaches to counseling – which they describe as "shallow" and as having "no consistency" – with their more "professional" approach after receiving Tuko Pamoja training. One woman counselor described, "Before, we were practicing in the dark, unlike now, we are working in the light. Tuko Pamoja has given us knowledge, equipped us, and widened our minds" (Wall, Kaiser, Friis-Healy, Ayuku, & Puffer, 2020).

In their limitations, material technologies can constrain the care they intend to provide. As seen with the case of Yvonne, the program's guide lacked coverage of an experience thought fundamental to pregnancy among women in Goa. On the other hand, the flexibility provided

to Tuko Pamoja counselors in going beyond the manual poses its own limitations as far as ensuring appropriate care. In certain moments, interventions' material technologies can become larger than life, influencing what is said, and not said, about the program. They are perceived as critical to manualized care, in which the daily interactions between peer and counselor are sought to be replicated, disseminated, and scaled-up. In other moments, these same materials act to generate spaces in the exchange of care. They can invoke a recognition and articulation of the subjective and conversation of the intimate. The material objects of the counseling role - from the hefty field manual to the requested ID card - can generate shifts in their own and their communities' recognition of lay-counselors' roles, ultimately facilitating the exchange of care.

5. Assessment: what is at stake?

A clear way that lay-counselors' experiences, expertise, and sensibilities can become side-lined by technologies of global health is in assessment. Randomized controlled trials (RCTs) like THPP are considered the highest form of evidence for a treatment's effects (Adams, 2016, Smith-Morris et al., 2014). Touted by their adherents as universal and value-free, RCTs in fact reflect culturally specific epistemologies and priorities that drive global health decision-making (Adams, 2016). RCTs ultimately become the arbiters of "what counts," what receives funding, and what ultimately gets enacted (Adams, 2016; Sangaramoorthy & Benton, 2012). Yet part of decisions regarding what counts is inevitably shaped by what is most easily *countable*. Important elements of program success, such as relationships, processes, and contexts, do not lend themselves to assessment via these quantitative outcomes (Smith-Morris et al., 2014).

Anthropologists have used ethnography of RCTs to reveal the strengths of expanding beyond a singular type of evidence. For example, in their analysis of a Veterans Affairs rehabilitation program, Smith-Morris and colleagues (2014) use ethnography to reveal aspects of RCT success and processes that would otherwise go unmeasured. Although qualitative research is increasingly gaining value in global health, it continues to be considered a lower form of evidence than quantitative data, particularly when the latter is produced through RCTs (Colvin, 2015). Lay counselors' roles embody this tension between forms of evidence that are readily produced, communicated, and measured through RCTs, on the one hand, and recognition of the complexities and relationships that are central to program success yet remain unmeasured. For example, THPP and Tuko Pamoja's primary outcomes – which are used to evaluate its success – are mental health and family functioning, respectively, with emphasis on distress severity and remission. Yet these straightforward quantitative measures elide the complicated relational work and processes that yield these outcomes (cf. Smith-Morris et al., 2014).

The specific evaluations used for lay-counselor performance are one way that global health assessment tends to create distance between outcomes and the processes that produce them. Typically, lay-counselors are evaluated using fidelity checklists, structured lists of steps that should be completed for specific sessions. Achieving fidelity – or a treatment being delivered as intended – is a key aspect of demonstrating an intervention's effectiveness (Smith-Morris et al., 2014). Fidelity checklists are derived from treatment manuals, meaning

that what is evaluated is strict adherence to steps of the treatment rather than introducing new material, skipping steps, or changing aspects of the treatment. Requirements created by fidelity checklists present challenges for lay-counselors when treatment contexts require "going off book" as in THPP. The ultimate result is that sakhis either avoid bringing in any outside material - such as discussion of sex during pregnancy - or they turn off the recorder, making these adaptations invisible to the RCT researchers and their supervisors. Tuko Pamoja allows more flexibility here, with counselors "getting credit" if they eventually complete manual steps, even if there is significant "going off book" beforehand. At the same time, the specific novel material is not reflected in evaluations except to the extent that it contributes to or detracts from competence ratings (see below). For THPP, fidelity ratings carry weight because low scores are often interpreted among sakhis as an incapacity to provide care. In Tuko Pamoja, lay-counselors whose fidelity or therapeutic competence is poor receive extra training and supervision but do not have scores reported to them.

As part of trials, both programs depend on adherence to the interventions' principles and structure to ensure that the intervention can be replicated and scaled-up. In THPP, the Therapy Quality Scale (TQS), a 0–2 point assessment that sakhis are given in supervision, is based on their use of the curriculum with attention to the field guide (see Fig. 4). Early in the trial, before it became addressed among the research team, the TQS was a central concern in how sakhis delivered the intervention. A sakhi, at the onset of the trial, explained how if she found a mother less interested in the session, she would sometimes "close" the guide to discuss the mother's problems with her, personally. In supervision, however, she would receive several zeros on the TQS. Another sakhi shared in this frustration, expressing that if she "just focused on the guide," then the mothers would feel that they were being "ignored." Yet when she departed from the guide, she was penalized for not using it "appropriately." Often the sakhis get confused, she concluded, and wonder, "*what shall I do*?" Early in the THPP trial, as is often the case across peer-counseling programs, the fidelity checklist ratings did not account for the complex decisions and relationship-building that sakhis navigate in therapeutic settings. Notably, in addition to the fidelity-focused component of the TQS (labeled THPP Specific Skills), there is a second section of the measure, Treatment Approach Skills, to assess common factors – general clinical skills, such as active listening (Singla, Ratjen, Krishna, Fuhr, & Patel, 2020). It is possible that some of the positive aspects of sakhis' more organic conversations could have been captured in these ratings, but this did not emerge in the sakhis' descriptions across the ethnographic study.

The tension between fidelity to the treatment manual and flexibility in delivery is somewhat more ambiguous for Tuko Pamoja lay-counselors. The flexibility in care delivery that is promoted by Tuko Pamoja is not reflected in assessments using the fidelity checklist, as the focus is only on completion of manualized steps. At the same time, the application of fidelity checklists somewhat accounts for flexibility by allowing treatment modules to be delivered – and therefore scored – over multiple sessions. Therefore, unlike THPP sakhis, Tuko Pamoja lay-counselors are not penalized if treatment steps are interrupted or extended in new directions. Yet none of the new material they introduce is explicitly evaluated because it does not derive from the manual. In this sense, flexibility is accommodated yet likewise invisible in this particular form of evaluation.

Yet Tuko Pamoja uses an additional way of assessing lay-counselors' performance that does allow for more flexibility and creativity, giving lay-counselors another way to receive "credit" even if they go off script. Lay-counselors are assessed based on competence, including ratings of common factors (e.g., active listening) but also of therapy-specific competencies (e.g., in-session communication of all family members, maintaining a focus on solutions); high ratings on these therapy-specific competencies reflect a counselors' ability to retain the main clinical strategies underlying Tuko Pamoja, even if they deviate from the manual. The common factors items included adapted items from the ENhancing Assessment of Common Therapeutic factors rating scale (ENACT; Kohrt et al., 2015), and therapy-specific items follow the same structure. In contrast to fidelity checklists, this multi-layered competence assessment evaluates all aspects of the therapeutic encounter, whether based on content directly prescribed in the manual, indirectly prescribed based on fundamental treatment elements, or newly introduced by the lay-counselor. One item directly corresponds to the introduction of "cultural" material by counselors (see Fig. 5). These multiple layers of performance were not only assessed but also prioritized in training and supervision to underscore the importance and value of these ratings and parts of the therapeutic encounter.

Inclusion of measures like ENACT are a step in a sound direction as far as moving beyond a sole reliance on fidelity checklists to understand therapeutic skills in context. Yet, even when these tools are used in tandem, neither is designed to capture novel practices and contributions, or to account for the relationships, processes, and complexities that ethnography captures yet RCTs overlook (Smith-Morris et al., 2014). At the same time, we do not want to imply that these processes remain hidden to intervention developers simply because they tend to be left out of assessments. On the contrary, research meetings across the THPP trial included sakhis who shared their experiences with measures like the TQS to the study's Principal Investigator and research team. Similarly, throughout Tuko Pamoja, lay-counselors receive supervision from Kenyan psychologists, who are supervised by US-based psychologists. Supervisors use fidelity checklists and competence ratings to guide supervision but do not communicate these numeric values to counselors. They also provide feedback that goes beyond the manual and quantitative tools. For example, it is very straightforward for counselors to complete a manualized step of eliciting discussion among family members. However, the process of skillfully supporting, motivating, and facilitating such discussion requires coaching during supervision.

Additionally, structured assessment tools were not solely experienced negatively by lay-counselors. While supervision assessments were identified as an early challenge in their intervention delivery, sakhis described the enumerated tools that they used in their counseling sessions as helpful in creating opportunities to expand upon counselor and participant experiences. Mimi recalled a typicalcounseling session: "To begin the session, we ask 'On which number are you 0–5?'" "And did that ever feel unnatural to you? I mean, these moms become like your friends, right? What was that like for you?" I asked. "In the beginning I was having problems," she explained. "After a period of time, I got experience how to ask them and all. It is helpful. On the rating, there are five numbers, including 'Not too good,' 'Not good,' and 'Bad,' also. We can understand, exactly, her mood. Whether she is happy or sad, with that number we can recognize the exact mood of the mother.

Sometimes she'll say she's not happy, but not sad also. In that way, we can get out her mood through that number. Whether she is not happy on 4th number, on 5th, depressed. On 2nd, happy. On 1st, very happy. So, from that we can recognize her level: how happy she is or how sad she is. We can recognize." Mimi describes the technical dimensions of assessment as providing specificity and clarity in communication and ultimately serving as helpful tools in her experience with intervention delivery.

For Mimi, the quantitative entity of 0–5 is stripped from her daily context. In contrast to the terms and frameworks she uses in her everyday, the numerical rating asks her to consider her everyday on an external scale. As anthropologists have engaged technologies as invoking engagement with subjectivity, Mimi perceives the scale as a framework for the mother to articulate her subjectivity. Asked to find meaning through a tool she is unfamiliar with, the mother is invited to rearticulate her experience using enumerated values, and in doing so, reconsider it. The external generates a reconsideration of the internal.

6. Conclusion

Materials of global mental health programs can at times constrain the care they intend to facilitate. In other moments, they expand upon the exchange of care in generative ways, opening an engagement of the subjective between and among program deliverer and recipient. Across the Thinking Healthy Program-Peer delivered and Tuko Pamoja, we observe that the tensions historical to the lay-counselor role are manifest through the material technologies for protocolizing and evaluating lay-counselors. The historical ambiguities of the lay-counselor are often observable in the materials of interventions themselves: with field guides that draw upon, yet manualize, lay-counselor experience and assessment tools that can overlook lay-counselor sensibilities or expertise. While THPP reflects a stricter scripting and assessment typical to global mental health interventions, Tuko Pamoja provides greater flexibility for lay-counselor expertise to be incorporated, yet this expertise still remains largely absent from manualized materials and assessment tools. These findings invoke the historical imagination of the community health worker as those who, to return to Frankel and Doggett (1992), remained 'answerable' to communities and held a skill-set that distinguished them from other community members, yet were "not necessarily a part" of broader health systems.

Our findings across these contexts suggest that global mental health technologies are critical to better understand how lay-counselor roles are conceptualized, valued, and placed in tension and are useful in considering avenues for more active shaping of these roles by lay-counselors themselves. Historically in the community health worker model and at present across lay-counselors in global mental health, stakeholders have asserted the sensibilities and expertise of community members as valuable to the delivery of care and advocated for their position on the frontlines of task-sharing. There remains a need, we suggest, to ensure that these practices are reflected in a material sense. We find this to be particularly important in the everyday technologies of care, from manuals and workbook exercises to assessment criteria, that can materialize into a central challenge in intervention delivery.

For global mental health researchers and practitioners, it can be difficult to know how to address these challenges and tensions, particularly within the constraints created by funders, research timelines, and scientific norms. While there is often a stated valuing of lay-counselors' expertise, these do not always translate into material practices. Based on strengths and limitations of THPP and Tuko Pamoja, we offer the following suggestions – some of which reflect practices already used in THPP and/or Tuko Pamoja and others of which are novel.

First, lay-counselors' expertise should inform intervention planning on a more in-depth level, ideally as early as possible. During formative work for selecting, developing, and/or adapting interventions, lay-counselors – or people in the types of roles where lay-counselors will be recruited – should be closely engaged. This could include selection of interventions and activities, manual development, assessment procedures, and other aspects of protocolization and evaluation. An important emphasis that is not often included is explicitly providing the space during development and lay-counselor training for bidirectional knowledge transfer related to culturally relevant examples and clinical strategies. Interventionists and trainers could actively seek input from lay-counselors in this way and integrate it into the technologies that formally guide and evaluate the intervention. This goes beyond *allowing* adaptations to recognizing them as central to interventions. While there are valid arguments against developing interventions that are so context-specific as to be non-transferable, companion materials for certain settings – or specific locations in the manual to integrate context-specific material – could fulfill this purpose without sacrificing the potential for interventions to be applicable across diverse settings.

Second, in designing assessment protocols, researchers should think beyond fidelity checklists. Even when applied flexibly and paired with competency measures that recognize adaptations as positive, a short-coming is that these very structured fidelity checklists usually do not allow space for recognizing when lay-counselors cover topics not included in the manual. The material they are adding – and new strategies they are using – often lead to being penalized with lower fidelity scores when their additions could, in fact, be strengthening the intervention. While it might be time-consuming to develop novel assessment tools focused on lay-counselors' contributions that go beyond the manualized intervention, it is possible to complete a rapid adaptation of existing tools such as ENACT (Kohrt et al., 2015), as done in Tuko Pamoja. In addition to these quantitative assessments, researchers should incorporate qualitative and ethnographic data wherever possible, including interviews and/or focus group discussions with lay-counselors and analyzing existing data, like session and supervision transcripts, with a recognition of lay-counselor expertise broadly defined (Kaiser et al., 2019; Puffer et al., 2020; Wall, Kaiser, Friis-Healy, Ayuku, & Puffer, 2020). Findings from these data can feed back into adjusting manuals, as described above. Additionally, one of the clearest ways to enact valuing of lay-counselor roles is to ensure that they are paid for their work (Maes, 2016). This can extend after the timeline of a specific project, by exploring avenues for sustaining the role through existing institutions and advocating for continued funding of lay-counselors.

Finally, technologies of care like manuals and fidelity checklists can lead lay-counselors to question their own expertise, leaning into the technologies as legitimizing their role

and representing the fullness of expertise that they bring to clinical encounters. Therefore, at the same time that we argue that interventionists must put greater attention and value on lay-counselors' existing expertise – such as by facilitating them being reflected more fully in technologies of care – a paired challenge is encouraging lay-counselors to continue trusting their own judgment and sensibilities and to see their value as extending beyond their connections to their quasi-professional roles and technologies of expertise. The practice of incorporating lay-counselors' expertise into material technologies might contribute to this goal, but we encourage interventionists to go further in emphasizing lay-counselors' value and expertise throughout training, supervision, and assessment.

Acknowledgements

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Point to the picture on the opposite page and ask:
"What do you think is going on in this picture?"

Pause for the mother to respond, summarize what she says, and praise her for participating.

Then say:
"The mother here may be feeling left out because she used to spend a lot of time with her three women neighbors, but since she had her new baby, she has been so busy and not had any time to spend with them. She might also be feeling left out and lonely occasionally. Here, however, it looks like she still spends time with her friends when she can and allows her friends to enjoy spending time with both her and her baby."

Pause and then say:
"Let's look at an example how these little actions can make a difference to your relationship with others around you."

Read one of the examples given in the table.

"**(Situation)** Lakshmi has been feeling very isolated. She used to spend a lot of time with her three women neighbors, but since she had her new baby, she has been so busy and not had any time to spend with them. She is worried that if she goes back to communicating with them that her relationships with them will not be the same as they were before. **(Action)** Lakshmi isolates herself from her friends. However, when they stop by to visit, she does acknowledge them and look at them and invites them into her home. **(Consequence)** Lakshmi's learns that her friends let her know that they understand she has been busy with her new baby. They miss her company and want to spend time with her in any way they can, even along with her new baby. Lakshmi feels less isolated and lonely and again feels a connection to her friends. Lakshmi knows that her friends understand and does not feel lonely. They are still there if she needs help."

Give an example from your own experience when you went through a similar situation. Remember to also tell the mother and the family how it affected you.

Ask the mother if she has felt similarly and when. Ask what happened (situation), what she felt/ did (feeling/ action) and what happened after that (consequences).

Note these down in the space provided in the activity workbook (page no. 17)

Fig. 1.
Example Pages from Thinking HealthY Program – Peer Delivered Field Guide.

A1: Joint Sessions

Step 3: Positive Communication Skills
Goal: Teach communication skills that can help them reach their goal.

We are going to talk about ways you can climb up the scale to make a stronger tree. Before we begin talking to each other a lot, let's learn some communication skills.

Show Video 3: CLEAR Skills

General Positive Communication Skills ("CLEAR" Skills)
1. **Conversation** –Take turns talking. Do not interrupt. Ask and Answer questions.
2. **Listening** – Hear and understand what the other person says. Respond to show you are listening.
3. **Encouragement** – Help the other person with problems and offer words of comfort and encouragement.
4. **Appreciation** – Tell the other person what you like about them and say thank you for good things they do.
5. **Respect** – Use polite language and do not use insults. Do not say things to make them feel small or stupid.

Show Video 12: Role-Play of Parent and Child Communication

Discuss video.
- How did they use the skills in the video?
- How do you think each person felt after the conversation?

We will have time to practice the skills as we continue talking together.

Step 4: Identify Feelings / Build Empathy
Goals: (1) Help them say how they are feeling and what they are thinking.
       (2) Help them understand the other person's perspective.

Now I want you to tell each other what you think about the problem and how you feel about it. Remember to use your CLEAR skills.
- *Ask each person: What are the feelings in your heart and the thoughts in your head about the problems?*

*Ask them to **repeat** each other's thoughts and feelings.*
- What did (*NAME*) just say about their feelings and thoughts?

Confirm with the other:
- Did he/she get it correct?

If you are meeting with only the parent or only the child, ask them:
  ○ Why do you think your (parent/child) does that?
  ○ How do you think they are feeling when they do that?

Fig. 2.
Example Page from Tuko Pamoja Manual.

a. **Transcript of CLEAR skills video**

b. **Excerpt from a session transcript after a lay-counselor has played the CLEAR skills video**

> I am going to talk about five skill of communication known as CLEAR skills in English. The five skills are Conversation, Listening, Encourage, Appreciation and Respect.
>
> The first skill that is Conversation is taking turns to talk. When the other person is talking, do not interrupt, when it reaches your time, you will be able to talk. During that time, you can ask questions and you can answer questions.
>
> The second skill is listening. This is listening and understanding what the other person is saying. Answer their questions to show that you are listening.
>
> The third one is Encouraging. This is helping someone with the problems he or she is undergoing. Talk to the person telling them encouraging words, comforting and encouraging to be able to continue with the work they are doing.
>
> The fourth skill is Appreciation. This is telling the other person something that you love about them. Thank them for the good things that they are doing.
>
> The third and last is Respect. Respect is using polite language and do not use abusive language. Do not say things that can make the other person feel small or stupid. Those are the five skills of communication.

> Counsellor: Okay I hope you have gotten something from the video. Should I go through it a little bit?
>
> Caregiver: Yes
>
> Counsellor: The first is conversation. Take turns talking. When one is talking the other is listening. The next is listening. When someone is talking, the other should listen. Then show signs that will let the other know that you are listening. Are we together [mother's name]?
>
> Adolescent: Yes
>
> Counsellor: Okay, the next technique is encouragement. Tell each other words that will encourage and motivate. The next is appreciation. Whenever anyone does anything, thank them. The next is Respect. Use polite words and do not use abusive language. Do not use words that will let the other think they are stupid. So next, I will show you another video then thereafter discuss it and be done.
>
> [Plays video role play of parent and adolescent communicating]
>
> Counsellor: Have you understood the video?
>
> Mother and adolescent: Yes, we have understood.
>
> Counsellor: I will ask something concerning the video. What are some of the techniques that we have discussed that you noted that they have used?
>
> Mother: The mother has used wisdom to talk to the daughter about how life is. She has also talked politely and with a lot of respect. The child also shows that she is attentive. The mother also appreciates the child.
>
> Counsellor: Okay let's move on to the adolescent
>
> Adolescent: The mother also appreciates the child, and they are talking with respect.
>
> Counsellor: Another? Was there no conversation between them?
>
> Mother and adolescent: There was.
>
> Counsellor: It falls under which technique from what we have learnt?
>
> Adolescent: Conversation.
>
> Counselor: As they were talking, was there anyone who interrupted as the other was talking?
>
> Mother and caregiver: No, they were talking turns.
>
> Counsellor: Good, so what do you think each of them felt after the conversation?
>
> Mother: I think each of them felt good.
>
> Counsellor: How about the adolescent, what do you think each of them felt?
>
> Adolescent: I think the child felt good and the mother was contented.
>
> Counsellor: Good. For now, let us stop there. In the next session, we will continue. Here there are 10 steps and we have done to step 3. I hope at the end of these steps, our tree will be stronger.

Fig. 3.

Example of Tuko Pamoja Video Script and Lay-Counselor's Expansion and Application of Concepts

a. Transcript of CLEAR skills video

b. Excerpt from a session transcript after a lay-counselor has played the CLEAR skills video.

THPP Specific Skills

	1. REVIEWS PREVIOUS SESSION		NOT APPLICABLE
0	NOT DONE	= DOES NOT REVIEW THE PREVIOUS SESSION OR = DISPLAYS ANGER AND FRUSTRATION IF MOTHER IS UNABLE TO REMEMBER THINGS FROM PREVIOUS SESSIONS.	
1	NEEDS IMPROVEMENT	= REVIEWS THE PREVIOUS SESSION, BUT DOES NOT ASK MOTHER ABOUT HOMEWORK	
2	DONE WELL	= EXPLORES BARRIERS RELATED TO HOMEWORK AND BRIEFLY SUMMARIZES THE PREVIOUS SESSION	

	2. USES MATERIALS APPROPRIATELY		NOT APPLICABLE
0	NOT DONE	= DOES NOT USE THE FIELD GUIDE AND WORKBOOKS APPROPRIATELY OR FORCING THE MOTHER TO SHARE HER EXPERIENCES	
1	NEEDS IMPROVEMENT	= USES PICTURES AND WORKBOOKS, BUT DOES NOT ENCOURAGE THE MOTHER TO SHARE HER EXPERIENCES	
2	DONE WELL	= USES PICTURES AND WORKBOOKS APPROPRIATELY AND ENCOURAGES THE MOTHER TO SHARE HER EXPERIENCES	

	3. SHARES PERSONAL EXPERIENCE		NOT APPLICABLE
0	NOT DONE	= SHARES AN INAPPROPRIATE EXPERIENCE OR DOES NOT SHARE ANY EXPERIENCE WITH THE MOTHER	
1	NEEDS IMPROVEMENT	= SHARES EXPERIENCE, BUT DOES NOT ENCOURAGE THE MOTHER TO SHARE A SIMILAR EXPERIENCE	
2	DONE WELL	= SHARES RELEVANT AND APPROPRIATE EXPERIENCE AND ENCOURAGES THE MOTHER TO SHARE A SIMILAR EXPERIENCE	

	4. DEALS WITH BARRIERS ARISING IN SESSION		NOT APPLICABLE
0	NOT DONE	= DOES NOT FOCUS ON THE MOTHER, GETS CARRIED AWAY WITH DISTRACTIONS. EG. CHILDREN, NEIGHBOURS, TV, ETC.	
1	NEEDS IMPROVEMENT	= SPENDS SOME TIME IN THE SESSION ON DISTRACTIONS (NOT PART OF ENGAGING THE MOTHER OR RAPPORT BUILDING)	
2	DONE WELL	= BRINGS THE FOCUS BACK TO THE MOTHER AND THE SESSION; HANDLES BARRIERS EFFECTIVELY	

Common Counselling Skills

	1. ACTIVE LISTENING		NOT APPLICABLE
0	NOT DONE	= INTERRUPTS THE MOTHER IN THE SESSION OR DOMINATES THE CONVERSATION	
1	NEEDS IMPROVEMENT	= ACKNOWLEDGES THE MOTHER WITH VERBAL CUES, BUT INTERRUPTS THE MOTHER OCCASIONALLY	
2	DONE WELL	= ACKNOWLEDGES THE MOTHER WITH VERBAL CUES, AND DOES NOT INTERRUPT THE MOTHER	

	2. USES OPEN-ENDED QUESTIONS		NOT APPLICABLE
0	NOT DONE	= USES QUESTIONS THAT ONLY LEAD TO "YES" OR "NO" ANSWERS [WILL YOU, CAN YOU]	
1	NEEDS IMPROVEMENT	= USES QUESTIONS THAT LEAD TO MORE EXPLANATION, BUT OCCASIONALLY USES QUESTIONS LEADING TO "YES" OR "NO" ANSWER	
2	DONE WELL	= USES QUESTIONS THAT LEAD TO MORE EXPLANATION [WHAT HAPPENED, TELL ME ABOUT]	

	3. ATTENTIVE, GENUINE & WARM		NOT APPLICABLE
0	NOT DONE	= USES MOBILE PHONE FOR A PERSONAL CALL IN THE SESSION = ASKING INTRUSIVE, INAPPROPRIATE QUESTIONS (E.G., FINANCIAL, IN-LAWS, HUSBAND-WIFE RELATIONS) UNLESS RAISED BY MOTHER = PUSHING A TOPIC THAT THE MOTHER DOESN'T WISH TO SPEAK ABOUT	
1	NEEDS IMPROVEMENT	= PAYS ATTENTION TO THE MOTHER'S FEELINGS BUT DOES NOT ENCOURAGE THE MOTHER TO SHARE HER FEELINGS	
2	DONE WELL	= IS ATTENTIVE TO MOTHER'S FEELINGS AND EXPRESSES INTEREST BY SHARING AND ENCOURAGING MOTHER TO SHARE FEELINGS	

	4. APPROPRIATE LANGUAGE		NOT APPLICABLE
0	NOT DONE	= USES LANGUAGE THAT IS TECHNICAL = USES STIGMATIZING TERMS (include Konkani examples, e.g. पागल for Hindi)	
1	NEEDS IMPROVEMENT	= GENERALLY USES LANGUAGE THAT IS EASY, BUT DOES NOT USE THE SAME PHRASES THAT THE MOTHER USES	
2	DONE WELL	= USES SIMPLE LANGUAGE AND THE PHRASES THAT THE MOTHER USES MOST OF THE TIME	

Fig. 4.
Example Items from Therapy Quality Scale for Thinking Healthy Program – Peer Delivered. This figure has been reproduced from Singla et al. (2020). Relevant permissions for reproduction were attained in October 2021.

Item 8	Appropriate Integration and Use of Culturally-Relevant 'Life Lessons'	
Short Title	Life Lessons	
Description	Counselor appropriately utilizes culturally grounded teachings (e.g., quoting religious texts or proverbs) to provide support, encouragement or instruction to the family. Counselor only gives life lessons when appropriate	
Ranking levels	1: Does not meet needs or does harm	Religious or 'life lessons' are not relevant, confusing, or not applicable to the family, or appear to be judgmental towards the family.
	2: Minimally meets needs	Lessons are minimally relevant and minimal discussion about the lesson/application of the lesson to their lives. Gives life lessons that are not always needed but does not do harm.
	3: Moderately meets needs	Lessons are moderately relevant and moderately successful in engaging the family in the discussion about the lesson/application of the lesson to their lives. Lessons are generally not given when not needed.
	4: Skillfully meets needs and promotes optimal outcome	Lessons are relevant, clear and applicable and effectively discussed with the family concerning lesson/application to their lives. Life lessons are not given when not needed.

Fig. 5.
Example Item from the Tuko Pamoja Clinical Competence Assessment.