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A meta-ethnography of participatory health research and co-production in Nepal

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ABSTRACT

As global health research seeks to decolonialise, democratise, and become more culturally engaging, researchers are increasingly employing participatory and co-productive methods. Working from post-structural perspectives, this meta-ethnographic review explores how such health research in Nepal engages with the epistemological, methodological, and ethical questions it encounters. Five databases including Nepali NepJOL were searched for studies from inception to March 2021. The review included seven studies covering women's group co-production, interviews guided by photo-elicitation, observational methods to explore maternal and child health, mental health, and environmental determinants of health. This meta-ethnography identified that, against the background of a pluralist heritage of health practices, global collaborations involving Nepali researchers and practitioners used participatory research methodology to work with the local populations to improve health and co-production seek primarily to promote Western biomedical and psychosocial interventions. Both advantages and disadvantages were acknowledged. Empirical verification and global acceptance of Western biomedical and psychosocial knowledge were seen as beneficial. Moreover, Western biomedicine was perceived by some as more effective than some local practices in improving health; nevertheless, Nepal faces many challenges that neither can address alone. For participatory and co-productive approaches to become epistemologically enculturated within Nepali health research, researchers need to co-develop more local models and methods which are culturally sensitive and appropriate. Meaningful and effective participatory research can promote active involvement of people who deliver as well as people who use the community-based health care support. These are crucial to optimise sustainable change that global health research partnerships set out to achieve. This meta-ethnography recommends that researchers engage at a deeper level with the epistemological differences between themselves and the communities with whom they seek partnership. Cross-cultural research teams should discuss and address the power differentials which might affect them.

1. Introduction

1.1. Rationale and context for the meta-ethnography

1.1.1. Participatory health research and co-production: background and contemporary debates

Broadly speaking, participatory forms of health research and co-production draw from two academic traditions. In the Global North, theories of active and experiential learning as facilitators of organisational development (Lewin, 1948) and educational innovation (Kolb, 1984) have historically generated evidence which demonstrates that engagement and collaboration between health service users, professionals, and managers leads to improved service design and delivery, as well as to better health outcomes (Robert et al., 2021). Across the Global South and in working with marginalised or indigenous communities worldwide, more emancipatory models of consciousness-raising and social change (Freire, 1970; Fals Borda, 2001) assert political and moral as well as empirical arguments for more democratic participation, aiming to challenge the structural determinants of health inequalities to promote more equitable health outcomes. Increasingly, proponents of participatory forms of health research have sought to draw from both traditions, through approaches such as Community-Based Participatory Research (Minkler, 2005; Wallerstein and Duran, 2006), Participatory Action Research (Rahman,

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2008) and the use of both within Experience-based Co-design (Donetto et al., 2014; Robert et al., 2021).

In recent years, however, the philosophical and moral integrity of different models of participatory health research and co-production has increasingly been challenged. Most participatory health researchers from the Global North tend to be motivated by a strong sense of social justice, and by an awareness of how problematically and unethically many of their predecessors have operated (De Zulueta, 2001). Nevertheless, most forms of participatory health research tend to uncritically accord epistemic privilege to Western medical knowledge, and in so doing to overlook the often complex heritage of colonialism, patriarchy, and racism embodied within Western medicine (King et al., 2021).

In response to these critiques, participatory health research is increasingly moving from a Marxist to a post-structural understanding of power and social relations, emphasising the complexity and intersectionality of marginalisation and emancipation (Muhammad et al., 2015), and emphasising the need for reflexivity and cultural humility amongst all academic researchers (Roura, 2020). Participatory research and co-production from all disciplines is becoming increasingly aware of its own colonial heritage, and for its need for ethical underpinnings which redress this (Banks and Brydon-Miller, 2018; Turnhout et al., 2020). This awareness is particularly evident within participatory and co-produced health services research with indigenous communities of Canada (Lepore et al., 2020) and Australia (Scrine et al., 2020). Across the Global South, and particularly across the Indian subcontinent, academic health researchers using participatory and co-productive methods are increasingly seeking to develop strategies for engagement and practice based upon local cultures (Rahman, 2008; Singh, 2018).

One perennial debate throughout the history of participatory theory has been the methodological question of to what degree participation must occur to qualify the project as meaningfully "participatory". Arnstein (1969) proposed a Ladder of Participation model, which she described as "deliberately provocative" in challenging the "exacerbated rhetoric and misleading euphemisms" (p.216) she sought to critique. Tritter and McCallum (2006) have sought to redevelop this ladder into a more multi-faceted edifice which recognises the diverse and constantly re-negotiated power dynamics between professional and lay groups across a range of community development, research, and service co-production activities. Across the world, the need to acknowledge this complexity within health services research and development has been, in part, driven by the neo-liberal economic processes of task-shifting which delegate healthcare delivery to lay and peer health workers, often in ways which empower local knowledge, but also in ways which entrench inequalities by insufficiently remunerating the groups involved (Yoeli and Cattan, 2017). Moreover, global austerity has placed researchers and services under pressure to deliver outcomes rapidly, something which inherently undermines the relationship-building and collaborative reflection required for meaningful participation (Cook, 2009).

Within Nepal, the imperative to ensure that "participatory research" and "co-production" offer a meaningful degree of involvement and influence is shaped in part by endeavours to redevelop community cohesion following the Nepali Civil War and by the threat of climate change to Nepali health resources, but also by methodological stipulations of the foreign donors who fund most Nepali health research (MacFarlane et al., 2015; MacFarlane, 2016; Phuyal et al., 2020; Yadav et al., 2021). As the following sub-section explains, the contexts and challenges facing Nepali wellbeing are unique and highly localised, requiring lay participation to be understood.

1.1.2. Traditional Nepali understandings of health

Concepts and constructs proximal and analogous to Western descriptions of health have been present across the geographical region of Nepal for over 3000 years (Kohrt and Harper, 2008; Pham et al., 2020b).

Particularly but not exclusively within Nepali cultures of animist, pantheist, or Hindu and Buddhist origin, sanctity is often attached to their interactions with the highly biodiverse and yet localised plant species, many of which are known to hold specific medicinal properties (Joshi and Joshi, 2000; Kunwar et al., 2006). This knowledge is often associated with traditional Tibetan healing systems, which are growing in popularity throughout Nepal (Kunwar et al., 2006; Blaikie et al., 2015). Within Tibetan healing systems, ill-health comes from bodily imbalances, and mental or emotional distress comes from disturbances in the wind or air inhaled during times of environmental or social disruption. The concept of illness as wind-borne can also be identified in the shamanic practices across Nepal which seek to blow away malevolent spirits (Desjarlais, 1989). Traditional healers use a variety of techniques or rituals to restore or to safeguard the soul within one's being (Pigg, 1995; Kohrt and Harper, 2008; Pham et al., 2020b).

Within both Hindu- and Buddhist-influenced healing traditions, the pursuit of health is inseparable from religious or spiritual practice (Pigg, 1995; Schwartz et al., 2005). Inherent within all understandings of wellbeing are notions of harmony and unity between the human body and divine beings (Hardman, 1996).

Recent Western research has sought to understand Nepali illness categories such as heart-mind disturbances and *jhum-jhum* – described in the literature as "local idioms of distress" – in relation to biomedical diagnostic constructs such as depression and chronic pain to enable those affected to gain better access to drug treatments (Kohrt and Harper, 2008; Jordans et al., 2015).

1.1.3. The role of western biomedicine in Nepal

Nepali cultures take a highly pluralist approach to the pursuit of health (Pigg, 1995; Kohrt, 2005). Often, individuals and their families seek concurrent help from one or more forms of traditional healers, astrologers, or shamans at the same time as they consult practitioners of Ayurvedic, Chinese, or Western allopathic medicine. Historically, little cultural or spiritual contradiction has been perceived in this, because Nepali culture has long valued epistemological humility and the idea that no single set of ideas can fully explain everything. Many Nepalis qualified in Western medicine continue to maintain their specialism in Ayurvedic practice. This pluralism does not sit comfortably with the positivist or realist assumptions inherent within the systematic review methods of Western biomedicine, which often seek a definitive answer or singular explanation. As Pigg (1995: 27) explains:

> People consider the universe of influences affecting them to be open-ended, and they assume from the beginning knowledge of illness is incomplete. New ghosts and spirits may wander into community and be discovered, and new diseases may also come to be. There is always more to learn.

One of the main Nepali critiques of traditional healing practices, and one of the main reasons that many Nepalis prefer to rely upon Western medicine, however, is the stigmatisation, shaming, and disempowerment which often attaches to individuals, families, and communities identified as spirit possessed. For some Nepalis, the secularisation and biological reductionism of biomedical explanations for ill-health is preferable because it is seen as more progressive, more democratic, and more compassionately disposed to those affected (Kohrt and Harper, 2008). Despite their pluralistic heritage, Nepali communities may increasingly be favouring Western medicine over traditional forms of healing. Given that Nepali people have traditionally sought simultaneous help from many sources, proponents of Western allopathic medicine in Nepal use the concept of evidence-based practice to argue that their methods are more successful than those of traditional healers.

As this overview of Nepali perspectives has identified, both traditional and contemporary Nepali understandings of the self and health, and of local and Western healing methods, are diverse, pluralist, and constantly open to new thinking.

1.2. Aims and focus of the meta-ethnography

This meta-ethnography aims to explore how the literature of participatory health research and co-production in Nepal engages with the epistemological, methodological, and ethical questions it encounters. This meta-ethnography does this by focusing upon the processes of engagement, collaboration, and partnership described within studies.

In so doing, this meta-ethnography addresses two research questions:

1. What are the advantages of and problems with introducing global health studies using participatory methodology interventions to Nepali communities?
2. What do health participation and co-production mean within Nepali contexts?

The research aims and questions highlight that this diversity and plurality should be meaningfully appreciated in participation and co-production.

1.3. Rationale for using meta-ethnography

1.3.1. Methodological rationale

In recent years, a number of reviews have used systematic or scoping methods to detail the geopolitical, cultural, and psychosocial determinants of health and ill-health in Nepal (Tol et al., 2010; Ranabhat et al., 2019). These reviews have successfully been employed to inform a range of clinical and public health interventions, as well as further research studies (Kohrt et al., 2012; Amundsen et al., 2016; Neupane et al., 2016; Dahal et al., 2020).

Systematic and scoping reviews have traditionally been anchored in the Western positivist or realist paradigms within which constructs of health are regarded as universal phenomena which exist irrespective of how languages or cultures interpret or describe them (Bhaskar, 2014). Historically, research tended to juxtapose or to assess indigenous "explanatory models" or "health beliefs" against what it regarded as the more "real" or objective "knowledge" of Western biomedical science (Kleinman, 1988), an approach long criticised as colonialist and disrespectful of local knowledge. As described in 1.1.3, most Nepali philosophical systems favour pluralism and multiple knowledges over the pursuit of a singular explanation of reality. In Nepali health research, this pluralism has led to a corpus of primary research studies (Tol et al., 2005; Jordans et al., 2015) and literature reviews (Pham et al., 2020a) seeking to assimilate local models and understandings of health into Western diagnostic and therapeutic frameworks. As 1.1 has explored, this openness to understanding and engaging with multiple perspectives and standpoints has enabled many new possibilities for participatory health research and co-production. Within global health research, post-structuralism is increasingly becoming recognised as an effective stance from which to understand the fluidity and complexity of knowledge and power relations, as well as the pluralism which emerges from non-universalist approaches to culture and language.

As a literature review methodology, meta-ethnography (Noblit and Hare, 1988, 1999; France et al., 2019) lends itself to a post-structurally pluralist ontology. Whereas most review methods aim to appraise, aggregate, or synthesise research findings or outcomes, meta-ethnography is also able to explore research contexts and processes (France et al., 2019). As a form of ethnography, meta-ethnography is thereby able to evaluate research studies not only against one another but against concurrent social or clinical processes which enable the development of higher-order observations or arguments regarding the dynamic role of culture and power in the creation of research knowledge.

1.3.2. Positionality in rationale

The review team comprised of researchers with diverse personal and professional backgrounds who worked together as equal partners. HY is an academic participatory health researcher of white British heritage, descended from colonial officials of the British Empire and married to the descendants of colonial subjects. She works with epistemological plurality, seeking alternatives to biomedicine and psychosocial practice. RD is originally from Nepal, grew up in the UK and has close ties with family and friends in Nepal. In London, she practised as a community pharmacist, an addiction specialist pharmacist and in public health for several years. This led to her research career exploring how alcohol problems in low-income countries, such as Nepal, could be better understood through participatory research approaches. SH is a white, cisgender European woman. She is a qualitative health researcher who uses co-production to privilege the voices of people with lived experience. She has previously worked on community projects to alleviate the exploitation of young people in Nepal. JS is a Chinese mental health nurse from Hong Kong. She has worked in the UK for over 20 years as a clinician-researcher, promoting patient and public involvement (PPI) in health education, research, and service development.

As individuals, we live across societies that are bound together by the legacy of colonialism. The tension surrounding concepts of homeland and heritage, nationalism and neo-colonialism that exists in our own lives, is reflected in this review. From the outset, our team was partisan to the belief that Western biomedicine is not at odds with traditional and contemporary understandings of health in Nepali communities and that participatory research and co-production can facilitate meaningful, and decolonial development of healthcare in local contexts.

2. Methods

The methodology and methods of this study were guided by a post-structural perspective on Noblit and Hare's (1988, 1999) seven-stage process for meta-ethnography and were structured to conform to the 2019 eMERGe framework designed to ensure the systematic rigour of meta-ethnographic practice (Cunningham et al., 2019; France et al., 2019). However, neither standards nor frameworks inherently guarantee qualitative rigour (Barbour, 2001), and in a meta-ethnography of participatory research and co-production, the co-authors sought to be inclusive and collaborative in working together, and discursive as well as systematic.

2.1. Search strategy and process

Pilot and iterative database searches were undertaken by two co-authors (HY and SH) with support and advice from a number of Nepali and global experts in participatory health research. These were used to inform an agreed search strategy including MeSH and key terms addressing the research questions: (Nepal* AND (health OR wellbeing OR mental health) AND (participat* OR co-produc* OR co-design OR emancipat* OR EBCD OR (user OR action) ADJ1 research OR CBPR (community based participatory research) OR co-develop* OR co-construc*)). We applied this search strategy to the following databases from inception to March 2021: PubMed, Web of Science, Google Scholar, ProQuest for academic theses and dissertations, and NepJOL, the latter being a specialised database of peer-reviewed Nepali academic publications not necessarily indexed elsewhere.

Alongside this search strategy, co-authors also invited experts to contribute any literature they perceived as relevant. All such contributions were added to the material produced by the databases to create a shortlist. HY then completed backward and forward reference searches and looked up all publications by authors on the shortlist to identify any additional relevant studies.

2.2. Sifting and selection strategy and process

HY, SH, and JS then worked independently of one another to read and evaluate the titles and abstracts and full text of all identified papers against the eligibility criteria for inclusion in the review. Where

disagreements arose, HY, SH, and JS then read and discussed the full-text articles for consensus. The review sought to include studies published in English or Nepali, which investigated a specified health topic in Nepal, using a participatory or co-production research method.

In embarking upon the sifting and selection process, the co-authors of this study were confronted by the existential question facing all participatory research and co-production: *what degree of involvement is necessary for meaningful participation? Which potential studies were sufficiently and meaningfully participatory to warrant inclusion, and which were not*? As post-structural researchers, co-authors regarded this as a semantic construct rather than an ideal-type phenomenon, addressing all questions of participatory-ness through a collaborative discussion. As this process of discussion progressed, three principal eligibility criteria emerged:

1. Labels of "participatory" or "co-production" should only be applied to studies which involved participants in designing or shaping process as well as outcomes.
2. "Participatory" studies which applied the same model of research across several national or international settings should be regarded with caution, implying there may have been little local input into the research design or process. This is a consideration particularly pertinent to Nepal, a country renowned for its exceptional cultural heterogenicity and diversity of resources and challenges.
3. Papers under discussion which were primarily discursive or theoretical in nature often tended to foreground the voices, interpretations, or perspectives of researchers from the Global North. As a result, co-authors agreed to include only papers based upon empirical primary participatory studies.

2.3. Quality assessment

The 10-item Critical Appraisal Skills Programme (CASP) Checklist specifically for qualitative studies (CASP, 2019) was used to assess the methodological quality of the included studies. The CASP checklist consists of ten criteria covering three broad aspects:

1. Are the results of the study valid? (including items on research aims, recruitment, and data collection strategies used)
2. What are the results? (including items prompting consideration of ethics and analytical rigour)
3. Will the results help locally?

Two reviewers (RD, JS) assessed the studies across each of the ten criteria, rating them as "yes" if issues concerned were extensively justified or fully elaborated, "no" if lack of evidence, or "can't tell" in the event of inadequate reporting or details. Any differences were resolved through discussion involving RD, HY, and JS.

2.4. Reading, exploration, and analysis of studies; establishing relatedness

This process adhered to Stages 2–4 of Noblit and Hare's initial iteration of meta-ethnographic method (1988; 1999), and was guided by Barthes' (1981) post-structural approach to inducting multiple and subjective meanings from within the text. HY read each study rigorously and repeatedly, in order to engage inductively and reflexively with the apparent assumptions, attitudes, and worldviews both explicit and implicit within them (Terry et al., 2017). In so doing, she noted any commonalities and contrasts of terminology, metaphor, structure, and academic convention within each study, and noted any emerging parallels and discrepancies between the constructs, concepts, or discourses visible beyond a textual or thematic level (Noblit and Hare, 1988). Other co-authors supported this process, enabling the discussions and the consensus which emerged to add robustness to the meta-ethnographic process.

The process and outcome of this reading was documented within an iteratively developing spreadsheet framework to validate both the detail of the reading and the points of relatedness established. Post-structural processes were applied to the reading and relatedness, to challenge binaries, to integrate dichotomies, and to blur categories (Derrida, 1998), to replace hierarchies with scaffolds (Tritter and McCallum, 2006), and to deconstruct concepts, constructs, and terminologies (Fairclough, 2013).

2.5. Translation and synthesis of emerging themes, assertions, and arguments

Within Noblit and Hare's (1988) seven-stage process of analysis, the points of connection or relatedness identified between studies – whether as terminology, metaphor, structure, and academic convention or as constructs, concepts, or discourses – are further interrogated, or translated into one another. This was undertaken by HY and the research team, through collaborative reading, reflection, and discussion. Because the inclusion criteria of this meta-ethnography sought studies united by epistemology and methods rather than their subject of enquiry, directly comparable or commensurate reciprocal and refutational translations proved relatively sparse, with the result that the process of translation and synthesis focused upon constructing this line of argument. Given, however, that this research aimed specifically to engage with the multi-dimensional and non-hierarchical web of power dynamics and differentials between participant and researcher (Tritter and McCallum, 2006), this meta-ethnography assumed the more critical post-structural position of regarding the distinction between the assertions of participant and researcher as of questionable validity (Thorne, 2017). Similarly, post-structural literary theory has recognised the relationship whereby the reader can only experience the author's writing and can only perceive the author's meaning (or, in a participatory research context, the co-authors' or co-producers' meaning) through subjective interpretation (Suleiman and Crosman, 2014): essentially, the reader (or, in the case of meta-ethnography, the reviewer) is the one who writes the meaning of the text (Barthes, 1981). Therefore, this meta-ethnography drew only tentative and nuanced distinction between "lower-order" and "higher-order" constructs, arguing each to be interpretations of potentially equal degrees of abstraction.

3. Findings

3.1. Outcome of study selection

The process of study screening and inclusion is displayed in Fig. 1; seven studies met all eligibility criteria. The main characteristics of these seven studies are summarised in Table 1, and their location in Nepal is shown in Fig. 2.

3.2. Characteristics of included studies

3.2.1. Overview of included studies

Table 1 and Fig. 2 offer an overview of the seven studies included within this meta-ethnography. Three were located primarily in rural areas surrounding Kathmandu (Shrestha, 2002; Morrison et al., 2005; Rai et al., 2018); three were located in remoter regions (Gibbon and Cazottes, 2001; MacFarlane et al., 2015; MacFarlane, 2016; Yadav et al., 2021); and one was intentionally situated at three geographically and culturally very distinct sites (Phuyal et al., 2020). With the exception of Yadav et al. (2021), each dealt in varying combinations with considerations of maternal and child health, mental health, and environmental aspects of public health. All used qualitative methods of group-based co-production, interviews and/or participant observation, though Phuyal et al. (2020) also involved a survey.

3.2.2. Quality appraisal of included studies

Table 2 presents findings of the quality assessments of the included

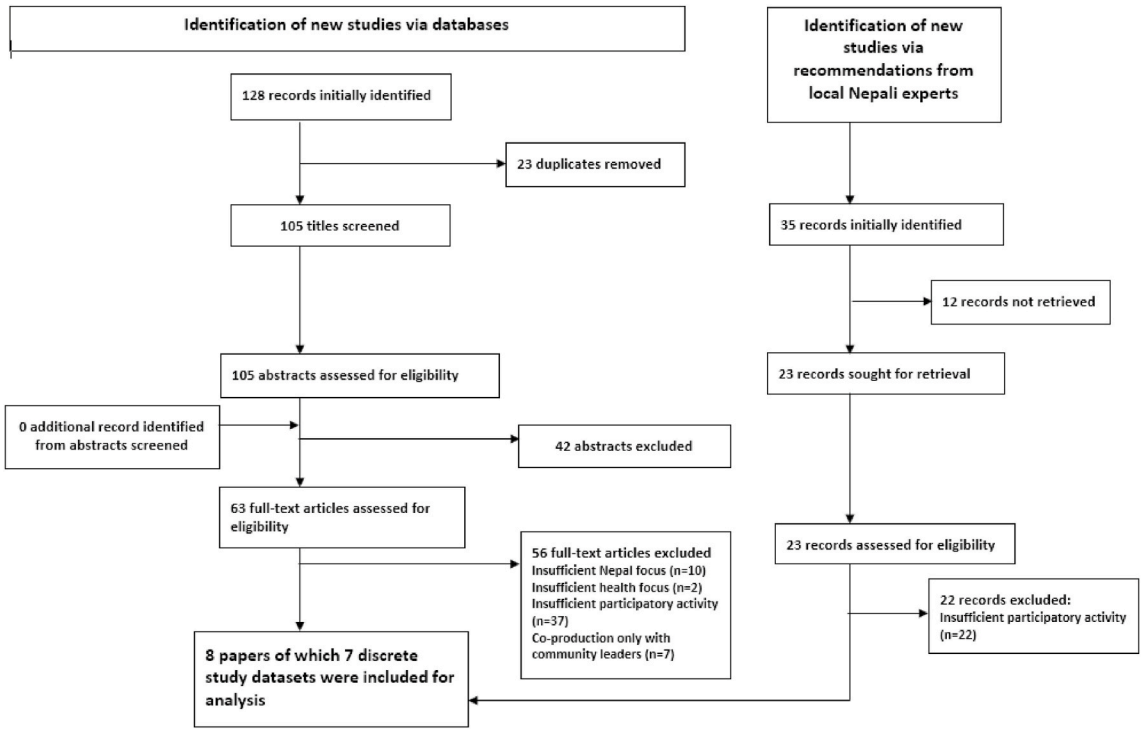

Fig. 1. PRISMA flow chart.

studies (CASP, 2019). On items relating to the validity of the study results we found the overall quality of the included studies was high; all studies apart from Gibbon and Cazottes (2001) reported the study aims clearly and used an appropriate design to address such aims. When reporting on recruitment strategies used it lacked details for three studies (Gibbon and Cazottes, 2001; Morrison et al., 2005; Yadav et al., 2021) but was satisfactory for the remainder. Data collection strategies in all studies, apart from Yadav et al. (2021), were found to be appropriate in addressing the research aims. However, in five out of the seven studies it was not clear whether the relationship between researcher and participants had been adequately considered (item 6). In terms of the study results, it was not possible to tell whether the data analysis was sufficiently rigorous for six studies, and two of these (Shrestha, 2002; Yadav et al., 2021) fell short in making clear statements of findings. All studies were rated as high quality in terms of ethical consideration. Overall, for most studies the results were considered valuable to their communities. Yadav et al. (2021) was the exception, because it did not describe in what way the research process and outputs would support those with chronic obstructive pulmonary disease (COPD) in rural Nepal.

3.3. Outcome of reading and relating studies

3.3.1. Subject area: women's health; mental health; environmental determinants of health

The Venn diagram of Fig. 3 shows the relatedness of studies reviewed by this meta-ethnography to one another with regard to research area. The health and wellbeing of women, particularly reproductive health, proved the main focus. Both Gibbon and Cazottes (2001) and Morrison et al. (2005) study how women's groups understand and engage with questions of maternal and child health – such women's groups are a common feature of Nepali village culture (Morrison et al., 2017; Gram et al., 2018; Heys et al., 2018) – with Gibbon and Cazottes (2001) working with pre-existing groups, and Morrison et al. (2005) working with female community health volunteers (FCHVs) to establish a network of groups. Like Morrison et al. (2005), Shrestha (2002) identifies FCHVs as instrumental in supporting the health of their village's women. Whereas Morrison et al. (2005) seek to make use of FCHV knowledge and influence, however, Shrestha (2002) works instead to challenge their gendered subordination within Nepali hierarchies of primary care providers, developing more co-productive forms of training which acknowledge and empower their pre-existing skills. Like Shrestha (2002), MacFarlane et al. (2015, 2016) work with women largely on an individual basis, seeking to foreground and to emphasise their lived experiences.

MacFarlane et al. (2015; 2016) and Rai et al. (2018) use Photovoice methods (Wang and Burris, 1997) to focus on what they described as "mental health". MacFarlane et al. (2015; 2016) seek specifically to understand the mental health impacts of climate change upon women in a remote mountain village. Located within a more developed urban area, Rai et al. (2018) seek to explore how co-produced and co-facilitated user groups might challenge the social stigma which people living with mental ill-health experience. Although not aiming to engage with gender considerations, Rai et al. (2018) nevertheless identify gendered elements to the lived experience of mental health stigma: people regarded as "crazy" or "mad" are often denied autonomy and agency by their families who wish to keep them out of public view, and this is doubly the case for women, who are accustomed to disempowering gender roles. Like MacFarlane et al. (2015; 2016), Phuyal et al. (2020) locate their studies in particularly remote and vulnerable mountain villages, researching health challenges which they assert to be environmentally as well as economically determined. Like Rai et al. (2018), Phuyal et al. (2020) find that gender as well as poverty determines health; burns largely affect women, because it is women who cook, and because of hazardous local cooking practices which reflect the vulnerability of the environment. Concern for the detrimental health effects of gender inequality permeated even those studies which had not sought to focus on women's health.

Within Yadav et al. (2021), by contrast, the researchers appear to have afforded little consideration to the status of women. Their participant groups and co-production workshop were primarily composed of men, and they reported that their female participants rarely spoke in group discussions. Nevertheless, they assert that the way the women so frequently nodded in apparent assent should be interpreted to convey

Table 1
Overview of included studies.

	Topic investigated	Setting	Author's philosophical/ epistemological standpoint	Methodology/ methods	Author's findings and/ or conclusions	Author's recommendations/ implementation to co-production/participation
Gibbon and Cazottes (2001)	"to improve health by working with women's groups" (p.729)	Pelangma, Sankhuwasabha District	Female subordination is key to health problems affecting women - these must be solved by structural and cultural change beyond what PAR can address.	Health analysis and Action Cycle with women's literacy groups which partner organisation had previously established.	HAAC shows how communities and health educators can reach consensus understanding through discussion processes.	Participatory Action Research should take time to understand contexts. Requires good facilitation. Research can enable shared understanding between professionals and communities through dialogue.
MacFarlane et al., 2015 **(paper in BJPsych), 2016 (PhD thesis from Duke University)**	Whether using CBPR to address environmental challenges associated with climate change might improve mental health	Mountain village of Jumla District	Gender inequality means that women in low-income countries are particularly vulnerable to the problems caused by climate change.	(1) Photovoice "modified to meet the cultural context"; (2) BDI, BAI, resilience scales	QUANT: significant reduction in depression QUAL: (1) benefit of sharing environmental best practice (2) importance of building community capacity (3) importance of sharing stories	Mental health services should educate about climate change and promote resilience.
Morrison et al. (2005)	To test impact of participatory women's groups on perinatal/neonatal mortality	111 women's groups across Makwanpur District	Participation, to whatever degree, is beneficial to maternal and child health. The challenges are global and universal.	Part of RCT. Women's Group Participatory Intervention, based on Warmi project in Bolivia (O'Rourke et al., 1998). Groups established specifically for study purpose.	Mostly around engagement and progress - but some outcomes (1) credit union for pregnancy costs (2) clean home delivery kits (3) stretchers for hospital transport of women in labour (4) sharing of video (5) card game	All conclusions should be derived from solutions developed by groups in study.
	Subject investigated	**Setting**	**Author's philosophical/ epistemological standpoint**	**Methodology/ methods**	**Author's findings and/or conclusions**	**Author's recommendations/ implementation to co-production/participation**
Phuyal et al. (2020)	Co-creation of burns prevention strategy	(1) Indrasarowar, Makwanpur), (2) Ama Chhodingmo (3) Laxminiya, Dhanusha	All global health challenges should be evidenced and measured by quantitative data. Surveys are a valid way of doing this.	Co-designed head-of-household survey.	(1) women and children most affected, mostly whilst cooking (2) home remedies varied by community/ regions, none as effective as water	(1) Prevention: should focus on women and children, homes, and cooking (2) Education: water cooling, stop-drop-roll
Rai et al. (2018)	"How caregivers perceive and facilitate service user's involvement in an anti-stigma programme" (p.198-9) Part of PRIME study, based upon WHO mhGAP	Bharatpur, Chitwan	Mental illness is a universal challenge, yet families - and particularly the attitudes of families - can determine the course of mental illness. Indigenous Nepali health beliefs are wrong because they are unscientific, and should be challenged because they lead to patient ill-treatment.	Photovoice.	(1) Caregivers perceived benefits to service users and family from participation (2) Increased stigmatisation because of participation (3) Caregivers struggled to trust the study (4) Challenges of family information, involvement (5) Time management - families wanted service users working at home	Services should engage with families and caregivers as a means to challenge MH stigma.
	Subject investigated	**Setting**	**Author's philosophical/ epistemological standpoint**	**Methodology/ methods**	**Author's findings and/or conclusions**	**Author's recommendations/ implementation to co-production/participation**
Shrestha (2002)	"To enhance contraceptive acceptance amongst CMWRA through empowerment training of FCHVs" (p.156)	Kakani, hills north of Kathmandu	Uncontrolled fertility is central to the health challenges faced by Nepali women and children, and to female disempowerment. Women need to be empowered by educating them about family planning methods and reproductive health.	Empowerment training using PAR and re-enforcement mechanisms: community mapping, storytelling-with-scenarios, effectiveness evaluated by survey on contraceptive use.	FCHVs understood contraception better, recommended it to women more, and women used it. But little qualitative enquiry to explain why - unclear whether there was the social/ attitudinal change	Women need ongoing emancipation.

(*continued on next page*)

Table 1 (*continued*)

	Topic investigated	Setting	Author's philosophical/ epistemological standpoint	Methodology/ methods	Author's findings and/ or conclusions	Author's recommendations/ implementation to co-production/participation
					needed for results to be sustainable.	
Yadav et al. (2021)	To understand feasibility of co-design for integrated services for people with multimorbid COPD	Rural Sunsari district	Participatory co-design leads to more effective health service design.	"Focused ethnographic" co-design workshop (using Hasso Plattner) preceded by stakeholder videos, key informant interviews. Included observational work recording interpersonal interactions, relatedness, power dynamics, etc.	Co-design proved empowering and effective.	Should pilot method in other LMICs.

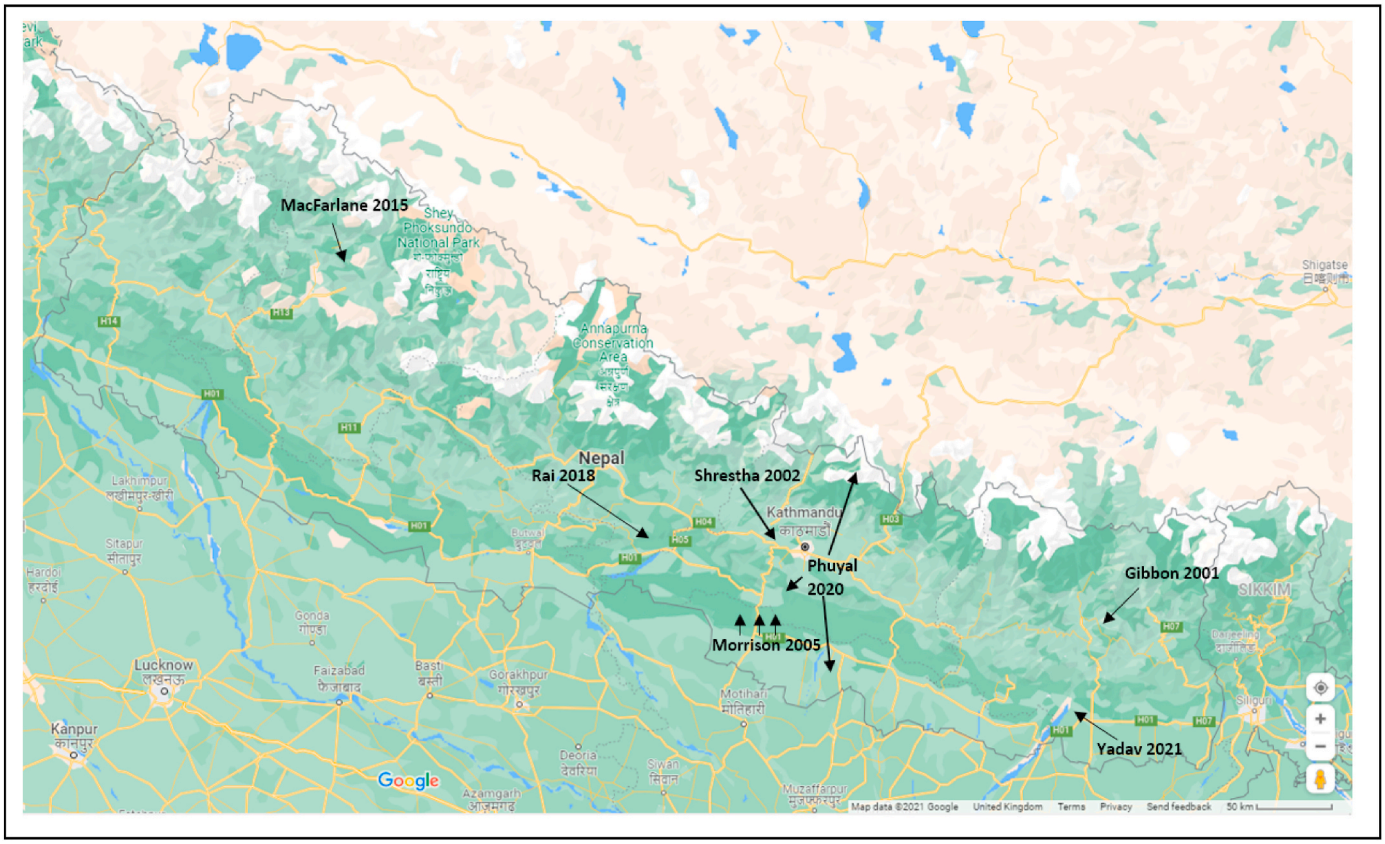

Fig. 2. Map showing study locations in Nepal.

that the women felt fully involved in the research process. This assertion suggests that the researchers of Yadav et al. (2021) might not have engaged with local culture to the same extent as other studies reviewed by this meta-ethnography.

Participatory research and co-production in Nepal are making some progress towards addressing the gendered inequalities which undermine women's health. To understand these challenges requires continual and meaningful engagement and dialogue with local cultures and communities.

3.3.2. *Stated approaches: empowerment versus empiricism; local versus global*

Participatory health research has long faced the dialectic of its endeavour to make the study process meaningfully transformative to participants whilst producing empirical findings which generate scientifically valid evidence for structural or systemic change at a higher level. Beyond Europe and the Americas, participatory health researchers face the further challenge of drawing from theory and approaches which have been established as effective elsewhere, whilst developing culturally engaging and locally owned research methods. Fig. 4 explores the relatedness of studies in approaching this dialectic.

The terms "empowerment" or "empowering" are frequently

Table 2
Quality appraisal of included studies.

CASP sections	Are the results of the study valid?						What are the results?			Will the results help locally?
Paper	1.Was there a clear statement of the aims of the research?	2. Is a qualitative methodology appropriate?	3. Was the research design appropriate to address the aims of the research?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Was the data collected in a way that addressed the research issue?	6. Has the relationship between researcher and participants been adequately considered?	7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	10. Is the research of value?
Gibbon and Cazottes (2001)	Can't tell	Yes	Can't tell	Can't tell	Yes	Yes	Yes	Can't tell	Yes	Yes
MacFarlane et al., 2015, 2016	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Yes	Yes
Morrison et al. (2005)	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Can't tell	Yes	Yes
Phuyal et al. (2020)	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes
Rai et al. (2018)	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Yes	Yes
Shrestha (2002)	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Can't tell	Yes
Yadav et al. (2021)	Yes	Yes	Yes	No	No	Can't tell	Yes	Can't tell	No	Can't tell

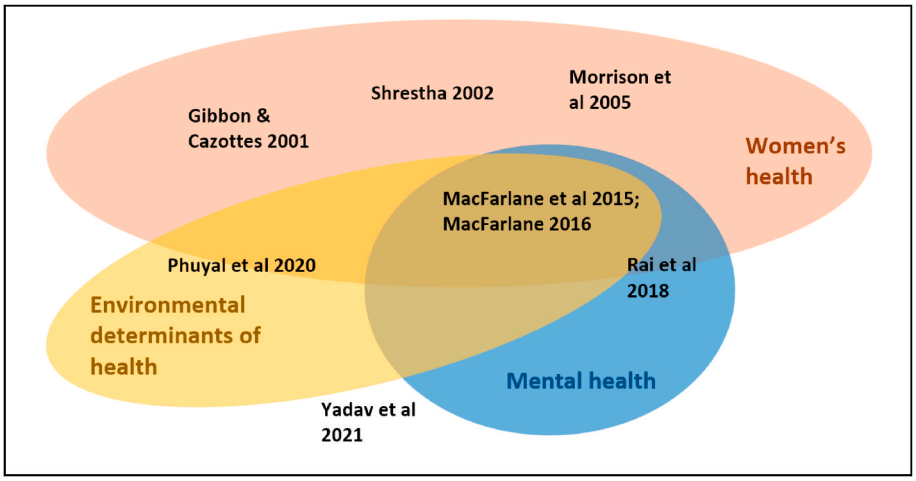

Fig. 3. Women's health; mental health; environmental determinants of health.

deployed within a number of studies (Gibbon and Cazottes, 2001; Shrestha, 2002; Rai et al., 2018; Yadav et al., 2021) and are used with particular frequency to translate the words of Nepali healthcare practitioners and by other local informants:

The purpose of the study was to increase awareness, competence, and confidence of the FCHVs in the delivery of family-planning services, thereby empowering them to facilitate increased contraceptive acceptance … The FCHVs who were empowered by training were expected to empower the community in controlling their fertility through increased awareness and compliance toward contraception.

(Shrestha, 2002: 157).

"Gaining trust and commitment of marginalised communities is not an easy task. The reason why you people [research team] got this [committed participation] is because you all invested your resources in building trust, educating and empowering the people."

("Senior Health Officer, workshop participant", quoted in Yadav, 2021: 6).

Rai et al. (2018) and MacFarlane et al. (2015; 2016) sought to balance the imperatives of empowerment and empiricism through piloting health promotion initiatives. Both describe the struggle this involved. As Rai et al. (2018) themselves acknowledge, their research team's expectation that participants should stay overnight in a hotel between training sessions had shown some lack of cultural awareness or cultural sensitivity. For the families and communities of participants, such hotels were perceived as places of excessive male drinking and female sexual exploitation, and to accommodate participants in hotels was regarded as neither empowering nor beneficial to the research.

The two most recently-published studies – those of Phuyal et al. (2020) and Yadav et al. (2021) – sought to engage with local community leaders to "empower" participants. Like MacFarlane et al. (2015; 2016),

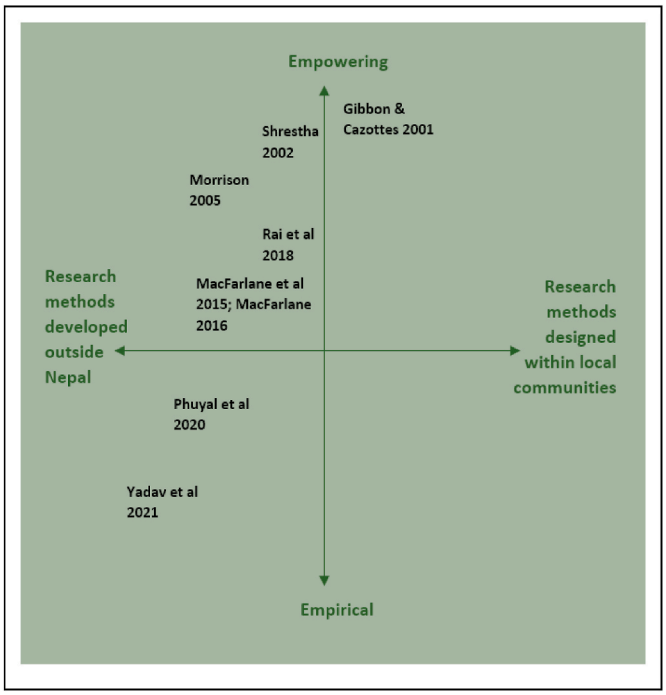

Fig. 4. Stated approaches: empowerment versus empiricism; local versus global.

Phuyal et al. (2020) succeeded with this engagement in gaining the participation of particularly remote Himalayan villages. Whereas Phuyal et al. (2020) engaged with women as well as men – researchers visited village homes to observe how women cooked, seeking to understand more about how burns occurred during cooking – Yadav et al. (2021) engaged primarily with men and did little to recruit or meaningfully involve women. Despite the frequent use of the word "empowerment" targeting communities, FCHVs, and participants (in particular women) across these studies, little evidence exists in terms of output or end-product, such as co-produced care pathway or service, beyond rather inactive participation in the study by the local population. Irrespective of the empowerment their community engagement produced, however, Phuyal et al. (2020) and Yadav et al. (2021) both regard their participatory work as a precursor to the research process rather than as an outcome to be described; they regarded their generation of empirical findings as the single aim of their research. By seeking to find local solutions to the global challenges of burns and COPD, both sought, ultimately, to address global as well as local research agendas.

Of the three studies operating from an explicitly emancipatory or empowerment-promoting feminist standpoint (Gibbon and Cazottes, 2001; Shrestha, 2002; Morrison et al., 2005), only Gibbon and Cazottes (2001) use methods of enquiry which had been fully co-developed with participating women's groups: for example, drawing body maps and making calendars. Morrison et al. (2005), by contrast, initiate and adapt a women's group model developed in Bolivia (O'Rourke et al., 1998). Rather than seeking purely local solutions, Morrison et al. (2005) encourage participants to engage with and adapt interventions developed elsewhere: for example, card games and clean delivery kits (WHO, 1999). Similarly, Shrestha (2002) draws upon global arguments to support the empowerment that contraception offers. As 3.3.5.3 describes, the studies emphasised how models of consciousness-raising through participation developed in similarly disenfranchised communities elsewhere in the Global South could effectively be drawn upon.

3.3.3. *Critical consciousness: power imbalances between versus within*

Within cross-cultural forms of participatory health research, researchers are traditionally expected to acknowledge their positionality and the epistemic, economic, and power imbalance between themselves and participants. All studies published by non-Nepali lead authors engage with this in detail (Gibbon and Cazottes, 2001; Morrison et al., 2005; MacFarlane et al., 2015; MacFarlane, 2016), with Morrison et al.

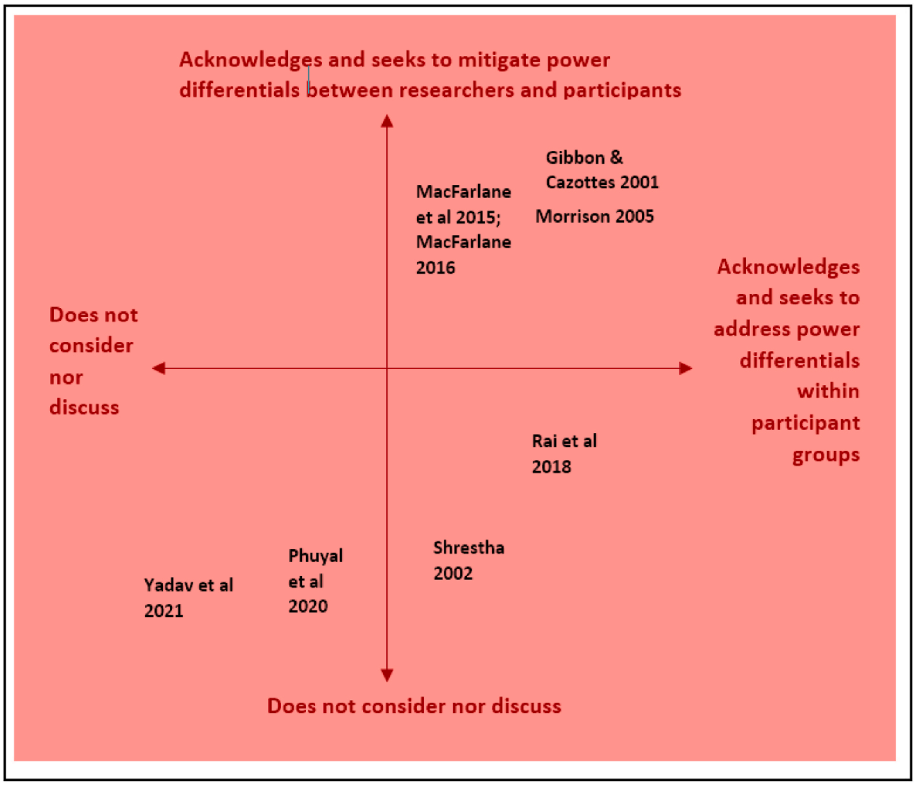

Fig. 5. Critical consciousness: power imbalances between versus within.

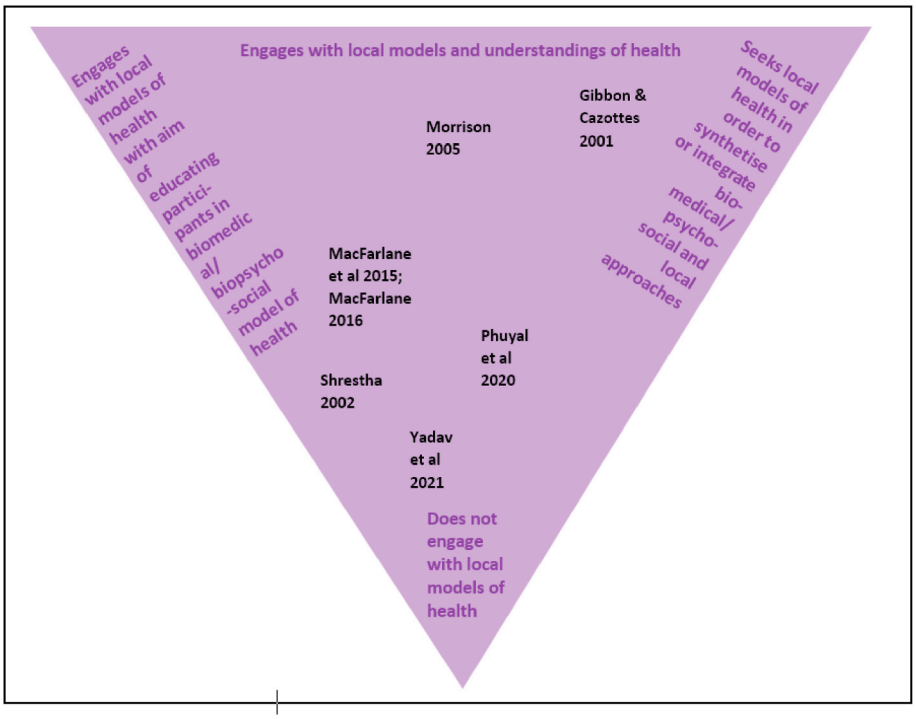

Fig. 6. Epistemologies: local versus biomedical/psychosocial.

(2005) describing their insistence that all British team members should be competent in the Nepali language, and Gibbon and Cazottes (2001) reflecting upon how the study had challenged their Eurocentric concept of feminism. Gibbon and Cazottes (2001) acknowledge that some of their participatory activities were only accessible to women whose husbands supported their involvement, to women who could read, and to women who spoke Nepali. They describe some of their dilemmas as researchers in addressing this; how the only people able to translate between the local language and Nepali were men, but how the presence of men may have inhibited discussion of certain health concerns.

For the international research team which authored Rai et al. (2018), the power differentials between different groups of participants (people living with mental ill-health, their families and carers, primary health care workers) proved more problematic and challenging than the differentials between researchers and participants. The study findings detail how stigma can disenfranchise and oppress people living with mental ill-health, and acknowledge that researchers have the power either to challenge or to exacerbate this.

Within Yadav et al. (2021), the study authors use ethnographic observations to assert that they achieved meaningful co-production. From their description of workshop and interview participants, however, it is unclear whether researchers had considered the power differentials within Nepali society: most were healthcare professionals rather than people with COPD or carers, and most were male. This lack of diversity is not acknowledged. Gibbon and Cazottes (2001) explore the status and power that Nepali healthcare professionals command, observing that women showed more respect for healthcare professionals than the professionals showed to them. However, the datasets and discussions of several studies suggest that differentials of status and respect are also caste-based; almost all professionals come from the higher Brahmin and Chhetri castes, and members of the lower Dalit caste and tribal groups are least likely to have any literacy or education (Morrison et al., 2005; MacFarlane et al., 2015; Phuyal et al., 2020).

Whereas the studies reviewed engage to varying degrees with the differentials between researcher and participant and between different participant groups, most of the studies co-authored by an international team (Morrison et al., 2005; Rai et al., 2018; Phuyal et al., 2020; Yadav et al., 2021) leave unexplored the power differentials within research teams. MacFarlane et al. (2015; 2016) are the singular exception to this, with MacFarlane (2016) acknowledging the ethical discomfort of having gained a PhD produced from the data collected by her Nepali research assistant. International research teams, this meta-ethnography suggests, should do more to address the power differentials between Nepali and Western researchers.

3.3.4. *Epistemologies: local versus biomedical/psychosocial*

Studies engage with local models and understandings of health to varying degrees. Those that do so articulate one of two reasons for understanding how participants conceptualise or construct health. Gibbon and Cazottes (2001) seek to understand and to engage with local models of health in order to synthetise participant concerns and explanations with those of local public health systems and the WHO policies which inform and fund these. They conclude that:

> The convergence between the solutions generated by the women's groups and those that a health educator might want to hear may seem surprising. This can be explained through the dialogical process: past experiences gained by the group through the management planning cycle phase … [although] there were differences in understanding, such as the women's group members seeing respiratory infections being caused by bad air. However, if beliefs did not have negative effects on health, they were not necessarily challenged immediately, but facilitators would note them for future discussions.
>
> (Gibbon and Cazottes, 2001: 748).

To some extent, then, Gibbon and Cazottes (2001) have some health promotion or health education agenda. Morrison et al. (2005) make this agenda explicit throughout their work, encouraging women's groups to collaboratively and discursively re-interpret their health concerns within what they describe as the "allopathic" framework. However, Phuyal et al. (2020) find this re-interpretative approach unsuccessful, claiming that they find their participating communities have no effective or consistent local understandings of how to prevent or treat burns.

Whereas Gibbon and Cazottes (2001) and Morrison et al. (2005) seek collaboration or partnership with local models and understandings of health, Shrestha (2002) and Rai et al. (2018) engage with these models

and understandings only in order to challenge or refute them. For Shrestha (2002), contraception is essential to women's emancipation. She describes negative community attitudes towards contraception as oppressive towards women, and seeks to address at an individual and a structural level how this undermines what FCHVs are taught about contraception. For Rai et al. (2018), a biomedical model of mental illness is essential to combatting the stigma which causes the intense prejudice and discrimination against people with *jhum-jhum* or heart-mind problems in Nepali society.

3.3.5. Practice recommendations

3.3.5.1. Understanding how women determine the health of their families and communities. Studies aiming specifically to improve women's health (Gibbon and Cazottes, 2001; Shrestha, 2002; Morrison et al., 2005; MacFarlane et al., 2015; MacFarlane, 2016) each predicated their methodological development and participatory recommendations upon their feminist standpoint that co-production empowers women, and that empowerment improves health. Each found that the traditionally gendered role of women as primary caregivers meant that women's health knowledge impacts upon their health, their children's health and wider community hygiene. However, the findings of both Phuyal et al. (2020) and Rai et al. (2018) demonstrate more broadly that women's lifestyles and attitudes are significant determiners of the health of their communities. For Phuyal et al. (2020), how women use domestic and communal cooking facilities, how women perceived kitchen hazards, and how women treated accidents and injuries was found to determine the prevalence, morbidity, and fatality of burns. For Rai et al. (2018), women's attitudes towards mental health and mental ill-health were found highly to influence how families and communities responded to members experiencing mental ill-health. Therefore, understanding these much broader women's lifestyle and attitudinal considerations could also have a positive influence on wider issues such as kitchen safety and mental health stigma.

3.3.5.2. Building upon existing community structures and resources. As 3.3.1 details, Gibbon and Cazottes (2001) and Morrison (2005) structured their studies upon local traditions of women's groups for discussion and collaboration, and similarly, Morrison et al. (2005) and Shrestha (2002) identified FCHVs as the community members most knowledgeable about their community women's health. Phuyal et al. (2020) worked initially with community leaders as a means to engage individual households in the study. All found these to be effective strategies for co-production. Yadav et al. (2021) also sought to work with local leadership and the Nepali culture of group discussions, but in accordance with their US-derived for participation, created groups which mixed genders, castes and professional statuses. These groups therefore led to less participation from women and lower-status individuals, underscoring the importance of Gibbon and Cazottes (2001) and Morrison's (2005) emphases upon working in accordance with local community norms and structures.

3.3.5.3. Learning from participatory approaches developed elsewhere in the Global South. Gibbon and Cazottes (2001), Morrison et al. (2005) and Shrestha (2002) drew upon local structures for participation, but also succeeding in developing consciousness-raising theory established elsewhere in the Global South (Freire, 1970; O'Rourke et al., 1998). In reflecting upon their methodology, Yadav et al. (2021) observe how similarities of health challenges and economic contexts may enable parallels to be drawn between co-production across different low-resource settings, recommending greater co-learning and knowledge exchange between them. From each study, it appears that drawing upon approaches developed elsewhere in the Global South are particularly beneficial to the empowerment of women.

3.4. Outcome of translation and synthesis

This epistemological assumption or line of argument runs through each of the studies reviewed by this meta-ethnography. The authors of each contend, essentially, that the introduction of biomedical and psychosocial models to local healthcare services proves an "empowering" influence which helps to combat many of the inequalities and inequities within Nepali society. The studies reviewed by this meta-ethnography assert this argument in the following four ways.

3.4.1. Western biomedical knowledge can validate and empower local health knowledge

The lack of confidence which participants displayed in their local health knowledge often proved unfounded. Shrestha (2002) found that FCHVs had always observed that children from smaller families were usually healthier and better nourished than children from larger ones. Until her study piloted a training programme to validate this awareness, the FCHVs did not feel sufficiently confident in this knowledge to use it to advocate in favour of contraception. Once provided with the medical information about how different contraceptive methods work, FCHVs felt validated to talk to women about the benefits of smaller families.

Gibbon and Cazottes (2001) and MacFarlane (2016) found that women's lay knowledge often provided explanations for diseases as women described diarrhoeal illnesses as caused by dirty water and soil containing human faeces. By becoming aware that their knowledge could lead to action that could promote their family's health, Gibbon and Cazottes women's groups (2001) felt empowered to build latrines and to encourage their neighbours to cover their drinking pots. However, MacFarlane et al.'s (MacFarlane et al., 2015; MacFarlane, 2016) participants had observed their drinking water becoming progressively more contaminated as landslides and crop failures became more common, and they felt powerless against this. Although participatory studies promote localised action in health promotion, they also highlight public health measures which require systemic and structural changes in the wider contexts; MacFarlane et al.'s (MacFarlane et al., 2015; MacFarlane, 2016) study, climate change, a global challenge which arguably more pressing in places like Nepal. Empowerment was, ultimately, limited.

On a more philosophical level, the discussion of 4.1.1.1 asks: *Why should Nepali health knowledge need Western validation to empower itself*?

3.4.2. Some traditional Nepali healing practices are known to be limited

Although the studies reviewed found that participants often had a great deal of valuable health knowledge that was very congruent with researchers' prior knowledge (Gibbon and Cazottes, 2001), they found that participants lacked confidence in their knowledge because they were aware that many of their traditional health practices could not cure illness. Generally, participants appeared keen to learn about and to engage with Western biomedical interventions. Whereas members of Morrison et al.'s women's groups (2005) generally preferred to give birth at home, they knew that their villages lacked the resources to manage retained placentas, post-partum bleeding or similar complications. In addition to producing clean delivery kits, the women therefore also decided to design stretchers to transport those in difficult labour to hospital.

Through the focus groups and ethnographic enquiry which accompanied their survey of burn injuries, Phuyal et al. (2020) found that a significant number of respondents knew of no effective local remedies and would instead transport the burns sufferer immediately to the nearest hospital or clinic. They report that communities welcomed, and felt informed/advised by, the first aid advice to "stop, drop, and roll" (2020: 4) and to apply water immediately. Like the work of the women's groups in Gibbon and Cazottes (2001) and Morrison et al. (2005), this advice proved particularly valuable to women, who do the cooking and therefore suffer the majority of burns.

With regard to mental health, Rai et al. (2018) reassert the prevailing

view from Western practitioners and academics in Nepal that local health knowledge and traditional healing methods are not only ineffective but harmful, because they lead to the stigmatisation, isolation, and abuse of those affected and of their families (Kohrt and Harper, 2008; Neupane et al., 2016). Whereas they found that psychosocial interventions could challenge mental health stigma as it affected specific families and communities (Rai et al., 2018), they established no evidence that the biomedical assumptions underpinning anti-stigma initiatives could lead to broader structural social and attitudinal transformation. In the same way, MacFarlane et al. (MacFarlane et al., 2015; MacFarlane, 2016) found that whereas introducing Western concepts of mental health to a vulnerable community enabled women to discuss their experiences in mutually beneficial ways, they could not use the tools gained to challenge the water pollution arising from climate change. As the discussion of 4.1.1.2 outlines, all approaches have their limitations.

3.4.3. *Western medicine may offer new ways of understanding and talking about health*

The studies of both Rai et al. (2018) and MacFarlane et al. (MacFarlane et al., 2015; MacFarlane, 2016) suggest that many Nepali cultures have few ways of describing or understanding what Western practice would categorise as "mental health" because of the differences between the languages or frames of reference to do so. The terminologies of mental illness enabled community members to identify shared experiences and thereby to feel more connected to one another (MacFarlane, 2016), and they enabled participants and their families to describe their experience in ways that were not pejorative or shaming.

The process of co-learning through which the women's groups studied by Morrison et al. (2005) identified and prioritised local health challenges involved facilitators helping groups to articulate their priorities in their own terms, as they see fit and relevant to their circumstances. Morrison et al. (2005) describe how promoting the idea that women could determine the causes and solutions to their own problems, overcoming a sense of fatalism which may undermine individuals' sense of agency, was particularly empowering. This was evident from participatory work, building upon women's own experiential knowledge, to develop card games and music to teach others about health in pregnancy.

In highlighting the ability of foreign biomedicine to validate and to empower local knowledge, however, Gibbon and Cazottes (2001) challenge the assertion that local languages need outside help to find ways to speak about health. As the discussion of 4.1.1.3 explores, the claim that Nepali communities need the empowerment of Western language remains a matter of debate. The idea that new frames of reference can empower communities to describe their experiences more accurately has long been contentious (Bhandari, 2021), particularly in post-colonial settings of the Indian subcontinent within which the imposition of new languages has historically made it difficult for communities to express their indigenously specific forms of distress (Fanon, 1961).

3.4.4. *Engaging with western biomedicine enables access to global health resources*

Studies which relied most assumptively on a Western biomedical perspective (Shrestha, 2002; MacFarlane et al., 2015; Rai et al., 2018; Phuyal et al., 2020; Yadav et al., 2021) tended to do so for one or both of two reasons.

Firstly, they drew from the global nature of the biomedical model, using literature from across the world to evidence their research aims and study methods (Shrestha, 2002; MacFarlane et al., 2015; Phuyal et al., 2020; Yadav et al., 2021). This approach is valid when approaching diseases and injuries which show a similar physical presentation globally, such as the flame burns and scalds described by Phuyal et al. (2020) which seem always to be associated with cooking, irrespective of cooking practices. However, this same approach is less valid in relation to aspects of health which are largely determined by social and cultural attitudes, such as questions of fertility and sexual practices; Shrestha's (2002) citation of a Filipino study (Casterline et al., 1997) is of questionable validiy because she asserts no claim to describing a global problem. The two mental health-related studies (MacFarlane et al., 2015; Rai et al., 2018) adhere to Kleinman's (1991) model of cross-cultural psychiatry, regarding mental illness as a universal biomedical phenomenon which remains clinically valid despite culturally mediated variations in presentation. Whereas this appears the consensus model of mental health practitioners and academics in Nepal (Kohrt and Harper, 2008; Luitel et al., 2013; Jordans et al., 2015), Rai et al. (2018) also acknowledge its limitations by questioning the relevance of Western research into mental health stigma. Social and cultural attitudes to heart-mind problems, they reveal (Rai et al., 2018), are so culturally specifically embedded and so socially excluding as to shape the existential experience of being a person or a family affected. The global relevance of biomedicine, again, has its limits.

Secondly, studies may adhere to the Western biomedical model because health research in Nepal is largely financed by Western governments and universities and Western-funded NGOs. This is also the case for participatory forms of health research and co-production; of the seven studies reviewed, all were funded from outside Nepal. In some cases, this led to effective partnerships; for example, Gibbon and Cazottes (2001) were supported by a British charity to explore the commonalities between Western and local models of health, and Shrestha (2002) had received a WHO grant to address a locally-identified research priority by strengthening indigenous health researchers. In other instances, however, this led Western researchers to impose research questions which had not fully engaged with local contexts; for example, MacFarlane et al. (MacFarlane et al., 2015; MacFarlane, 2016) had given little consideration to local understandings or meanings of mental health, and Yadav et al. (2021) had not considered how a US-developed model of co-production workshop might preclude the participation of lower castes and women. In each of the three studies which reported a Nepali component of a larger international research project (Morrison et al., 2005; Rai et al., 2018; Phuyal et al., 2020), the research topics and aims (maternal and child health, mental health, and burns, respectively) had been pre-determined by funders. This funding sometimes stipulates that researchers address local priorities; for example, the international mhGAP PRIME study (Lund et al., 2012) within which Rai et al. (2018) were located had drawn upon local knowledge (Luitel et al., 2013, 2015) to focus their research on the identified priorities of mental health stigma and post-conflict trauma. A reliance on global biomedical research agendas can make it difficult, nevertheless, to attract funding for studies into challenges which have no resonance or implications for the Global North. Externally-funded research projects led by overseas researchers run a risk of low sustainability; it is unclear whether Macfarlane's study (MacFarlane et al., 2015; MacFarlane, 2016) resulted in improved local mental health provision.

4. Discussion

4.1. *Summary and critique of findings*

4.1.1. *The advantages of and problems with introducing western biomedical and psychosocial interventions to Nepali communities*

When synthesised into a line of argument, the studies convey that the introduction of biomedicine to Nepali healthcare services proves an empowering influence which helps to combat many of the inequalities and inequities within Nepali society (3.4). This is an argument which has four strands. Firstly, biomedical knowledge is viewed as able to validate and empower the health knowledge which communities already possess (3.4.1). Secondly, biomedicine and psychosocial practice is known to be effective in addressing some of the local health challenges which indigenous healing practices cannot (3.4.2). Thirdly, biomedicine is able

to offer ways of understanding and talking about health that local languages and cultures cannot always provide, which is regarded as empowering (3.4.3). Finally, the globalised nature of biomedicine is viewed as a valuable resource for Nepal (3.4.4).

As a counter-current to this synthesis, however, this meta-ethnography has also revealed a number of difficulties with this argument. The concept of biomedicine as empowering can also be problematic, as the questions now posed reveal.

4.1.1.1. Why should local health knowledge need biomedicine to empower it?. Studies reviewed by this meta-ethnography found that Nepali communities felt empowered by the discovery that much of their local lay and traditional knowledge concurred largely with the knowledge of Western biomedicine (Gibbon and Cazottes, 2001; Shrestha, 2002; Morrison et al., 2005; MacFarlane et al., 2015; MacFarlane, 2016). They identified significant points of consensus between these understandings – which are described by Kleinman (1988) as "explanatory models" – and biomedicine. Often, discovery of these points of commonality enables communities to work together to improve their collective wellbeing, for example by building latrines (Gibbon and Cazottes, 2001) or encouraging contraception (Shrestha, 2002).

This strand of argument raises, nevertheless, a deeper philosophical question: why should local health knowledge depend upon or require biomedicine to validate or empower it?

The idea that biomedicine is more effective, reliable, and authoritative than the many forms of traditional health knowledge and practice comes essentially from two sources. Firstly, Nepalis recognise that the Western medical innovations introduced in the nineteenth and twentieth centuries did reduce morbidity and mortality and improve life expectancy, particularly through the introduction of antibiotics and vaccines, but also through the building of clinics and hospitals.

Secondly, however, a "West is best" or orientalist heritage (Said, 1978) may still pervade Nepali thought. Although unlike much of the Indian subcontinent, Nepal was never colonised by Western powers, it was nevertheless introduced to Western biomedicine by colonialists, traders, and missionaries. Historically, Western biomedical practice has accorded little credibility or authority to alternative systems of knowledge, because it has traditionally regarded its own model and methods as the only valid, effective, and superior route to health. This attitude, often termed "medical colonialism", has frequently been associated with the appropriation of Western medical benevolence into imperial endeavours (Bala, 2015; King et al., 2021). The concept that Western colonialists held privileged and enlightened forms of authority and knowledge that they were entitled and obliged to impose on natives (Kipling, 1899) has long been explicitly or implicitly instilled and embodied throughout socialisation processes and healthcare professional training throughout the Global South (Fanon, 1961; Said, 1978).

The idea that Nepali local healing methods should need biomedical validation is therefore at least partially interwoven with notions of ongoing orientalism and embodied colonialism which tend automatically and uncritically to accord epistemic privilege and authority to Western practitioners and researchers. Whereas the promotion of Western biomedicine may empower Nepali communities, it may also attenuate power differentials between Western countries and Nepal, to the detriment of Nepali wellbeing.

4.1.1.2. What about what neither local health knowledge nor western biomedicine can address?. Nepali culture has long emphasised the value of epistemological humility and pluralism, the idea that knowledge is always provisional and incomplete, that others can always teach new things, and that multiple explanations for the same phenomena can always co-exist (Pigg, 1995). As such, studies reviewed by this meta-ethnography found that Nepali communities welcomed the health innovations which researchers brought, particularly around improving the safety of childbirth (Morrison et al., 2005) and in treating burns (Phuyal et al., 2020).

The studies reviewed by this meta-ethnography also encountered, however, a number of challenges which neither Western biomedicine or psychosocial knowledge, nor local practices, could address. This was particularly the case for studies engaging with women's health or climate change. The status of women and the impact of gender imbalances and injustices upon health have long been recognised, and remain a perennial challenge in Nepal as across the world. Meanwhile, the geopolitical location of Nepal, together with its high levels of poverty, renders Nepal particularly vulnerable to the health impact of climate change.

Whereas a number of the studies reviewed sought specifically to improve the equality and wellbeing of women (Gibbon and Cazottes, 2001; Shrestha, 2002; Morrison et al., 2005; MacFarlane et al., 2015; MacFarlane, 2016), others encountered additional gendered health challenges which their research could not address (Rai et al., 2018; Phuyal et al., 2020; Yadav et al., 2021). In focusing upon the mental health effects on women of climate change, MacFarlane et al. (MacFarlane et al., 2015; MacFarlane, 2016) acknowledge that, like the community within which they were working, little is currently known about how to prevent or to mitigate the environmental and public health effects of climate change, nor about how gendered inequality meant that these effects were being experienced primarily by women. MacFarlane et al. (MacFarlane et al., 2015; MacFarlane, 2016) were aware they were engaging with consequences rather than causes.

Emerging research from Nepal suggests that the disruption caused to Nepali society and healthcare systems by the Covid-19 pandemic has had a particularly detrimental effect on the status and safety of women and upon women's health and that climate change is undermining Nepali resilience to the virus (Ashish et al., 2020; Mahaseth, 2021). Arguably, therefore, the studies reviewed by this meta-ethnography foreshadow what the Covid-19 pandemic has since made more apparent. Western biomedicine is limited in what it can achieve by the inequalities that it cannot address.

4.1.1.3. How might the language of western biomedicine disenfranchise local knowledge?. Most of the studies reviewed by this meta-ethnography regarded the Western biomedical language, terminology, and concepts they introduced as offering Nepali communities new ways to talk about and to understand health. However, the work of Gibbon and Cazottes (2001) challenges the contention that Nepali communities need any biomedical language or frames of reference to enable them to conceptualise or to talk about health. Gibbon and Cazottes (2001) found that communities understood the cleanliness of water and sanitation facilities as a key determinant of health and that, because they often lacked the resources to act on this view, they were disempowered by the perception that their knowledge was not valuable. Whereas the women's group facilitators of Morrison et al. (2005) supported participants to describe local health challenges and priorities in the language of Western biomedicine, those of Gibbon and Cazottes (2001) sought intentionally to rely instead upon local concepts and idiom.

Even when local language and frames of reference possessed the capacity to speak about health, the culture of Western biomedicine appeared to take precedence. This idea that local explanatory models should be translated into biomedical frameworks perhaps explains the lack of confidence which participants displayed in articulating their own knowledge (Shrestha, 2002; MacFarlane, 2016; Phuyal et al., 2020). This same perceived superiority of biomedical language, culture, and knowledge is also evident within the co-production workshop of Yadav et al. (2021); the majority of participants were male medical professionals with no lived experience of COPD, and the small number of selected patients and carers present tended to defer silently to the views they expressed.

Whereas the language and concepts of biomedicine have the potential to "empower" local communities, they may also disenfranchise local

knowledge. Following linguistic contentions that language and terminology can be used to determine and to manipulate how individuals think (Sapir and Whorf, 1956), Fanon (1961) asserts that the introduction of a colonial Western language alienates local communities from their traditional ways of thinking and knowing, and thereby prevents individuals and communities from expressing or explaining that which often cannot easily be conveyed in the new language. Whereas constructs such as depression and psychosis have been researched to such an extent that they can be more clearly defined within Western languages, Fanon (1961) argues that such conceptualisation and clarity cannot straightforwardly be applied to the mental health of those for whom Western languages are a colonial imposition. All endeavours to translate local idioms of distress into the terminology of Western mental health will inherently fall short of capturing the cultural and emotional depth of what it means as a Nepali person to experience or to embody heart-mind disturbance or *jhum-jhum*, or to be the *pagaan* which Rai et al. (2018) attempt to describe as "crazy" or "mad". The language and terminology of Western mental health, whether expressed in biomedical or psychosocial terms, may therefore never fully communicate all forms of Nepali distress.

When taken to their fullest extent, Fanon's (1961) ideas could be taken to assert that the colonial disenfranchisement of local health knowledge is of such detriment to local communities that Western models of mental health should not be introduced globally. However, Kleinman (1988, 1991) challenges this argument with the contention that many aspects of human experience and human distress remain cultural universals, and that all understandings and concepts of mental health have the potential to relieve human suffering around the world. Kleinman (1988, 1991) argues that the barriers of language can be overcome by encouraging Western healthcare professionals and researchers to listen respectfully to local cultures and to understand their ways of manifesting and expressing this universal distress. In Nepal, Kohrt et al. have followed Kleinman's approach, seeking to engage with local concepts of heart-mind distress and *jhum-jhum* (Kohrt, 2005) to relate them to Western concepts of depression and psychosis (Jordans et al., 2015), and exploring Nepali concepts of the self and relationship to introduce culturally informed psychosocial interventions such as psychotherapy (Ramaiya et al., 2018; Rose-Clarke et al., 2020) and anti-stigma campaigns (Rai et al., 2018; Kohrt et al., 2020).

This meta-ethnography has demonstrated that Rai et al. (2018), like most international research teams working in Nepal, need to do more to engage with local cultures, and particularly with regard to women. As the work of Fanon (1961) highlights, the directionality of this engagement, and its implicit assumption that Nepali cultures have everything to learn from but nothing to teach Western biomedical and psychosocial models of health, perhaps retains echoes of the colonialist notion of Western superiority. That Nepali researchers seek such solutions potentially reveals some level of embodied colonialism. Future research might redress this by considering how Nepali local languages and worldviews might help Western cultures to improve their understandings of mental health.

4.1.2. What do health participation and co-production mean within Nepali contexts?

The studies reviewed within this meta-ethnography generally regard the globalised nature of Western biomedicine and of health research as a valuable resource for Nepal (3.4.4). In its epistemological pluralism, Nepali culture has long sought and welcomed new approaches to health research (Pigg, 1995), and Nepalis have long been inspired and empowered by knowledge and ideas from Western countries (Shrestha, 2002). Participatory health research and co-production are, arguably, as much a Western import to the Indian subcontinent as Western biomedicine itself (Rahman, 2008; Muhammad et al., 2015), though Western models of participatory health research and co-production are not inherently problematic to Nepali culture. However, the very Western-led nature of studies reviewed by this meta-ethnography suggests that, whereas biomedical approaches to health research are well embedded and enculturated within Nepali society, participatory and co-productive approaches are still largely being introduced and directed by Western researchers. Participatory research and co-production in Nepal, we now argue, will only achieve its aims when it is led and owned by local researchers and local communities, addresses local health priorities, operates from a distinctively local epistemology, and generates its own methods.

The studies reviewed by this meta-ethnography suggest that participatory health research and co-production in Nepal tends to focus upon social justice challenges which are of global as well as local relevance: for example; the status and health of women (Gibbon and Cazottes, 2001; Shrestha, 2002; Morrison et al., 2005; MacFarlane et al., 2015; MacFarlane, 2016); and the health impacts of climate change (MacFarlane et al., 2015; MacFarlane, 2016; Phuyal et al., 2020). This may be because each of the studies reviewed were funded either by a department of the UN or by a charity or research institution in the USA or UK, or because only one of the seven (Shrestha, 2002) was delivered by a team comprised entirely of local researchers. Research undertaken across the Indian subcontinent and more broadly across the Global South has long been known to reflect the agendas, priorities, and academic or clinical interests of research funders and institutional collaborators from the Global North, rather than the most pressing local challenges (Vidyasagar, 2006). In theory, the democratising and emancipatory principles which motivate and direct participatory health research and co-production should challenge this inequity (Fals Borda, 2001; Wallerstein and Duran, 2006; Robert et al., 2021) by ensuring that studies foreground local priorities. Within the studies reviewed by this meta-ethnography, only a minority provided local communities with sufficient ownership to enable this (Gibbon and Cazottes, 2001; Morrison et al., 2005). If participatory and co-productive research in Nepal is to focus upon the most relevant and pertinent health challenges, this research will need to be funded and led in ways which facilitate greater Nepali control and greater local community ownership over research questions.

Given that participatory health research and co-production seek to invite and to learn, they are approaches which, by definition, cannot methodologically or ethically be imposed upon potential participants or communities. Participatory health research and co-production require from researchers a significantly greater degree of cultural engagement and cultural literacy than more biomedical approaches to research. As the tension caused by Rai et al.'s (2018) use of hotel accommodation for participants and as the inability of the women to speak in the co-design workshops of Yadav et al. (2021) has illustrated, individuals and communities cannot participate in co-production unless they consider all aspects of the research process accessible, appropriate, and safe. Most of the studies reviewed by this meta-ethnography sought to some extent to ensure that their research methods engaged with local cultural assets and values. This was particularly evident within the four studies working with women, which harnessed their traditionally strong and well-organised village networks and FCHV structures (Gibbon and Cazottes, 2001; Shrestha, 2002; Morrison et al., 2005; MacFarlane et al., 2015). For participatory and co-productive approaches to become epistemologically embedded and enculturated within Nepali health research culture, participatory researchers will need to co-develop more culturally competent and locally relevant models and methods.

Notwithstanding what we argue to be the need for greater local control and ownership over research agendas, and notwithstanding the need we identify for more culturally competent co-production, we remain aware that, for a country as ethnically and geopolitically diverse as Nepal, advocating localism may also be problematic. Since the end of the civil war, nationalism has arisen as a political force (Bhandari et al., 2009; Bhandari, 2016). As such, those seeking to assert a cohesive and distinctive "Nepali" worldview or epistemic of health and illness tend to advance the views and interests of the more educated, urbanised, and dominant castes; they do not necessarily represent those of people from

remoter areas, ethnic or religious minorities, or historically-marginalised castes (Bhandari, 2016). As exemplified by Yadav et al. (2021), participatory research and co-production which empowers local health professionals may not empower the communities within which those professionals work.

In recent years, political instability and some nationalism across the Indian sub-continent has increasingly led governments to reduce research and aid funding from foreign governments and NGOs. Irrespective of the value of the resulting independence and self-reliance, the communities in question have often not possessed the resources for equivalent levels of investment, to the detriment of the most marginalised groups.

4.2. Strengths, limitations, and reflexivity

This meta-ethnography has sought to invest systematic and rigorous post-structural consideration in a range of participatory and co-productive health research studies undertaken in Nepal. We also appraised the quality of the included studies, to provide a comprehensive overview of the evidence reviewed and critiqued. In so doing, we hope that our recommendations – that participatory research teams reflect upon and engage with their epistemological differences and power differentials, and that researchers seek local methods for participation – will prove beneficial to future researchers.

At the same time, however, as this meta-ethnography advocates local participation and Nepali ownership, its research was based predominantly in Britain rather than Nepal, and was led by the only British member of the research team. Although Nepali researchers contributed to this meta-ethnography, it nevertheless represents a primarily British perspective which, it could be argued, serves only to replicate the embodied colonialism it critiques. Had it not been for the Covid-19 disruptions to international travel, this study would have been strengthened by having been written with all co-authors based in Nepal itself. Given the ongoing effects of the pandemic, increased awareness of climate change, and rapidly improving technologies for remote working, it is likely that online, virtual, and cross-cultural research will continue. We hope that our recommendations will assist research teams in thinking through the challenges this might pose.

4.3. Conclusions and recommendations

4.3.1. Greater discussion of epistemological differences

As a meta-ethnography, this research has highlighted a range of often unacknowledged epistemological differences which may exist within and between participatory health research teams and Nepali communities: for example, the authority of Western biomedicine, the relevance of Western concepts of mental health, the status of women, and the meaning of empowerment. Identifying and discussing these differences can add depth to co-production, because it enables researchers and participants to understand tensions within the research process, to respond to one another in a culturally informed way, to learn from one another, and to pursue consensus solutions. Within the studies reviewed in this meta-ethnography, this is particularly illustrated by the case study described within Rai et al. (2018), which demonstrates how engagement in co-production required not only individual motivation and consent (as had been assumed by researchers) but the trust and approval of the participant's family and friends. We recommend that participatory research teams in Nepal invest time and consideration in reflecting upon and discussing such epistemological difference which may exist between themselves as colleagues, and which may exist between their research team and the participating community.

4.3.2. Greater discussion of the complexity of power differentials within Nepal

As a post-structural study, this meta-ethnography has exposed something of the complex and multi-faceted power differentials which exist within international collaborations with Nepali researchers. Within participatory forms of research and co-production, which seek to elevate research participants to the status of co-researchers, those power differentials between communities and researchers will also impact even more upon the research process. The studies reviewed by this meta-ethnography have described a range of ways that women are disempowered both within Nepali society and within research processes, and have begun to explore the marginalisation of people living with mental or emotional distress. This meta-ethnography has begun to consider how the legacy and embodiment of colonialism might in part explain how Nepali researchers and clinicians are often keen to introduce Western biomedical or psychosocial practice and equate this to a progressive and empowering move. Understanding such power differentials may therefore prove valuable in discussing and engaging with the epistemological differences which sometimes impede participatory research. Similarly, we recommend that participatory research teams in Nepal invest time and consideration in reflecting upon and discussing the power differentials which different members embody.

4.3.3. Developing local methods and models of participation and co-production

As the studies reviewed by this meta-ethnography have illustrated, the methodologies of participatory health research and co-production are essentially Western forms of research, which tend still to be led by Western researchers, research institutions, and funders. Epistemologically and ethically, participatory and co-productive research methods cannot straightforwardly be introduced or translated between cultures. We recommend, therefore, that participatory and co-productive researchers from Nepal and working in Nepal use their understanding of local epistemologies and power differentials to engage with communities to develop local methods and models of participatory health research and co-production. As the studies which worked with local women's groups and existing FCHVs demonstrate (Gibbon and Cazottes, 2001; Shrestha, 2002; Morrison et al., 2005), building upon existing structures is particularly effective.

4.3.4. Using post-structural meta-ethnography to explore power differentials in global participatory research and co-production

As a country, Nepal possesses a striking geopolitical diversity and a distinctive legacy both within the world and the within the Indian subcontinent. This, together with its complex caste system, renders Nepal somewhat unique in the power differentials which exist within its health systems. Nevertheless, power differentials are present everywhere in the world: within and between communities, and within and between nations at all levels of economic development (Tritter and McCallum, 2006; Fairclough, 2013). We hope that the post-structural methodology of this meta-ethnography, which foregrounds, explores, and deconstructs these power differentials, might offer a framework for future researchers focusing on participation and co-production both within and beyond health in communities beyond Nepal.

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Appendix A. Supplementary data

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