Empowering Communities through University Partnerships in Public Health: Comparing Approaches and Perspectives from Nepal and the Philippines

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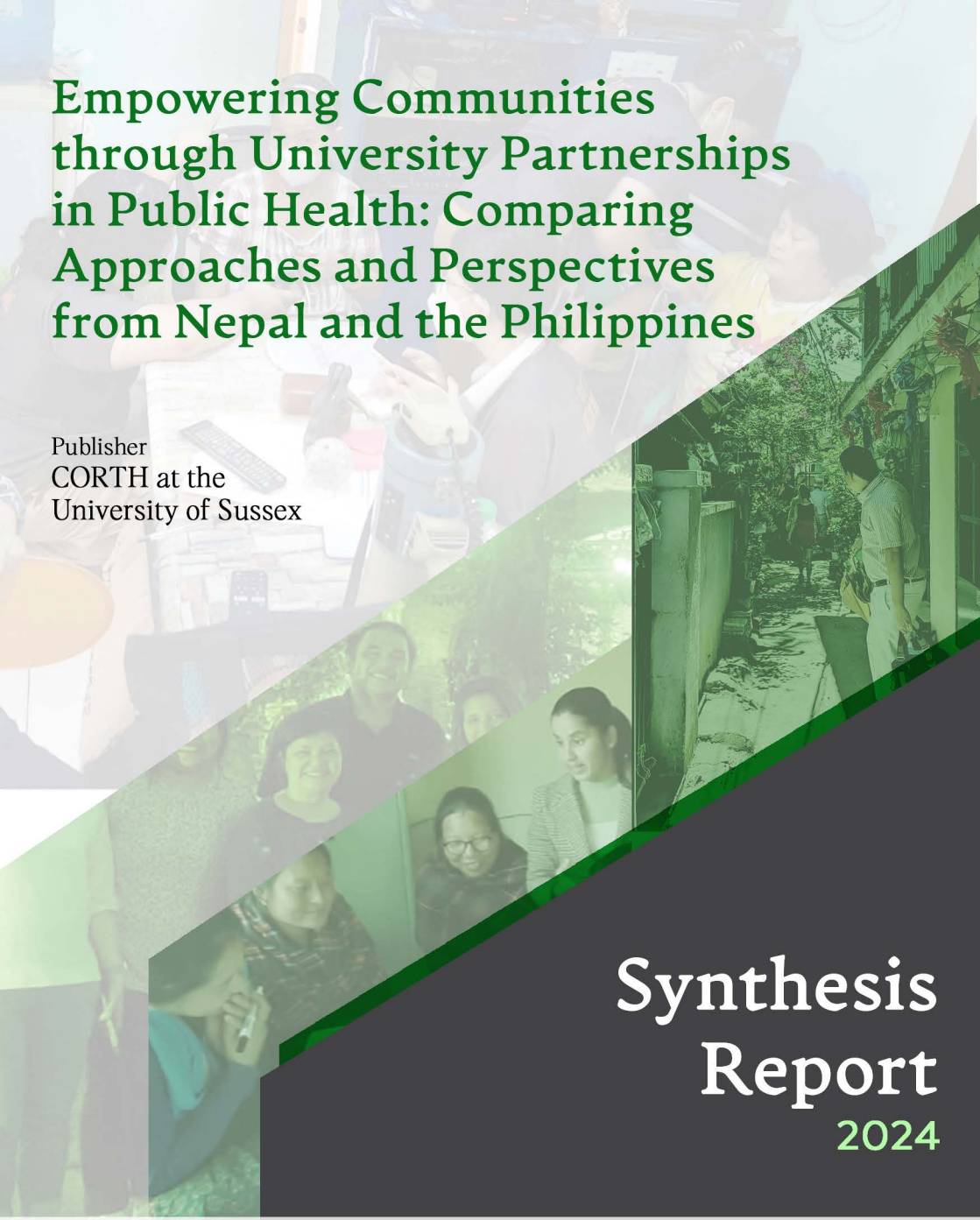

Synthesis Report

2024

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This report provides a comparative perspective on the findings, methods and outcomes of the Medical Research Council-funded Public Health Intervention Development (PHIND) project in Nepal and the Philippines (from March 2023 to August 2024). It should be read in conjunction with the separate country research reports and the literature review. It incorporates reflections from informal interviews with the project team and a comparative analysis of country-specific findings.

Acknowledgements

'Empowering communities through university partnerships in public health: a pilot project in Nepal and the Philippines' is the title of the University of Sussex's Medical Research Council PHIND project (MR/Y50323X/1), based in CORTH (Centre for Cultures of Reproduction, Technologies and Health) in the School of Global Studies. The 'Empowering Communities' team would like to acknowledge the excellent support provided by Tribhuvan University Research Centre for Educational Innovation and Development (CERID) and the University of Santo Tomas (Research Centre for Social Science and Education, Faculty of Medicine and Surgery and the Graduate School), and our colleagues at the University of Sussex: Prof. Maya Unnithan, Prof. Geert De Neve, Mark Raven, Paul Grant, Amy Collyer and Katie Meek. The project was proposed by and informally supported by the University of East Anglia UNESCO Chair in Adult Literacy and Learning for Social Transformation, particularly: Dr. Hélène Binesse, Dr. Catherine Jere, Dr. Qingru Wang and Theresa Frey. Dr. Anna Magyar provided editorial support and Vermon Bryan Yap Revillosa designed the final reports.

List of Abbreviations

CBR	Community-Based Research
CERID	Research Centre for Educational Innovation and Development, Tribhuvan University
CEU	Community-University Engagement
CLC	Community Learning Centre
CORTH	Centre for Cultures of Reproduction, Technologies and Health, University of Sussex
CURA	Community -University Research Alliances
CURP	Community University Research Partnerships
FGD	Focus Group Discussion
FMS	Faculty of Medicine and Surgery, University of Santo Tomas
ICT	Information and Communication Technology
IoM	Institute of Medicine, TU
MBBS	Bachelor of Medicine and Bachelor of Surgery
MOU	Memorandum of Understanding
PAR	Participatory Action Research
PE	Patient Engagement (PE)
PHIND	Public Health Intervention Development, UK Medical Research Council funding stream
PI	Principal Investigator
PPI	Patient and Public Involvement
RA	Research Assistant
RCSSED	Research Centre for Social Sciences and Education, University of Santo Tomas
SU	University of Sussex
TU	Tribhuvan University
UST	University of Santo Tomas

Glossary

Barangay	Filipino word for the smallest government unit that usually oversees the operations of a local community but is often referred to also as the community
Biomedicine	allopathic or Western medicine
Dalit and Brahmin	lower and higher caste groups in Nepal
Magar	indigenous ethnic group in Nepal
Palikas	Nepali word for municipalities
Participatory Action Research (PAR)	is a qualitative research methodology in which researchers and communities collaborate to investigate social issues and take action towards social change.
Photovoice	a participatory photography method
Ulat sa barangay	general assembly or community meeting in which the UST university teachers and students consult, treat and give medicines to community members
Vlog	a social media account where someone regularly posts short videos

Note: all quotations are extracts from the Nepal and Philippines research reports, apart from those which come from interviews with named individual team members.

Figure 1: Team members listening to doctor from UST in Manila fieldsite.

Executive Summary

Overview of the Project

In Nepal and the Philippines, communities have had little voice in public health initiatives. Health providers often take a top-down approach, telling families about how they can live more healthy lives and ignoring their everyday realities. Effective health promotion is however dependent on approaches that recognise local health knowledge and beliefs and build on existing community resources. With their key role in educating future public health workers, universities can contribute directly to transforming attitudes towards marginalised communities.

Bringing together two institutes of medicine - at Tribhuvan University (TU) in Nepal and University of Santo Tomas (UST) in the Philippines - this project aims to contribute understanding of the range, scope and perceptions of community-based learning in public health courses. The Medical Research Council PHIND funding scheme

offered an ideal opportunity to develop collaborative and comparative research in this field. The Centre for Cultures of Reproduction, Technologies, and Health (CORTH) at the University of Sussex (UK) provided an appropriate project base, with its focus on cultural-ethnographic perspectives and knowledge transfer partnerships between anthropologists, social scientists, medical professionals and others. An action-orientated ethnographic study explored approaches to community-based learning in the two medical institutes and investigated the health practices and beliefs of partner communities around food. Informed by the research question - *How best can universities engage communities in a mutually respectful and equal partnership to advance public health education?* – the project piloted a more democratic model of partnership between university medical institutions and local communities.

Research Context

The Philippines and Nepal were selected as the focus countries for this project, due to these two universities' eight-year partnership with the UNESCO Chair for Adult Literacy and Learning for Social Transformation, which the P.I. holds. In relation to public health, these countries face similar issues around migration and the 'brain drain' of qualified medical staff. Health providers in both contexts have to address challenges of accessibility and infrastructure, responding to the Philippines' 7000+ islands, and Nepal's mountainous terrain. Both countries have a strong policy focus on primary care within communities, with the Philippines Universal Health Care Act of 2019 marking an important shift from purely individual and curative care. In Nepal, the ayurveda

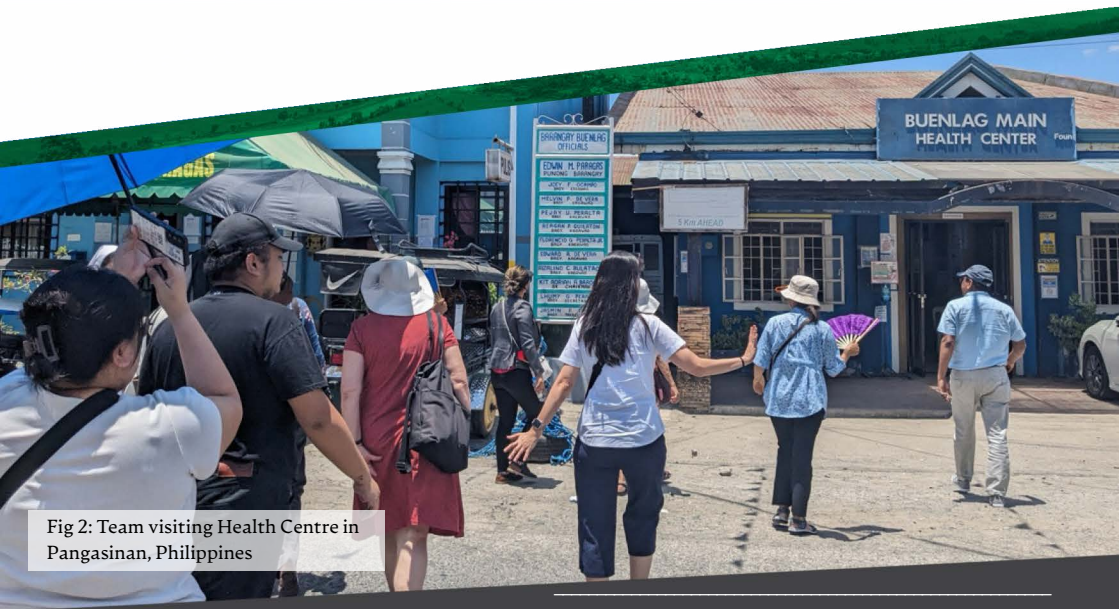

Fig 2: Team visiting Health Centre in Pangasinan, Philippines

Fig 3: View over the Gandaki Province, Nepal
Credits: Sushan Acharya

system of medicine, dating from 5000 years ago, is now being professionalised through degree-level programmes.

The partner medical institutions offered a valuable comparative dimension, given their different approaches to community-based learning in public health. Whereas Tribhuvan University focuses on what students can gain educationally, the University of Santo Tomas has an additional aim of offering service to the community. Public health and community medicine are essential elements within the UST medical degree, but are not stand-alone degree courses as in TU.

In each country, a field site was selected from areas where the university medical or public health students regularly or previously visited for community placements. UST students now work with partner communities in the heart of Manila in Sampaloc, which is very close to the university campus. Many of the residents are informal settlers, living in small rented rooms with several of their extended family and earning within or below the daily wage rate. In Nepal, Sahid-Lakhan Rural Municipality in the middle hills was selected – around a day's road journey from Kathmandu. The majority Magar community here have their own language, culture and health practices related to Shamanism and herbal medicine.

The contrast between the urban (Philippines) and rural (Nepal) field sites emerged as significant, not only in terms of food and health practices observed, but in shaping the nature of community engagement by students in these communities. TU public health students were immersed intensively in a remote community for a thrity-day residential stay, whereas UST medical students were regularly visiting a community just next-door to their campus where the department was able to sustain a long-term relationship.

Methodology

The project was designed around five stages, informed by a participatory action research (PAR) cycle. This began with reconnaissance (investigating the current situation of community-based

health learning, within the universities and communities), moving to action/ implementation, and concluded with evaluation (including final dissemination/ development of this approach with stakeholders).

Interviews and focus group discussions were held with faculty and public health/ medical students who had experienced community placements. Ethnographic research, involving participant observation and informal discussion in a range of community spaces and households, explored how people engaged with health knowledge and how they viewed university interactions. As the main actors involved in food preparation and production, women were positioned centrally in the research process, through a community-level intervention focused on nutrition. Through photovoice activities, they shared local food practices related to community health and co-developed ideas for future action with the team.

Comparative analysis took place throughout the project, including team visits to Nepal (April 2023) and the Philippines (April 2024), to learn from each other's context. An international hybrid conference was held at UST with over 3,000 participants being introduced to the project findings and approaches to community-university partnership. At local level, community members who had acted as co-researchers through the photovoice activities also presented their analysis to government officials. The teams facilitated workshops with key stakeholders in the health sector at national and local levels, and with university faculty and students, to take forward the project findings in relation to curricula and more formalised partnership agreements.

Key Findings

Food and Spaces

In the urban community that UST partnered with, the main space for preparing and cooking food was not a kitchen. Rather, it was streetside and food carts, as most people relied on street vendors for daily meals. The differences between the urban setting of Manila, with poor quality housing and little space for cooking, contrasted with the intergenerational kitchen environment in rural Nepal. Here, women took charge of the cooking space and with this came knowledge and solidarity. When they presented at the municipal offices, this breaking out of the kitchen space, for the women to share their knowledge and have that recognised and valued was what the TU team saw as most empowering. The UST team's observation of the structural inequalities, including clean and safe spaces to cook, influenced their decision to

develop a longer-term partnership with this community.

Who is learning what from whom?

The project facilitated and captured learning and flows of knowledge on different levels – within the community, within the university and within the research team (including across cultures and disciplines). From the analysis of student and faculty interviews around the current public health curriculum, it appeared that knowledge was viewed as either 'academic' (belonging to the students and faculty) or as 'everyday' knowledge (belonging to the community). Whilst both parties were sharing this knowledge with each other to some extent through the conventional community placements – including through a survey – the static binaries of formal academic versus informal everyday knowledge prevented deeper collaboration. Through PAR, a concept of knowledge as co-constructed and owned by both community and university began to emerge, which had potential to reshape relationships between the community, researchers and university staff/students.

Responding to Change

It was clear that communities recognised major transformations taking place in their lives – whether through technologies, governance structures, migration or beliefs around health and food. In relation to the university public health curricula however, changes are just starting to take place after a long period of conducting community placements in a routinised way. In both

Fig 4: Local food and Refreshment Halo-halo stall in Sampaloc, Manila

universities, the MRC project coincided with an opening up after the COVID-19 pandemic when community placements had had to be paused. This sense of change – whether welcomed or not (as in the case of the pandemic) – influenced how our project was implemented and received by the university departments and the communities.

Project Outcomes

This PHIND project provided the partner universities with hands-on experience of facilitating a new kind of partnership with local communities through ethnographic and participatory research. We had not expected to embed these approaches in the public health curricula during the short timeframe of this project (18 months). However, the initial outcomes indicate that both medical schools are already revising the modality of community placements to draw on these methods. Both country teams considered that photovoice was more effective in reshaping the university-community relationship than their previous approach of conducting a survey. They also plan to establish longer-term agreements with the communities to formalise their relationship and provide a framework for articulating expectations from both sides.

An unexpected outcome of this project was the depth of interdisciplinary and intercultural learning facilitated – for both the educational faculty and public health researchers. A key impact is the greater visibility and importance attached to public health within both universities. The partner institutions valued the unusual opportunity to work together across disciplines within their universities and will be looking for possibilities to extend this collaboration in future.

Fig 5: PAR: Photovoice preparation with community in Sahid-Lkhan rural municipality

Figure 6: Team members from UST, TU, and SU on field visit in Nepal

Synthesis Report

Background to the Project

In Nepal and the Philippines, communities have had little voice in public health initiatives. Health providers often take a top-down approach, 'preaching' to families about how they should live more healthy lives and ignoring their everyday realities. Effective health promotion is, however, dependent on approaches that recognise local health knowledge and beliefs, and build on existing community assets, including staff and infrastructure. With their key role in educating future public health workers, universities can contribute directly to transforming attitudes towards marginalised communities.

Bringing together two institutes of medicine - at Tribhuvan University in Nepal and University of Santo Tomas in the Philippines - this project aimed to contribute understanding of the range, scope and perceptions of community-based learning in public health courses.

Extending our team's established community-based learning approach to public health and our earlier research on indigenous/ intergenerational learning, we set out to pilot a new kind of partnership between universities and local communities. Community-based learning in medical institutes can be unidirectional, with the main intention of introducing students to health issues faced by communities so that they can offer advice based on their medical knowledge. Such initiatives have also often been framed in terms of a 'service' objective, rather than setting out to engage in mutual learning about different perspectives on health and wellbeing.

This project was framed around a relationship of respect for differing health beliefs and practices. Through conducting an action-orientated ethnographic study, we explored community-based learning interventions of the two medical institutes and the health practices and beliefs of community members. Our focus on food and nutrition reflects the growing importance of public health interventions in the Global South that address non-communicable diseases. We positioned women centrally in the research process, as the main actors involved in food preparation and production. Women were encouraged to identify a specific health issue that they would like to address through participatory action research.

Theoretically, the research team adopted a decolonising lens to investigate and find ways of addressing inequalities within related institutions, including public health organisations and universities. Comparative analysis of the two country contexts was intended to encourage questions and analysis of the broader health systems that are often influenced by practice in the Global North. The project outputs include guidelines for public health workers on how to build on indigenous learning and knowledges, developed through interaction in workshops with key stakeholders in the health sector at national and local levels. The project is now working closely with relevant departments in the university to take forward the findings regarding university curricula on public health. A key impact is the greater visibility and importance attached to public health within both medical institutions and across both universities. As Camilla Vizconde, Co-Investigator from UST Faculty of Education, commented at the end of the project:

> *'I hadn't really understood before what public health was. I assumed that it just involved doctors... But now I see this project has changed that perception... It can be embedded in the curriculum and often we didn't notice that the curriculum in other areas involves health. I became more aware of UST's work in public health because of this project'.*

Introducing the research contexts

The Philippines and Nepal were selected for this project, due to the two universities' eight-year partnership with the UNESCO Chair for Adult Literacy and Learning for Social Transformation, which the PI holds. Having worked closely together on a UKRI research project on indigenous and intergenerational learning (UEA UNESCO Chair 2021), the team had been approached at dissemination events by colleagues in their institutes of medicine who had an interest in learning about participatory and ethnographic methods in relation to community health. They also wanted to develop a more effective approach to democratising community-university partnership in community-based education led by the institutes.

The MRC PHIND funding scheme offered an ideal opportunity to develop collaborative and cross-country research in this field. The Centre for Cultures of Reproduction, Technologies, and Health (CORTH) at the University of Sussex provided an appropriate project base, with its unique focus on cultural-ethnographic perspectives and knowledge transfer partnerships between anthropologists, social scientists, medical professionals and others. During the project, the full team met in Nepal (April 2023) and the Philippines (April 2024). The purpose was to hold 'hands-on' methodological workshops and to enable each country team to learn firsthand about the other partner's public health training context and health facilities. An important element of the project was to develop comparative insights across

Fig 7: Team on fieldtrip in Sampaloc, Manila, Philippines

the two country contexts regarding public health provision and university education. This understanding is key to investigating how to embed the project findings in existing provision and courses, as well as exploring the implications for other country contexts. This section introduces some of that learning as well as comparing the specific research contexts.

Health policy context in Nepal and the Philippines

In the wider context of public health, Nepal and the Philippines face similar issues around migration and 'brain drain' of qualified medical staff. During our informal talks with medical students at TU and UST, it was clear that most aspired to work abroad. However, the TU public health graduates would expect to be based in a municipality in Nepal, where they would have to oversee all public health activities.

Both countries face similar challenges around physical accessibility: the Philippines has more than 7000 islands and telemedicine has provided a temporising measure. In Nepal, the mountainous terrain poses similar challenges in terms of accessibility and road infrastructure. However, mobile phone networks now reach nearly every corner of the county and mobile phone ownership is widespread, even in the poorest communities. A mobile app has been developed and used to monitor the health of pregnant women in many rural areas. By contrast, during our team visits to communities in Manila where UST is working, we found that only a few people had smart phones – which had implications for our planned Photovoice activities.

There are significant differences between Nepal and the Philippines in relation to health services provision. The Philippines' Universal Health Care Act (UHC Act) of 2019 marks a shift from purely individual and curative care to a balance with population-based primary health care. It prioritises prevention and promotes a system that is inclusive and accessible for all. These reforms involve developing government and private partnerships, offering financial risk protection and a seamless coordination system. This means that if a patient goes to primary care and cannot be treated, they can be referred to a secondary or tertiary hospital and be financially protected. In Nepal, one of the objectives of the National Health Policy (NHP), 2019, is to promote multi-sectoral partnership and collaboration between governmental, non-governmental and private sectors and to promote community involvement. Our team visit to Nepal included meetings at the ayurveda campus and the TU Institute of Medicine teaching hospital. Ayurveda is a system of medicine established over 5000 years ago and there has been a policy

Figure 8: Teams visit UST campus gardens in Manila, Philippines

shift in terms of the professionalisation and formalisation of this sector through degree-level programmes, supported by the government. This contrasted with the strong emphasis on Western medicine in the Philippines. The policy focus in both countries on primary care within communities was seen as particularly relevant to our project.

University of Santo Tomas and Tribhuvan University Institutes of Medicine

The two partner medical institutions offered a valuable comparative dimension, given their strikingly different approaches to community-based learning in public health within current courses. At Tribhuvan University (Kathmandu, Nepal), community-based learning constitutes an integral and ongoing part of undergraduate and postgraduate medical degree and public health curricula, involving a three-phase community study (community diagnosis, family health exercise and health system study) spread over the entire programme period for MBBS. The Bachelor of Public Health (BPH) has two residential field programmes in communities and institutions and a comprehensive practicum in an organisation in the final year. Such involvement by students is normally positioned in terms of what they can gain educationally, rather than developing longer-term partnerships in public health.

The University of Santo Tomas (Manila, Philippines) has a one-month placement in communities during the four-year medical degree, with the main aim of offering health service to the community. Public health

and community medicine are essential elements within the medical degree, but are not stand-alone degree courses as in TU. As an experiential pedagogy focusing on critical, reflective thinking and personal/civic responsibility, service learning is emerging as a new teaching approach across the whole university. UST has integrated 'service' elements and community work into all degree courses (even subjects like music) and reflective of the 'Thomasian' approach to education.

During our visits, we noted that methods of documenting the community placements by students varied between the two institutions. In TU there was a large collection of student reports – written up in a formal style like a dissertation. UST team shared vlogs created by the students during their community work, as well as project proposals and reports. TU students also write up experiences as articles and blogs. We could therefore access a wide range of reflections on fieldwork by students and in diverse formats as a source of secondary data.

Community placements and the research

In each country, a field site was selected from areas where the university medical or public health students regularly or previously visited for community placements. In the Philippines, the approach/site for community engagement by UST medical students changed significantly after the COVID-19 pandemic. Rather than an area three hours' drive away, they now work with partner communities in the heart of Manila in Sampaloc, Barangay 458 and 429. These communities or *barangays* (smallest government unit that usually oversees the operations of a local community but is often referred to also as the community) are very close to the university campus. Many of the residents in the area belong to the lower income level, usually earning within or below the daily wage rate. Many are informal settlers or live in small, rented areas with their extended families, earning their living by doing odd jobs and by selling various items in local markets or in their neighbourhood.

In Nepal, Sahid-Lakhan Rural Municipality in the middle hills, Gandaki Province was selected – around a day's road journey from Kathmandu. The community includes several indigenous groups. The Magar (60% of the municipality) have their own language, culture and health practices related to Shaminism and herbal medicine. TU's usual informal partners here include mothers' groups, female community health volunteers, a community learning centre and a health-related NGO. The contrast between the urban (Philippines) and rural (Nepal) field sites emerged as significant, not only in terms of food and health practices observed, but as shaping

the nature of community engagement by students in these communities. TU public health students were immersed intensively in a remote community for a one-month residential stay, whereas UST medical students regularly visited a community next-door to their campus where the department was able to sustain a long-term relationship.

Comparing across contexts

The following key contextual differences should be noted in relation to our project methodology and findings:

- In TU (Nepal), the project was working with public health and medical students and staff, whereas within UST (Philippines), the focus was solely on medical students and staff as there is no public health undergraduate degree. This has implications for the 'impact' aspects of our project and which departments/ curricula we would be working with. The students in Nepal would later have the scope to use PAR methods from this project in community field postings as part of their training and in subsequent professional postings as public health officers, in place of conducting a survey.
- It should be noted that TU is a government-funded university, whereas UST is a private pontifical university - meaning it is strongly connected to the Catholic Church. This difference in governance has implications for the procedures for making curriculum change and resourcing. UST had greater freedom to develop their own ethos, for instance, promoting community service across the university, but the curriculum was strongly influenced by religious values.

Fig 9: Magar Women preparing PAR in Sahid-Lakhan, Gandaki Province

- The two partner departments had different approaches to community placements – with a greater emphasis on 'service' at UST and on 'learning' through community engagement at TU. The TU students spent a longer period on community placements in remote areas, though UST's proximity to their selected partner communities meant students could drop in more frequently and develop longer-term relationships.

- The field sites in each country are contrasting in terms of rural/urban lifestyles (and health issues/provision) and proximity to the university. This had implications not only for the fieldwork but also for how the proposed new methods of community engagement would be implemented after the pilot ended. The proximity of UST to the selected partner communities could enable more regular engagement and supervision by staff, as compared to TU, where the students would work independently at a considerable distance from their university in Kathmandu.

Theoretical Framing

Decolonising and indigenising health

There has been a recent turn towards 'decolonisation' in critical global health, education and anthropological literature. The PHIND intervention was conceptualised in relation to these debates around hierarchies of knowledges and resources. This 'turn' should perhaps

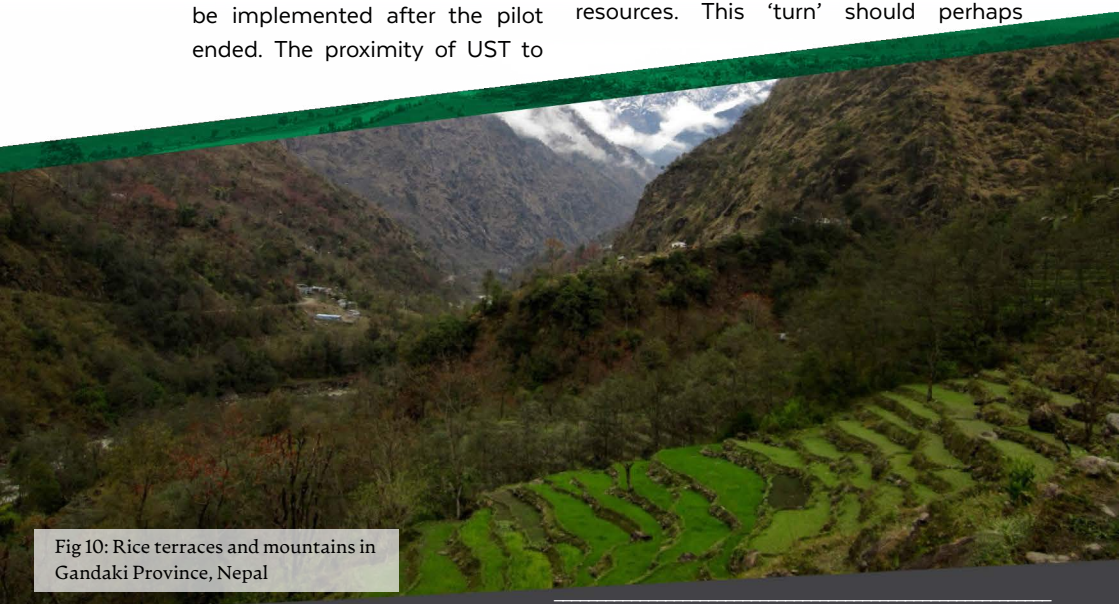

Fig 10: Rice terraces and mountains in Gandaki Province, Nepal

be acknowledged as a 'return', as we recognise that many aspects of calls for decolonisation of health draw on existing frameworks for Indigenous Knowledge research and medical anthropology.

These calls include a recognition of inequitable racial and North-South power relations, and their effect on health outcomes. The 'Empowering Communities' project aimed to respond directly to this challenge. Despite policy discourses and agendas promising positive change, commentators have observed that 'no real progress has been made to decolonise the major knowledge and political institutions of academia' (Smith 2021: xii). In part this is due to the recognition that, despite laudable aims to 'decolonise global health', an ideal implementation process remains ill-defined (Kulesa and Brantuo 2021). Whilst a common view is to shift power to local owners, there are few clear plans on how to make this a reality (Mogaka et al. 2021). Some call for local leaders to lead global health research, with foreign academics providing support - rather than the other way round. Others call for radical transformation to undo the white supremacy of global health institutions (ibid), or for equitable economic ownership of global wealth (Kwete et al. 2022). What is clear is that decolonisation requires deep examination of socioeconomic and political contexts (Mogaka et al.).

To date, in discussions about decolonising health, consideration of the ontological foundations of global health has been limited (Hindmarch and Hillier 2020). Where it has been noted, deconstructive calls for 'unlearning' and 'ontological pluralisms' (Affun-Adegbulu & Adegbulu, 2020) have not included reconstructive discussions of alternatives to Western ontologies. Moreover, these critiques have been developed using primarily non-indigenous frameworks, remaining comfortably within Enlightenment ontologies and biomedical approaches. Decolonising health should not only mean tackling the inequalities implicit in colonial epistemologies, but also the legacy of power structures and the very ontological foundations that health knowledge is built upon. There is current recognition of the need to deconstruct the ontological foundations and reconstruct them with indigenous ontologies. This means moving from the decolonisation to indigenisation of health knowledge (Hindmarch and Hillier 2020).

Researchers have also noted the need to explore the relational and situated dynamics of health from the outset of any research. This is why Roberts (2021) proposes the use of ethnographic engagement and collaboration to co-create research questions, so we can ask better questions that help to create better knowledge. However, collaboration requires not only mutual trust and ethical engagements

but within this, a consideration of the power dynamics between different types of knowledge and crucially, a reflection on positionality of different ethical and moral values across a wide range of settings (Dilger et al. 2015). This includes adjusting ethical procedures towards a more 'situated ethics' (Simons and Usher 2000). These ideas around decolonising and indigenising health, have influenced our research aims, as well as our ways of implementing the project at local, national and international levels.

A social practice view of literacy

From the field of education and anthropology, a notion of literacy as multiple ('literacies') and situated in everyday practices underpins the project's overarching aim and approach. This 'ideological' model of literacy (Street 1984) posits that 'different literacies are associated with different domains of life' (Barton et al, 2000: 8) and that 'literacy practices are patterned by social institutions and power relationships' (ibid). By contrast, an 'autonomous' model of literacy emphasises the divide between literacy and orality, and these theorists believe that literacy has cognitive implications for individuals, enabling more complex thought.

The starting point of this project was that health literacy has tended to be unidirectional (giving messages/ information through texts) and promoted through 'school-like' literacy and teaching methods. The assumption is often that

Fig 11: Health posters on a door in Sampaloc, Manila, Philippines

people need to be literate to understand health information and the way to become literate is through formal instruction. Taking a social practice view of literacy or adopting an 'ideological model', involves recognising not only different but unequal hierarchies of literacies and languages which could shape the relationships between health professionals and communities. We also drew on the notion that so-called 'illiterate' people can engage in analysis of their own situations and already do share health-related knowledge. This understanding was central to the project aims around co-construction of knowledge and informed our research methods which were based on accessible oral and visual communicative practices – rather than privileging complex written texts, such as surveys. We recognised that the hierarchies between universities and communities could be intensified by the dominance of 'schooled' literacy and set out to explore what kind of literacy is promoted and how – not only through health promotion activities by the students, but also through texts used within the project research process.

Informal learning

Related to the recognition of literacy as embedded in everyday practices is the concept of informal learning. Formal learning has often dominated health and educational research, whereas we set out to explore multiple modes of learning in everyday life, particularly in relation to food preparation practices and nutrition. Rather than a divide between informal and formal learning, Rogers proposed seeing learning as 'a continuum ranging from accidental/ incidental learning, through self-directed learning to non-formal and formal learning' (2014:21). Informal learning has often been defined only in terms of formal learning and what it is not (e.g. unstructured in terms of objectives, flexible learning time and non-certified, Colley et al 2003). Rogers (2014) identified diverse ways in which adults learn informally: 'natural, like breathing', a process of osmosis or assimilation, situated learning, task-oriented learning, social learning (informal scaffolding by peers) and individual learning.

These ideas shaped the project design and analysis – both in the university and the community research sites. For instance, the UST students' engagement in the Manila *barangays* involved 'individual' informal learning, a process described by Mezirow et al. (2000: 7) in relation to how 'we transform our taken-for-granted frames of reference ... to make them more inclusive, discriminating, open, emotionally capable of change and reflective'. TU ethnographic researchers drew on the concepts of 'situated' and 'task-oriented' informal learning to analyse indigenous and intergenerational practices within households.

Fig 12: Stupa with Buddha's eyes at Swayambhunath Temple, Kathmandu, Nepal

Indigenising/decolonising health in universities through teaching and generating knowledge

Drawing together these ideas about decolonising health, learning and literacies, the project set out primarily to enhance practice in university public health courses and local communities. The decolonising turn in global health encouraged us to look at 'whose knowledge' is privileged in the university, as well as in community health programmes. Global health education partnerships have been seen as perpetuating colonial legacies which limit health access and contribute to poor outcomes (Kulesa and Brantuo 2021). Implicit hierarchies remain in which practitioners from high income countries and backgrounds assume the role of educators. Kulesa and Brantio (2021) suggest local partnerships should promote 'positive defiance' by discussing local, contextual health practices and cultivate 'cultural safety' which involves predicting the overall impact of their work on the communities, including power imbalances.

The term 'decolonisation' has often been used to refer to eliminating colonial legacies in global health. However, this has been seen to mask the root of the problem: racism and white supremacy (Binagwaho et al. 2022). These commentators suggest that eliminating white supremacy should thus be the call, and that the role of universities should be to equip students with the tools to critically analyse, question and create new kinds of partnerships, ones that are mutually beneficial and

equitable. In addition, we have to question if institutions are ready and equipped to carry out these sort of partnerships – are universities ready to welcome and facilitate authentic engagements which would be defined by the community? (Bourgeois and Palmer 2022:15). In other words, what work is needed to ensure that the structures within their institutions are ready to engage meaningfully with indigenous groups and their ontologies?

Lastly, power and local hierarchies are still issues amongst Southern scholars and institutions. These in turn affect the inequalities and asymmetries that run through global knowledge production (Roy 2023). Indigenising health requires not just making health more holistic by incorporating indigenous teachings, but also recognition of historical inequalities (Hindmarch & Hillier 2020). Different ways of thinking about global health include excavating Western philosophies such as Cartesian dualism which separate human and natural worlds. They may also include shifting approaches to indigenous notions of holistic health which involves balancing individuals, communities and ecosystems in a way that is circular and regenerative, rather than a path of linear progression. Decolonising health thus means anchoring it to local issues whilst acknowledging the larger global and economic structures that affect it (ibid). Thus, indigenising and decolonising health requires institutions, including universities, to be ready to engage locally on local terms.

It should be noted that this project had its roots in the Global North, as the funding came from the UK Medical Research Council. Based at the University of Sussex, the part-time PI and RA liaised between the country teams, guided funding management, and led the comparative analysis of findings from this project. While TU and UST teams did not use the discourse of decolonisation explicitly to discuss their work, they focused on indigenous knowledge and health

Fig 13: UST Team member Philina Pasicolan with female leaders in Sampaloc, Manila, Philippines

practices and were particularly conscious of knowledge and power hierarchies throughout the project. They were willing to have their assumptions challenged and be reflexive around their positionality as researchers, educators and health professionals. Through their immersion in the communities, the 'decolonisation' of structural inequalities and knowledge hierarchies came through their appreciation of what communities wanted and needed, and the knowledge they shared. This approach to the decolonisation and/or indigenisation of health was through a process of localisation of health, which if scaled up, could transform hierarchies in other locations and on a larger scale.

Methodology

The objective of the project was to pilot a more democratic model of partnership in public health between medical institutions and local communities, informed by the following overarching research question:
How best can universities engage communities in a mutually respectful and equal partnership to advance public health education?

To explore the implications for enhancing current public health practice in medical schools and investigate community perspectives, the following sub-research questions informed the research:

1. What approaches to university-community engagement in public health are in evidence?
2. How do communities perceive partnerships with universities?
3. What health practices and knowledge can university partners learn from communities?
4. How can medical schools apply this model in practice? How can this intervention support the national public health system/strategy?

The project was designed around five stages, informed by a participatory action research (PAR) cycle. This began with reconnaissance (investigating the current situation of community-based health learning), moving to action/implementation, and concluded with evaluation (including final dissemination/development of this approach with stakeholders).

As mentioned in the introduction, TU has community-based learning as an integral part of all undergraduate and postgraduate courses, with a focus on student education, rather than longer term partnerships with the community. In comparison, UST has a one-month placement in communities

during the four-year medical degree, with a blend of service and learning. These differences informed how the two country teams approached the research methodology. The TU team focused on what could be learnt from community members, as one TU co-investigator saw it: '*The community is a source of knowledge for health, nutritional practice… there are best practices in communities which we academics have to listen to and incorporate into policy*' (Kamal Raj Devkota). UST adopted a more service-based learning approach, focusing on what could they learn about how to improve how they served the community, with the overall aim being '*to improve the health and well-being of the partner communities.*'

Two field sites were selected in each country, based on the team's ongoing involvement with community partners. In the Philippines, the UST team encountered delays due to the death of a key community stakeholder who was helping to connect the team with research participants. In Nepal, the TU team worked in Sahid-Lakhan Rural Municipality, with two communities, a Magar indigenous community and a mixed community of Brahmin and Dalit people (i.e. higher and lower caste groups).

A key difference was each team's decision around whether to involve students in facilitating the research activities. Due to difficulties coordinating a residential placement for public health students in a rural area within the timeframe of the research project, the TU team decided against conducting the research when students were in the field. By comparison, UST were able to conduct their research alongside students in a *barangay* right next to the university and were thus able to engage students actively in the research methods. Both approaches had advantages and disadvantages: the TU team were freer to explore the methods more fully as a group of researchers, whereas the UST were able to introduce the research methods directly into their teaching and placements with students.

In terms of task distribution, both teams decided that the educational researchers would facilitate focus group discussions and interviews with health faculty and students to introduce an 'outsider' perspective to the data collection and analysis. Each team also assigned their members to lead activities which drew on their specific expertise. For instance, a UST food scientist led the food study in the Philippines and TU CERID researchers with expertise on indigenous learning and knowledges led the ethnographic study in Nepal. Educational specialists with participatory research expertise, led and facilitated the photovoice activities in both countries.

Fig 14: STU Team member Poojan Sharma with community in Sahid-Lakhan Rural Municipality, Nepal

The reconnaissance stage was intended to draw on ethnographic methods, particularly participant observation in community settings, as a way of removing power from the researcher and developing informal relationships with people. Participant observation involves simultaneously observing and participating in a situation to explore cultural practices and knowledge from an insider perspective through spontaneous conversations. Whilst this stage was valued by both teams, participant observation was not conducted as a discrete activity and was more often combined with other project activities. This was due to the TU team having two intensive periods when they could travel and stay in the field site (a day's journey from Kathmandu) and the UST team visited the field site on days when their students were involved in community engagement activities.

An important principle of the project was that each country team should adapt the overall research design and methods to their specific context as outlined below.

Stage 1: Inception Stage

The project launch and full team meeting took place at TU, Nepal in April 2023, to finalise the design of the project and crucially, to share comparative perspectives on public health and community-based learning. The UST team also met with health professionals and visited public health institutions in Nepal, including the Institute of Medicine's public health department. The team also began the literature review on university-community partnerships in public health, later supported by the RA at Sussex.

The full team took part in PAR and ethnographic workshops to inform their skills for stage three. A TU researcher reflected that the workshops introducing the methods could form a key part of future student training as preparation for placements. A UST researcher noted that

the methods could contribute awareness about how to approach and engage with community members and thinking through the relational and logistical issues that might occur, as well as providing new ideas for themselves as educators. In addition, the workshops helped bring together team members from different disciplines, sharing visions and learning each other's expectations and approaches:

> *'We were from different streams, medicine, education and even literature. So we had different expectations. Our understanding on the project was so different as we were such a diverse group. The Kathmandu workshop last year helped a lot.'*
>
> (Poojan Sharma)

The initial workshops set the foundations for interdisciplinary learning and collaboration during the project by showing how team members could learn from one another, despite coming from entirely different academic backgrounds:

> *'I have found working alongside non-medical people very positive... It is more productive as you get to absorb what they know, and this started in the workshops in Nepal.'*
>
> (Ma. Teresa Tricia Bautista)

Stage 2: Understanding existing community-university health partneships

This stage involved gathering perspectives from medical staff, students and community members about their current university programmes. Interviews were conducted with university lecturers and students in the respective medical schools, and two FGDs with students who had already experienced community-based postings. Health professionals in the communities were also interviewed, and two FGDs conducted with community groups about their interactions with medical students and staff. Relevant public health curricula and students' field reports were reviewed by both teams.

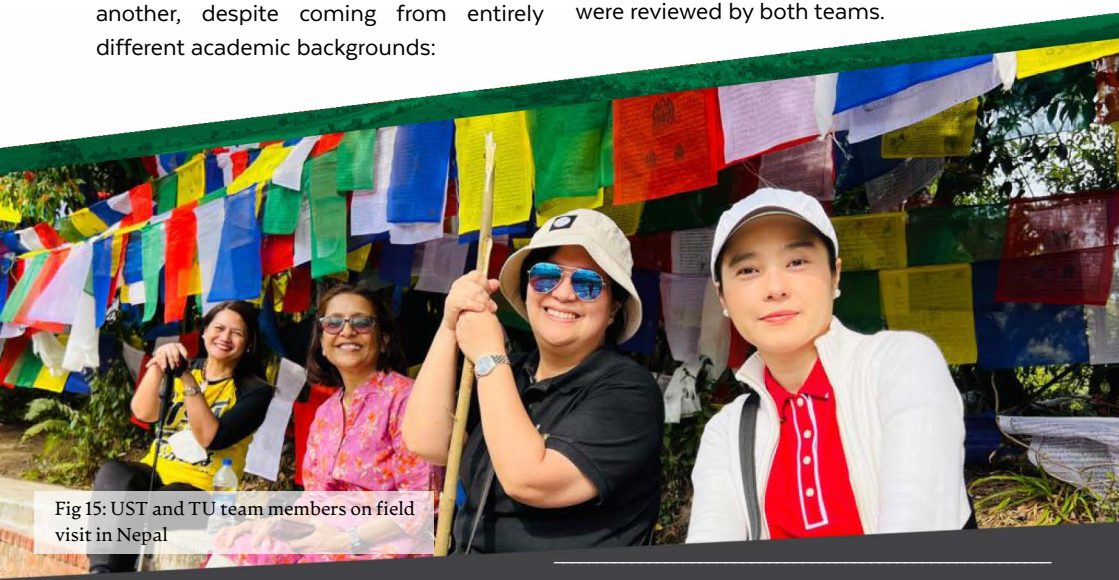

Fig 15: UST and TU team members on field visit in Nepal

Fig 16: UST Students attending to community in Sampaloc, Manila, Philippines

Due to COVID-19 restrictions at the start of the project in Manila, initial interviews at UST were conducted online through Zoom, and face-to-face interviews resumed when health protocols were relaxed. In some respects, the timing of this project was useful as the pandemic caused a rupture in usual community-university relationships and reestablishing a relationship post-pandemic offered an opportunity to try something different:

> *'With faculty, it was the first time after 15 years to make them reflect on how we can make a difference and think about how we interact with the community. Because of the pandemic, we had just resumed face-to-face interaction and I didn't really expect them to show appreciation for community partnership as we were just getting back to it.'*
>
> (Ma. Teresa Tricia Bautista)

UST medical doctors and teachers who had participated in the community immersion programme were invited for the interviews, while medical students were selected after their month-long immersion. From the community, the team purposefully sampled ten households and potential study participants were identified with the assistance of community officials.

UST found that students in their month-long immersion were consulting, treating, and monitoring children and adults. The teachers and students would conduct a *'ulat sa barangay'* or 'general assembly', a public session where the university reported data on the community's health concerns. The community leaders and *barangay* officials led the community, often providing tents and spaces for meetings, discussions, and treatments, whilst coordinating with university officials and teachers. They spread the word in the community about the visits. Men usually work outside the community, so largely women and children visit the university tents for information, treatments, and medicines. This includes medicines for treating hypertension and diabetes for most of the senior citizens.

In Nepal, TU researchers conducted the interviews and FGD with students later in

Fig 17: Food cart vendor selling corn in Sampaloc, Manila, Philippines

the study. Documentary analysis was also done as the project went along, with the face-to-face fieldwork in the community being prioritised. Pandemic restrictions did not affect the research. They visited the two communities, fitting visits around national holidays and local festivals. This timing was useful because during festivals, special local foods are prepared, allowing the team to ask more about local indigenous practices. They chose to work with a Magar community and a mixed community of Brahmin and Dalit for cultural comparison. Overall, the community's impression towards TU students being in the community was positive, but some TU members felt that if the project could have worked alongside the students in the field, they might have gained a deeper firsthand understanding about students' interactions with the community.

Stage 3: Community-focused study on food and health

This stage was based on ethnographic approaches. Participant observation was conducted community centres and communal spaces to explore how people engage with health knowledge and how they interact with health services. The teams planned to conduct participant observation in 10 households in relation to cooking, food preparation and health practices.

When visiting the community to find out about food practices, the UST team made a surprising observation that challenged their

expectations. Most community members in their study did not cook at home. Rather, food preparation took place on street stalls, or in the front rooms of houses which line the neighbourhood's narrow streets. Through interviews with community members, the team came to understand the reasons why:

> *"We buy cooked meals because they are cheaper. Onions and garlic are expensive. If we have to cook, we cook at night for dinner when we can buy the ingredients with money earned from the day, besides not many vendors sell at night".*
>
> (Community members)

These insights through ethnographic-style observation were revealing to the UST team who had expected to find food preparation practices within home kitchens. They also discovered that many homes did not have kitchens or refrigerators, or in some cases, access to electricity. Home visits for interviews and participant observation were scheduled rather than ad hoc to ensure that participants were ready to show and explain how they prepare their daily food. The process of observing and interacting informally with families proved an important source of learning for the researchers:

> *'I anticipated what I would observe about food practices from the literature as I had read about what is usual in low-income settings. And some of these practices are common. But I was surprised when I found that they buy food, that they*

Fig 18: Clean water vending machine in Sampaloc, Manila, Philippines

don't prepare the food. I thought that was just the middle classes. But even for the low-income families, that is just what they do. It's about practicalities.'

(Elizabeth Arenas)

For the UST team, participant observation revealed that food hygiene and sanitation practices were primarily rooted in insufficient tools and equipment and environmental conditions. Ethnographic observation provided a more holistic perspective on people's lives. In addition, health practices were not what medical members on the team anticipated, as a researcher observed:

'I was actually surprised to find out that even here in the Philippines, even in the 'metro' (urban area), there are still differences in practices. Not all areas practise Western medicine. There's still rampant use of traditional medicine that is not necessarily aligned with what we teach... use of herbs and other shaman practices.'

(Adonis Basa)

This part of the methodology (participant observation) was new for some: one UST member reflected that he did not even know this was *'data'.* The team were also conscious of power imbalances and frictions related to the medical students working in the community which had been noted by officials and students, observing that previously: *'Residents, expressing a sense of intrusion, largely declined actual entry of students into their homes. While no explicit concerns about privacy or student presence were voiced, a persistent feeling of scrutiny remained'.* They suggested that the active engagement and unique methods of the PHIND project created a different dynamic:

'I was able to see more engagement with the community members. It gave me more confidence to talk to them and I can communicate our plans with them because they could see something more concrete this time.' (Philina Pasicolan). In addition, the health researchers were already familiar with community members from their usual visits with students and this friendly rapport meant that during interviews and observation of food and meal preparation: 'they were very comfortable...you felt their hospitality and willingness to answer questions'

(Elizabeth Arenas).

During participant observation, the Nepal team visited several family homes and involved community partners like mothers' groups and the community learning centre (CLC). In contrast to the UST fieldwork, where traditional home kitchens were

largely absent, the family kitchen became an important space in their ethnographic research. This was also a gendered space with implications for amplifying women's perspectives through the research, as a woman participant explained:

> *"Kitchen is everything for us, except for the four days during menstruation, when we do not enter the kitchen. We not only cook food to eat, but we also make different herbal medicines, store grains, and preserve food for future use..."*

The team found, as expected, that almost all households consumed local foods, as well as packaged foods. Staple foods such as rice, dal and potatoes could be grown and consumed for 5-6 months a year, after which households would buy these items from local markets. However, they also found less familiar indigenous practices such as mushroom farming and hornet farming. This part of the methodology showed the team that there were new things to learn too: *'it has given me a different insight. OK, fine, things do exist in the community that you do not know or you're not aware of.'* (Ambika Thapa)

The team observed a range of storage methods such as hanging and drying meat and leaves, and all families had kitchens and kept poultry. The kitchen was a great space for ethnography. Listening to community members was recognised as central to ethnographic methods:

> *'It's all part of being able to listen, like when we went to the community...we also found out about the traditional herbs that they were using... and for what purpose... So being able to listen to the people with whom we are working becomes more important.'*
>
> *(Ambika Thapa)*

The team initially approached the community, identifying themselves as university teachers to explain that their intentions were different from local NGOs:

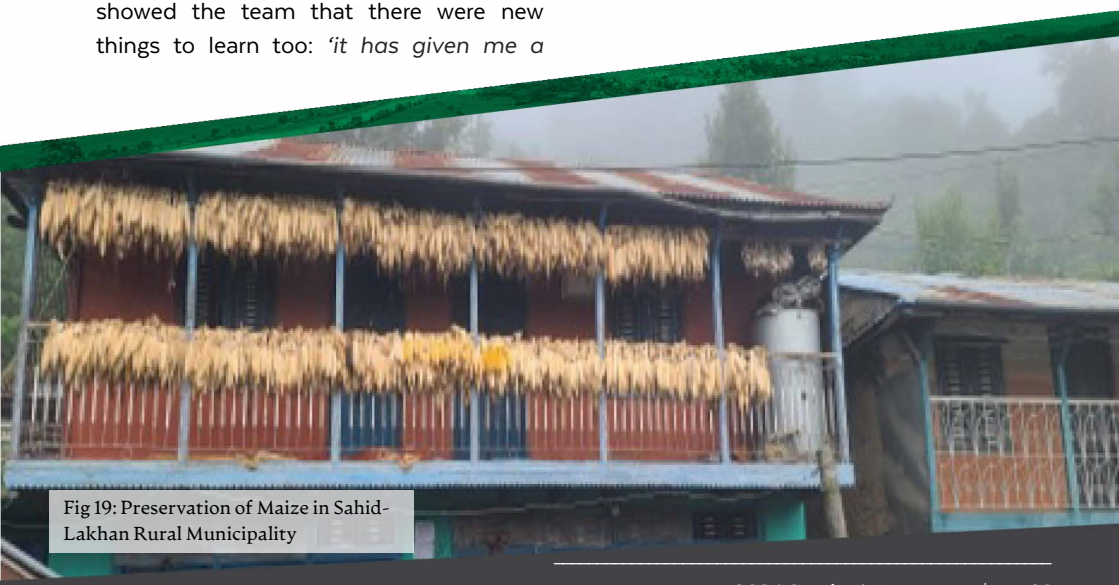

Fig 19: Preservation of Maize in Sahid-Lakhan Rural Municipality

*'Some were not confident in taking part - but they learned a lot, especially older women. It surprised me that they could do the photovoice as it needed technical knowledge and English language. But they learned from their children how to take photos and videos.' (*Poojan Sharma*)*
This was also the first time for some of the TU health researchers to visit CLCs, opening new possibilities for collaboration with different stakeholders.

Stage 4: PAR around food/health/ indigenous practices

PAR was conducted with the team's respective community members to develop, pilot and test new ways to build partnerships, including community-based health workers, students and local groups and organisations. PAR (Participatory Action Research) is a qualitative research methodology in which researchers and communities collaborate to investigate social issues and take action towards social change. Community members were encouraged to take the lead in setting the agenda for the research and proposed outputs. Both teams and communities opted to use photovoice to document local food practices related to community health. Photovoice is a research method to enhance participatory action through people taking photographs that are meaningful to them, as a focus for discussing their key concerns and setting an agenda for action.

In Nepal, the team had observed in stage 3 that the community was concerned about the loss of indigenous knowledge and food practices. Thus, photovoice was a method that could not only facilitate documentation but also help share food-related knowledge within the community. Initially dubious about the methods, the community were unsure how they could contribute anything new, particularly to a university curriculum which they knew little about. However, the team took time to discuss community food practices from daily meals, to festivals, foods during illnesses and related to childbirth. The researchers even shared some of their own food preparation styles and mothers' recipes, which helped the community to recognise their potential contribution:

> *'They [the community] eventually realised they possessed unique cooking and food preservation styles. They agreed that they had specific knowledge about diet. Furthermore, we discussed some herbs they used in their kitchens regularly and occasionally. We created a list of different foods on chart paper and had more discussions.'*

Sharing experiences helped to explain the methodology as well as build trust and rapport. Women community members were encouraged to take photos of cultural foods practice over a period of four months,

Fig 20: Magar women taking picture while frying hornet larvae

along with whatever else they thought important. In between, the team was in touch with them continuously by phone. In the second phase of field activity, the team held meetings separately with different communities. The women showed their photos, explaining about the process of food production, harvesting, and its significance. The researchers asked them to organise the photos in a meaningful way. The women themselves organised the meeting and finalised their presentation for the PAR workshop. Then the team went back to the field and used a laptop to sort the photos into themed folders with the women.

Some TU team members were concerned about the short time frame that they had to conduct photovoice. But letting the participants take photos over a longer period (due to the gap between the fieldwork periods) yielded over 400 photos and videos. Working with a small number of women, five in each community, meant that the researchers got to know the participants well. The team learned that 'The *community is a source of knowledge for health, nutritional practice'* (Kamal Raj Devkota). They also reflected on the fruitfulness of engaging community women as co-researchers: *'We realise that people don't need to be well educated to be a researcher. It's about demystifying research.'* (Sushan Acharya). Through PAR they also realised the importance of language and expression, as when it came to food and health Magar participants explained *"these are our things, we express them in our own way"* (related by Kamal Raj Devkota).

The PAR stage of the fieldwork changed the communities' view of university members in the field and enabled them to realise their own agency in these engagements:

> *'They [community] said that they [students] came for their own work, collected data and went back... But after organising PAR and with health stakeholders, the community said they realise they can better engage public health students to target their health needs.'*
>
> (Kamal Raj Devkota)

The UST team facilitated the photovoice activities with students while they were on community placements, which gave ivnsights into how this method might be used within the curriculum. This resulted in a more structured approach. The team gave the community members a theme for the photos in advance, then came back to take photos with them using the team's smart phones and community members provided captions. Though this limited the number of pictures that the community could take, in some ways photovoice became more focused. The students took a set of questions for the community to prompt them in taking photos, such as asking them to think about the most common health issues and other problems in the community. They also gave a different question to children who took part such as 'what in the community makes you happy?', 'what do you like best?' and 'what do you like least?'. The research team would then accompany them when taking the photos.

As one UST member commented, they would have found it hard to analyse the 400 photos acquired by the Nepal team. Instead, they were able to hang the photos on one of the streets and invited participants for a 'gallery walk' to analyse and discuss issues:

> *'even when they take pictures and ask them to give a short caption for it, you would see that they view things a little different to each other. But they're all only talking about one thing and one of the key problems that we can see with the photovoice is the issues with the cleanliness in in their surroundings.'*
>
> (Philina Pasicolan)

This method encouraged more open discussion between community members:

> *'During the processing, wherein many of the quieter ones during the barangay meeting or when we would flash all these pictures, they would start talking about what was happening before compared to now: "What is the problem with the current system?"'*
>
> (Philina Pasicolan).

Overall, the UST team reflected that in future they would consider buying disposable cameras, or some cheaper digital/phone cameras to leave with the community. They also discussed issues of trust around the implicit notion that doctors could be taking advantage of the community for their own studies and academic gain, rather than concentrating on their wellbeing. Ma Teresa Tricia Bautista reflected on the changes through photovoice:

'Maybe it has to do with the approach and 'hearing them out'. That we make a process built on their own inputs. Before, we only did surveys; it was all paper/pen. This time, we presented what they had said to/ about the community. They owned the responses – "yes, I did say this". The photovoice method made their ownership evident as they took the photos.'

Stage 5: National/ International dissemination of the intervention and final evaluation

In the final stage, an international hybrid conference was held at UST to present the methodology and research findings from their respective communities. This was an opportunity for the TU team to visit the Philippines, meet with health professionals and academics, visit the UST field site and share reflections across our teams.

The international hybrid (onsite and online) conference hosted by UST, involved over 3,407 participants, including 2,581

Fig 21: 'Empowering Communities' international hybrid conference hosted by UST.

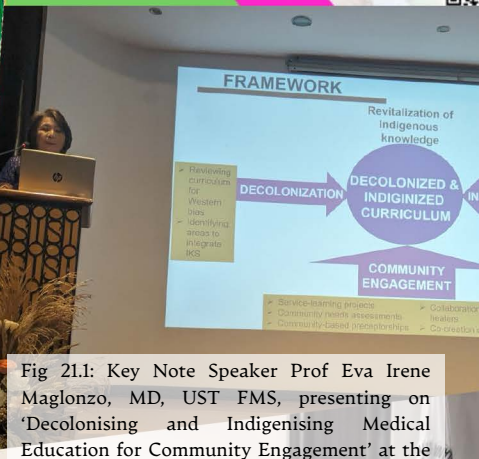

Fig 21.1: Key Note Speaker Prof Eva Irene Maglonzo, MD, UST FMS, presenting on 'Decolonising and Indigenising Medical Education for Community Engagement' at the international hybrid conference hosted by UST.

nurses and 281 medical doctors among others. It featured presentations by all team members, including a keynote on university-community partnerships, and plenary sessions on the findings from both teams. Plenary presentations were also delivered on the topics of 'Decolonising and Indigenising Medical Education for Community Engagement' by scholars from UST and TU, and 'Addressing Health Inequalities through Community Engagement' by health and economic specialists in the NGO sector. Panel discussions and presentations about UST community programmes and research projects also featured. Workshops on PAR and ethnographic methods were provided by the project team alongside a 'writeshop' for graduate students. Lastly, a World Café on 'Formulating Actionable Steps in University-Community Engagement' was facilitated in a hybrid format. The conference evaluation sent out to participants afterwards received positive feedback, despite limitations on in-person attendance due to severe heatwave warnings.

After the conference, the team visited several fieldwork sites including community health centres and presented at a workshop 'Beyond Boundaries: Empowering Communities for Sustainable Development' at the Marie Poussepin Community Development Centre in Pangasinan, which has a working relationship with UST.

The cross-cultural and interdisciplinary collaboration proved to be an important aspect for our team. Members also reported that they were taking PAR methods to other places in their respective disciplines, such as conferences and workshops. The World Café used in the conference also provided a new approach to analysis and facilitation. The team ran PAR and ethnographic workshops for medical faculty and students, which was an important professional development step for the project Research Assistants:

Fig 22: Participants and Team members at ' Beyond Boundaries' workshop in Pangasinan

Fig 23: Team members and attendees watch panel presentations on PAR at hybrid international conference hosted by UST.

'I got the opportunity to present myself in the Philippines conference as I was given an opportunity to facilitate the workshop...and to speak in the conference. You know that is, I think the biggest learning part for me ... I've even been given the chance to write the report and contribute, you know, my knowledge is in the report as well in the field as well in the conference.'

(Sudha Ghimire)

In terms of national and local dissemination, the teams had slightly different approaches. The TU team invited their photovoice participants to the municipal office to present their findings. This was a new opportunity for the women who had been engaged as co-researchers in the project and the municipal office realised how women could be engaged in policy making and developing local programmes through PAR. This led to discussions about how the women could be invited to local events to present their knowledge. In addition, the women, as co-researchers, also realised that their knowledge was valued and that they could contribute to the political domain:

'Working with the community provided a lot of information but more importantly, in that process they are empowered. Women were never asked to do this kind of work, to do a presentation, and the municipality didn't know that they could do it... This new concept of research and impact will be applied from now on and it really builds peoples' confidence.'

(Sushan Acharya)

The UST team's intervention came in other forms. Not only were students and faculty already exploring PAR methods, but shortly before the end of the project, the UST medical school decided to negotiate a Memorandum of Understanding (MOU) with the community. They have signed an agreement for the co-creation of a programme in the community about sanitation. This will start with a curriculum review during the summer break and co-designing selecting community-based activities based on the project to integrate into the course plan.

Additional dissemination events included team members participating in two hybrid seminars at the University of Sussex to share findings with CORTH, and the two UST Research Assistants travelled to Nepal to present at the final national dissemination event in August 2024. During this last stage, notes for a comparative analysis of the country reports on findings and interventions were also gathered by the team members from Sussex through individual interviews with each team member. This enabled the reflections of the team to be shared with one another during the writing of their country reports and informed this synthesis report.

Key Findings

The data was analysed separately by each country team through a bottom-up approach, and in relation to the research questions. Here, we discuss three themes which emerged from a comparative analysis of the two country reports.

Food and Spaces

Food and nutrition were the focus of this project due to the importance of food and nutrition to noncommunicable diseases and the fact that local knowledge around cooking and eating practices are often overlooked by health professionals. A key theme within their findings was the spaces that food was cooked and consumed in and surprising ways these spaces were used.

A major finding from the UST team was that in the urban community they partnered with, the main space for preparing and cooking food was not a kitchen. Rather it was streetside and food carts. The team were surprised to learn that most of the community did not have kitchens and relied on street vendors for daily meals. Community members either sold, bought or swapped food items:

> *'It was found to be more economical to purchase cooked meals in the preferred and exact amount than to prepare a full recipe at home considering the cost of ingredients and utilities (i.e. electricity, gas or water). Moreover, excess, or unconsumed food will result in a waste of food and money since some households do not own a refrigerator at home.'*

The team themselves were interested in the hygiene and safety aspects of this and the photos that came out of photovoice showed different cooking areas used by the community.

In Nepal, food preparation was done in kitchens that were the domain of women. The team reflected on this space as not just

Fig 24: Burger Store street vendor in Sampaloc, Manila, Philiuppines

one of exclusion but also one of solidarity. The kitchen was a multigenerational space where support and learning took place, and also the domain that women were embedded in: *'not just a place for culinary activities; it is providing them [women] with freedom and an avenue for discussion and learning.'* The kitchen was a domain where men did not enter and where women were therefore safe to discuss their dissatisfactions: *'Women couldn't share their problems or ideas like men do [in public spaces]'*. The team documented forms of food preservation as well as the use of indigenous medicine. The link between food and health became apparent in the notion of food as medicine.

In the Philippines, street vendors provided access to a variety of food and the findings focused on food preparation in relation to hygiene, vendor licences, healthy food, and highlighted the role of food as a possible danger to health. This was in part influenced by the team's expertise in nutrition and family medicine. The Philippines team found that hygiene practices were problematic due not to insufficient knowledge but because of lack of access to resources:

> *'residents living below the poverty line in these identified barangays do not have kitchen facilities and have no access to water and electricity which makes home cooking impossible.'*

This helped the team to consider what they could offer in terms of resources for the community in the long term:

'The discrepancy between food safety knowledge and practice among vendors highlights the complexities of implementing public health guidelines, emphasising the need for continuous education and support.'

(Gina Lontoc)

Food and space were clearly political. In Nepal, there was a strongly gendered aspect to the kitchen space, which was both exclusionary and productive. Women were in charge of the cooking space, and with this came knowledge and solidarity. However, when the community members and research team presented their research findings at the municipal offices, this breaking out of the kitchen space, for the women to share their knowledge and have that recognised and valued was what the team saw as most empowering.

In the Philippines, food vendors and the community were those whose limited accommodation and income, and different work schedules meant that cooking as an individual or for individual families was expensive. The differences between the urban setting of Manila, with poor quality housing and little space for cooking, contrasted with the intergenerational kitchen environment in Nepal. In Manila, the communities spilled out of their homes onto the streets to prepare, sell and eat food, making it an altogether more communal activity that happened to be more convenient and economical for their lifestyle. The structural inequalities, including access to healthcare, as well as clean and safe spaces to cook, were

Fig 25: Women preparing for photovoice in Nepal

observed by the team as issues which were likely to affect the communities in the long term. This made the UST team more dedicated to serving the community, and they went on to sign an MOU with the community leaders to work together in future.

As the methodology section explained, both teams conducted photovoice about food preparation with the communities, though with different interpretations of the methods and adaptations for their context. The Nepal team found that there was indeed new learning to share about food, and women's domain of food preparation led to a presentation about local food practices with the local municipality. Food became a site of empowerment for women who previously felt that their food knowledge was unimportant. For the Philippines team, the topic of food, with a focus on safety and nutrition was an entry point into a deeper and more formal mutual relationship with the community.

Despite some ambivalence, looking at everyday domains such as kitchens or food spaces, proved to be a source of learning for both communities and universities.

Flows of Knowledge: Who is learning what from whom?

Learning and teaching emerged as an important theme, not only in relation to the university public health courses, but within the overall research process. The participatory approaches facilitated sharing of different knowledges and practices between researchers, public health practitioners, university teachers, students and communities.

The community as a 'learning laboratory'

The two institutes shared a similar starting perspective, that university-community partnerships were for the purposes of training of medical/public health students, so were largely for the universities' benefit in terms of learning and teaching. The term 'laboratory' (used by TU faculty interviewees) carried this notion of the university framing and determining the kind of learning and teaching that would take place in the community. In the Philippines, UST faculty saw community immersion as an opportunity for students to apply the theories taught in the curriculum. However, there was also a strong emphasis on providing a service, whilst conscious of sustainability issues and the importance of not just 'giving doleouts'. At the same time, UST faculty were aware of what they could learn from the communities, emphasising the importance of these relationships for better communication and more effective services. The community members for their part, welcomed these services, appreciating the expertise of the UST practitioners, including the students.

Fig 26: UST Doctor visiting the community in Sampaloc, Manila, Philippines

In Nepal, TU faculty did not mention students offering health services during community placements. Instead, they focused on the different kind of learning: *'Through this course, we show the world that villages and community people can teach more than what is taught in the classroom. Community is believed to be a teaching and learning laboratory'*. In the community, public health students were exposed to different knowledges, for example, indigenous practices:

> *'We realised that we were 'blind' when we were placed in the field. I mean we were not aware of all these [local] practices.'*

Both TU and UST students were required to use a survey tool to collect information about basic health and population data in the community. Community members and students themselves were aware that they were often repeating research that had been done before. A TU faculty member commented:

> *'...students were oriented to extract limited and focused information. When they encountered more and unexpected information and cases in retrospect, they realised how limiting their research methodology and skills were'.*

Much of the information from the survey was available in the public domain:

'I was most surprised that our medical professional education courses are still carrying on the same traditional methods, using surveys to ask the same questions when the information is now available. For example, the records about children's births etc are available in the municipality. So there is no need for a third party to ask for this information again - as the students are required to do by the Institute when they are on the community placement.'

(Sushan Acharya)

This sometimes generated a degree of indifference towards the medical students:

'The community said the students do their work, we do our usual thing... they were not actually connected at all.'

(Ambika Thapa)

Similarly, medical students at UST were told by community members that they had done these surveys before, although people were polite and willing to help out. The survey thus formed the basis of the students' initial engagement with the community in both countries and appeared to contribute to a more detached and formalised relationship.

Although the aim of TU and UST courses was stated in terms of students learning from the community, we found that both groups of students were also expected to 'teach' improved health practices to the community during their placements. This often consisted of health information given in a didactic way. UST faculty commented that students sharing their knowledge became frustrated if the community did not apply their ideas in practice, such as the diet that diabetic patients should follow or the cleanliness that should be maintained for the children's health. In Nepal, there was a sense that the same health information had been shared for many years and was not that useful. A community member said '*students come and teach hand washing, how to cut vegetables and suggest not to use pesticides in the crops. We already know those things. They do not need to tell us such things anymore.*'

In both country contexts, some community members contested both the content and the ways of teaching about health issues, suggesting that their local practices had been ignored. A UST informant commented on some gaps in language and communication styles. Simply giving information was not seen as appropriate. Ma. Teresa Tricia Bautista argued that that there needed to be more learning on the part of the university teachers and students too, particular around the community's perspectives on their lives:

'It is about acknowledging the pre-existing knowledge and skills of community members and using these as leverage to make things succeed in a project. There is a tendency for doctors to think that they (the community) have zero knowledge, and this is what we have to do for them. But I think there may be some wisdom in what people do now. When their knowledge is acknowledged, they will be more motivated to take on what we are imparting.'

Learning through the research process

In adopting ethnographic and participatory approaches to research community health practices, the project set out to develop more democratic relationships around co-construction of knowledge. Previous reliance on survey tools highlighted that the communities were often distanced and bored by this approach; the information collected was replicating other sources and this kind of knowledge was difficult to share with communities.

The research team's learning

What the team learnt from the communities came as a surprise. The previous focus had been on students learning about the communities, gaining real-world experience and be better able to service the community. However, our team conversations revealed the rich learning amongst ourselves, not just about indigenous and local food practices, but also about different ways of interacting with health stakeholders through research. Above all, we began to question many taken-for-granted assumptions about community learning, knowledge, food, health and social change.

In Nepal, the research team emphasised their learning about indigenous knowledge

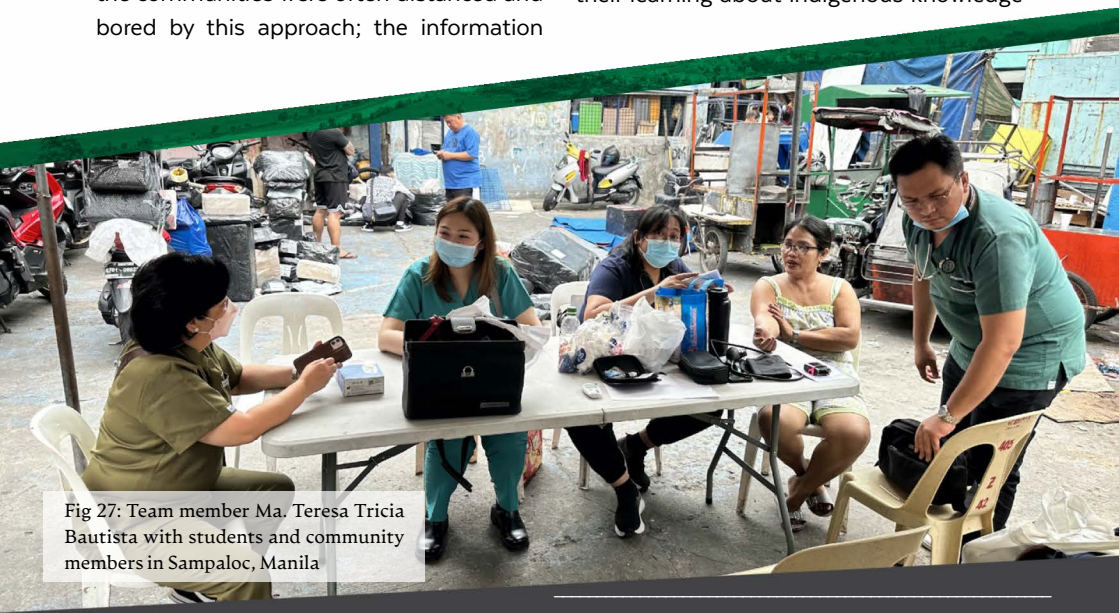

Fig 27: Team member Ma. Teresa Tricia Bautista with students and community members in Sampaloc, Manila

related to food at festivals and medicinal practices. The communities recognised that their knowledge was valued, not only by the researchers but by local municipality officers. The focus became about learning for the team, as well as empowerment for the community. Previous assumptions that '*empowerment would require some kind of education'* (Ambika Thapa) were challenged when the researchers observed women's agency and knowledge in the home.

Witnessing the participants' decision making and confidence when it came to health, the team members acknowledged that the women were already 'empowered' due to their understanding and use of traditional knowledge passed down from mothers, mothers-in-law and grandmothers. This was not only ayurvedic medicine or traditional remedies but '*practices that were around the kitchen'.* Their awareness and knowledge made them confident. During FGDs, women spoke of the medicinal plants they used, as if promoting or selling the benefits to the researchers. Team members commented on the resourceful practices engaged in by the community and their self-empowerment. Added to this, they observed that the community members used other health activity programmes and groups, such as those run by community health volunteers, not only for health awareness, but to discuss economic and financial issues such as credit unions/microfinance groups.

A strong contrast emerged in both countries between survey as entry point into the community, and the informal ethnographic observation and conversations: 'I think with that we were able to help them more rather than concentrating on the survey alone... I was able to see more engagement with the community members and it gave me more confidence to talk to them and I can communicate our plans with them because they could see something more concrete this time.'

(Philina Pasicolan)

In the Philippines, Elizabeth Arenas also reflected on the value of 'hands-on' learning, how it challenged her assumptions that lower-income communities would prepare rather than buy their food. Through participant observation, she learned more about how people lived. Whereas she only knew a few families in her immediate vicinity, in this *barangay* people knew and interacted closely with neighbours over the whole area. Analysing the difference, she realised that this might be because this community lived in a more open way, with no private gardens, and were sharing public conveniences (toilets and tap), thus becoming more interdependent. This kind of learning from real life, she suggested, could help her students too:

Fig 28: Team Member Sudha Ghimire with participants in Sahid Lakhan Rural Municipality

'Perhaps students would be more appreciative of what's happening if they saw it in practice. I wasn't surprised at what I saw as I had read in journals. But it was a different feeling when I actually witnessed the preparation. I learned a lot and if I am teaching food safety courses, I would draw on this first-hand experience with the students.'

(Elizabeth Arenas)

Drawing a distinction between academic learning (from journals) and first-hand experience, Dr. Arenas emphasised the importance of empathy and taking a more holistic perspective on people's lives. She also recognised a tension between her training as a food scientist, which encouraged her to judge food practices in terms of hygiene, and her desire to find out why people prepared the food as they did.

In both Nepal and the Philippines, the team learned about indigenous and local practices which were either absent from or presented a conflict with, the current public health or medical curriculum. Kamal Raj Devkota highlighted this as the most important learning:

'Sometimes there are pejorative feelings as if traditional health practices are not important and an assumption that communities need modern medicinal practices. This project made me realise the importance of alternative approaches of health. For example, hornet larva can be used as a source of protein and if this is implemented in farming, it could be important not only for promoting people's health but also their economic advantage for the families.'

In Nepal, where ayurvedic medicine is recognised as a parallel system, the relationship between Western and traditional medicine was addressed differently (as the UST team members noted on their visit to the ayurvedic hospital and campus in Kathmandu).

In addition to learning about food practices, hierarchies within the research teams and their institutions were also challenged to some extent through the project aims and methodology:

'Being here I never felt that I'm on the bottom of the project's organogram or something like that. Because I found that elsewhere as an RA, I might not have access to this or that, I never felt like that... actually the project itself is a bottom-up process.'

(Sudha Ghimire)

The project challenged a 'top-down' approach to curriculum development through setting out to engage communities and local health workers in a collaborative process of learning. As part of the process, research team members worked together to develop a more democratic approach to managing and implementing the project, thereby gaining experiential learning of a 'bottom-up' approach to research planning and implementation in practice.

Learning within the community

Another form of awareness was created within the communities themselves, particularly through the photovoice method. The researchers and medical students commented that they were introduced to parts of the community they do not always see, such as inside the houses. Community leaders were able to gain new insights into their community too:

'The community leaders, I think, are able to see their community in the eyes of their other community members, of their constituents...it's a way to monitor the effectiveness of their policies.'

(Philina Pasicolan)

Fig 29: Food Preservation in households- Lakhan Rural Municipality Nepal

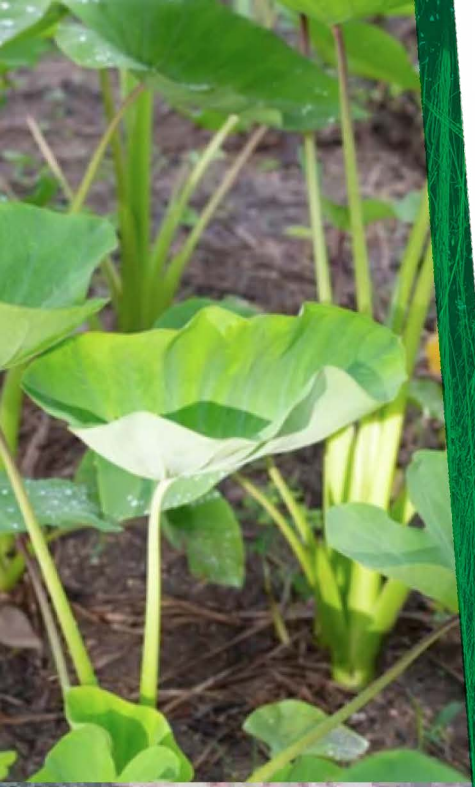

Fig 30: Taro Preservation in Sahid Lakhan Rural Municipality Nepal

In one community, the photovoice activity initiated a discussion about rubbish. Whilst the community had rules on where people could put their rubbish, it was clear that people were not following them, and this was made apparent to the community leader through the photos. The photovoice method enabled them to see things they might otherwise miss. This PAR method thus had the effect, not only of initiating equitable relationships between the community and the university, but also within the communities' own hierarchies.

As discussed earlier, the kitchen emerged as an important site of intergenerational learning, particularly for women. A 68 year-old-woman participant in the Magar community explained: '*It took me nearly three months to learn how to put on the pressure cooker lid, and about two months to light the gas stove'.* She had learned this from her sons, but commented that her grandchildren would probably never learn her skills of cooking using firewood or cow dung. Another woman observed that she had learned about different herbal medicines *'from our seniors, who know more than us, and our children know very little about it'*. Through participant observation and focus group discussions, the research teams found that women like these two participants felt their knowledge and skills were no longer valued or easily passed on to younger generations.

In this respect, the photovoice activities provided an important community learning space. In Nepal, women participating in this activity learned to use mobile phones to take photos and videos, and they led the

analysis of the photos into themes. It was through presenting their findings at a public meeting that women gained confidence and began to realise that their knowledge about food – which they had disregarded as 'nothing new' - could be valuable in policy contexts. A woman participant commented that, unlike her husband who is a local leader, her role was usually to serve the tea when meetings took place: *'I have talked to them in person but never in a group. I am feeling awkward presenting myself in from of them, because I have not been given chances or never tried.'*

In the Philippines, the photovoice activity culminated in a 'gallery walk' so that everyone could see and discuss the photos in a public space in the *barangay*. Dr. Bautista compared the process with the survey approach, noting that the community said they had learned so much through the PAR process that they asked the students to come back and work with them again.

Beyond binaries

The project facilitated and captured learning and flows of knowledge on different levels – within the community, within the university and within the research team (including across cultures and disciplines). From the analysis of student and faculty interviews around the current public health curriculum, it appeared that knowledge was viewed as either 'academic' (belonging to the students and faculty) or as 'everyday' knowledge (belonging to the community). Whilst both parties were sharing this knowledge with each other to some extent through the conventional community placements – including through a survey – the static binaries of formal academic versus informal everyday knowledge, prevented deeper collaboration. Through the PAR activities, a concept of knowledge as co-constructed and owned by both community and university began to emerge, which had potential to reshape the relationship between the community, researchers and university staff/students.

Responding to change: politics, technology, migration, and the pandemic

An overarching theme which influenced many of the smaller sub-themes in this project was that of 'change' as a concept that was talked about in positive, negative and neutral ways by both researchers and community participants. Small shifts and big changes to the social and political landscape were noted, sometimes indirectly, in the participants' and researchers' reflections. Their responses to and understanding of change shaped both the research process and the public health/medicine courses.

Changes in the political and policy landscape

In Nepal, major political changes have taken place since the community health department was established in TU, yet the community immersion part of the curriculum has remained relatively unchanged over the decades. Since the 1970s: '*they have used the same modality, despite changes taking place outside in the system... Other universities here probably do the same survey as this has been approved as part of the curriculum by the Medical Education Council'* (Sushan Acharya). The decentralisation of government services through establishment of a federal system had implications for community placements of public health students. Previously students were sent to wards which were much smaller units than the current *palikas* (municipalities). So they were now expected to work across a significantly larger area and the curriculum had not been updated accordingly. Local health workers commented on the need for the university and students to respond to current health issues, such as mental health, and the worrying rates of suicide now recorded amongst male migrants. Instead, students continued to give them advice about hygiene and sanitation which have been familiar to them over the decades.

Political shifts such as the appointment of a new mayor in Manila and new health policies were also touched upon by community members and the UST team. The Co-Investigators saw the national move towards universal healthcare as an

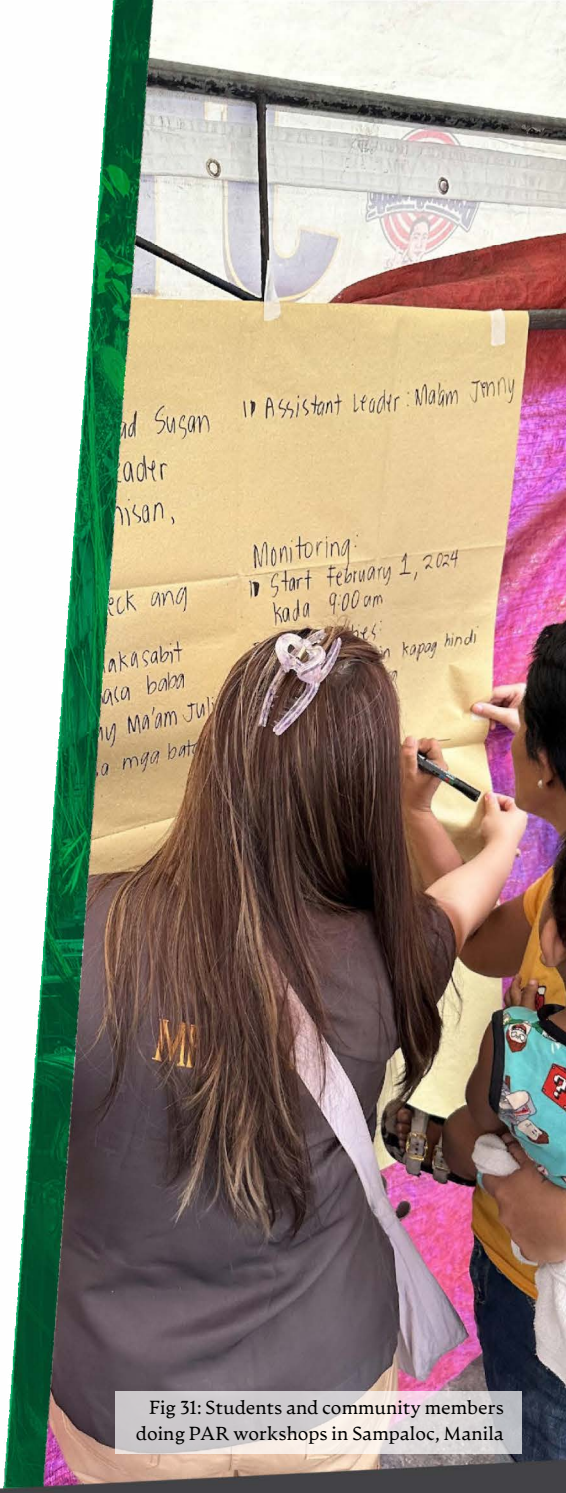

Fig 31: Students and community members doing PAR workshops in Sampaloc, Manila

important opportunity to revisit and revise the community medicine curriculum. The UST researchers recognised that they had to operate within the constraints of the university structure and values. As UST is a pontifical Catholic university, this meant that Catholic approaches to sexual and reproductive health had to be followed. Community members and the research team were also aware of micro-politics within the *barangay* which influenced how policies were actually implemented at local level and whose voices were heard.

In both universities, the MRC project coincided with an opening up after the COVID-19 pandemic when community placements had had to be paused. This sense of change – whether welcomed or not (as in the case of the pandemic) – influenced how our project was implemented and received by the university departments and the communities.

Technological and generational change

As discussed earlier, data from the food studies indicated that changes were rapidly taking place in the ways that people prepared their food. In the UST study, participants were more likely to have bought rather than prepared their meals. The shift towards time-saving and money-saving strategies was welcomed within these lower-income households. In Nepal, a generational shift was apparent in the cooking equipment used, as discussed earlier in relation to older women learning to use a gas stove.

The 'digital divide' became apparent in the photovoice methodology, albeit in unexpected ways. In Nepal, community participants all had smartphones, largely used to connect with a family member working overseas, who had sometimes been the one to purchase the phone and bring it back. In addition, taking photos or videos created a space for learning between participants: several older women learned to use mobile phones through the photovoice activity and help from their children.

By contrast, urban communities in Manila did not have smart phones to use for the photovoice exercise, and so the researchers accompanied them with their own phones to take pictures around the community. It also transpired that this digital connection became useful for the community in other ways. In 2024, the Mayor of Manila had introduced a new online booking system for health appointments, meaning that when students went to conduct their community engagement work, they were able to use their own phones to help people to book appointments. Though an opportunity for their students to be of assistance, the UST team were concerned about how this switch to online bookings could further

Fig 32: Students and community members presenting photovoice to others in Sampaloc, Manila

marginalise poorer communities. Whilst community members saw telemedicine and virtual checkups as valid approaches, they had limited access to devices, internet, connectivity and suitable environments in which to conduct the appointments at home. The rooms could be small with limited lighting and noise from the road or other community members, so privacy was an issue.

Responding to situations with limited technology turned out to be a learning opportunity for the UST students: *'students tend to be more into IPads, computers, phones etc and think that is the way to go. But this showed them that even traditional ways of doing things with paper can be more engaging. They would previously just set up the projector outside, but they realised this wouldn't work. So we printed the photos and stuck them up and had a gallery walk with the community.'* (Ma Teresa Tricia Bautista)

Migration and health professionals

Changing demographics, influenced by overseas migration has implications for communities and health provision in both countries. In Nepal, community members where the students had conducted placements were more likely to be female, as their husbands and sons were overseas or young people had gone to Kathmandu. In the Philippines, overseas migration was actually more of an issue for the students, as many training in medical professions aimed to seek work overseas. For those planning to work abroad, community immersion was seen as less relevant to their career.

During the team visit to Nepal, UST researchers commented on the Nepal policy of training more grassroots public health workers as a potential solution to the current situation of 'brain drain': '*Regarding public health in Nepal, I was interested particularly in their human resource development, and the scheme for training health assistants in junior high schools -*

that they then had a career waiting there for them. This is something I would like to explore further here.' (Ma Teresa Tricia Bautista). Camilla Vizconde also noted the different approach to learning: '*The practice of putting* [grade ten] *students in the health posts was good as they would learn more than in the classroom'*. The dependence on highly-trained doctors to staff community health centres in the Philippines was a constraint on implementing the proposed universal healthcare provision – as they would be more likely to move abroad after training than lower-level staff.

Change as a backdrop to this project

As indicated by both research teams, these findings around how the communities and universities were responding (or not) to change, were important to the project implementation and how to take forward the PHIND intervention. It was clear that communities recognised major transformations taking place in their lives – whether through technologies, governance structures and policy, migration or beliefs around health and food. In relation to the university public health curricula, after a long period of conducting community placements in a routinised way, changes are being made. The research team noted that a space appeared to be opening up for community-university interventions such as this project.

Project Outcomes

This section directly addresses the research questions in relation to the project outcomes in each country observed so far and proposed future directions, particularly in relation to public health university curricula and partnership approaches. In

Fig 33: Dissemination event to Faculty at TU, Nepal

Fig 34: Meeting with Community Leader and Team Members in Sampaloc, Manila

addition, we reflect on the interdisciplinary and comparative aspects of the project, in relation to professional development.

As discussed earlier, the research questions guiding this study were:
How best can universities engage communities in a mutually respectful and equal partnership to advance public health education?

Sub-research questions:

1. What approaches to university-community engagement in public health are in evidence?
2. How do communities perceive partnerships with universities?
3. What health practices and knowledge can university partners learn from communities?
4. How can medical schools apply this model in practice? How can this intervention support the national public health system/strategy?

Towards an equal partnership between universities and communities: two-way learning (sub-research questions 1,2, and 3)

The project set out to pilot a new approach to partnerships between universities and communities to advance public health education. Our earlier discussion has offered detailed insights into the first three sub-questions (see above), including how communities perceived these partnerships and what health practices and knowledge universities could learn from communities. This section reviews the key outcomes in relation to these areas.

Both medical institutes had previously followed a similar approach to community engagement, with the students initially conducting a survey. The university departments saw the partnerships in terms of experiential learning for the students, as well as a form of community service (in the case of UST). The findings suggested that previously the community felt obliged to 'help' the students by providing information, but they were also described

as quite 'passive' and 'indifferent'. The main benefits in the partnership had appeared to be for the university, not the community: '*Before, there was the notion that doctors were 'using' them to some extent, taking advantage of them for academic gain, not necessarily advancing their well-being.*' (Ma Teresa Tricia Bautista).

In the case of TU, the process was seen as quite formalised and was highly structured. A public health researcher recalled from her own experience of community placements that the process did not encourage the students to go with an open mind, nor to challenge their initial impressions: '*So it's more directed like you have to do ABC things in your field and you have to come back and do most of the literature review, developing the questionnaires... in the college itself. So they are with some pre-judgmental status when they go to the community'.* (Ambika Thapa). When the students did engage with the community around particular health issues, they often felt constrained: *'Students also said that if the community were asking for something, they had to do something else as the curriculum mandated this'.*

The major outcome – related to our overarching research question - was to signal the potential for a more democratic form of partnership, as Kamal Raj Devkota emphasised:

> *'Usually, the university has a health pedagogy and curriculum and is engaging students in community diagnosis programme on its approach. The community is also implementing health practices in their own way. The project taught us how we could better link these two sectors.'*

The PHIND intervention helped to facilitate a different kind of relationship with the communities in both UST and TU field sites. From the outset, the communities

Fig 35: Preparation of partnership guidelines with chairperson of Sahid Lakhan Rural Municipality

Fig 36: Community and UST Students in Sampaloc, Manila, Philippines

were encouraged to take a lead, rather than simply responding to questions as part of a survey. This involved explaining that '*We need your active participation and you will experience something in return'* (Poojan Sharma). The photovoice approach and ethnography enabled community members, not only to express their health concerns, but also to share their own knowledge and experiences. This led to a different kind of learning and the UST medical students began to understand the constraints on putting into practice the ideas that they were giving to people. More significant was that the interaction between 'experts' and 'community' changed, and the health professionals began to listen more.

This different approach resulted in what was described as a more trusting relationship between the university teams, students and the community. Members of the team who had previously worked with communities, recognised their own changing attitude, as a UST medical researcher reflected*: 'I actually value the community more as a partner now. So back then I would see the community as you know, recipients of my services'* (Adonis Basa). The UST team – who worked alongside students during the research process – found that the community had very different expectations of the partnership by the end of the project. This has resulted in the signing of a partnership agreement and discussion of longer-term inputs. UST Co-Investigator, Ma Teresa Tricia Bautista, commented: *'I was also surprised that they [community] are keen to sustain the relationship. I thought their expectations were more short-term before. They saw it as just part of the student's learning, but this time, they were worried that the programme might not continue.'*

From the university side, the two project public health Co-Investigators were previously unfamiliar with PAR but are now strongly committed to incorporating these methods into their courses in future. In the case of UST, medical students and faculty who participated in the research activities with the community, are already using photovoice in other areas of their courses and publications. In Nepal, PAR workshops

are being run for the TU Institute of Medicine faculty and students to share the methods used during the fieldwork. Poojan Sharma has published an article introducing the principles and methods of photovoice for her nursing colleagues. The TU public health Co-Investigator reflected on his own learning: *'I had learned before that people had indigenous knowledge, but I really learned more detail through the PAR approach. For instance, when we facilitated discussions about food preparation, using the mobile for photos, I had not expected that they could produce such good documentation. It was surprising to me that they could do it by themselves...It gives me confidence that PAR works as I got to know it in the field.'* (Bishnu Choulagai)

Through focusing the PAR on a specific area – food – researchers and medical students were able to gain new insights into local practices, beliefs and constraints. In both contexts, community participants grew in confidence through the photovoice activities, feeling that they owned the findings and could work with the researchers to put their ideas to policymakers in their district. The researchers too gained a different perspective on policy development: *'now I believe there are best practices in communities which we academics have to listen to and incorporate into policy. I used to think that policy was always made at the top and driven to the bottom for implementation.'* (Kamal Raj Devkota)

As researchers, we are cautious about overstating the impact of this very short-term intervention. However, we are also exploring the potential to expand and adapt the methods, and UST colleagues have continued to use photovoice in their student community placements, framed around different themes/health issues. Both Co-Investigators leading the project in the two medical institutes are optimistic that this approach can be integrated into

Fig 37: UST Students doing cultural sensitivity training

existing curricula and can help to shift the kind of 'top-down' communication that has often characterised university-community engagement activities.

How can medical schools apply this model in practice? How can this intervention support the national public health system/ strategy? (Sub-research question 4)

In both medical schools, the Co-Investigators have identified ways in which approaches from this PHIND project can be taken forward. Recognising the difficulties of making major changes to the curriculum, they have started to introduce PAR as an alternative approach for students to use when on community placements. In both contexts, team members agreed that there were ways to adapt the curriculum to develop a more participatory ethos. The challenge is to find what Franks (2011) refers to as 'pockets of participation' – in this case, opportunities within a structured curriculum where participatory activities could be included. More widely, both Co-Investigators noted that they have key roles on national bodies which are currently revising university curricula, so there may be potential to make changes in the overarching university public health curricula in relation to community engagement.

In both UST and TU, the project researchers identified the importance of changing attitudes amongst faculty as an important first step - if participatory approaches like photovoice are to be introduced. In UST, the Co-Investigator had specifically involved the younger medical faculty and they proved particularly enthusiastic about the project aims and approaches: *'They were more engaged and enthusiastic and will spread this kind of energy'* (Ma Teresa Tricia Bautista). Conducting ethnography and PAR requires different skills and mindset from the more conventional survey approach, and the researchers recognised the opportunity for 'soft skills' development, for faculty and students: *'Students will have the opportunity to develop communication skills, cultural sensitivity, and adaptability - all are essential for building successful partnerships.' (*Gina Lontoc). UST are planning curriculum changes, inserting the principles of cultural sensitivity, democratising concepts, co-creating programmes, and participatory practices from the PHIND project.

The different duration and location of the community placements in UST and TU provided valuable insights into the comparative advantages and disadvantages. The TU Co-Investigator, Bishnu Choulagai, had previously considered introducing the concept of 'teaching communities' so that the Institute could work more intensively and

regularly in selected communities, rather than travelling to different areas across the country for each batch of students. Having seen this model in action at UST, he noted that this seemed a more efficient approach. In the past, UST had also had relationships with rural communities, but proximity offered a different experience, as Camilla Vizconde observed: *'The university being so near the community can be an advantage... so accessible, any time we could go there. The relationship was more formalised as the students go on a regular basis.'* Ma Teresa Tricia Bautista commented that interacting with nearby communities had been an eye-opener for her as compared to a longer residential rural placement: *'I realised it was not the number of hours they spent in the community but the quality of engagement.'*

Both project teams emphasised the importance of establishing longer-term agreements with the communities to formalise the relationship and provide a framework for articulating the expectations from both sides. Municipality staff interviewees in Nepal had suggested that the university should be *'organising a modality for community-university engagement, not just ad hoc'* and TU staff acknowledged that there is currently no written agreement. In UST, the signing of an MOU with the local community leaders has been seen as a major step forward in developing and sustaining a new kind of partnership. Addressing the quality of engagement and formalising relationships should enable communities more room for negotiation. This should help to prevent communities feeling 'used' for academic gain, or students being used to fill gaps in healthcare sectors, such as helping patients navigate inaccessible appointment booking systems.

In terms of how to take forward the methods used in this pilot project, the team have already begun adapting tools to their specific contexts. In UST, photovoice activities are now facilitated with different groups within the community (e.g. younger and older participants separately) to enhance participation and bring out different perspectives. TU are also considering this adaptation when they implement photovoice with their public health student cohorts. Recognising that the power of the 'gallery walk' was dependent on the immediacy of paper rather than PowerPoint, the UST team are considering alternatives to using mobile phones: '*What if we went more traditional with the materials used as opposed to digital?*' (Adonis Basa). The issue of accessibility to smart phones remains and team members wonder whether to provide cheap cameras so that community members would not need to rely on the students' phones.

Interactions with the communities through photovoice and ethnography led to useful feedback on the national public health

Fig 38: Team photo at visit to health center in Pangasinan

systems and strategy. For example, the UST team found that the newly implemented e-system of appointments set up barriers for the poorer members of the community without access to ICT. Building on these findings in terms of longer-term public health strategies was beyond the scope of the project, but this pilot stage points to the potential for university students and staff to help enhance communication between health providers and communities. In Nepal, PAR activities led to women presenting their knowledge and ideas to health officials, initiating a process of policy interaction with community stakeholders and possible new directions in public health strategies at municipality level. As TU Co-Investigator Bishnu Prasad Choulagai explained, many medical students will be based in health centres at small or rural municipality level. Here they will be involved in public health activities or working on specific project with NGOs: *'in any role, PAR will be useful as there are community aspects.'*

Lastly, the examples set by two medical schools emphasise the importance of localising and situating medical education. The micro-level impact was noted by Sudha Ghimire in a blog about the opportunities being involved in the project had brought to one participant (see https://empcommunitiespublichealth.wordpress.com/). For her, the project was about much more than simply asking people to take photos. Rather, it was about creating agency for individuals. From localising forms of health education, the team saw a possibility to transcend hierarchical scales, from the individual, to the municipal, to medical schools and wider health activities and policy making.

Learning across disciplines and cultures

The comparative dimension of this project offered deep learning, not only about a different public health system, but also into unfamiliar health and community practices. A UST researcher highlighted the broader implications of this cross-cultural learning: *'It was fascinating to see how different cultural contexts influenced health practices and community engagement*

strategies. Working across countries has underscored the need for cultural sensitivity and a deep understanding of their local contexts'. (Gina Lontoc*).*

The interdisciplinary composition of the research teams was an important element of the project, which highlighted the potential for educationalists and health professionals to work more closely together in future too. The researchers from the two institutes commented that they had gained a lot from this intensive participatory research experience, and now have plans to publish and work on qualitative research papers in future. Kamal Raj Devkota from TU Education Faculty has begun to expand his research to language, nutrition and health, having interacted with the Magar-speaking community during this project. Poojan Sharma is introducing PAR methods to her colleagues in the Nursing Faculty as she felt this research approach offered a more holistic perspective. Elizabeth Arenas (UST) has already successfully introduced participatory methods of facilitation (Photovoice and World Café) to regional conferences for food scientists.

Working across disciplines was not without its challenges. As Poojan Sharma (health researcher) commented in relation to our diverse research team*: 'We thought one way and they thought another. Feeling and dealing is different in health sciences, and I had to learn a different way of approaching people in social sciences.'* As well as learning to interact in more informal ways with participants during the research activities, team members from science and medicine found the analysis and writing approaches unfamiliar. UST health researcher, Adonis Basa, reflected on his own learning about participatory and ethnographic research*: 'I thought it would be hard to interpret this data, to be honest, I didn't even know if there was data to be gathered from what we were doing. As things went along, I got to understand better the processes and what we were doing and how impactful it is in the storytelling of the bigger picture.'* Other members noted the communication skills they had learned: *'For writing the report, exploratory rather than explanatory writing matters more in social sciences. It should matter in health sciences too. I learned so many new things and I feel lucky to be a part of the study'* (Elizabeth Arenas).

Although the research process and methodology were familiar to the educational researchers on the team, they faced challenges around how to present and mediate the research findings to a wider public health audience. This had particular implications for the impact stage of the project, when considering how to introduce new ideas and methods to the existing public health curriculum. Sushan Acharya (an educational researcher) analysed the differences she had observed

from interviews with public health faculty and students: '*Education takes a more deconstructive approach, there is no fixed structure, and we talk a lot about context. For medicine, it is more structured, so the students had to follow the set frame, 1, 2, 3, 4, 5 when they go to a community.*' The question of when to 'judge' or evaluate local health practices as good or bad, and how to offer advice, arose frequently within the research process, particularly in relation to analysing data. Our different disciplinary backgrounds also influenced early discussions about which 'intervention' was most important to the project outcomes. We debated whether our main focus should be on taking forward the findings from the health intervention around food, hygiene and nutrition, or whether to concentrate on the educational intervention facilitating different kinds of interactions between communities and university students and staff.

Conclusion

This PHIND project provided the two partner universities with hands-on experience of facilitating a new kind of partnership with local communities through ethnographic and participatory research. We had not expected to embed these approaches in the public health curricula during the short timeframe of this project (18 months). However, the initial outcomes indicate that both medical schools are already revising the modality of community placements to draw on these methods, having recognised that a new kind of relationship was initiated with communities through the research activities. The timing of the project was fortunate – coming just when student placements in the community were being resumed after the COVID-19 lockdowns. As noted in the project literature review (see Burke, 2024), times of crisis can provide an opportunity to revisit and reflect on how to change established institutional practices.

The project conference (hosted by UST in April 2024) provided the chance for the team to adapt and introduce ethnography and PAR, alongside the research findings, to over 3000 participants who participated in person and online. This was the first step towards engaging with a wider international community of health professionals and their critical discussions at the conference helped the team to identify which parts of the intervention might be transferred to other contexts. The photovoice method proved particularly accessible to medical students, faculty and local community members. The photos taken could be considered in terms of Duignan-Moffat and Hill's (2020) concept of a 'boundary object' which helped facilitate deeper collaboration with the communities. Informal learning

was facilitated through the photovoice activity, being based on visual literacies, in contrast to the formal learning and literacy associated with a survey. Both country teams considered that photovoice was more effective in reshaping the university-community relationship than their previous approach of conducting a survey.

An unexpected outcome of this project was the rich scope and depth of interdisciplinary and intercultural learning facilitated – both for the educational faculty and public health researchers. The two partner institutions valued the unusual opportunity to work together across disciplines within their universities and will be looking for possibilities to extend this collaboration in future. The project had begun with a strong commitment to 'decolonising public health' – but, ironically, this was perhaps a stronger agenda for the UK research team than those based in Manila and Kathmandu. This reflects discussions about who decolonisation is for, given that academic projects are primarily located in the Global North and distanced from actual political struggles (Kamal and Courtheyn 2024).

Our project however explored inequalities between universities and communities in the specific contexts of Philippines and Nepal, with a view to challenging and transforming these situated power relationships. There was less explicit emphasis within the project on interrogating Global South/North hierarchies and construction of knowledge within global health. The debates around co-constructing knowledge in this wider context could provide a starting point for our academic writing collaboration in future, whilst emphasising the importance of building projects from the local, from lived experiences and power hierarchies, in order to challenge global inequalities in knowledge and learning.

Fig 39: PAR workshop hosted by UNESCO Chair team at UST

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