An Ethnography of the Mental Health System, Aid, and Modern Nation Building in Post-Earthquake and Federalising Nepal.

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Declaration

I declare that this thesis has been composed solely by myself and that no part of it has been submitted in any previous application for a degree. Except where I state otherwise by reference or acknowledgement, the work presented here is entirely my own.

Signature:

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December 2023
Edinburgh, UK

For Ayla, Kora, and Eric.

Thesis Abstract

Following a short-lived increase in funding and heightened attention on mental health in the aftermath of Nepal's 2015 earthquakes, the actors and institutions within the country's mental health system had to renegotiate their roles and responsibilities to ensure the ongoing availability of resources and interventions for mental health care.

Drawing on fourteen months of multi-sited ethnographic fieldwork conducted two years after the earthquakes, during a period of political transition towards a federal system, this thesis traces the remnants and rippling effects of short and mid-term care and funding for mental health at both the national and individual levels. It explores the key question of who is mediating mental health efforts in post-earthquake and federalising Nepal, and why. In charting these rippling effects this thesis not only provides ethnographic evidence of the process of implementing aid norms and policies, and the state of Nepal's mental health system, but offers an understanding of the shifting landscape of aspirations and possibilities for social change in the country. I argue that the renegotiations between stakeholders to reshape the mental health system in accordance with the latest mandates for health systems strengthening presented transformation opportunities, not only for mental health care but also for local agendas and the aspirations of social change and modern nation-building.

This thesis is organised into three parts. Part I historicises and ethnographically introduces Nepal's mental health system. I show that its history is intrinsically linked with wider national and international political, aid and development histories; that mental health is a contested object of care; and that the current mental health system is characterised by fragmentation and multiplicity, reflecting broader market-oriented economic forces. Part II explores how mental health brokers and translators navigate and translate current international development aid norms. Specifically, I show that state and non-state institutions are mutually dependent on one another to perform "country ownership" of mental health efforts and display "good" statehood and NGO-hood. In addition, I shed light on how mental health NGOs broker the demand for evidence-based practice on the ground, and how this demand affects different NGOs inequitably, contingent upon their epistemic frameworks. In so doing, this thesis challenges simplistic narratives of aid dependency, and emphasises the agency of mental health brokers in translating constantly shifting aid norms and in shaping the mental health system. Part III shows how psychological knowledge circulates and transforms within Nepal's social fabric. Through analysis of public psychoeducational activities and formal psychology education, these chapters reveal how psychological knowledge becomes "Nepalised" in different ways – from its communication to various public audiences to its role in shaping new professional identities among urban middle-class youth. Together, these chapters demonstrate how psychological knowledge enables both individual transformation and broader social change, while highlighting the tensions that emerge as new psychology professionals attempt to navigate between modern aspirations and existing social structures.

Overall, this thesis evidences the continuous negotiation of tensions arising between aspirations – encompassing policy, aid norms, and modernity – and lived realities experienced in practice in Nepal. I contend that these tensions exist both at the national and individual levels,

where the aspirations for rapid social change must coexist with the necessity of operating within slower-changing societal structures.

Lay Thesis Abstract

Following Nepal's 2015 earthquakes, there was a temporary increase in both funding and attention directed towards mental health care. However, as this funding waned, a necessary process unfolded to redefine the roles and responsibilities of various individuals and institutions within Nepal's mental health system. This re-evaluation was crucial to secure ongoing support for mental health care and strengthen the healthcare system for the longer-term.

Based on fourteen months of fieldwork conducted two years after the earthquakes and during a period of political transition, this thesis investigates the lasting effects – on national and individual levels – of short and medium-term mental health care and funding. The main question explored is who is mediating mental health efforts in post-earthquake and federalising Nepal, and why. This study offers insights into the implementation of aid policies and their impact on Nepal's mental health system. It also sheds light on the evolving landscape of social change aspirations in the country. I argue that the negotiations among stakeholders to reshape the mental health system presented opportunities for transformations both in mental health care and more broadly in Nepali society.

This thesis is organised into three parts. Part I provides both a feel for, and a historical understanding of Nepal's current mental health system, highlighting its connection to national and international political histories, as well as its contested nature. It reveals how market-led forces have influenced the fragmented mental health system. Part II looks at how mental health brokers and translators navigate international development aid norms. It shows how state and non-state institutions collaborate to perform "country-ownership" of mental health efforts and display both "good" statehood and NGO-hood. The impact of evidence-based practices on different NGOs, depending on their orientation towards knowledge production is also explored. This section challenges the notion of aid dependency and highlights the agency of mental health actors. Part III examines how psychological knowledge spreads and changes as it moves through Nepal's society. It looks at how this knowledge reaches the public through activities like radio shows and community programs, and how it shapes the lives of young urban professionals studying psychology. These chapters show how psychological ideas are adapted to fit Nepal's context – from how they are taught to different audiences to how they influence new career paths. This section reveals how psychological knowledge can transform both individuals and society, while showing the challenges faced by new psychology professionals as they try to balance modern ambitions with traditional social expectations.

Overall, this thesis underscores the ongoing negotiation between aspirations of policy, aid norms, and modernity, and the practical realities on the ground in Nepal. I argue that there are tensions between the aspiration for rapid social change and the imperative to operate within the constraints of existing societal structures.

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Abbreviations

AIDS: Acquired Immune Deficiency Syndrome

CIDT: Community Informant Detection Tool

CNMH: Chhahari Nepal for Mental Health

CVICT: Center for Victims of Torture

EBM: Evidence-Based Medicine

EBPM: Evidence-Based Policy Making

EBP: Evidence-Based Practice

GMH: Global Mental Health

HICs: High-Income Countries

INGO: International Non-Governmental Organisation

LMICs: Low and Middle-Income Countries

MHPSS: Mental Health and Psychosocial Support

MHCP: Mental Health Care Plan

MoH: Ministry of Health

MoHP: Ministry of Health and Population

MRC: Medical Research Council

NIM: Nepali Isai Mandali

NHRC: Nepal Health Research Council

PHQ-9: Patient Health Questionnaire - 9

PRIME: Programme for Improving Mental Health Care

RCT: Randomised Controlled Trials

TPO-Nepal: Transcultural Psychosocial Organisation - Nepal

USAID: U.S Agency for International Development

WHO: World Health Organization

Chapter 1. Introduction

I woke up on Saturday the 25th of April 2015 and checked the news half-asleep on my phone. My body started to shake before I could consciously comprehend why. The breaking news that morning felt deeply shattering to me – more so than any other terrible disaster and tragedy I had ever read about.

A major, and devastating, 7.8Mw earthquake had struck Nepal. The images and videos that accompanied the news articles were of utmost suffering, desperation and loss. I desperately tried to contact my Nepali friends. I dialled Rupa's number stubbornly – I must have tried hundreds of times. It was impossible to get through, and it felt as though every time I refreshed the news website, the number of deaths multiplied.

Eventually, Rupa's phone rang. Not a tone had passed before she answered. It was the first phone call she had been able to receive. "All signals have been down", she said. She, her immediate family, their tenants and her esteemed dogs were all safe, but she was worried about those she could not directly see: had her loved ones survived? That was the heaviest question in everyone's heart that day.

Rupa was standing outside with her immediate family, their guard, and some neighbours, without knowing what to do, trying to contact their loved ones and consoling each other after the shock. She spoke fast, adrenaline still rushing through her. She described the sudden and violent sway she had felt and the disorienting sensation of fully losing grip, control and awareness of her body in space. I heard her checking in with neighbours and people passing by. "Are you okay?" "Have you managed to speak to your relatives?". Abruptly, I heard her, and those in her vicinity, scream. It was a short, piercing yell. "There are so many aftershocks, Pia" she resumed telling me briefly afterwards, "and who knows how long this will last". She kept me on the phone, sharing her on-going sensations and fears. We both were, and felt, utterly helpless.

Then, she asked me what the news was reporting in terms of death tolls and infrastructural damage. Being stuck in the thick of the experience, the larger impact and consequences of the quake she had so vividly experienced, escaped her. The intensity of her bodily sensations were testimony to the power of the experience. Yet from where she was standing, in a wealthier part of Kathmandu, people around her were alive and the buildings, although swaying, remained erect. Rupa was concerned and curious about the wider effects and experiences of the earthquake across her country.

In that instance, my affectively close yet physically distant positionality, could provide her with a different type of information that was not immediately available to her.

This is also what ethnographers do.

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This thesis is an ethnographic study of the mental health system in post-earthquake and federalising Nepal. It sheds light on the tensions that arise between aspirations – of policy, aid norms and of modernity – and the actual experiences encountered in practice across various scales. The study is based on fourteen months of ethnographic fieldwork, from July 2017 to September 2018, following mental health actors and institutions engaged in implementing, mediating and shaping mental health efforts in Nepal.

The study was initially driven by a desire to provide experience-near research and ethnographic evidence regarding the effects, implications, and the complexities surrounding the implementation of humanitarian, development and global mental health policies in Nepal. It has ended up addressing these entanglements in ways that I had not anticipated at the outset, offering insights into local aspirations, agendas and identity of individuals occupying diverse social positions, as their lives intersect with current aid regimes and transnational mental health projects. Post-earthquake global interventions brought not only material resources, but also a shifting landscape of aspirations and possibilities for social change. Local actors engage with these projects not only to address immediate needs, but also to advance their own agendas and visions of modern Nepal. In so doing, this study challenges simplistic narratives of aid dependency, and contributes to our understanding of contemporary and modern Nepal.

While the 2015 earthquake and its immediate aftermath were central to my initial conceptual framework and research questions, the temporal distance from this event during my fieldwork in 2017 naturally shaped the evolution of my research focus. As the immediacy of the disaster receded, what emerged was not simply a story of humanitarian response and system development, but a more complex narrative about how various actors engaged with and transformed the mental health system in Nepal. The earthquake had created a unique window of opportunity through which multiple processes of change – institutional, professional, and societal – became visible and analysable. This temporal shift allowed me to observe how the initial humanitarian response had catalysed longer-term processes of change, leading me to examine how mental health became institutionalised as an object of care, how various actors negotiated and stabilised new aid norms, and how individuals across different social positions engaged with and transformed psychological knowledge. These evolved research questions, while different from my initial focus on the direct impact of humanitarian response, emerged organically from the field conditions and reflected the ongoing processes of change that the earthquake had set in motion.

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The seeds of this research project, and the start of my own journey as an ethnographer of global mental health and development began in Nepal with Rupa, a local researcher, in January of 2014 – just over a year before the earthquakes and the telephone call with which I began this chapter.

In 2014, I worked for five months as a volunteer and researcher for one of the few mental health dedicated non-governmental organisations (NGOs) in Kathmandu called Chhahari Nepal for Mental Health (CNMH). This NGO was, and continues to be, a small organisation with a dedicated team of four staff members and a few volunteers. They support underprivileged individuals with mental health difficulties and their families in Lalitpur district, situated in the southern region of the Kathmandu Valley. During this time, Dhriti, who back then held the position of CNMH's program officer, approached both Rupa and I to conduct a research project for the NGO. CNMH had noticed an increasing number of individuals they were supporting belonging to the Pode community – a low-caste Newar group. Concerned about this, they wanted to gain a deeper understanding of the factors contributing to the mental health challenges within the Pode community and asked us to carry out qualitative research. And so, Rupa and I began conducting participant-observation, focus groups discussions, and semi-structured interviews with local families, as well as mental health professionals and traditional healers. Throughout this process, I developed meaningful connections with the people I worked with, as well as an increased understanding of the mental health system in Nepal. It was also in CNMH's office one day, amid a brainstorming session with Dhriti and Rupa, that I heard for the first time the term global mental health. This term would subsequently shape my future research and professional path after I left Nepal, in May 2014.

When the powerful earthquakes struck Nepal in 2015, about a year after I had left, I could only witness the awful sense of terror and fear experienced by those affected from a distance, yet it reinforced my previous commitment to carrying out mental health research in Nepal. Motivated by my previous psychology and social anthropology studies and my experience with CNMH, I decided to pursue a MSc in global mental health (GMH).

When I began the MSc, in 2015, GMH was a burgeoning and increasingly critiqued field of research and practice (Patel & Prince, 2010; Mills, 2014). At its core, the field aimed to address what GMH proponents saw as a pervasive "treatment gap" in low and middle-income countries (LMICs): that is, the large disparity between individuals in need of mental health care and those who receive it (Patel et al., 2011). The field's initial and primary objective was to bridge this gap by scaling-up evidence-based mental health interventions (Patel & Prince, 2010). However, alongside the growing enthusiasm for GMH, there were also significant concerns and critiques towards it. These concerns included viewing the GMH enterprise as a neo-colonial project (Mills, 2014) and a form of medical imperialism (Summerfield, 2008). In addition, many scholars were denouncing the dominant biomedical model of mental illness underpinning the global efforts, emphasising the importance of cultural and social factors in shaping the experience and expression of mental distress, and were alerting of the dangers of the internationalisation of western psychiatric knowledge (Summerfield, 2008; Watters, 2011; Mills & Fernando, 2014; Davar, 2017).

Thus, while my previous research experience in Nepal had focused on understanding the experiences of those living with mental ill health, following the humanitarian responses to the earthquakes during my MSc made me increasingly aware, and curious, about the politics of care involved in the mental health system in post-earthquake Nepal.

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Immediately after the earthquakes, there was a surge of new funds and projects aimed at providing mental health and psychosocial support (MHPSS) to those affected by the disaster, as well as an increase in mental health discourse in Nepal (Seale-Feldman & Upadhaya, 2015). This brought about a fresh wave of energy and resources into mental health work; and, initially, there was a sense of hope among mental health advocates in the country that the field would undergo a transformation for the better (Seale-Feldman, 2020).

Relief efforts focused on the deployment of psychosocial counsellors and psychologists to affected areas; training volunteers, counsellors and social workers on psychosocial aspects of disaster management; raising public awareness about the psychological impact of the earthquakes and providing crisis interventions (Military Medicine Worldwide, 2016; Sherchan et al., 2017; Chase et al., 2018). At the same time, previously established mental health actors and institutions reaffirmed their commitment to strengthening the country's mental healthcare system for the long run (Seale-Feldman, 2018). The efforts aligned with prevailing discourses in international development and MHPSS that emphasised the principles of "Building Back Better" as advocated by the World Health Organisation (WHO, 2013) – an approach that aims to leverage the resources and political will that arise from disasters to bolster mental health systems for the long term.

Despite the discourses and aspirations of health systems strengthening and sustainability, when I returned to Nepal two years after the earthquakes to conduct my doctoral ethnographic fieldwork in July 2017, most of the attention, funding, and humanitarian interventions for MHPSS had come to an end. While the mental health actors and institutions engaged in post-earthquake interventions intended to eventually hand over ownership and responsibility to the state, the focus of these efforts had primarily revolved around short and medium-term interventions. Thus, when I arrived in 2017 for my doctoral fieldwork, I was well placed to witness the remnants and rippling effects of short and mid-term humanitarian care and funding; not only on the mental health system itself but also on local agendas and aspirations. This temporal distance from the immediate post-disaster period proved analytically valuable, as it allowed me to observe how initial humanitarian interventions had transformed into longer-term processes of change. Moreover, the post-earthquake context had a significant impact on the process of enacting the country's new constitution, rendering it a pivotal moment in the country's political history, as it marked the transition from a centralised system to a federal structure of government. Overall, my fieldwork took place at a crucial juncture in time when mental health actors and institutions had to renegotiate their roles and responsibilities in ensuring the ongoing availability of resources and interventions for mental health care. This process involved renegotiating the mandates between stakeholders and reshaping the overall mental health system. It also had, as this thesis will show, broader societal implications, such as impacts on the identities and professional aspirations of certain members of the population.

Studying Nepal's Mental Health System: An Ethnographic Approach

This ethnography focuses on Nepal's mental health system, and I situate it within the emerging field of anthropology of health systems (Closser, Mendenhall, Brown, Neill, & Justice, 2022). This field emerged from ethnographic research exploring the social organization, power dynamics, and political aspects of the global health enterprise, building on critical ethnographies that had focused on policymakers and health staff since the 1950s (Closser et al., 2022). This anthropological approach to health systems developed alongside the field of Health Policy and Systems Research (HPSR), a multidisciplinary and interdisciplinary area of study devoted to investigating and enhancing healthcare policies, systems, and processes that grew in popularity in the 2010s (Sheikh et al. 2011), inspiring, in turn, an increase in ethnographic research on health systems (Closser et al., 2022; Kielmann, Hutchinson, & MacGregor, 2022).

More recently, despite not yet having a common anthropological stance on specifically what a health system is, or what makes these entities *systems*, anthropologists have started to conceptualize the anthropology of health systems as a distinct field (Closser et al., 2022). Within this evolving field, a subtle conversation is taking place between those who argue that anthropology inherently resists or challenges the idea of systems (Closser et al., 2022), while others insist on the existence of a system and advocate for the need to identify and understand what is systemic (Kielmann et al., 2022).

My approach is located at the heart of those conversations. While I concur with the incongruity between the anthropological lens and the conceptualisation of systems, and the mechanistic representations of health systems that are dominant in global health in particular, I also observed ways in which the notion of system animated actors and relationships in the field. Anthropologists of health systems – me included – recognise that health systems are not monolithic entities but rather dynamic and multifaceted structures that are embedded within broader sociocultural contexts. We acknowledge the interconnectedness of different components within the system (Sheikh et al., 2011). Rather than approaching a "health system" as a coherent entity, we adopt a more nuanced approach by focusing on a specific aspect or entry point into the system that allows us to delve into the intricacies of the locally situated dynamics that govern the functioning of a health system (Sheikh et al., 2011). It is through the exploration of these dynamics from a localised perspective that one can gain deeper insights into the complexities and nuances of how health systems operate and are enacted within their specific cultural and social contexts.

Against this backdrop, I do not set out with an understanding of Nepal's mental health system as being a unified and coherent whole, nor do I intend to describe it as such. Instead, I examine Nepal's mental health system through two key entry points: the role of brokers and translators (cf. Mosse & Lewis, 2006) in negotiating international aid norms (in Part II), and the circulation and transformation of psychological knowledge within Nepali society (in Part III).

When examining brokers and translators in part II, I draw on an actor-oriented approach that centers on practices of brokerage and translation, drawing inspiration from Mosse and Lewis's (2006) framework for studying development processes (Mosse & Lewis, 2006). Their framework integrates three elements: the actor-oriented approach in anthropology, a focus on brokerage, and a Latourian emphasis on the role of translation in actor-network theory (Latour, 1999). The actor-oriented approach, emerging from the Manchester school of anthropology, emphasises individual agency within social contexts rather than viewing societies as holistic entities (Long, 1990). This approach proved particularly valuable for studying development work, where intermediaries increasingly mediate aid projects (Hönke & Müller, 2018). Given that Nepal's mental health efforts since the 1990s have operated largely within the aid and development apparatus, involving diverse brokers, this approach offers valuable analytical tools.

These brokers serve as intermediaries between different social groups, facilitating communication and negotiation across diverse social worlds. While their study has seen fluctuating attention in anthropological literature, brokers gained renewed significance following neoliberal reforms that complicated interactions between state institutions, market forces and local communities (Lindquist, 2015). Mosse and Lewis (2006) expanded this framework by incorporating Latour's concept of "translation", viewing brokers not merely as mediators but as active agents who transform social, cultural and knowledge landscapes as they navigate development contexts.

In what follows, I present the ethnographic approach that guides this study, one that moves beyond binary perspectives to understand how mental health initiatives unfold on the ground.

Understanding the "implementation black box"

In 2005, anthropologist David Mosse conducted a comprehensive assessment of development scholarship, highlighting the presence of two distinct perspectives that, he argued, have hindered its progress. These perspectives revolve around contrasting views of policy: the instrumental viewpoint and the critical perspective (Mosse, 2005a). According to Mosse, the instrumental perspective considers policy as a rational and problem-solving exercise, while the critical perspective perceives policy as a technical discourse that obfuscates the underlying ambitions of bureaucratic power or dominance, which actually drive the political intentions behind development (Mosse, 2005a). He contended that both perspectives fail to capture the intricacies of policy-making, its connection to project implementation, and the skills and negotiation processes involved in development (Mosse, 2005a). He argued that these opposing views overlooked the institutional processes and the role of actors in the delivery of aid and the mediation of global development policies and called for a more insightful ethnographic approach to development: one that could illuminate the "implementation black box" (Mosse, 2004; Lewis & Mosse, 2006). He emphasised the need to shift analytical focus toward the *actual* practices of actors and institutions, both formal and informal, rather than solely focusing on the intended objectives of development and argued that this shift in focus would facilitate a deeper understanding of the gap between development objectives and outcomes (Lewis & Mosse, 2006). With Lewis, they argued that the apparent congruence and coherence within development projects, despite fragmentation and disagreements, requires analysis and explanation and suggested that it was ethnographers' task to demonstrate *how* diverse actors involved in development constantly engage in negotiations and collaborations to establish order, despite the complex and dynamic nature of the development field (Lewis & Mosse, 2006).

The global mental health literature, until more recently, had also been characterised and constrained by the same opposing perspectives (Bemme & D'souza, 2014; Lovell, Read, & Lang, 2019). The instrumental perspective views mental health and the so-called global "treatment gap" as a technical issue to be addressed through evidence-based interventions (Chisholm et al., 2007). This perspective emphasises the need for scaling up effective treatments in LMICs and focuses on standardising interventions, promoting professional training, and developing infrastructure to deliver interventions at a larger scale. The critical perspective, on the other hand, focuses on the political and social context in which mental health interventions take place and critiques the dominant biomedical model of mental illness, emphasises the importance of cultural and social factors in shaping the experience and expression of mental distress and denounces the dangers of the internationalisation of western psychiatric knowledge (Summerfield, 2008; Watters, 2011; Mills & Fernando, 2014; Davar, 2017). From the critical perspective, mental health interventions are recognized as intricately intertwined with power dynamics that may inadvertently perpetuate existing social inequalities. In contrast with these opposed, polarised perspectives, a growing middle-ground perspective suggests considering social, cultural, and structural contexts when designing and implementing mental health programs in attempts to build a more inclusive and culturally sensitive approach to mental health intervention (Kohrt & Mendenhall, 2015).

In keeping with this growing middle-ground, more recent anthropological engagements with global mental health, including my own ethnography, seeks to transcend the binary thinking that divides the instrumental and critical perspectives. Instead, anthropologists like myself are now exploring an approach that treats global mental health as both a subject and object of study (Jain & Orr, 2016; Lovell et al., 2019). This perspective recognises the inherently unstable and dynamic nature of global mental health, and encourages the use of ethnography as a method to uncover the actual practices and processes involved in its continuous construction and transformation (Seale-Feldman, 2018; Bemme, 2019; Chase, 2020).

Within this evolving anthropological perspective on global mental health, it is important to note that while Nepal's mental health system intersects with both global mental health and international aid frameworks, it remains analytically distinct. Where global mental health represents a field of research and practice focused on addressing mental health disparities worldwide, and the aid system encompasses the broader apparatus of international development assistance, the mental health system I examine is more specifically the network of institutions, actors, practices, and knowledge forms through which mental health care is conceptualized and delivered within Nepal. This system includes government health services, NGOs, private practitioners, traditional healers, and educational institutions, as well as the policies, funding mechanisms, and cultural understandings that shape how these different elements interact. Though profoundly influenced by global mental health frameworks and aid structures – particularly given Nepal's position as an aid-receiving nation – the mental health system has its own locally specific dynamics and logics. My analysis focuses on how these global frameworks are transformed and reworked as they become embedded within Nepal's particular social, cultural and political context. This conceptualisation of Nepal's mental health system as a dynamic ecosystem shaped by multiple actors, processes, and forces serves as the organising framework for this thesis.

Research questions

Initially, I had two broad sets of questions and objectives guiding my research, although these evolved over time. First, I sought to map out existing MHPSS resources available to people in the Kathmandu Valley to get a broad understanding of the institutional and epistemological landscape of mental health and its care. Thus, I was initially guided by questions such as: what individuals and institutions are providing care for mental health? How do these different individuals and institutions talk about, and care for, mental health? Who is receiving such care? How and where does the interaction take place? And how is care provided and communicated? Secondly, I wanted to study the effects the humanitarian response to the 2015 earthquakes had on the development of the mental health system in Nepal and the perception of mental health work in the post-earthquake context. The questions I had in mind were: how did the humanitarian response influence the development of the mental health system? And how did it contribute to shaping public perceptions and awareness of mental health in Nepal?

As my fieldwork progressed, it became clear that the earthquake's impact had catalysed more fundamental transformations in Nepal's mental health system than initially anticipated. Whilst I did begin fieldwork mapping out the mental health resources and support available, I became increasingly interested in understanding who was mediating mental health efforts in post-earthquake and federal Nepal, and why. I have ended up reflecting more generally about the ways in which local aspirations, agendas, sense of self and identity of individuals occupying diverse social positions intersect with current aid regimes and transnational mental health projects. This provided me with an understanding that mental health actors act on various scales. This thesis focuses on both institutions brokering aid norms, and on individuals translating discourses of mental health as being part of modernity. Consequently, this has led me to think about how mental health projects are embedded within wider national histories of development and nation building. Thus, my research questions have evolved to encompass the following:

1. How has mental health emerged over time as an object of care in Nepal? What does the present state of mental health care tell us about the object of care, and how does it mirror prevailing social and economic influences?

2. How do mental health brokers and translators navigate, stabilise and normalise constantly shifting aid norms and projects? What is at stake in doing this, and how do these norms and projects intersect with their local ambitions and agendas?

3. In post-earthquake Nepal, how do individuals with varying gender and socioeconomic positions engage with and transform psychological knowledge, and what are the impacts on both individual identities and broader social change?

These research questions are designed to examine different but interconnected dimensions of Nepal's evolving mental health system. The first question traces how mental health has been conceptualised and institutionalised as something requiring care in Nepal. This involves examining how mental health has been defined, problematised, and addressed over time, particularly as Nepal's social and economic context has changed. The scope encompasses both historical developments and contemporary arrangements in mental health care, allowing us to understand how current approaches to mental health care reflect broader societal transformations. The second question focuses specifically on the role of brokers and translators in Nepal's mental health system. Here, I examine how various actors – including NGO workers, mental health professionals, and community leaders – mediate between international aid frameworks and local contexts. The scope includes analysing how these actors interpret, adapt, and implement mental health programs and policies, while also pursuing their own professional and personal aspirations. This question helps understand the complex negotiations that occur as global mental health approaches are localised within Nepal. The third question examines how psychological knowledge circulates and transforms within post-earthquake Nepal's social fabric. The scope encompasses both individual level impacts (such as changes in professional identity and personal aspirations) and broader societal changes (such as shifting understandings of mental health). This question elucidates how psychological concepts are not just passively adopted but actively transformed as they become integrated into local aspirations for modernity and social change.

Together, these questions allow for an examination of Nepal's mental health system as a dynamic field shaped by historical processes, institutional arrangements, and individual agency. They explore not only how mental health care is delivered, but how it becomes meaningful within Nepal's broader social and cultural context.

Thesis summary

In order to answer these questions, I divide the thesis into three parts. Part I, entitled “context”, is composed of chapters 2 and 3. It establishes the foundations for understanding Nepal’s mental health system by examining both its historical development and current configuration. Together, these chapters reveal how the system has been shaped by broader political and economic forces, particularly the market-oriented reforms that have led to its current fragmented and competitive nature. **Chapter 2** offers, on a macro-scale, a political history of mental health care, aid, and development in Nepal. Through a review of relevant literature, it sheds light on how mental health has emerged as an object of care over time in Nepal and contextualises the historical and political factors that had an impact on the mental health system I observed and studied between 2017 and 2018. This analysis shows that the history of mental health intervention in Nepal is intrinsically linked with national and international political, and aid, histories. **Chapter 3** builds upon, and brings to bear, how the macro-level processes outlined in chapter 2 happen on a micro-scale by taking the reader on a journey through a patchwork of ethnographic fragments of different places and therapeutic spaces where mental health care takes place in Nepal, derived from multi-sited participant observation. The fragments provide a glimpse into the current landscape of mental health care in Nepal. It shows how there are various treatment approaches, multiple stakeholders, and diverse conceptualisations of mental health that compete with one another. This chapter illustrates the multiplicity and fragmentation that characterises the present-day mental health system in Nepal, which will be a recurring theme explored throughout the thesis. Together, chapters 2 and 3 establish mental health, within the current market-oriented system, as a contested object of care that manages to enrol multiple actors in the project of its care. Moreover, the diverse array of actors engaged in mental health care reflects the role that contemporary market forces, which promote privatisation and foster market competition, have played in giving shape to mental health as an object of care.

Against this backdrop of the historical and political milieu and the accompanying aid norms, funding mechanisms and discourses that shape the current mental health system in Nepal, Part II, entitled “brokering and translating aid norms” is composed of chapters 4 and 5. Part II directs its focus towards examining *how* mental health brokers and translators use different strategies to navigate, stabilise and normalise the constant and ongoing shifts in the mental health system. Two current aid norms and ideals are explored: chapter 4 focuses on “country ownership” and chapter 5 on “evidence-based practice”. **Chapter 4** shows how state and non-state institutions are mutually dependent on one another to perform the current norm of “country ownership”, to consequently be able to display, concurrently, “good” statehood and NGO-hood. **Chapter 5** sheds light on how two disparate mental health NGOs broker the demand for evidence-based practice on the ground. Both chapters emphasise the active engagement of local actors in performing and stabilising the ever-changing relevant norms within the field. However, chapter 5 also reveals the limitations faced by certain organisations conditional on their epistemic frameworks.

Part III is entitled “psychological knowledge and social transformation” and comprises chapters 6 and 7. Chapter 6 examines how psychological knowledge is communicated and gains legitimacy through different psychoeducational activities in Nepal. Through analysis of three distinct cases – a psychiatrist's radio show, a Christian NGO's community training, and a forum theatre performance – the chapter demonstrates how mental health messages are adapted and legitimised through different discursive frameworks while maintaining core ideas about proper mental health care. The chapter argues that these psychological pedagogical interventions, through their connection with institutions of modernity and development (*bikas*), introduce and legitimise particular ways of understanding distress that may increase perceived value of psychological expertise and generate greater demand for mental health care. This examination of how psychological knowledge is "Nepalised" reveals how psychoeducational activities, while not explicitly intending to generate new subjects, can have the effect of compelling individuals to align with modern discourses of the self through the process of subjectivation. Finally, **chapter 7** examines how mental health becomes intertwined with aspirations of modernity, shaping the formation of new professional identities in Nepal. Based on twenty-eight semi-structured interviews with a group of young urban middle-class psychology-educated individuals, this chapter argues that these individuals are not only using psychological education as a technology of self to construct their subjectivity, but also feel the need to provide psychological knowledge to help others and achieve social transformation. Psychology educated individuals view psychology knowledge as an essential tool needed to live a good life, to be modern, to advance professionally, and to uplift and transform Nepal into a modern nation. However, chapter 7 also brings attention to the tensions between the promises of the ideal of modernity and the need to navigate the slower-changing operating modes embedded within society.

As a whole, the thesis sheds light on tensions that arise between aspirations, encompassing policy, aid norms and modernity and the lived reality experienced in practice across macro and micro scales.

Guiding theories and concepts

Throughout the thesis, each chapter draws on different theoretical stances. However, there are concepts that surface in multiple chapters, such as Foucault's "technologies" and other concepts, such as neoliberalism, that weave throughout the thesis. In the following, I first provide a brief background on neoliberalism and Foucault's "technologies" of power and self and outline an analytical approach that views neoliberalism as a technology of power and of self; as these understandings speak to different parts of the thesis. However, I want to highlight that while I occasionally draw upon a Foucauldian lens to think through the impact of market-oriented policies on aid policies and practices and on certain subjects' sense of self in the Nepali context, I do not straightforwardly impose a Foucauldian analytical framework to my analysis. Instead, I maintain a commitment to empirical ethnographic evidence, exploring and documenting the unique historical, social and political circumstances in which power operates, is contested, and negotiated in Nepal. Further, this thesis is not confined to theoretical concepts, but rather aims to illuminate wider societal dynamics and transformations taking place in Nepal, such as the interactions and reshaping of gender, class, and to a certain extent, caste dynamics.

Neoliberalism

While there are other economic regimes and ideologies that have influenced and currently influence the mental health system in Nepal, the choice of focusing on neoliberalism in this thesis is largely supported by the time during which my fieldwork took place. At the time of the earthquakes and during their aftermath the mental health system had been largely shaped by neoliberal aid policies and discourses that emerged in the 1980s, and was increasingly influenced by post-liberalisation discourses seeking to contrast those.

At its core, neoliberalism is an ideology that advocates for a *laissez-faire* approach to economics, emphasising the importance of free markets, deregulation, privatisation and individual freedom (Steger & Roy, 2010). Some view it as an economic theory suggesting that the optimisation of entrepreneurial liberties, alongside an institutional structure encompassing private property rights, individual freedom, open markets and free trade, leads to the most effective enhancement of human welfare (Harvey, 2007). In non-profit making sectors like development and aid, neoliberalism has operated most evidently in the Structural Adjustment Programs (SAPs) implemented by international financial institutions, which advocated for market-centric approaches (Pfeiffer & Chapman, 2010). However, the term has evolved over time and has been applied to a range of political and economic policies and practices, making it a highly contested and complex concept that seems to defy a singular definition (Steger & Roy, 2010).

Since the early 2000s, the concept and framework of neoliberalism have gained significant traction within the field of anthropology and has been extensively employed as a critical lens to examine various aspects of our modern world (Ganti, 2014). However, due to its multifaceted nature and its wide-ranging applications, it often becomes synonymous with the global political and economic order, purportedly explaining much of contemporary life. This, in turn, has raised questions about its effectiveness as an analytical and theoretical framework and about whether it might hinder rather than enhance anthropological inquiry and our understanding of the contemporary world (Ganti, 2014). Despite these criticisms, and without an intention to over-determine neoliberalism as a unique theoretical force, the consequences of market-oriented aid policies and their effects on subjects organically emerged from my conversations and observations in Nepal.

In addition to an economic ideology, neoliberalism can also be understood as a set of instructions and norms necessary to implement and sustain a neoliberal economic framework. Thus, in accordance with a Foucauldian understanding of power, neoliberalism can be understood as a technology of power; which means as a set of techniques used by institutions, governments, and other entities to exert control over individuals and populations. Further, since neoliberalism is largely implemented by decentralising and devolving power to individuals or subjects, its impact on shaping subjects can also be analysed via Foucault's concept of technologies of self.

Technologies of power and of self

Michel Foucault’s central focus was on understanding and elucidating the functioning of power within society and its profound influence on different facets of human life. He contended that power does not rest solely with individuals or institutions but instead permeates throughout society like a capillary network. According to Foucault, power functions through diverse techniques and mechanisms that mould and regulate human behaviour, deeply ingrained in institutions, social costumes, discourses, and systems of knowledge. This intricate amalgamation of power, knowledge and social control constitutes Foucault’s conception of technology.

Throughout his lifetime, he formulated a classification system comprising four inter-related “technologies”: technologies of production, technologies of sign systems, technologies of power (or domination) and technologies of the self (Besley, 2005). His primary areas of interest centred on technologies of power and of self. In his earlier works, he focused on “technologies of power”, meticulously examining institutional practices, disciplinary measures, surveillance systems, and discursive formations that work together to produce and maintain power relations within society. He described “technologies of power” as mechanisms that influence and shape the behaviour of individuals, subjecting them to specific forms of domination and control and showed how these technologies operated by objectivising the subject, treating individuals as objects to be observed, regulated, and moulded according to established norms and power structures (Besley, 2005). As he reached the later stages of his intellectual journey and life, he became interested in what he termed “technologies of self” (Foucault, 1988). This led him to explore the practices and techniques individuals employ – by themselves or with the help of others – in order to actively shape and cultivate their own selves, identities and subjectivities (Besley, 2005). He showed how these techniques that individuals use to govern and modify themselves are not solely individual endeavours but are intertwined with broader systems of power and knowledge.

Power and subjects

In this thesis, the technologies of power and self within Nepal’s mental health system take on various forms and expressions. Technologies of power can be read in the influence of global aid norms in aid-receiving Nepal (discussed in chapters 4 and 5) and the impact of psychiatric and psychological expertise on subjects (chapters 6 and 7). On the other hand, technologies of self come to light when psychiatrists encourage individuals to recognise and acknowledge mental health issues within themselves and engage in practices of self-disclosure (chapter 6) as well as in the promotion and dissemination of psychological knowledge for personal and professional development and improvement (chapter 7).

Neoliberalism is also examined as a form of power in chapters 4 and 5, highlighting its role in shaping the structural context within which mental health efforts and local life worlds of mental health brokers and translators take place. Chapters 6 and 7 contribute to the analysis of neoliberalism through a Foucaudian framework, focusing on technologies of self and governmentality, where subjectivities are formed or refashioned in alignment with values of individualism, entrepreneurialism and market competition. As a whole, the thesis elucidates aspects of the interplay between techniques of governance and techniques of self-making.

Finally, throughout the thesis, the scale and understandings of what constitutes institutions of power as well as the entities considered "subjects" over whom they wield power varies. The analysis of power relations revolves around the complex relationships between foreign aid, Nepal's government, and its citizens. Consequently, the focus alternates between examining the impact of foreign aid institutions and norms on Nepal as an aid-receiving nation (chapters 4 and 5) and exploring the interactions between Nepal's government and its citizens as they navigate modernity (chapters 6 and 7).

Nepali society and social change

This thesis is also necessarily about Nepali society and the process of social change in the pursuit of modernity. Nepal's particular journey to modernisation has been marked by a quest for *bikas* – development – which has been folded in the sea change of neoliberal forces and which has been both a driving force and a shaping element in the country's social and economic landscape. A significant aspect in this continuous transformation is the ongoing process of reconfiguration of gender, caste and class dynamics. Throughout the thesis, there are both markers of enduring threads from the past, emphasising their persistent influence, and markers of social change, illustrating the constant reworkings, negotiations and transformations that shape the current societal landscape.

Gender dynamics surface in different chapters. In line with other scholars who have highlighted how women are often presented as emblematic of suffering and distress (Appignanesi, 2011; Burgess, 2016), this thesis also provides evidence for this in Nepal. This is illustrated in several instances, such as in the overrepresentation of women in the psychiatric outpatient department compared to men, in chapter 3, the teachings to Christian farmers that women require double the time than men to grieve, and the use of the image of a female villager as a narrative tool to depict mental health issues in chapter 6. Further in line with other scholars that have highlighted the gendered practices of employment and remuneration in global mental health practice (cf. Chase, Gurung, Shreshta & Rumba, 2021), women in this thesis too are present as part of the mental health workforce, yet often occupy non-paying or lower-paid positions (e.g. community health workers) in contrast to higher-paying, more privileged, and authoritative roles predominantly held by men (e.g. psychiatrists). The particular gendered forms of distress experienced by men also surfaces in this thesis, expressed through stereotypical masculine forms, including substance use (cf. chapter 3). Finally, Amina, in chapter 7, speaks directly about traditional gender norms as significant sources of mental distress. She reflects on how societal constructs related to family and gender roles, particularly concerning women, are at the core of what she calls "dysfunctional guilt" and suffering.

However, the material in this thesis also evidences the constant reworkings, negotiations and transformations in the way people perceive themselves, and are perceived by others, and the ways in which these changes also come to shape the current societal landscape. Most explicitly, in chapter 7, I explore with a focus on young and urban individuals, how historical gender roles and caste dynamics intersect with the emergence of urban classes and the pursuit of modernity – ultimately shaping their identities, desires for modernity and approaches to social change. Shifts in gender norms are exemplified in the official recognition

Kamala received as part of her work (e.g. Women's Achievers Award, the Global Peace Women Young Leader Award) but also by Amina's personal journey as an entrepreneur, business owner and professional. Her active resistance and efforts to challenge gender norms in her society further exemplify the evolving perceptions and attitudes towards traditional gender roles.

Whilst caste is undeniably a significant social marker in Nepal (Gellner, 1986), my research does not provide an explicit analysis on caste, but rather, has a more muted presence in it. In line with observations made by Liechty (1994; 2001; 2003) that in Kathmandu – particularly among the emergent middle classes – there is a diminishing emphasis on identities based on caste compared to class, it is possible that the absence of an explicit analysis on caste was influenced by several intersection factors. Heaton-Shreshta (2004) noted that in specific professional spheres, such as among NGO workers, there was a deliberate tendency to "bracket out" caste as a category of development. Thus, the nature of the spaces I navigated during my research, which were mainly professional and development spaces, could have played a role in the muted presence of caste as it is made invisible in such spaces.

However, it is crucial to emphasise that this "bracketing out" or invisibilisation of caste in certain spaces does not mean caste hierarchies and discrimination have disappeared. As scholars working in both Nepal and India have shown (Bennett, 2008; Mosse, 2020), caste continues to profoundly shape access to resources, opportunities, and social mobility, particularly for Dalits and other marginalised groups. Rather, the relative silence around caste among my informants may itself reflect privileged positions where caste can be treated as irrelevant precisely because it does not present barriers in their lives. Moreover, as recent scholarship demonstrates, in middle-class and professional spaces, caste privilege often gets reconstituted and obscured as class privilege (Fernandes & Heller, 2006), allowing advantaged groups to maintain their social position while presenting themselves as modern and meritocratic. This transformation of caste into class distinction represents not the erasure of caste, but rather its reconfiguration in ways that align with aspirations towards modernity.

Relatedly, my outsider status, coupled with a potentially perceived association with modernity, could have led my informants to be reluctant to discuss caste dynamics explicitly with me. This hesitancy could stem, in accordance with the literature, from the perception of caste as a marker of social backwardness, contrasting with the image of an urbane and modern identity (Pigg, 1992). Finally, my positionality as a white European person may have made me less attuned to caste dynamics.

Methodology

Ethnographic fieldwork

During fourteen months of ethnographic fieldwork, I lived and primarily worked in the capital city of Kathmandu. However, when mental health actors were happy for me to tag along, I also accompanied them to various districts, wherever their mental health related activities took them. This meant I also ended up doing research in various districts across the central and eastern hilly regions, as well as the western region of the country.

Constructing the multi-sited field

I began fieldwork mapping out existing resources for MHPSS available to people in the Kathmandu Valley. To do this, I reconnected with mental health related people and institutions I had met during my time in Nepal three years earlier, when I worked in Kathmandu from January to May 2014.

The intention behind the mapping exercise was never to achieve an exhaustive list of care providers, but rather to begin getting an idea of the institutions and individuals who were providing or advertising care for mental health, to get an understanding of what they meant by mental health and what the care they provided looked like. My initial contacts included a few people who worked for mental health NGOs, psychiatrists, social workers, Tibetan doctors, and an astrologer. From there, I continued mapping using snowballing techniques, as well as more informally contacting people that self-identified or promoted themselves as providing mental health and/or psychosocial support. In practice, this mapping exercise never fully stopped during my fieldwork, and expanded to include other places other than those providing mental health care in the Kathmandu Valley, as I met more mental health care providers who invited me to accompany them to other places in the country where they provided their services or undertook mental health related activities.

The ways in which I came to meet mental health care providers varied. At times, I was directly introduced by my previous contacts, friends, and colleagues; other times I contacted them directly via email or phone to set up a meeting. And, often I met them at various mental health related events such as academic conferences, advocacy events and social gatherings. Most of my initial contacts had known me as a volunteer for the NGO Chhahari Nepal for Mental Health (CNMH). I made sure to be open and explicit about the new role(s) that had brought me back to Nepal, those of a doctoral student and a researcher. Whilst CNMH was officially my "host organisation" and I did resume my volunteer role with them as part of my research, I made sure to clarify, explain and remind my previous contacts, as well as the new ones, about my present role as a researcher.

Over the course of fieldwork, I compiled a long list of individuals and institutions that provided mental health care and visited as many of these as I could. This included around six governmental organisations and several health posts, four INGOs, twelve NGOs, eight private organisations and a few traditional healers. This mapping exercise served as my initial point of contact with these institutions and mental health actors, allowing me to negotiate access for more in-depth participant observations and/or interviews.

As an anthropologist studying the mental health system in Nepal, I faced the challenge of how to understand the system not in isolation, but rather as interconnected with larger power structures and processes (Wright & Reinhold, 2011). In line with current trends in ethnographic research, the inherent multi-sited nature of my object of study encouraged me to adopt an ethnographic methodology that prioritises the being "here and there" (Van Duijn, 2020, p. 283). This approach situates my work within the framework of "multi-sited" ethnography, as introduced by Marcus (1995). While I draw on elements of multi-sited ethnography, I depart from Marcus's original vision of using multiple sites to construct a comprehensive view of a system. Instead, I align more closely with Candea's (2007, p. 27) concept of "arbitrary locations" - using carefully chosen sites as specific windows into aspects of mental health care in Nepal, without claiming these represent or construct the totality of a mental health system. This modified multi-sited approach allows me to examine how mental health care manifests across different institutional spaces and social contexts, and how global mental health frameworks are translated and transformed within Nepal's social fabric. While I do not aspire to explain or construct a total system through these multiple sites, I remain attentive to how actors themselves articulate and engage with the idea of a mental health system. This allows me to examine specific institutional arrangements and practices while considering how they are situated within broader historical and structural contexts in Nepal.

According to Marcus, this approach moves beyond conventional single-site research designs, allowing for an "exploration of the circulation of cultural meanings, objects, and identities in diffuse time-space" (Marcus, 1995, p. 96). He further contends that:

> "This mobile ethnography takes unexpected trajectories in tracing a cultural formation across and within multiple sites of activity that destabilise the distinction, for example, between lifeworld and system, by which much ethnography has been conceived. Just as this mode investigates and ethnographically constructs the lifeworld of variously situated subjects, it also ethnographically constructs aspects of the system itself through the associations and connections it suggests among sites" (Marcus, 1995, p. 96).

Indeed, the multi-sited approach transformed ethnographic fieldwork into a matter of "being there…, and there…, and there!" (Hannerz, 2003, p. 202). Whilst I did attempt to clarify who or what could be considered part of my "field" before starting fieldwork, I remained mindful of the fact that the boundaries of the field are not given (Atkinson, 1992), are inherently "fuzzy" (Nadai & Maeder, 2005) and can only be demarcated along the way (Van Duijn, 2020). Importantly, I often reminded myself of the insight that the field is not discovered but *produced* through the social transactions engaged in by the ethnographer and that therefore whatever my field would end up being, would be the outcome of, as Atkinson (1992) has so accurately observed, what I as the ethnographer end up encompassing in my gaze; what I negotiated with hosts and informants, what I omitted or overlooked as much as what I have ended up writing.

The core principles of multi-sited ethnography revolve around the strategies of "following", encompassing individuals, objects, ideas or processes, as well as employing techniques of juxtapositions and comparison (Marcus, 1995; Falzon, 2016). In the context of my fieldwork, I did “follow” mental health actors and I used techniques of juxtaposition of data. However, it is important to acknowledge that the original conception of multi-sited ethnography has faced considerable scrutiny and criticism. Indeed, this approach also presented specific challenges that required careful consideration. As scholars have noted, the primary critique of multi-sited ethnography concerns potential lack of depth – by studying multiple sites, researchers risk sacrificing the deep, sustained engagement that characterises traditional single-site ethnography (Englund & Leach, 2000). I addressed this challenge by maintaining longer-term engagement with key institutions like CNMH while conducting shorter observations at other sites. Another limitation, as Candea (2007) points out, concerns the implicit assumption that multiple sites could provide a coherent picture of a “system”.' Rather than claiming to capture the entirety of Nepal's mental health system, I used these multiple sites as windows into how different actors understand and engage with mental health care.

As stated previously, I never intended, nor do I believe it would be possible, to offer a holistic account of mental health systems. In this regard, I concur with scholars who criticise the explicit intention of the multi-sited ethnographic project in “…construct[ing] aspects of the system itself through the associations and connections it suggests among sites” (Marcus, 1995, p. 96) (cf. Candea, 2007; Cook, Laidlaw, & Mair, 2009). Instead, I embrace Candea’s proposition (2007) that fieldworkers should take responsibility for defining the boundaries of their field and his suggestion that the concept of “arbitrary locations” as a methodological tool for doing so. The concept of “arbitrary locations” functions in my writing in similar ways to Closser and colleagues’ (2022) “entry points”. Candea’s proposition allows multi-sited research to incorporate relevant contrasts and comparisons aligned with the theoretical questions that guide the research, without implying that sites serve as windows into larger global structures. When analysing specific events or practices, I examine how they reflect particular institutional arrangements, social relationships, and cultural processes within Nepal’s mental health system, rather than claiming they represent larger systematic or global patterns. While I do not aspire to explain the totality of a wider system, I pay attention to how actors themselves articulate the existence of a system (Closser et al., 2022; Kielmann et al., 2022). My analysis examines specific institutional arrangement and practices while remaining attentive to how they are situated within, and shaped by, broader historical and structural contexts in Nepal.

It is important to note that the depth and type of data varied significantly between organisations. For instance, in Chapter 5’s comparison between Chhahari Nepal for Mental Health (CNMH) and Transcultural Psychosocial Organisation Nepal (TPO Nepal), while I had rich ethnographic data from sustained engagement with CNMH, my analysis of TPO Nepal relied heavily on official documents and therefore on their own public representations. While this is a methodological limitation, it is also a reflection of broader power dynamics within Nepal’s development world where smaller organisations like CNMH tend to be more accessible to researchers, while larger, more influential institutions like TPO Nepal can exercise greater control over their institutional narrative and representation. It is important to acknowledge that this differential access may result in an uneven portrayal of these organisations. My reliance on publicly available documents for TPO Nepal means I analyse their public institutional narrative rather than the more nuanced, day-to-day realities that ethnographic observation so importantly can reveal. While this limitation shapes my analysis, it also offers insights into how different organisations navigate visibility and representation within the country's mental health system.

Research strategy

In my research strategy, I integrate concepts from Nader's "studying up", Shore and Wright's "studying through" and Gusterson's "polymorphous engagement" (Nader, 1972; Gusterson, 1997; Shore & Wright, 1997).

Nader's concept of "studying up" advocates for anthropologists to expand their focus beyond the lower end of power structures and examine the middle and upper echelons of society (Nader, 1972). She suggested that this broader approach would allow for a better understanding of power dynamics and the exercise of authority, enabling meaningful challenges to power, and encouraged anthropologists to extend our analysis to "study up, down or sideways" (1972, p. 8). This call was taken up by anthropologists studying development and policy, leading to valuable insights into how institutions, elites, and power operate and perpetuate themselves (Shore & Wright, 1997; Eyben, Lister, Dickinson, Olivié, & Tejada, 2004; Eyben, 2010; Fechter & Hindman, 2011; Fechter, 2012; Fechter, 2016).

My decision to study mental health actors in Nepal aligns with Nader's approach. Whilst my research can be categorised as "studying up" due to the relative social power of these individuals in Nepali society, I am aware of the critiques and limitations of this approach raised by other scholars (Gusterson, 1997; Bowman, 2009). Notably, the assumption of a power hierarchy between those that make policy and the rest. In fact, anthropologists Chris Shore and Susan Wright sought to eschew this assumption embedded in the "studying up" strategy and offered a re-articulation of Nader's strategy using Reinhold's concept of "studying through" where no linearity is presupposed in policy (1997, p. 14).

The strategy of "studying through", involves researchers analysing contestation across different sites and timeframes in a policy field to understand the emergence and institutionalisation of new governing discourses (Wright & Reinhold, 2011) and seeks to trace how power establishes interconnected networks and associations among individuals, organisations and discussions over time and space (Shore & Wright, 1997). This strategy entails a multi-sited ethnography and offers a more nuanced framework for tracing power, avoiding presuppositions of hierarchy. This approach requires researchers to critically examine historical and political contexts that shape events and individuals, promoting political and epistemological reflexivity.

To study up and through, I used different methodologies and approaches to writing in my research that mirror the fragmentation within the field. Primarily, I relied on participant observation, evident in chapters 3, 4, 5 and 6. However, I also engaged in what Gusterson aptly termed "polymorphous engagement" (1997, p. 116), interacting with informants across numerous dispersed sites and gathering data from various sources. As such, chapters 2 and 5 heavily rely on document analysis and chapter 7 is composed entirely of formal and semi-structured interview data.

Research assistance and translation

Although the majority of my informants ended up being educated professionals fluent in English, and students in Kathmandu that had a higher propensity to know English compared to other parts of Nepal, this was not something I could have entirely foreseen before starting my doctoral fieldwork and I was determined to establish a strong foundation in Nepali.

Prior to starting my research, I had a five month stay in Nepal in 2014, which provided me with some initial exposure to the Nepali language. However, to deepen my language skills, I worked with a private tutor who provided me with intensive language training during the first six months of my fieldwork. This training allowed me to develop conversational skills that were essential in building rapport with my informants, who appreciated my willingness and efforts to learn the language, and set me aside from tourists or short-term development workers. To address any remaining language barriers during the initial couple months of fieldwork, I enlisted the assistance of a local interpreter with personal connections with CNMH. This interpreter was fluent in both Nepali and Newari. Her assistance played an important role in facilitating my rapport with CNMH's clients and their families, and in enhancing my understanding of their life stories.

Later on in my research, I collaborated with two bilingual research assistants, both masters' students in psychology at Tribhuvan University in Kathmandu. Their primary motivation was to gain practical experience in the field of qualitative research. Together, we designed an interview schedule to interview their peer psychology students. The schedule was designed to collect demographic data, explore educational paths, motivations for studying psychology, views on career prospects in Nepal, assess the impact of the 2015 earthquakes on the perception of psychology expertise, and elicit students' future professional aspirations. The research assistants conducted and translated the interviews, and I carried out the data analysis. This collaborative process ended up being essential to the data informing chapter 7. My decision to collaborate with psychology master's students as research assistants for conducting interviews was fundamentally grounded in an ethical commitment to building local research capacity and supporting emerging Nepali scholars. These students gained hands-on experience in qualitative research methodology, interview design and data collection – skills they were explicitly keen on practicing and that they believed would advance their academic training and professional development. This collaborative methodology also produced significant research advantages that enhanced data quality in ways that traditional ethnographic interviews could not have achieved. The research assistants' linguistic fluency and shared positionality as psychology students created peer-to-peer dynamic where interviewees were notably candid about their personal struggles and professional uncertainties. For instance, participants openly discussed their own mental health challenges as motivation for studying psychology – such as one student's detailed account of living with depression from age thirteen and feeling abandoned without support – vulnerabilities they might not have shared with a foreign researcher. Students also expressed honest doubts about their field's legitimacy and career prospects, candidly discussing how family members questioned their choice to study psychology or how they themselves worried about creating job opportunities in a context where psychology expertise is poorly understood. This peer dynamics enabled rich discussions about the tension between their sense of possessing valuable, transformative knowledge and their frustration with a society they perceived as clinging to outdated attitudes toward mental health, revealing their complex positioning as aspiring modern professionals in a context where psychology expertise remains misunderstood and undervalued. I believe this collaborative approach aligned with my broader commitment to ensuring the research process contributed to strengthening local research capacity while producing knowledge relevant to local contexts.

Beyond this core collaboration, as I progressed with writing up the thesis and additional translational needs arose, I hired a separate Nepali translator for specific translation tasks to ensure accuracy in my analysis.

Ethical considerations

Before starting this research, I underwent two formal, institutional ethical review processes, one with the University of Edinburgh and the other with the Nepal Health Research Council. After negotiating approval from gatekeepers, I conducted participant observation in various settings, including clinical spaces and offices of non-governmental organisations, as well as training venues.

Even though the gatekeepers were fully informed about my research, as is the case for much observational research, I necessarily ended up observing people who were less familiar with or fully understanding of what I was doing. For instance, I observed patients during hospital ward rounds and in the out-patient department in hospitals, and it was evident that they may not have been fully aware of my specific role and purpose. In those cases, I relied on certain visual cues, such as my physical characteristics, specifically my whiteness, to signal that I was not a regular member of the healthcare team and that my presence had a different purpose. Additionally, I did not interfere, express personal opinions or behave in a manner that might suggest a clinical role. I also made sure to keep a notepad out, further intending to indicate that my presence was primarily for observation and data collection. By adopting these non-intrusive approaches, I aimed to respect the privacy and autonomy of the individuals I observed while minimising any potential misunderstandings or discomfort that might arise from my presence as a researcher in that environment. Furthermore, when appropriate, and feasible, I took care to ensure that my research intentions and presence were properly introduced to the patients, clients or trainees, either by the professional I was observing or by myself and sought consent for my presence and data collection. Additionally, I engaged in, and witnessed, interactions concerning mental health within public spaces and events, including the suicide prevention walkathon described in chapter 3, where gatekeeper consent was not relevant. When recounting these interactions and events, I purposely maintain a broad perspective by avoiding references to specific individuals. Instead, I focus on general professional categories such as “clinical psychologists” or “mental health advocates”.

In addition to participant-observation, I also carried out semi-structured interviews with psychology and social work students (30), mental health and psychosocial professionals and advocates (18), mental health and psychosocial program managers and advisors (5), healers (5), development and humanitarian workers (5), media professionals (3), mental health entrepreneurs (2), a mental health funder, a policy maker, and a police officer. Before the interviews, I made sure my identity and interests as a student researcher were clear and obtained verbal informed consent from the interviewees. In addition, I provided them with my contact details, so they could reach out to me if they had any follow-up questions or concerns. Further, I also engaged in numerous conversations about mental health with a diverse array of individuals, ranging from complete strangers such as taxi drivers and pharmacists, to close neighbours, trusted friends, recovered mental health patients and compassionate caregivers. These observations and conversations became the cornerstone of my fieldnotes.

Finally, I gathered and analysed publicly available data including radio programs, research publications, and documents from NGOs. I took special care to handle the sensitive nature of some information, such as personal stories shared on the radio programs. Despite the data being publicly accessible, I remained cautious and refrained from using any details that could potentially compromise individuals' privacy or confidentiality. In this thesis, I have made diligent efforts to anonymise the information adequately, ensuring the protection of identities.

In addition to the ethics of conducting fieldwork and informed consent, the ethical aspects concerning writing and representation have deeply weighed on me, especially considering the relatively small size of the mental health system in Nepal. In such a close-knit community, where everyone knows each other, preserving full anonymity becomes a significant challenge. To address this, I have made the conscious decision to use pseudonyms for all individuals, projects, and certain organisations throughout my work. However, it is important to note that certain organisations such as Transcultural Psychosocial Organisation Nepal (TPO-Nepal) and CNMH are well-known within the mental health, development and global health context in Nepal. As a result, attempting to disguise or scramble their identities would be futile for readers familiar with the field. Additionally, because I cite document trails and provide references, concealing such organisations would be practically impossible.

Recognising my limitations in ensuring complete confidentiality for organisations, I have been extra cautious in seeking feedback from some of my informants during the drafting process. I shared writings based on complex observational data, which can sometimes be ambiguous, rather than data from interviews or documents. I decided to do it this way because documents were sourced from publicly available materials, and the interview process allows for addressing uncertainties or inquiries, unlike during observations.

Further, I have sought to be scrupulous in attending to the tone of my observations, avoiding, for example, value judgements or emotional language. Where I offer criticisms, these are intended as critical solidarity to a shared cause. My intention is not to undermine efforts to improve mental health care in Nepal nor to engage in an exercise of fault-finding, but rather to contribute to the cause constructively. And I have exercised caution to avoid discussing any significant disclosures to which I have been privy to, wherein individuals have granted me access to certain information that might be potentially detrimental to the organisation or individuals involved. In such cases, I have refrained from disclosing the information to maintain confidentiality and safeguard the interests of the organisation or individual involved.

Finally, I am aware that doing fieldwork, and focusing my research mainly in Kathmandu may elicit pushback as well as empirical and ethical critiques. An important limitation that can be held against my research is that Kathmandu is not representative of the predominantly rural population in the country and that conducting research in Kathmandu can perpetuate a power imbalance between the urban and rural communities, where the voices and perspectives of the latter are so often excluded. This critique holds significant weight and has been central to crucial social and political struggles in Nepal. For instance, there have been structural critiques that highlight how the concentration of power and development in Kathmandu, often led by the elite, has contributed to inequality and conflict within the country (Bista, 1991; Deraniyagala, 2005). Nonetheless, it is essential to emphasise that studying those who wield social, economic and political power, as discussed earlier (cf. "studying up"), can also be of great significance. Furthermore, my focus on Kathmandu is also reflective of where certain mental health discourses and practices are taking place in the country, and where they are more absent; and I believe contributes to an understanding of the broader issues impacting Nepal's mental health system.

Within this thesis, I often focus on specific events or moments – a mental health training ceremony, a radio broadcast, a community theatre performance. I do not analyse these events in isolation. Rather, they take place within specific networks of actors and institutions in my field sites: particular NGOs working with certain state institutions, local practitioners engaging with specific global actors, and mental health professionals interacting with communities in distinct locations. When I describe a training ceremony or a therapeutic intervention, I examine how these moments illuminate relationships between ideas of tradition and modernity, between different scales of practice, and between various institutional actors. This methodological approach allows me to ground theoretical insights firmly in ethnographic evidence - showing how concepts like modernity, brokering, and social transformation emerge from observed practices and relationships rather than being imposed from outside frameworks.

Part I – CONTEXT

Part I lays the groundwork for understanding Nepal’s mental health system by examining its evolution and present-day manifestation. Through historical analysis and ethnographic observation, these chapters demonstrate how the system has been fundamentally shaped by broader forces - from international aid regimes to national political transitions to market-oriented economic reforms. Chapter 2 traces the system’s historical development, while Chapter 3 provides an ethnographic window into its current fragmented and pluralistic nature. Together, these chapters reveal how the mental health system has come to reflect and embody broader transformations in Nepal's political economy, particularly the shift toward market-oriented approaches that have fostered competition and multiplicity in mental health care delivery.

Together, these chapters provide a historical and political context for the thesis, and establish mental health as a contested object of care that manages to enrol multiple actors in the project of its care. Moreover, the diverse array of actors engaged in mental health care reflects the role that contemporary market forces, which promote privatisation and foster market competition, have played in giving shape to mental health as an object of care.

More broadly, Part I serves as a gateway for readers to immerse themselves into the complexities of the mental health system being studied. By presenting the context and feel of the system, Part I prepares readers to delve deeper into the subsequent Parts that elucidate how mental health brokers and translators navigate and normalise constantly shifting aid norms and projects (Part II) and how current aid norms and regimes impact Nepali citizens (Part III).

Chapter 2. A brief political history of mental health care, aid and development in Nepal

This chapter aims to shed light on how mental health has emerged over time as an object of care in Nepal, with particular focus on the period following the 1990's economic liberalisation that shaped the current mental health system. Foregrounding the history of mental health care development, I trace other interrelated histories that have come to shape it: namely, the country's political and development history. I begin with a brief overview of the pre-1990 period to highlight key contextual elements that continue to influence mental health care today. The bulk of the chapter then focuses on examining how the introduction of market reforms, changing aid regimes, and evolving development norms have shaped mental health care delivery in Nepal, particularly through the growing role of NGOs and non-state actors. This historical context is crucial for understanding the current system where, as I explore in the following part of the thesis, mental health brokers and translators navigate between international frameworks and local realities.

This chapter traces this evolution chronologically across key periods that marked significant shifts in mental health care delivery: from pluralistic healing in the pre-1990 era, through the transformative period of democratisation and NGO expansion (1990-1996), the civil war years that saw the rise of trauma-focused interventions (1996-2006), the post-conflict period that coincided with the emergence of global mental health (2006-2015), and finally the post-2015 earthquake era that ushered in new humanitarian and development frameworks.

Through this historical analysis, several key themes emerge: the growing role of non-state actors in mental health care delivery; the impact of changing international aid regimes and development norms on local mental health systems; the influence of humanitarian crises in reshaping mental health priorities and approaches; and the ongoing tension between international frameworks and local realities. By examining these intertwined histories, the chapter provides crucial background for understanding how Nepal's current mental health system has been shaped by broader political economic forces and sets up the ethnographic exploration of contemporary mental health care that follows in subsequent chapters.

Pre – 1990 Historical context

From the twelfth to the eighteenth century, the Kathmandu Valley was under the rule of the Malla Dynasty. At that time, people sought medical treatment from many healers such as dhami-jhakris and matas (shamans), gurus, and Ayurvedic and Tibetan doctors (Desjarlais, 1992; Craig, 2012a). This medical pluralism continued as Nepal emerged as a nation state in 1768, coming under the sovereign rule of two Hindu families – first, the Shah family (1768-1846), and then, the Ranas (1846-1951).

Partly due to the alliance cultivated between these monarchs and the British empire during colonial times, Nepal was never colonised and has always remained a sovereign state, although only formally recognized in 1923 (Rose & Joshi, 1966; Adams, 1998). The absence of British colonisation in the country meant that there was relatively little legacy of colonial medical infrastructure such as big hospitals and mental asylums (Seale-Feldman, 2020).

Towards the end of their dynastic period, the Ranas began to acknowledge their duty in raising the living standards of the population as a whole, and this objective became central to the rhetoric of the governments to follow (Whelpton, 2005). In 1951, a significant political shift occurred when a movement led by the elite and exiled Nepali people, supported by Shah King Tribhuvan, successfully abolished the institutionalised hereditary prime minister system and established a multi-party democracy. This political transformation inaugurated an initial push for development in a new era and marked the beginning of a more systematic introduction of biomedicine and biomedical infrastructure into the country. This shift, along with the period of relative isolation, began to change when Nepal signed the Four Point agreement of technical cooperation with the United States and joined the Colombo Plan for Cooperative Economic and Social Development in Asia and the Pacific in 1951. This marked the debut of foreign aid and international development projects in Nepal. However, this opening was short-lived. In 1960, King Mahendra staged what became known as the “royal coup”, banning political parties and establishing the Panchayat system – a party-less system of governance that would last until 1989. Despite the political restrictions, international aid continued to flow into Nepal, bringing reinforcements to the government’s efforts to develop a biomedical health infrastructure through multinational, bilateral organisations and other NGOs (Adams, 1998). The early health developments were heavily focused on curative health care, disease-specific programs and hospital-based services in Kathmandu, with mental health notably absent from these initial interventions (Justice, 1989; Dixit, 1999; Seale-Feldman, 2019).

It was during the Panchayat period that the earliest psychiatric services initiatives appeared in Nepal, sponsored by His Majesty's Government and headed by foreign-educated Nepali doctors (Seale-Feldman, 2019). While traditional healers continued to be the primary source of mental health care for many Nepalis, especially in rural areas, the first psychiatric services began in Bir Hospital in 1961, and throughout the 1960s and 1970s a few more hospital-based psychiatric services were established. The psychiatric department at Bir Hospital later moved to Lalitpur in 1985, becoming what continues to be the only dedicated public psychiatric inpatient facility in the country, known as mental hospital Lagankhel (Upadhyaya, 2015). These early services were primarily focused on biomedical interventions, with treatment restricted to medication and electroconvulsive therapy, with very little emphasis on rehabilitation (Acland, 2002).

While the early Panchayat period saw an expansion of hospital-based services, the 1970s brought growing discontent with existing development strategies both globally and in Nepal. Despite gains in disease-specific programs, community health needs, especially in rural areas where most of the population lived, were not being met (Justice, 1989). This led to a shift in international development thinking towards securing “basic needs” of populations, including health care. Nepal's rural health program, supported by WHO, USAID, and UNICEF, exemplified this new approach by attempting to provide basic health services to the widest possible population (Dixit, 1999). These efforts influenced the WHO's landmark Alma-Ata Declaration of 1978, which emphasised primary health care and, for the first time, included mental health in its vision. While the declaration's comprehensive approach remained an ideal, in practice, development efforts often reverted to vertical programs and technological solutions (Justice, 1989; Packard, 2016).

The global economic recession of the 1980s marked another crucial shift. The rise of neoliberal policies reversed previous development thinking that had advocated for state intervention, instead promoting free-market economies and reduced state involvement (Harvey, 2007). Nepal implemented structural adjustment policies in response to a balance of payment deficit between 1982 and 1985 (Shrestha, 2009). These World Bank-mandated reforms required the state to balance its budget and reduce trade deficits while simultaneously addressing poverty reduction – a challenging set of conditions to meet (Whelpton, 2005). This economic context led international donors to increasingly channel development funds through NGOs rather than the state, justified by concerns about governance (Sharma, 2016).

These economic shifts had important implications for mental health care delivery in Nepal. The shift was exemplified by the United Mission to Nepal (UMN), which in 1984 began the first NGO-led Mental Health Project. This project, undertaken in collaboration with Tribhuvan University and the Ministry of Health, aimed to develop mental health services at multiple levels, including psychiatric services, rehabilitation programs, and community mental health initiatives (Seale-Feldman, 2020). The UMN's community mental health project was conceived as a "demonstration project" that the government could potentially adopt and implement more widely (Acland, 2002, p. 131).

The UMN were pioneers in decentralising psychiatric knowledge and practice from hospital settings into the community, and their approach would influence many subsequent mental health initiatives. However, the arguments for why mental health services were needed, for whom they were intended, and what constituted appropriate care would change considerably throughout the 1990s and 2000s, reflecting broader shifts in Nepal's political and development landscape. These changes would be particularly dramatic following the political and economic liberalisation of the 1990s, which fundamentally reshaped Nepal's mental health care system. It is to these changes that the chapter now turns to.

1990 – 1996 Return to an unstable democracy, the rise of NGOs and critiques of aid

The 1990s brought about a lot of shifts in Nepal that are still informing the political and development landscape today. In 1990, a coalition of political parties, which had been banned since King Mahendra’s “royal coup” in 1960, united for the first time, and a series of strikes and pro-democracy riots began the First People’s Movement (aka. Jana Andolan I and/or the movement for the restoration of democracy, cf. Adams, 1998, for detailed analysis of the 1990 movement). Around the same time, a new political party, the Unity Center Party – which was declaring the intention of working towards launching a People’s War and would later become the Communist Party of Nepal (Maoist) – began accumulating support and strength in the villages of the mid-western hills. The Movement forced the king to become a constitutional monarch and led to the re-establishment of a multiparty democracy. However, the resulting government was, once again, highly unstable and there was a general political discontent that continued to grow in the following years.

Meanwhile, a neoliberal economic order was entrenching itself in Nepal, as elsewhere. In this context of political restoration and of economic liberalism, there was a drastic expansion of civil society in the form of NGOs that thrived in many social welfare sectors (Rademacher & Tamang, 1993; Packard, 2016). Echoing the calls from major international development agencies such as the World Bank to involve NGOs in development (Paul & Israel, 1991), the NGO Federation of Nepal was established in 1991. Tellingly, the number of organisations registered with the Social Welfare Council in Kathmandu showed a notable increase over the years. This council, previously known as the Social Welfare National Coordination council during the panchayat era when it was overseen by the queen, serves as the government agency responsible for overseeing NGOs. In 1989, there were 350 registered organisations, which escalated to 1,210 in 1993 and subsequently soared to an astonishing 5,878 in 1997 (Shrestha, 2006). The public sphere came to be at the forefront of not only providing public goods, but also in promoting "good governance", human rights, women's empowerment, child welfare and people's participation in development (Shrestha, 2006; p. 119). Because of that, some scholars have argued that Nepal became "a 'pet country' of international donors" (Donini & Sharma, 2014, p. 119).

In mental health, the hospital-based psychiatric services continued apace, as did the community mental health efforts by the UMN (e.g. psychiatric out-patient clinic in Tansen, cf. Harper, 2014). In addition, there were a few more specialised centres in the hands of Jesuit missionaries (e.g. a drug rehabilitation centre led by Father Gaffney that later became the Freedom Center) and a handful of voluntary organisations that took the form of NGOs. A couple of examples of these were a faith-based NGO called MaryKnoll Nepal (that later became the Aashadeep rehabilitation and treatment centre) that worked to release and rehabilitate women who had been locked and abandoned in jails with no criminal offences - solely on the grounds of mental ill health (Robertson, 2001). Second was The Center for the Victims of Torture (CVICT), established in 1990 by a Nepali medical doctor who sought to provide support – including psychological – to victims of political and institutionalised violence during the panchayat regime (Sassene & Triantafillou, 2011). In addition to these organisations, other international development organisations working, for instance, to promote human rights and women's empowerment also began embedding what they called a "psychosocial" component within their programs and work (Abramowitz, 2009). Yet, it was not until a few years later, from the mid 1990s and throughout the 2000s, at the back of two complex emergencies in the country and a growing acceptance of a new global discourse around mental health in humanitarian emergencies, that an increasing number of NGOs dedicated to mental health were established in Nepal offering psychosocial interventions for different "victim" groups.

Indeed, the political discontent in the country continued, until 1996 when the Communist Party of Nepal (Maoists) (CPN-M) submitted a letter to the Prime Minister with forty demands, and an ultimatum (Seale-Feldman, 2019). When the letter was ignored, the Maoists started an armed rebellion across six districts (Rukum, Rolpa, Jajarkot, Salyan and Gorkha in the mid western and western regions, and Sindhuli in the central region) with the aim of toppling the monarch and establish a "People's Republic" (Donini & Sharma, 2014). This was the start of a ten-year civil war known as the "People's War". At the same time, the eastern part of Nepal saw an enormous influx of ethnically Nepali Bhutanese refugees fleeing their country to escape persecution from the Bhutanese authorities (Ikram, 2005).

Retrospective analyses of the war's causes have linked development failures, in addition to inequality, systemic corruption and weak rule of law, to the conflict (Panday, 1999; Donini & Sharma, 2014). As the war progressed, there was a growing realisation that it may have been connected to the aid policies that foreign donors and agencies had been implementing since the 1950s. This led to increased discontent and criticism of aid by both Nepali citizens and foreign actors (cf. Panday, 1989, 2011, 2012; Bista, 1991; Khadka, 1994; Donini & Sharma, 2014).

1996 – 2006 Crisis, trauma, psychosocial interventions & paradigm shifts in aid and development

From 1996 to 2006, thus, Nepal witnessed warfare and crisis. At the start of the war, the Maoists were a small fringe party, with few weapons and active members, with only the support of small pockets of people in the remote hills' areas. Over the years, it transformed "into a powerful force capable of standing alongside, and even overshadowing Nepal's major established political parties" (Donini & Sharma, 2014, p. 117). After the ten years of war, there were over thirteen thousand deaths, thousands of people had been tortured by both state forces and the Maoists, and many had disappeared (Pathak, 2016). In addition, the displacement of over 100,000 Bhutanese people to refugee camps in Nepal had a significant and ongoing impact on the health and mental well-being of those affected (Mills, Singh, Roach, & Chong, 2008). Both of these complex crises caused a great deal of suffering and ushered into the country additional United Nations and development agencies, which focused on the protection of human rights, peacekeeping and peacebuilding, and reconstruction. Thus, as stated earlier, while the Alma-Ata declaration principles including the recognition of the importance of strengthening health systems remained an ideal, development practice at the time of the war in Nepal largely reverted to offering vertical programs and proposing technological solutions and services for different "victim" groups (Justice, 1989; Packard, 2016). This practice aligned with how international donors were directing funds at that time, mainly through INGO/NGOs and private contractors rather than the state, making the development of systems challenging. Donors also grew increasingly wary of providing assistance to the government during the war due to concerns about corruption and human rights abuses, further reinforcing the channelling of funds through INGOs and private contractors instead of government.

During this period, Nepal saw the introduction of a new breed of mental health interventions in the language of "psychosocial interventions", justified by a discourse of trauma and post-traumatic stress disorder (PTSD) (Seale-Feldman, 2020). With this new discourse around mental health, the psychosocial needs of certain trauma-affected groups in Nepal (e.g. torture survivors, refugees, youth affected by armed conflict) received heightened donor investments and attention, and more INGOs, and their local counterparts, started integrating a psychosocial component as part of their social and development programs. In addition, two NGOs explicitly dedicated to psychosocial support began working in conflict-affected Nepal. Those were the Transcultural Psychosocial Organisation (TPO) and the Center for Mental Health and Counselling – Nepal (CMC-N). These NGOs would go on to become central to the development of mental health care in the country. CMC-N was established in 2003 as the local partner of UMN to continue their mental health project that started in 1984. On the other hand, TPO began working in Nepal in 1996 through a partnership with CVICT that would in 2005 result in the formation of a local NGO called TPO-Nepal. While TPO-Nepal's institutional history is further detailed in chapter 5, I want to highlight here that their intervention model, which sought to combine intervention and care with knowledge production, was both illustrative and a result of wider changes that would take place throughout the 2000s in development and global health funding, norms and practices.

Furthermore, during a period marked by warfare and crisis in Nepal, influential nations, prominent international organisations and key development agencies were driving significant changes in international development and aid paradigms. These changes, which began in the late 1990s and early 2000s and continued to take shape throughout the 2000s, would go on to directly influence the development and humanitarian discourses and practices I observed during my fieldwork in Nepal years later, between July 2017 and October 2018. In what follows, I briefly introduce the structural and normative shifts in aid and development practice that came about with the adoption of the Millenium Development Goals (MDGs), the endorsement of the 2005 Paris Declaration on aid effectiveness (OECD, 2005), and from the so-called 2005 Humanitarian Reform (Aderhold, 2016).

The year 2000 marked a pivotal moment for the international development community and practice. This was the year when 189 countries worldwide adopted the United Nations Millennium Declaration, which subsequently transformed into the MDGs (Chopra & Mason, 2015). The MDGs embodied a new approach to aid assistance (Murray & Overton, 2011). Firstly, they turned the focus from macroeconomic growth to improving social development; that is, in improving education, health (e.g. reducing maternal and child mortality and the burden of HIV/AIDS, tuberculosis and malaria), nutrition, and water and sanitation among others (Murray & Overton, 2011). This change in focus also helped revitalise the volume of global health aid (Travis et al., 2004; Thornicroft, Votruba, & the FundaMentalSDG Steering Group, 2015). Secondly, the MDGs established a new way of conceptualising and doing development by articulating specific global goals and targets, and promoting a culture of monitoring and accountability by establishing a results-oriented approach to development (Kamau, 2018).

These practices and norms put in place by the MDGs reflected the conditionalities imposed by new global development donors that began entering the field of global development in the late 1990s and early 2000s. Funding streams shifted away from United Nations institutions to different institutional actors such as private foundations and philanthropies including the Bill & Melinda Gates Foundation, the Global Fund and Gavi, The Vaccine Alliance (Packard, 2016). These new donors of global development and health started to increasingly demand aid recipients to evaluate and provide evidence for the effectiveness and impact of the initiatives, projects and programmes they funded (Packard, 2016) (cf. Chapter 5 for discussion on evidence-based practice). Before the MDGs, the global development community used a variety of methods to track progress, such as country-level monitoring systems, donor reporting, and periodic evaluations by international organisations like the World Bank and the United Nations but lacked a clear set of goals and targets and there was no consistent framework for measuring progress across countries and regions (ibid). As a result, it was difficult to assess the effectiveness of development efforts or to hold governments and aid organisations accountable to their commitments. Thus, it was thought that the establishment of a quantitative, time-bound framework of accountability could play a significant role in enabling progress to be made in development efforts (ibid).

In March 2005, the accountability of donors was explicitly addressed by the second High Level Forum on Aid Effectiveness convened by the Organisation for Economic Co-operation and Development (OECD) in Paris (Bissio, 2013). There, the Paris Declaration on Aid Effectiveness was endorsed by leading development practitioners and has been described as a land-mark reform in development cooperation (Bissio, 2013). The Paris Declaration aimed to improve the quality of aid by promoting accountability, transparency and effectiveness (OECD, 2005). This increased focus on the role of accountability and conditionalities in aid and development, with donors and international organisations seeking to ensure that aid was used effectively and efficiently, led to the development of new monitoring and evaluation frameworks and the use of performance-based funding models. Further, the declaration emphasised the importance of country ownership, alignment with national development plans, harmonisation of aid efforts and mutual accountability (OECD, 2005).

Finally, during the MDGs it was recognised that achieving global goals would require a coordinated and collaborative effort involving government, civil society organisations, private sector actors and international organisations and therefore highlighted the need for partnerships across multiple sectors and stakeholders (Scherr & Gregg, 2005). However, during the MDGs, the level of recognition and inclusion of the state as a partner varied across different regions and countries. It was not until the Sustainable Development Goals (SDGs) were developed that a greater emphasis on the inclusion of state as a key partner was placed. The drive to promote better coordination and effectiveness in international development practices, along with the emphasis on accountability and measurable progress, resonated within the field of humanitarian aid in the mid 2000s, with the so-called 2005 Humanitarian Reform (Aderhold, 2016). Efforts to increase global humanitarian coordination have been ongoing since the 1970s, coinciding with the rise in the number of humanitarian actors operating worldwide. However, significant changes in the structure and approach of humanitarian aid took place in the mid-2000s, prompted by mounting concerns about the insufficient and fragmented response to humanitarian crises (Aderhold, 2016).

Prior to the mid 2000s, humanitarian aid was typically organised in an ad hoc and fragmented manner. Multiple humanitarian organisations and agencies operated independently, often without coordination or clear lines of communication, leading to a lack of coherence and consistency in their responses. This, in turn, resulted in the duplication of efforts, inefficiencies in resource allocation, and higher risks of gaps in service provision, with some areas of need potentially being overlooked due to the absence of clear guidelines and standards (Aderhold, 2016). In fact, the lack of coordination and coherence among the different humanitarian actors involved in the response to the Indian Ocean tsunami of 2004, once again, highlighted to the humanitarian community the need for a more systematic approach to humanitarian coordination. Thus, in 2005, the Humanitarian Reform sought to enhance capacity, reinforce coordination, establish predictable leadership and partnerships, and promote accountability (Aderhold, 2016).

The key elements of the humanitarian reform included the establishment of the Cluster Approach, the creation of the Central Emergency Response Fund, the adoption of the Humanitarian Coordinator system, and the development of the Transformative Agenda (Aderhold, 2016). The Cluster Approach is a system of organising and coordinating humanitarian response in specific sectors (UNHCR, 2023a). It is based on the principle that no single organisation can provide all the necessary assistance in a crisis, and that a coordinated effort is needed to ensure a more effective response (UNHCR, 2023a). The Central Emergency Response Fund is a fund established by the United Nations to provide rapid and predictable funding for humanitarian emergencies (UNHCR, 2023a). The fund is used to support humanitarian response activities in the early stages of a crisis, when funding is often most urgently needed (UNHCR, 2023a). The Humanitarian Coordinator system is a leadership structure designed to ensure a coherent and effective response to humanitarian crises and to ensure that the needs of affected populations are met (UNHCR, 2023a). Finally, the transformative agenda is a set of initiatives aimed at improving the overall effectiveness of the humanitarian system (UNHCR, 2023b). It includes measures to improve the predictability and flexibility of funding, enhance the accountability and transparency of humanitarian organisations and strengthen the partnership between humanitarian actors and governments (UNHCR, 2023b).

In sum, thus, the new approach to aid assistance – development and humanitarian – that formed throughout the early 2000s was one that demanded effectiveness and accountability. CVICT and TPO, two mental health NGOs that were operating in Nepal during the civil war, pre-empted these increasing accountability demands from donors. As early as the late 1990s and early 2000s, they began combining the provision of medical, legal, and psychosocial rehabilitation programs for populations affected by political violence with carrying out population-based epidemiological studies (Shrestha et al., 1998; Van Ommeren et al., 2001) and testing and preparing instruments for transcultural research (van Ommeren et al., 1999; van Ommeren, Sharma, Makaju, Thapa, & de Jong, 2000). In chapter 5, I show how TPO Nepal's early emphasis on generating empirical evidence placed them as one of the main aid recipients for funding in the name of global mental health - a field of research, study and practice that gained increased recognition in the mid 2000s.

2006 – 2015 Political restructuring; global mental health; relief-to-development & Nepal's psychotherapeutic market

After ten years of conflict, the Government of Nepal and the Communist Party of Nepal (Maoist) signed the Comprehensive Peace Accord (CPA) in November of 2006. This event marked the cessation of insurgency and ushered in a political settlement that emphasised principles of equality and inclusion, and paved the way for the restructuring of Nepal (Sharma & Harper, 2018). Elections for a Constituent Assembly were put in place, and in 2008 Nepal was declared a secular, federal, democratic republic, bringing an end to the centuries old monarchy. The CPN-M joined mainstream politics and became the largest political party and formed a coalition government. A Constituent Assembly was elected in 2008 and tasked with drafting a new Constitution for the country. This mandate, which was initially aimed to be accomplished by May 2010 had to be renewed many times. Eventually, the Supreme Court ruled that there could be no more extensions and that elections should be held, dissolving the first Constituent Assembly in May 2012 (Lunn, 2013). Following the dissolution of the first assembly, new elections were held in November 2013, and a second Constituent Assembly was formed. Although no single party secured an outright majority in the elections, the Nepali Congress emerged as the largest group, and they quickly forged an alliance with the Nepal

Communist Party (Unified Marxist-Leninist) to produce a majority (Hutt, 2020). The second Constituent Assembly was also given the responsibility of drafting a new constitution. Since 2009, thus, Nepal had seen a rapid succession of governments, and its people waited for many years for a new constitution to be enacted. This was eventually accomplished by the second Constituent Assembly in September of 2015. It is important to note that the drafting and promulgation of the Constitution took place in the aftermath of two devastating earthquakes, and the process was mired with controversy, as I explain later.

Civil war followed by political instability meant that health system strengthening, as promulgated by the Alma Ata declaration, was challenging in Nepal. Instead, the country experienced a growing trend toward privatisation and an increasing reliance on NGOs, which extended to the field of mental health. After the war in the mid 2000s, Nepal saw an increasing number of NGOs dedicated to mental health, as well as private sector initiatives in this area. Alongside psychiatric services and psychosocial approaches to mental health care, there has been an ever increasing diversification of approaches to mental health, as will be evidenced in the following chapter, chapter 3. In 2009, the NGOs working in mental health recognised the diversity of approaches and interests within the field and attempted to establish a loose network they called the National Mental Health Network, to attempt to unite their efforts in policy advocacy (Upadhaya et al., 2014). However, the network did not last long due to lingering conceptual and political differences.

Earlier, I delved into the changes in aid and development practices that occurred at the beginning of the twenty-first century, both in terms of structure and norms. In the following, I narrow my focus onto the emergence of mental health as a global issue of importance, and the increasing attention it began receiving within humanitarian and global health agendas. I also highlight how these changes on international agendas manifested in the context of Nepal.

In the humanitarian context, until the early 1990s, emergency response mainly centred around addressing the immediate needs of affected populations such as food, shelter and medical care (Packard, 2016), and mental health and psychosocial support received little attention and resources. Though some efforts were made to provide care for those experiencing psychological distress during emergency situations; they were often restricted in scope and lacked a unified and coordinated approach due to conceptual and practical divisions within the field (Miller & Rasmussen, 2010). One major conceptual division was between those who supported a trauma-focused approach to addressing mental health needs in humanitarian settings, and those who favoured a psychosocial approach (Van Ommeren & Saxena, 2005). The advocates of trauma-focused approaches focused on traumatic stress (especially PTSD) as the cause of mental health issues and believed that providing specialised clinical treatment was sufficient. Meanwhile, proponents of psychosocial approaches viewed traumatic stress as just one of several factors contributing to mental illness. They emphasised that stressful social and material conditions played a significant role in causing distress and argued that mental health care should provide not only specialised clinical treatment but also social and economic support (Miller & Rasmussen, 2010). A parallel debate in the field had to do with the presumed universality of the Western discourse of trauma and its focus on PTSD. While some considered PTSD to be a universal psychopathological response to a traumatic experience, others viewed PTSD as being one of many ways of experiencing and expressing distress within a specific socio-cultural context (Summerfield, 1999). In practice, and in emergency situations, these divisions translated in poor coordination and collaboration across approaches and an unhelpful competition for funding that resulted in disorganised, fragmented, inconsistent responses and harmful actions, as exemplified by the 2004 Indian Ocean tsunami (Wessells & van Ommeren, 2008).

In 2007, in recognition of the need for a comprehensive and coordinated approach to addressing MHPSS needs in humanitarian responses, the Inter Agency Standing Committee (IASC) published guidelines on mental health and psychosocial support (MHPSS) in emergency settings (IASC, 2007). The specific aims of these guidelines were 1) to provide practical guidance for humanitarian actors on how to integrate MHPSS into all phases of emergency response, from preparedness and planning through to recovery and rehabilitation, 2) to promote a coordinated and multi-sectoral approach to addressing MHPSS needs in emergencies, involving collaboration among different sectors and organisations involved in humanitarian response, 3) to ensure that MHPSS interventions are delivered in a culturally sensitive and contextually appropriate manner, taking into account the diversity of cultures, languages and social structures of the affected populations, 4) to promote the active participation of affected communities and individuals in the design and implementation of MHPSS interventions, in order to ensure that interventions are relevant, effective, and respectful of their rights and dignity and 5) to advocate for the recognition of MHPSS as an integral component of humanitarian response, and to promote the development of policies and programs that prioritise MHPSS of affected populations (IASC, 2007). The guidelines, thus, enshrined a new understanding of MHPSS in emergency situations: one that emphasised the need for a multi-layered and integrated care approach to suffering in emergency situations.

The effects of the 2005 Humanitarian Reform and the implementation of the 2007 IASC MHPSS guidelines were not felt, or used, in Nepal until 2008; in the aftermath of a flood caused by the Koshi River. In 2008, the Koshi River broke its embankments in southern Nepal, causing a devastating flood (Devkota, Crosato, & Giri, 2012). In response to the disaster, TPO Nepal, a mental health NGO with connections to broader transnational humanitarian networks, collaborated in translating and validating several humanitarian tools for the Nepali context including the newly published IASC guidelines, the Psychological First Aid guidelines and the Humanitarian Emergency Settings Perceived Needs Scale (HESPER) (Semrau et al., 2012). The Koshi flood also led to the establishment of Humanitarian Clusters in Nepal, which have remained constantly active since then. Despite these efforts, MHPSS was initially not included in the health sector's contingency plan for emergencies in Nepal, and only saw its inclusion after the 2015 earthquakes.

In the global health context, while the MDGs led to a noteworthy rise in global health funding, mental health and disability were not incorporated into the health goals and targets of the MDGs (Thornicroft et al., 2015). The MDGs emphasis was on enhancing maternal and child health, decreasing the impact of infectious diseases like HIV/AIDs, tuberculosis, and malaria, improving access to clean water and sanitation, alleviating poverty and hunger, fortifying healthcare systems, enhancing access to essential medicines, and tackling emerging hazards like pandemic influenza and bioterrorism (Packard, 2016). Despite some early attempts in the 1990s and early 2000s to emphasise mental health as a development priority, it was not until the mid-2000s that it gained more recognition in this regard with the emergence of a new field of study, practice and research called global mental health.

In 1993, the World Development Report introduced an epidemiological measure, called the Disability Adjusted Life Years (DALYs), which combined years of life lost due to premature mortality and years of life lived with disability (Berkley, Bobadilla, Hecht, Hill, & Jamison, 1993). Unlike traditional health metrics that focused solely on mortality rates, the DALYs took into account the impact of disability on the global burden of disease. This helped to bring visibility to the suffering caused by mental health disorders on the global stage. A couple of years later, in 1995, a "World Mental Health Report" was produced by Harvard anthropologists, collaborating with people across the world, building on the global burden of disease data and providing ethnographic data and cases that presented mental health as both a universal human right and an economic concern (Desjarlais, 1995). The report called for enhancements in mental health care in poor countries, and highlighted the importance of addressing mental health issues as part of development efforts (Desjarlais, 1995). A year later, in 1996, the first Global Burden of Disease report stated that mental health contributed 14.5% to the global burden overall (Murray, Lopez, & Organization, 1996). And, in 2001, two global reports on mental health were published. Firstly, the first WHO World Health Report solely focused on mental health, which brought attention to the state of mental health care worldwide, particularly in LMICs (WHO, 2001a). It also highlighted the "treatment gap" that existed between those that needed mental health services and those who were able to access them, and underscored the importance of prioritising mental health as a key component of healthcare, recognising that mental health disorders are prevalent globally and that they have a significant impact on individuals, families and communities. Secondly, the WHO also published the atlas of mental health resources, which provided valuable information for policymakers, researchers and healthcare providers about the availability and distribution of mental health resources worldwide (WHO, 2001b). The following year, in 2002, the WHO launched the Mental Health Gap Action Programme (mhGAP) with the goal of creating a concise and effective plan to address the disparity between the urgent need for mental health resources and the limited availability of such resources worldwide (WHO, 2002). There were also beginnings of advocacy efforts for global mental health after the MDGs in the early 2000s (cf. Patel & Kleinman, 2003; Miranda & Patel, 2005). These endeavours drew inspiration from the strategies and insights gleaned from global health advocates who had called for the prioritisation of HIV/AIDS prevention efforts on a global scale.

Despite these efforts, it was not until the emergence of the field of global mental health in the mid 2000s that mental health gained greater prioritisation on global development and health platforms. In 2007, a consortium of prominent scientists, mental health advocates and public health professionals from academic institutions in the United Kingdom, along with the WHO, built upon previous initiatives and issued a "call for action", publishing a series of articles in The Lancet, with the goal to increase the provision of evidence-based mental health services in LMICs (Chisholm et al., 2007). Their articles drew attention to the need for greater prioritisation of mental health in LMICs, and coined the term "global mental health" (cf. Bemme, 2019 for a more in-depth description and analysis of the origins of the field). The Lancet series highlighted the significant burden of mental illness worldwide, the inadequacy of mental health services in LMICs, and emphasised the urgent need for increased attention, resources and political will to address mental health issues on a global scale (Chisholm et al., 2007). It was argued that mental health is a key component of global health and development, and called for its integration into broader health and development agendas (e.g. HIV/AIDS and non-communicable diseases) and the strengthening of health systems to improve the delivery of its care (Prince et al., 2007). This call for action was effectuated in the language of scientific evidence and human rights, and resulted in increased funding and attention for mental health programs and initiatives. Since then, mental health has gained increased recognition and momentum in international health and development discourse and practice. And, as I delve more in detail in chapter 5, this has also impacted the local mental health system in Nepal.

Over the course of the MDGs, and especially from 2005 onwards, many organisations started to bring their attention and resources to the issue of health systems strengthening after a period of concentrating on disease and service-specific initiatives (Hafner & Shiffman, 2013). It was becoming clearer to global health actors that many health systems in LMIC were weak, hindering the effective delivery of necessary services to achieve targets (Travis et al., 2004; Hafner & Shiffman, 2013). Towards the end of the first decade and beginning of the second decade of the twenty-first century, there was a renewed emphasis on, and return to, health systems development and strengthening goals (Packard, 2016). The shift was driven by the recognition of the necessity of a strong health system to achieve sustainable improvements in health outcomes, increasing awareness of the interconnectedness of health systems and the need for a comprehensive approach, and concerns over the impact of global health initiatives on health systems (Travis et al., 2004; WHO, 2007; De Savigny & Adam, 2009). Consequently, stakeholders recognised the need for collaboration and partnership building between governments, NGOs and other organisations to strengthen health systems (WHO, 2007). All of these efforts were steps towards the development mandates and norms that were eventually incorporated into the SDGs, that emphasise the importance of country ownership, sustainability, and integration of services, including mental health services (UN General Assembly, 2015).

These shifts towards sustainability and integration in international development during the later years of the MDGs were echoed in the field of humanitarianism where there was also a growing recognition of the need to transcend the divide between short term humanitarian aid and longer-term development efforts (Secretary-General, 2016). These changes were further reflected in the subfield of humanitarianism dedicated to MHPSS. The WHO published a report in 2013 called “Building Back Better – sustainable mental health care after emergencies” (WHO, 2013) that advocated an approach that sought to capitalise on the resources and political will that disasters elicit to strengthen mental health systems. This report highlighted the need to adopt an approach that promotes sustainable and long-lasting improvements in mental health care, even in emergency situations (WHO, 2013).

This drive towards a more integrated and sustainable approach that involves strengthening health systems and building capacity among health care providers was also felt in the context of mental health care in Nepal. Ever since around the 2010s, the main mental health NGOs in Nepal have been working towards strengthening mental health systems, and collaborating with the government (cf. Chapter 4 reflects on the notion and practice of “country ownership”). In fact, as I develop further in chapter 5, from 2011, TPO Nepal’s main source of funding came from research consortia in the name of global mental health (e.g. PRIME and EMERALD) and shifted the way the NGO worked: from working through stand-alone interventions to working in closer collaboration with the government, focusing on health systems strengthening and sustainable development.

In the above, I have outlined the local and global political, aid and mental health context and shifts that were taking place when, on the 25th of April of 2015, Nepal was struck by the strongest earthquake the country had experienced in eighty years, only to be followed by another major earthquake two weeks later, on May 12th. In the following, I provide a brief account of the impact and consequences of the earthquakes. I outline the humanitarian response that followed and highlight the enduring implications that unfolded in the aftermath of these events in conjunction with the official launch of the SDGs. This sheds light onto the interconnected nature of aid intervention, national political changes – such as the rushed passing of the new constitution – and their collective impact on the mental health system in Nepal and establishes the contextual backdrop that existed when I began my research.

Research context: Post-earthquake and federal Nepal in the era of Sustainable Development

Over the course of several months following the earthquakes, numerous tremors and aftershocks caused widespread destruction affecting thirty one of Nepal's seventy five districts (Hutt, 2020). Tragically, nearly nine thousand people lost their lives, more than twenty-two thousand suffered injuries, almost nine hundred thousand homes were destroyed, and thousands were displaced as a result (Hutt, 2020). The disaster prompted an immediate response from Nepali citizens (especially the youth), the army and the Indian government (Hutt, 2020). Further, the international community mobilised quickly, sending more relief than local authorities were prepared to handle, and committed to give $4.4 billion in emergency aid, which facilitated immediate rescue efforts as well as longer-term endeavours (Hutt, 2020).

It was amid the chaos of the earthquakes' relief efforts that the drafting of the new constitution took place. After waiting for years for the enactment of the new constitution, the second Constituent Assembly took advantage of the post-disaster context to fast-track the process, and promulgated it in September of 2015. With the adoption of the new constitution, the second Constituent Assembly was dissolved. The speed and manner in which the constitution was passed led to ongoing debates and discussions about the legitimacy and effectiveness of the constitution in addressing the diverse needs and concerns of Nepal's population (Sharma, 2021). Indeed, it was only when the national and international attention was focused on the relief from the earthquakes and with the pretext of having to start the rebuilding process, that the political parties reached a rushed agreement and enacted the new constitution, leaving some of the more contentious issues, such as the naming and the demarcation of the new federal provinces, unaddressed. Along with the many protests, political turmoil, and internal polarisations the enactment of the Constitution created, it had important structural and symbolic implications. Structurally, it meant Nepal was moving from a unitary system of government to a federal three-tier governance system with national, provincial, and local levels of governance, restructuring resource distribution and political power in a way that would be decentralising power. Symbolically, the new Constitution signified the transition to "Naya Nepal" (or new Nepal) (Sharma, 2021); that is, a symbolic break with past governance failures, and a new era for a welfare state.

Prior to the 2015 earthquakes, Nepal, like many other countries, had low prioritisation of mental health care by the state. As a result, MHPSS was not adequately addressed in the health sector's emergency contingency plan, leading to a one-month delay in coordinating mental health-related relief efforts (Sherchan et al., 2017). On the other hand, the earthquakes brought an influx of money to Nepal and an increased attention to mental health. Alongside coverage of human and material losses, the disaster prompted international concerns about the more invisible wounds of the survivors: the emotional and psychosocial effects experienced by survivors (ICRC, 2015). Shortly after the disaster, anxieties about the potential "unleash of a mental health disaster" were promulgated in the international media (Bennett, 2015). Within weeks of the earthquakes, various initiatives were undertaken. An online platform was created to facilitate the exchange of information on MHPSS, and a rapid situational assessment was conducted by the International Medical Corps (IMC) Emergency Response Team (IMC, 2015). Additionally, a Desk Review commissioned by the IASC and spearheaded by scholar-practitioners associated with the NGO TPO Nepal summarised the existing knowledge on mental health in Nepal (IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2015). TPO Nepal, with support from IMC, conducted a further MHPSS assessment in three earthquake affected districts (Antigua, 2015).

Indeed, this period witnessed a significant increase in mental health discourse and practice in Nepal, with a proliferation of stakeholders aiming to address the trauma experienced by the affected population (Seale-Feldman & Upadhaya, 2015). Efforts were made to deploy psychosocial counsellors and psychologists to affected areas, train social workers, volunteers and counsellors on psychosocial aspects of disaster management, raise public awareness about psychological impact of the earthquakes and provide crisis interventions (Military Medicine Worldwide, 2016). In addition to immediate relief efforts, local and international actors in mental health development and humanitarian efforts saw an opportunity to bring about lasting change in Nepal's mental health system following the earthquake. Operating within the framework of "Building Back Better" and increasingly emerging mandates around country ownership, they not only focused on providing immediate relief but also sought to initiate long-term transformation (WHO, 2013), and INGOs, instead of working directly on the ground did so through their local counterparts (Chase et al., 2018).

From September 2015, the SDGs were formalised, marking a crucial milestone by officially including mental health on the global development agenda for the very first time, recognising mental health as an essential component of the broader development agenda. In addition to this inclusion, the SDGs emphasised key norms for their successful implementation. These norms were about fostering partnerships, promoting country ownership, and actively involving multiple stakeholders throughout the development process. These principles aimed to promote collaboration and shared responsibility among governments, international organisations, civil society and other relevant actors. Following these newer development mandates, a significant portion of the financial support generated in response to the 2015 earthquakes in Nepal was directed to a limited number of established mental health NGOs (Chase et al., 2018). These NGOs tried to use the funding to go beyond short-term care in their earthquake-response programs. Their objectives included building capacity within the mental health system, raising awareness about mental health, facilitating the transition from immediate disaster response to what they hoped would be sustainable, long-term mental health services, and implementing structural changes such as the addition of psychotropic medications onto the Essential Drugs List (Chase et al., 2018).

The inclusion of mental health in the SDGs, combined with the specific post-earthquake context in Nepal and the "emergency imaginary" (Calhoun, 2008) it created, led to a momentary increase in funding allocated to mental health research in the country, including ethnographic research such as my own and that of others that came before me (Seale-Feldman, 2018; Chase, 2020). This period was deemed a unique opportunity by funders, paralleling the discourse around building back better, for researchers to document and analyse the impact of disasters and contribute to the knowledge base for future disaster response and recovery efforts.

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In this chapter, I have presented the historical and political background to the current mental health system, have underscored the dynamic nature of aid norms, funding mechanisms, and discourses surrounding mental health, and suggested that they are constantly undergoing transformation. To breathe life into these macro-level processes, the following chapter, chapter 3, takes a closer look at the micro-level realities through ethnographic fragments. By illustrating how these processes manifest on the ground, I offer a glimpse into the present-day mental health care landscape, providing also a feel for the enduring influences of the past outlined in this chapter. Despite the growing recognition of the significance of mental health in international development and ongoing efforts to establish cohesive systems with greater state involvement and ownership, the research I conducted during the period of 2017-2018 revealed a different reality within the mental health system – characterised by fragmentation and pluralism.

Chapter 3. The fragmented landscape of mental health care in Nepal

Introduction

Having explored the historical and political processes that inevitably influenced the social, political, economic and mental health system I observed in Nepal in 2017 and 2018 this chapter breathes life into those macro-level processes by providing a sense of their influence on the ground. In this chapter, I address the questions: what is the present state of mental health care, what does the present state tell us about the object of care, and how does this mirror prevailing socio-economic influences?

Drawing inspiration from anthropologist Nichola Khan (2021) and her experimental use of writing in fragments, in the following, I offer a patchwork of ethnographic fragments that take the reader to different places and therapeutic spaces where mental health care takes place in Nepal. These fragments not only provide context to the diverse sites and settings through which my research was conducted, but also challenge traditional anthropological narratives of “entering the field” (cf. Malinowski, 1922) and resist the impulse to impose an overarching coherence.

Instead of striving for a unified narrative or seamless whole, my aim is to establish an alternative and immersive sense of how I came to know and construct the “field”. Embracing the inherent incompleteness, absence, and partiality in knowing, I suggest that such factors do not diminish the insights that readers can glean from ethnography; but that it rather strengthens the learning process, as it forces both the ethnographer and the readers to confront and grapple with the complexities and nuances of the mental health system in Nepal, as well as the inherent partiality of ethnographic knowledge itself.

This chapter contributes to the thesis's broader examination of Nepal's mental health system by providing ethnographic evidence of how macro-level political and economic processes manifest in everyday care practices. While the previous chapter (chapter 2) traced the historical emergence of mental health as an object of care, this chapter illustrates how that history shapes the current fragmented landscape where, as I will explore in the following part of the thesis, multiple actors broker and translate different approaches to mental health care. The ethnographic fragments reveal a therapeutic marketplace created by neoliberal reforms where various providers – from public hospitals to NGOs to private practitioners – must navigate competing demands. On one hand, current policy aspirations and aid norms emphasise integration, collaboration, and health systems strengthening. On the other hand, market forces push these same actors to compete for resources, recognition and legitimacy. This tension becomes visibly apparent in the final fragment of the chapter, where what begins as a unified march for suicide prevention quickly fragments into separate groups behind their organisational banners. The fragments show these dynamics playing out across multiple scales – from brief encounters to community interventions to attempts at national coordination – exemplifying how mental health brokers must constantly translate between policy aspirations and practical realities.

Intrigued by the prospect of a writing form where the structure itself reinforces the content and message, I chose to apply this approach to illuminate Nepal's current mental health care landscape, which is characterised by plurality and fragmentation. Rather than presenting a neatly constructed portrayal, this writing form invites readers to steep themselves in the fragments, enabling a more nuanced exploration of the diverse modalities of care in Nepal.

Building upon the previous chapter, the organisation of the ethnographic fragments loosely mirrors the historical progression of care models, and the ongoing transformation of care providers in Nepal. As this chapter unfolds, it becomes evident that mental health care providers span a spectrum of domains. The chapter begins by offering insights into care within the public sector, highlighting practices within a public hospital in Kathmandu, as well as a health post, and a primary health care centre in a central hilly district. Subsequently, it illustrates a public-private partnership through the case of a regional hospital in the far western part of the country, showcases an older model of the private sector with a private psychiatric rehabilitation centre in Kathmandu, explores diverse approaches of non-governmental organisations, before delving into the emerging landscape of start-up ventures exemplified by an online counselling business. Finally, the chapter ends with a short-lasting attempt at collaboration between all stakeholders in the name of suicide prevention.

As a whole, the intention of this chapter is not to give an exhaustive coverage of mental health care provision in the country, but to provide a partial and incomplete window on to its inherent complexity and constant transformation and provide the reader with a feel for how I conducted research (cf. see section on "constructing the multi-sited field" in Introduction chapter).

Fragments of Fragmentation: Composing "the field"

Public care provision

Speed and pills at an Outpatient Department (OPD) in a hospital

At 10am, Dr. Bhargavi, the youngest member of the psychiatric team at a public hospital in Kathmandu, and I, step into one of the two outpatient psychiatric department rooms. The waiting area is filled with patients, some of whom have been waiting since 4am. As we take our seats, Dr. Bhargavi explains to me her goal of seeing twenty-five patients per day, aiming to share the workload with her colleague on duty. She tells me that, as opposed to her boss, she primarily handles new cases which requires a more extensive history-taking process that is more time-consuming. Her concern about being able to see "her share" of patients a day is evident in the speed in which she works and the tenor with which she probes the patients.

An excerpt from my fieldnotes reflects this experience:

1. A female patient, accompanied by her husband, walks into the OPD after travelling from Pokhara last night. She is a referral case. The patient reports experiencing a few symptoms including restlessness, extensive worry, and *gyastric* (gastritis) issues for the past two years, with no identifiable stressors currently. During the consultation, Dr. Bhargavi advises the patient to decrease her tea consumption and diagnoses her with an

anxiety disorder. The doctor prescribes medication to manage the symptoms, and the patient and her carer leave.

2. Another female patient walks in alone for her follow-up appointment. She was diagnosed two months ago with a seizure disorder but reports feeling okay now. Dr. Bhargavi writes "CST" (continue standard treatment) in the patient's medical file and prescribes medication for a one-month period. The patient inquires if the dosage is being reduced and the doctor says it is going to remain the same, with no further explanation. The patient leaves.

3. Another female patient with a diagnosis of anxiety disorder walks into the OPD alone. She explains that she finished her medication a few days ago but had been unable to see the doctor until now. She then says that she started feeling the onset of a panic attack half an hour before entering the OPD, and that she feels weak, has shortness of breath, and starts to cry. Dr. Bharvagi prescribes clonazepam – a benzodiazepine – and asks an intern to escort her to the emergency department.

4. Then, a male patient arrives with his wife for a follow up visit. He has a history of alcohol abuse. The doctor prescribes medication for a one-week period to manage the patient's condition and suggests he be admitted for treatment. The patient declines the offer and leaves.

5. Then, at his follow–up visit, another male patient with a history of alcohol abuse arrives at the medical facility with his wife. He says that he has stopped drinking, but his wife says that he still drinks from time to time. To evaluate the patient's condition, the doctor checks for tremors, wrists, and elbow movement. She also asks the patient to walk up and down the small room and advises him to change his diet and start exercising. She then prescribes olanzapine, to help the patient with his alcohol craving and consumption.

6. Next, a female patient comes in with her mother. She complains about sleeplessness, headaches, loss of appetite, and constant crying. The doctor prescribes some medication to manage her symptoms, giving the medication instructions quickly to the patient, who seems not to fully understand. Dr. Bharvagi explains the dosage again, this time to the patient's mother and asks her to ensure that her daughter understands the instructions later on. After that, they leave.

7. At her follow-up appointment, a female patient says she has migraine headaches and constipation. The doctor quickly asks probing questions, "aru…aru…aru…" (what else…what else…). The patient says she has finished her medications and needs more. Dr. Bharvagi prescribes the additional medication to manage the symptoms for another two weeks.

8. Then, a male patient starts to give his medical drug history to the clinician. The doctor interrupts him, saying that she is aware of his history because it is recorded in his medical record. She asks if there was anything new to report. The patient mentions having trouble sleeping and spending a lot of time on his phone. Dr. Bharvagi advises him not to look at screens one hour before bedtime, prescribes medication, and notes down CST.

Having spent between two to five minutes per patient, Dr. Bhargavi, frustrated, tells me: "I can't devote so much time to each patient". In total that day, the doctor managed to see twenty three patients and not one of them left without a prescription.

Stuckness in the inpatient department in hospital

Dr. Raj, the head of the psychiatric department at a public hospital in Kathmandu, hastens past the only guarded gate in the entire hospital and into the ward for morning rounds, followed by his entire team of four psychiatrists and one clinical psychologist. Medical interns, a house officer, nurses, and I join them, overcrowding the already very busy ward. Dr. Raj leads the way to see the first patient and carer of the day. They are both sharing the small bed labeled "P1". One of the nurses pushes the wheeled wooden cabinet containing every inpatient's paperwork. We huddle around the patient. Dr. Raj briefly greets the patient while a male intern pulls out the patient's history and medication document for today's "P1". We listen to the intern assigned to this bed read the notes out loud, giving a quick overview of the "case", speaking Nepali peppered with English words. The intern tells us that the patient has bipolar disorder. While the intern reads, Dr. Raj interjects, using the opportunity for pedagogical purposes, correcting some of the intern's terminology or testing his knowledge. This, he does in English: "What can you say from her physical appearance? And from how she is talking? And the content?". The intern answers shyly. Once the test is over, the intern consults the sheet where the pharmacological information is noted down and informs the doctors about the patient's current treatment. Once he has conveyed all of this, Dr. Raj checks in directly with the patient. The short interaction strongly resembles the interaction the doctor has with his patients in the OPD. It generally starts with "how is your heart-mind doing?" (*"maan kasto cha?"*), followed by a few questions around sleep and food intake. The patient says she is okay. The carer uses the opportunity to ask about how long it will take until discharge. Dr. Raj does not give a clear answer, but tries to comfort them both with a smile and says, "do not worry" ("*na attinus"*). Without another indication from Dr. Raj, the intern jots down CST on P1's notes.

Psychoeducation as an integral part of the psychiatric approach in a public hospital

M. Baral, a new addition to the team and one of the very few clinical psychologists in the country working among psychiatric colleagues in a public hospital, sits in his small office. This tiny office composed of a table, a couple of plastic chairs and a wooden bench is all the infrastructure he needs to provide his contribution towards the healing of the inpatients and their families. He and I wait a few minutes for "P5". A teenager with a temporary diagnosis of bipolar disorder is escorted and followed by his father into the office. They have both been in the ward for thirty-three days. The tired looking father takes a witnessing seat beside me. M.

Baral exchanges his position behind the table for the chair closest to the patient – the young man is about his son's age. The clinician tried to speak to him many days back but did not manage. "He was in a manic phase", he tells me. M. Baral asks the young man how he is feeling now, how is his heart-mind, is sleep coming to him, and whether he and his father had something to eat today. Nods and monosyllables are all the health provider gets from the patient at first. M. Baral wants to know what happened to him. After some encouragement from the father to speak, the patient tells the clinician about his interest in spirituality and how he tried to get involved with the "Om Shanti" group and learnt how to meditate thanks to a spiritual guru. He tells him that it was in search of spirituality that he began taking drugs. M. Baral warns him that he has to ask him a few questions about his drug and alcohol intake, and asks him whether he would prefer his father to wait outside. The patient does not seem to mind; nor does the father. The patient explains to all of us that he takes LSD and cannabis with his friends. "Real spirituality, sustainable spirituality cannot depend on substances", M. Baral offered, and continued probing the patient "or do you think your spiritual teachers always need cannabis for spirituality?". M. Baral explained that using cannabis over a long period of time can have very detrimental effects on a person's brain and in a person's life. He handed over an article he had printed off from the internet, explaining these long-term effects in more detail, and asked the patient to read it for the next meeting. He would be checking with him, "understood"? ("*bhujnu bhayo?*"). Then, he asks the patient what he wanted to do later in life. He had an interest in "AI". M. Baral was very encouraging about his interests and emphasised what a good life he and his family could potentially have if he pursued his interest. Then, referring to some of the adverse effects of cannabis, such as loss of attention, the clinician said, "But how can we even start to think about artificial intelligence before thinking about taking care of our normal intelligence, am I right?". The patient seemed convinced. The session finished with M. Baral asking the patient to try to be smarter than his friends, and to say no to them when they offered drugs, and to think about the bright future ahead of him.

These fragments from public hospital psychiatric services trace their roots to Nepal's earliest mental health interventions in the 1960s, discussed in Chapter 2. The rushed consultations and medication-focused approach reflects continuity with the initial hospital-based psychiatric services established during the Panchayat era, when treatment was primarily restricted to medication. However, the presence of clinical psychologists like M. Baral represents more recent attempts to diversify care approaches within public institutions - a shift that emerged as Nepal's mental health system became increasingly pluralistic after the 1990s economic liberalisation. I continue with the descriptions of other forms of public care: that of a health post and of a Primary Health Care Center.

Faint memories, dusty registers and "tension" at a health post

Tushil is a middle-aged man, father of two. He has been working as the health assistant in charge for the same health post, situated twenty kilometres away from the district's headquarter, for the last fifteen years. I tell him about my interest in mental health and its care in Nepal. He worries that there is not a great deal of relevant information he can share with me. He says he faintly remembers his health post had been part of a project intended to support people with mental illness post-earthquakes and had received medications to distribute for a while from an organisation that was trying to integrate mental health care within primary health care following the earthquakes. He cannot recall the name of the organisations involved, nor the length of time the support was put in place. But now, he says, they do not have any psychotropic medication at the healthpost nor do they see many people with "tension".

Tushil's understanding and experience of tension is that it arises from livelihood issues and from problems associated with having a family member working abroad. He explains that when people with "tension" come to his health post, they give them an ibuprofen and a referral to the primary health care centre that, since the 2015 earthquake, was taken over by a public-private partnership and patients can get "specialised pills for free". He apologises about the limited amount of information he can share with me but offers for me to spend a day with him and his colleagues and gives me the phone number of a friend of his working at the primary health care, who he believes will know more about the mental health situation in the district.

The next morning, after a bumpy bus ride, Tushil welcomes me at the health post, which comprises a dispensary area, a dressing room, and an office space for consultations and documentation. He opens a key-locked closet, moves a bunch of papers and yellow folders before dusting off and handing me a large and thick notebook. It is a barely used "mental health OPD register". These registers, designed primarily for health assistants to document mental health patients at the health post, also serve research purposes (see chapter 5). The columns of the registers are structured as follows: each entry includes visit number, date, weight, and an ethnic code; routinising caste information in data collection. The ethic codes read as follows: 1 for hill dalit, 2 for terai dalit, 3 for hill janapati, 4 for terai janapati, 5 for madhesi, 6 for muslim, 7 for brahmin/chettri and 8 for other ethnic group. The register also distinguishes between new and returning patients, records earthquake-related experiences, and details major presenting complaints. Additionally, it systematically records symptoms related to depression, suicide, psychosis, epilepsy, PTSD, and alochol use disorder, as well as other health concerns. There is a space allocated for the diagnosis, the prescribed medication or advice provided, referrals, and follow-up dates. There are also a couple of NGO logos on the register.

Tushil then leaves and I stay at the health post with another health assistant and an auxiliary nurse midwife throughout the day. The pace is slow, and most patients come in for a "BP (blood pressure) check". Others come asking for pills before explaining what they need them for. The health assistant reiterates what Tushil had told me, "the cases are not too serious here". As the day inches toward its close, a man walks in, filling the room with the strong alcohol odour. He sits next to me and tells me he has tension because his wife left him for another man. He says it is fine though, that he has already had a few beers because "alcohol cures all tensions". He laughs, and the health providers join in, attempting perhaps to maintain a masculine and jovial atmosphere. They are well-acquainted with him, familiar with his struggles and drinking habits. They try to cheer him up and reassure him saying, "you will find another one too", talking about a wife. The patient wanders back out the health post moments afterwards.

As the patient leaves, I am left with lingering thoughts about the gender dynamics that just unfolded: the man's reliance on alcohol as a coping mechanism, possibly reflecting a common preconception associated with masculinity – that men should suppress their emotions and seek solace in substances. The casual manner in which the health providers join in, encouraging him to find another wife, not only emphasising the societal expectation that men can easily replace a lost partner but also insinuating that women are replaceable commodities, reinforcing traditional gender roles and expectations.

Curious about their response, I ask the nurse about their typical approach in such cases. She says not to worry about it, that just having had some interaction with the three of us would have made him feel “fresh” and better.

Much more than “specialised pills for free” at a Primary Health care Center

At the primary health care centre where Tushil had told me people could get “specialised pills for free”, the psychiatrist tells me about the unique collaborative mental health care model they follow. First, he explains, patients are screened by a general practitioner (GP) or one of the primary care providers (PCP) at the outpatient department. If the PCP suspects some mental health problem, the patient is sent to a psychosocial counsellor (PSC). The PSC reviews the PCP notes, screens the patient by conducting an extensive interview in a private room using standardised screening tools such as the Patient Health Questionnaire 9 (PHQ-9 for gauging depression severity) and the PCL-C, a seventeen-item checklist for civilian post-traumatic stress disorder; provides an initial diagnosis and recommends a treatment plan that may include medication and counselling. In theory, he says, if the patient requires counselling but no medication, the PSCs are trained to provide such care utilising a variety of relaxation techniques, and basic counselling skills. “Hopefully one day, also psychotherapies like cognitive behavioural therapy” he says. However, in most cases medication is given. For those requiring medication, the patient is sent back to the PCP to get a prescription and they are asked to come back to the hospital for regular follow ups. Some patients are also followed up in the community itself with hospital community health workers who work in specific catchment areas. In addition, a consultant psychiatrist spends one to two weeks every three months, to provide further training and supervision, via panel reviews. When off-site, the psychiatrist provides e-supervisions over the phone. However, the doctor says that even when on-site, the psychiatrist does not provide direct consultations with patients as the aim is for the capacity of the PSCs and the PCPs to increase over time. “With time their knowledge is becoming broader and the drug treatment more nuanced”.

Team-based care for mental health at a regional hospital

The first hospital in Nepal that designed and implemented the collaborative care model for mental health described above was a regional hospital in the far western part of the country that operates as a public-private partnership since 2008. This hospital attracts patients from all around the region and provides medication for free, challenging the preconceived notions of urban dwellers. Despite being situated in a location often associated with “remoteness” and “backwardness” in the imagination of city-dwellers, the hospital is a beacon of modernity.

Three months had passed since Dr, Ram, the consultant psychiatrist, was last at the hospital. I join him for his next visit, and we both stay for a week. His duties throughout the week are to give daily lecture-style mental health training sessions for the new primary care providers, go on community visits, and hold his weekly panel review with psychosocial counsellors.

We sit down for breakfast right outside the canteen and see more and more patients arrive: some are carried piggyback by their kin, others are squeezed into shared vehicles, and many arrive on foot. The medical director joins us. He tells me that some patients walk for six to eight hours, all the way from neighbouring districts.

Dr. Ram and I make our way to one of the three private rooms designated for psychosocial counselling, labelled "mental health station" ("*maanaasik swaasthya kakshya*") . Each door is covered with a long green curtain, "for the session to be carried out privately, even when the door is open for temperature reasons" I am told. Dr. Ram and I sit with the three psychosocial counsellors working at the hospital for the panel review. There are two men and one woman, from the same district. They had all been working for the hospital in other capacities before retraining as counsellors. "We used to be four. We recently lost another to a government job" Bhimal – one of the counsellors – tells me. Then, he opens a Google sheet and starts reading out information from last week's "cases", expecting Dr. Ram's interpretation. They had seen ninety-six people of which twenty three were new cases. For the session with Dr. Ram, the priority was given to the new patients.

Bhimal announces the gender and age of the patient, a short list of symptoms including physical complaints, some indication around quality of sleep and appetite as well as the working diagnosis and the treatment prescribed. They work through the list. Dr. Ram agrees or disagrees with the counsellor's diagnosis according to the reduced list of symptoms and demographic information, and accepts or corrects the prescribed treatment, according to the working diagnosis. When the psychiatrist does not fully agree with the diagnosis or the drug treatment of a patient, the counsellor adds a note on the electronic health record system highlighting "Psychiatrist's recommendation" and the rationale behind it. I ask about this, and Dr. Ram explains "it is for learning purposes, for the primary care providers and to inform future cases". "In this case, for example" he adds, "phobic anxiety in particular, and anxiety in general, are being overly diagnosed. Anxiety is not as common as depression and I always find a lot during our panel reviews. Patients might start describing vague symptoms like not being able to sleep but then the more you ask, the more precise it gets, and at times it is depression rather than anxiety". Dr. Ram's knowledge about the general population's prevalence of depression and anxiety influences the patterns expected during the panel reviews.

The following day, I accompanied Dr. Ram on his community visits. A community health worker (CHW) joins us in the jeep, helping coordinate with other CHWs and guiding Dr. Ram, and I, to different homes. We drive through plains and rice fields surrounded by intensely green hills. There is a drastic change in temperature from the top of the hill where the hospital stands and the plains where the CHWs work daily. The heat is intense. We meet another CHW, who is waiting for us on the road, near a small shop covered in corrugated roofing sheets close to the house we are going to visit first. On our way, Ram gives his opinion about the patient we are going to see "I think he has been misdiagnosed with depression when it is, in fact, a kind of psychosis. And his family has lost faith in the medication from the hospital because he did not take the right dosage and is now going to India for treatment instead".

The patient's mother greets us, and invites us to sit on the bed in the main room. In this intimate setting, it becomes apparent how the provision of informal care is feminised, often rendered invisible and goes unacknowledged, yet is an essential and constitutive part of the mental health system. Her son comes in moving slowly and uncertainly, holding tight to his older brother's arm. The CHW takes his blood pressure while telling us that he has taken a total of three showers in the last six months. Dr. Ram asks the patient a few questions, making an extra effort to speak softly and clearly. The patient does not answer, and keeps his right hand closed, in a tight first. Dr. Ram speaks to me about suspiciousness. The patient looks down, avoiding direct eye contact with anyone. His personal and medical history is told and woven together by many: the CHW, the patient's mother, his brother, Ram's memories from the last visit three months back, the medical record and very few of the patient's own words. The psychiatrist asks the mother about the medication her son is taking. She brings him a plastic bag with several pills. "This is a typical Indian prescription" the doctor says "one antidepressant, one antipsychotic, one mood stabiliser and some vitamins". The mother tells us they are spending 6000-7000 NPR (60-70$) a month on medicine. Irritated, Dr. Ram informs the family that the hospital has the same medications that they are paying for in India but free of cost. Despite the cost, the mother says she sees some improvements in her son's condition with the Indian treatment. Dr. Ram explains that while some of the more disruptive behaviours have gone, there are other symptoms, such as his low mood that also require attention. She agrees without much commitment. Then, the mother asks about her things (*mero kura*). She says she went to the hospital for what she had been told are "panic attacks" and that she can sometimes feel her heart racing (*mutu dukduk*) and struggles to breathe. She starts sweating profusely and crying. Dr. Ram asks her to look at him, and to try to breathe slowly, in and out. She calms down a little. Dr. Ram reassures her and tells her he understands what is going on, and writes a prescription. After giving her the prescription, her older son asks the psychiatrist what he can recommend in terms of diet for his mother. Dr. Ram advises "less greasy food".

Then, we visit a new patient. The mother is lying down, leaning against one of the few frames of wooden studs that make up their family's room, together with a daubed mixture of stone and mud mortar, and a few corrugated sheets here and there to protect from the rains. She hands over her son's hospital report to Dr. Ram, shouts her son's name, and lays down again, keeping a distance to where we sit to wait for her son. The psychiatrist says his diagnosis is bipolar disorder. The young man sits near us, and Dr. Ram introduces himself, the CHW and me, and asks him for his "introduction". The patient avoids direct eye contact, fidgets incessantly with his hair and speaks about himself in third person. Dr. Ram tries to make him feel at ease before asking him about his hospital's visit. His mother provides a continuous commentary on the patient's words from afar, berating him. Dr. Ram asks the patient to talk for himself, mediating between the patient and his mother. The narrative is hard to follow. He had caused problems before the visit to the hospital, and after taking some medication for a while, he felt better and decided to go to India and join his brother who was working there, to try to get a job. He stopped the medication and became ill again. He tells us he wants to go live with his brother and complains about his mother, and the food she gives him. He says he does not eat what his mother gives him because he needs special food, because he is "one in a million" and believes he should be doing business with Modi, the current prime minister of India, instead of living at home or studying. To that comment, Dr Ram tells me, "a good example of a delusion of grandeur". The psychiatrist explains the importance of not stopping the medication before advised, and gets the young man to make a pact with him, shaking hands on the promise that he will not stop taking the medication until the doctor tells him to. In the meantime, the CHW had called another patient, a neighbour of the young man who, although is currently taking medication and feeling better, had been living with depression and had had several psychotic episodes. Dr. Ram uses the opportunity to ask the woman to tell her neighbour about her experience with medication, reinforcing the importance of medication adherence for recovery. Community visits surfaced to be about showing concern, mobilising hope, persuading to get medical treatment and adhering to it.

This collaborative care model exemplifies the hybrid approaches that emerged following Nepal’s market reforms described in Chapter 2. The hospital’s operation as a public-private partnership since 2008 reflects broader transitions in healthcare delivery after economic liberalisation. Its emphasis on training primary care providers and integration with community health workers demonstrates attempts to implement the decentralised care approaches first pioneered by UMN in the 1980s, while operating within contemporary market structures.

Older private care provision

Psychiatric residential rehabilitation centre in Kathmandu

In the centre of Kathmandu, nestled within narrow streets, is a private psychiatric rehabilitation residential centre. A four-story building stands before me, its entrance guarded by tightly locked gates. Contrasting with what I saw, I am told by a staff member that they adhere to a vision of healing that ostensibly diverges from the conventional approach of indefinite institutionalisation. Their belief, I am told, is rooted in the power of community reintegration, emphasising the crucial role families play in the recovery process. While the centre did not mandate a family member’s constant presence, as public hospitals require, they actively seek to reach an agreement with the patient’s family before admitting them. This agreement covers important aspects, including determining the maximum duration of the patient’s stay. Additionally, the centre emphasises the commitment they expect from family members to remain involved in the patient’s recovery by maintaining vital lifelines of visits and phone calls. These lifelines are considered crucial for nurturing the patient’s connection with their family throughout the healing process. However, despite these agreements on maximum stay durations and family involvement, there are instances where patients had been residing at the centre for over five years, earning them the designation of the “long-term ones” by the staff. Furthermore, there had been cases of complete abandonment, where families had severed all ties with their kin at the centre. During my visit, I see that there are ninety-seven patients, all classified as “clinical cases”, primarily dealing with depression, schizophrenia, bipolar disorder and some with alcohol abuse issues. There are six people sleeping and living in one small room, with a strong smell of toilets and a few patients handcuffed.

This residential centre exemplifies the private mental health institutions that emerged in Kathmandu during the 1990s, following the economic liberalisation described in Chapter 2. Despite its stated vision of community reintegration, the centre’s practices - including extended institutionalisation and physical restraints - echo earlier approaches to mental health care that Chapter 2 traced to the pre-1980s period when “mentally ill” individuals were often confined in prisons and institutions. The tension between modern rehabilitation rhetoric and actual practices reflects the broader contradictions within Nepal's market-oriented mental health system.

Non-governmental organisations

Creating community at Chhahari Nepal for Mental Health (CNMH)

I join Amma, one of the NGO's fieldworkers, for a home visit to Maya's. Before leaving the office, we call Maya's niece, as she is the one who manages the household phone, to check whether they are happy to receive a home visit. It is a new national holiday on Prophet Muhammad's birthday, and children are off school. Upon approaching Maya's home, we see her brother soaking in the sun in his wheelchair right outside their home. Next to him is his elderly mother, his wife, and his daughter preparing vegetables to make pickle (*aachar)*. They bring short colourful stools for us to sit with them, and their small chickens, in the sun. After four years of home visits from Amma and other CNMH-affiliated people, Maya and her family seem used to, and happy, to have us around. We bring biscuits and some fruit, and Maya prepares tea for all of us. While we sip our very sweet tea and help chop vegetables, we listen to whatever Maya and her family want to share with us on the day.

The main concern in the household is about Maya's physically disabled brother. He had just come back from another long stay in the hospital for physical rehabilitation. Although it had been ten years since he fell from a tree while working in the local zoo, he still feels the pain in his body daily, which intensifies in the cold. He says he is feeling slightly better, but that he knows it will not be long until he will need to go back for further bedsore treatment. People at CNMH had managed to get him a new wheelchair, with the hope that it would alleviate some of his pain and make it easier for Maya and others to push him around. They had also spent some time with the family jointly figuring out the specific mechanics to the new chair, to see whether it was a better alternative. However, Maya's sister-in law tells us that, although they appreciated the efforts and the joy of having a new wheelchair in the house, they prefer to keep using the old one. Her husband is more used to it, she says, and the newer chair does nothing to facilitate the strenuous manoeuvring on the unkept roads around their home, which was metres away from better-kept streets leading to tourist-frequented temples. Their frustration with the condition of the roads leads to a few comments about local politics. Amma inquires about whether they have understood where, when and how to vote in the upcoming elections, as she says she senses some confusion. The legislative and the first provincial elections for the new seven provincial assemblies are going to be held simultaneously. During the home visit, Amma is open and honest about her own confusion around voting and bonds with Maya and her family over their shared sentiment. Later she would go on to tell the NGO's program manager about the confusion, hoping she can provide some help to clarify the voting process for the clients and their families at the next Welcome Center session on Wednesday.

These more serious daily difficulties and challenges are mixed with moments of shared silence and presence, as well as lighter conversational topics. Maya tells us a story of a parrot they used to have who would know how to ask people for their names. Laughing, Maya's niece imitates the sound the parrot used to make. Maya's sister-in-law inquires about Amma and her family and is curious to learn about my own family. Maya's grandmother takes my arm, inspecting my hand lines, and then puts her arm against mine, comparing skin tones and wrinkles. She speaks to me, shouting, mixing Newari and Nepali. Her granddaughter reassures me that she does not understand her speech either, and that she is becoming more and more confused and deaf every day. Everyone comments on each other's situations. And Maya's mental health update is one topic among many discussed. She has a follow up appointment at the mental health hospital in a couple of days. Before we leave, Amma offers her company to the next appointment, but Maya says she feels confident to go on her own. The sun is gradually leaving us all in the shade, so Amma thanks Maya and her family for having us, and says she hopes to see some of them at the Welcome Center at CNMH's office on Wednesday.

CNMH, as noted in my introduction chapter, is a small, secular, and local NGO in Kathmandu aiding impoverished individuals with mental health issues in Lalitpur. CNMH's weekly schedule is structured around various activities, including outreach efforts encompassing street and home visits, their Welcome Center for clients and carers on Wednesdays, and their staff meetings on Fridays for weekly review and organisational planning. The NGO positions itself under the rubric of mental health yet their clients encompass a diverse mix of individuals and family members seeking assistance for an array of challenges and experiences of adversity. However, whilst most clients are from socially and economically disadvantaged backgrounds, CNMH's efforts are not exclusive to them. Similarly, certain clients do have one or even multiple psychiatric diagnoses; yet such classifications are neither obligatory nor necessary for engagement with the organisation. CNMH uses a rented space that comprises a cosy living room that serves as the hub for most of the activities; a kitchen area with a big dining table that is primarily used for meal preparation; two office spaces and a bathroom. The space has a lively and homely feel to it. The walls are filled with proudly displayed drawings and paintings done and signed by the clients, inspiring quotes, and pictures; the floors filled with sitting pillows, arts and crafts materials, some musical instruments, and a carrom board.

In 2011, Chhahari began a "street project" (which I describe in more detail in chapter 5), using street visits as the primary means to engage potential clients. Stemming from this initiative, a significant number of clients began their connection with CNMH through Amma who learns about potential clients through word-of-mouth referrals or her own observations within the community. This type of outward concern for and observation of others around her is deeply ingrained in her; an embodied way of being in the world. Knowing what CNMH may be able to provide as support for individuals and families in distress, she habitually scans her environment making brief mental notes on those she observes, their behaviour and location, no matter whether she is officially in working hours or not. If she encounters someone showing concerning behaviour repeatedly, she initiates conversations to understand their situation better. This often involves inquiries and establishing connections with community members like shopkeepers and neighbours, creating a network of informal surveillance. Over time, she builds trust and rapport with the potential client and tries to connect with their family, for a deeper understanding of their situation. The process of mutual understanding, acceptance and agreement is always ongoing, as CNMH's staff get to know the client and their families better over time, and clients learn what they may expect or not from what CNMH's has to offer.

As time has passed, street visits are no longer the sole avenue of contact between potential clients and the NGO, and informal networks have emerged as additional channels. Clients are enmeshed in webs of relations that make their medical care possible. Long-term clients of the NGO and their carers often speak about the organisation's support to other people in their lives that they believe could also benefit from their support. It is common for a caregiver to accompany another individual's caregiver to CNMH's offices for discussions with CNMH's program manager about their situation. Similarly, new potential clients are routinely identified by anyone who knows about the NGO's mission and trusts their approach – staff, board members, friends of friends, relatives, and volunteers. Each person relies on their own set of partial observations, assumptions, judgements and knowledge about another as well as their understandings of what a mental health problem is or looks like, in order to find or identify a potential client as needing or potentially benefiting from CNMH's support. To date, there have been no instances where a client directly reaches out to CNMH themselves. Unlike conventional models where a patient seeks out a healthcare provider (whether a doctor at a clinic or hospital or a shaman at home), the dynamic here is reserved - the client is sought out for care.

For the most marginalised and impoverished clients, often living on the streets, a visit from CNMH's staff and volunteers carries profound significance. The act of sitting beside them, inquiring about their well-being and sustenance, and expressing genuine concern for their personal and family circumstances offers a sense of being acknowledged and seen by another. Depending on the preconceptions existing within the client's surrounding community, observing the public interaction between the client with others can fend off negative stereotypes and potentially reduce the detrimental stigma and ensuing social discrimination.

Throughout my time with CNMH, I see fieldworkers routinely carrying out around three home visits per week, much like in Maya's case. These home visits serve multiple purposes, seamlessly blending gentle observation and follow-up of the client's well-being, providing companionship and offering practical guidance. During the home visits, not only the clients but also their family members receive encouragement and subtle oversight, guiding them into roles as caregivers. I see Amma skillfully engage the assistance of the client's relatives in their care of other tasks, amplifying the circle of support as well as linking clients and their families to external resources, both public and non-governmental, enhancing their support networks.

CNMH's staff approach to selecting whom to visit displays a certain flexibility, often taking into account factors like urgency, the specifics of each case, and the interval since the last visit. It is quite usual to observe fieldworkers swifty adapting their plans based on new information. For example, I see them change plans when they learn that a client has gone through a challenging psychotic episode or when a client is grappling with the loss of a family member. Moreover, there are other more common situations that prompt adjustments. For instance, if a client's prescription changes, leading to uncertainties about medication usage and timing, the fieldworkers visit and provide clarity and guidance. Additionally, there are other external factors that influence the frequency and timing of visits for each client. Things like weather conditions, the logistical intricacies of local festivals, and even the energy levels of the fieldworkers can play a role in shaping their schedules.

Aside from the tasks performed on a weekly basis, CNMH's annual calendar is punctuated by a series of cherished yearly occasions. I was lucky to participate in one of the NGO's most beloved and widely anticipated events: a day when clients, both past and present, along with their caregivers, members of the NGO's board, and dedicated volunteers, gather together for a full day of outdoor activities and a picnic. The NGO envisions the picnic as a moment of celebration, temporarily alleviating the burdens of daily life and nurturing companionship. A group of the NGO's clients skillfully knitted new purses, which they eagerly prepared to bring along to the picnic as accessories, making sure they had something special to carry with them and feel good about themselves. On the day of the event, they proudly showcase their handiwork, dress in their finest attire and have their photographs taken. Laughter, vibrant melodies of music and camaraderie fill the air as they all engage in various games, listen to music and dance, fostering a sense of unity and shared enjoyment. In the weeks that followed the picnic, the NGO's program manager thoughtfully printed and distributed copies of the group photograph they had taken – a tangible memento that served as a reminder to each client that they were part of a larger, caring community, in an attempt to dispel feelings of isolation.

CNMH's approach to mental health care emerges from the proliferation of NGOs that Chapter 2 traced to the post-1990 period of democratisation and economic liberalisation. Their holistic, community-based model focusing on marginalised populations exemplifies how NGOs filled gaps in state services during this period.

Empirical advocacy at Transcultural Psychosocial Organisation Nepal (TPO-Nepal)

I got to know TPO-Nepal, one of the leading mental health and psychosocial NGOs in the country, well before arriving in the field. Like numerous others, I came across their work and became aware of their impact in mental health in Nepal at various international conferences and events. Later, during my doctoral studies, the countless pages of their scholarly publications, manuals, policy briefs and more generally their prolific documentation output enabled me to gain important insights into the country's mental health system. Studying the organisation through their publication trail was not only a possibility – as opposed to for other organisations – but also felt like an appropriate means by which to do so. The network of academics and practitioners involved with the organisation have been working in the country since the mid-1990s and have, from the very start, been committed to – and proficient in – generating evidence-based knowledge (a history I elaborate on in chapter 5).

This dedication and capacity to generate scientific evidence has enabled them to participate in numerous international research consortia and to influence the evidence-based on mental health interventions in the country. Today, they proudly showcase on their website that they have published over eighty scientific studies in prestigious international journals and emphasise that the studies have not only earned scientific recognition but have also been widely utilised as valuable references in university courses, benefiting students, researchers and program designers alike.

Whilst their initial advocacy goal was to promote psychosocial counselling in the country, since their involvement in these international consortia, they have built strong partnerships with the Nepali government and try to advocate for the delivery of mental health services (both psychiatric and psychosocial) into the primary health care system. Their influence on the mental health system is such that when it comes to mental health efforts, the divides between state and non-state entities become ambiguous. This became evident to me when I walked into the National Health Training Center, who ostensibly coordinates and manages all trainings offered by the Ministry of Health and Population. When I inquired about data on the provision of mental health related trainings delivered by the Center and knowledge on the training manuals utilised for these trainings, they apologised for their immediate lack of knowledge and data and referred me back to TPO-Nepal's offices and documents, assuring me that they would know best.

As detailed in Chapter 2, TPO Nepal's emergence in 1996 coincided with both Nepal's civil war and the rise of trauma and PTSD discourse in humanitarian interventions. Their commitment to generating evidence-based knowledge from the start positioned them perfectly to benefit from the later emergence of Global Mental Health in the mid-2000s. Their evolution from providing psychosocial support to conflict-affected populations to becoming a key player in mental health research and system strengthening mirrors the broader shifts in international development approaches that Chapter 2 outlined - from direct service provision toward capacity building and evidence generation.

"Rescuing" and advocating psychosocial disability rights

A disabled people organisation (DPO) in Nepal working on mental health and psychosocial disability, is committed to prioritising advocacy, in addition to service provision. They are a team of about fifty, encompassing right-holders, social workers, psychologists, legal professionals, nurses, house assistants, and media staff and receive funds from a variety of sources, including international development and faith-based organisations, foundations, private donors, UN agencies and the Nepali government. While their outreach covers multiple districts across the country, their central office is nestled in Kathmandu.

I start my personal involvement with them informally, after an initial interview with the organisation's executive director, who built the organisation from the ground up, after his own experience with mental ill health. After the interview, the director enlists me in some of the organisation's everyday work – I am mainly asked to provide feedback, insights and revisions to a multitude of the organisation's materials, including concept notes, theory of change diagrams, funding applications, group meetings, and also to share global giving campaigns (aimed at fundraising) with my contacts.

In formal documents they advocate for a shift in the country's predominant mental health care approach: from a dominant charity-based approach and medical model to a comprehensive human rights-based approach for psychosocial disabilities, emphasising the removal of obstacles that hinder the full participation of people with psychological disabilities in society. However, this discourse often intersected with another discourse imbued with aspirations of "rescue" that imparted a distinct Christian mission undertone. Alongside their advocacy efforts, they also run a short-term transit home, providing care for an archetypal image of distress; that is, neglected or abandoned women with mental health problems. The executive director often refers to the beneficiaries of their work as his own family, and consistently emphasises his life's calling and purpose to care for individuals with mental health issues, instead of pursuing his own familial life. He says, "my life is for these people. They are my children".

Newer generations - For profit

A mental health business start-up

Pretvan, the CEO of an online platform providing mental health counselling for Nepalis living around the world, agreed over Facebook, to discuss his business with me. We connect on WhatsApp video. He is in his mid-twenties, and I see him sitting in an aeroplane in the United States. He tells me he is about to take off and only has a few minutes to talk. There is little space for me to ask questions, but Pretvan seems familiar with talking about his start-up story. He tells me that his main motivation for his business came from his personal experience of struggling with mental health issues after moving from Nepal to the United States to study, and that he wants to make sure other people like himself can have affordable options available to them if they want or need support. He says that together with another two friends, they invested substantial sums of money to kickstart the company and initiated a two year campaign to reach out to as many young people as possible. Using his background in data analytics, Pretvan heavily focuses on advertising through Facebook, which he believes is more effective than traditional marketing approaches. When I manage to ask him about their business approach, he says "I think INGOs and NGOs are a black hole for money, with their high salaries for staff and very little money going to the community. In the private sector, we have a financial incentive to give the community what they truly need".

The online counselling platform represents the newest generation of mental health care providers emerging in the post-2015 period that Chapter 2 identified as characterised by increasing privatisation and technological innovation. The founder's critique of NGOs as "black holes for money" and emphasis on market incentives exemplifies how contemporary entrepreneurs are positioning themselves against earlier aid-driven approaches. This reflects the full flowering of the market-oriented system that began taking shape with the 1990s economic reforms.

Momentary unity

It is early morning in September 2018, and an increasingly growing group of people composed of mental health advocates, professionals, students, and I, are standing in front of Everest Hospital in New Baneshwor. We are waiting to begin a march towards Maitighar mandala; a symbolic monument at the heart of Kathmandu where peace advocates gathered during the civil war to show solidarity for peace, and against war. Today, the aim is to gather and raise awareness about suicide prevention, and "celebrate" World Suicide Prevention Day (WSPD). While we wait to start the rally, white t-shirts and hand-made placards with standardised slogans in Nepali and English are being handed out to us all. Momentarily, the group of about two hundred attendees appears to embody the year's official theme for WSPD which is that of "Working together to prevent suicide". As soon as the march begins, however, this mirage of unity is exposed, as I watch members of each organisation unfold and erect their unique banner, as though flags. What had appeared and felt to be a united supra-group a few minutes earlier quickly disintegrated and split into many smaller groups. Suddenly, each person found their place behind the banners that displayed their professional, organisational and epistemic identities. There were separate banners for the psychiatrists, for the clinical psychologists, the psychologists, as well as for every organisation working in mental health. Whilst many mental health advocates and professionals came physically together for the march that day, I could not help but feel a strong sense of fragmentation, if not competition, between the groups and their different understandings of mental ill health and their approaches to its care.

This final ethnographic fragment serves as a powerful metaphor for the broader landscape of mental health care in Nepal that I have documented throughout this chapter. What initially appears as unity quickly reveals underlying tensions and divisions. These tensions emerged repeatedly across my fieldwork, from busy hospital corridors to intimate home visits, from NGO offices to community gatherings. As I draw together the threads of these diverse ethnographic fragments, several insights emerge about the state of mental health care in Nepal at the time of my fieldwork.

Conclusion

The ethnographic fragments presented in this chapter reveal several key insights about the current state of mental health care in Nepal, each grounded in concrete observations and experiences.

The fragments demonstrate the varied manifestations of mental health across different care settings. In the public hospital OPD, mental health becomes reduced to quick diagnoses and medication prescriptions, while at CNMH, it encompasses social support and community building. At the regional hospital, it takes the form of collaborative care involving multiple providers, while in the private rehabilitation centre, it becomes about long-term institutionalisation despite stated aims of community reintegration. This variation illuminates how mental health care lacks a unified definition or approach in practice.

The ethnographic material also surfaces clear power dynamics in care provision. In the public hospital, time pressures force doctors to rush through consultations, limiting patient agency. The difference between Maya's experience at CNMH, where she has time to share her story over tea, and the rushed 2-5 minute consultations in the public hospital OPD highlights how institutional constraints shape care experiences.

The fragments consistently show mental health care extending beyond individual treatment. At CNMH's picnic, community building becomes therapeutic. In the regional hospital's community visits, doctors mobilise neighbours to support medication adherence. These examples demonstrate that effective care often requires engaging broader social networks, not just treating individuals.

The World Suicide Prevention Day march powerfully illustrates how institutional divisions manifest in practice. What began as a unified group quickly separated into distinct professional and organisational identities, each carrying their own banner. This mirrors the broader fragmentation across the care landscape – from the dusty, unused mental health registers in the health post to the competing approaches of NGOs and private providers.

The emergence of new players like Pretvan's online counselling platform, alongside traditional providers, reflects how market dynamics are reshaping care provision. His critique of NGOs as “black holes for money” and emphasis on “financial incentives” shows how business logic is entering the mental health sphere. This connects to broader changes in Nepal’s political economy since the end of the Panchayat era.

Together, these insights have significant implications for understanding mental health care in Nepal. First, they challenge the assumption that mental health care can be standardised or integrated into primary care in a straightforward way. The ethnographic evidence shows how care practices are deeply embedded in specific institutional contexts and social relationships. Second, they reveal how attempts to strengthen health systems must contend with existing power dynamics and market forces that create fragmentation. The competition between providers seen at the suicide prevention march suggests that calls for collaboration often clash with institutional interests. Third, they demonstrate the importance of understanding mental health care as a social process involving families and communities, not just a medical intervention. The success of approaches like CNMH’s that engage broader social networks suggests the limitations of purely clinical models. Finally, they indicate how Nepal’s mental health system reflects broader tensions in the country’s development – between public and private provision, between standardisation and diversity of approach, and between market forces and public health needs. The fragments show these tensions playing out in everyday care practices.

Further, the ethnographic fragments presented in this chapter reveal a mental health system characterised by multiple competing approaches, where various actors must simultaneously collaborate and compete within a therapeutic marketplace shaped by neoliberal forces. This fragmented landscape, with its tensions between policy aspirations and practical realities, raises important questions that the following chapters will explore: How do state and non-state institutions navigate their roles and responsibilities within this complex system? How do different organisations access and utilise resources for mental health care when operating with distinct approaches and frameworks? And how do individual mental health professionals translate between these multiple approaches as they work to promote mental health care in contemporary Nepal? While this chapter has provided a snapshot of the current mental health care landscape, subsequent chapters will examine both how different actors - from institutions to individuals - broker and translate between these multiple approaches within this fragmented system (Chapters 4-5), and then how psychological knowledge circulates and transforms Nepal's social fabric through public education and the emergence of new psychology professionals who must navigate this complex landscape (Chapters 6-7).

These findings emerge directly from the ethnographic material and have relevance beyond individual cases, offering insights into the challenges of mental health care provision in contexts of rapid social and economic change. Through these varied fragments, Nepal’s mental health system embodies broader societal transformations while maintaining distinct local characteristics, creating a complex landscape where different approaches to care coexist, compete, and occasionally collaborate.

Part II – BROKERING AND TRANSLATING AID NORMS

Having established the historical development and current configuration of Nepal's mental health system in Part I, Part II explores how actors within this system work to maintain and transform it in response to changing global health imperatives. Through detailed ethnographic accounts, these chapters examine how different stakeholders in Nepal's mental health system navigate and stabilise two fundamental aid norms that shape its contemporary operation: country ownership (Chapter 4) and evidence-based practice (Chapter 5). In doing so, they reveal how Nepal's mental health system adapts to and incorporates shifting global health and development frameworks through the strategic work of local brokers and translators.

Before delving into the empirical chapters, I provide in the following a brief background of the origins and significance of both these norms and draw attention to the centrality of the process of brokering and translation.

Translating country-ownership

There has been a significant shift in norms in international development practice, transitioning from policies that disempowered the state to the rise of country ownership and partnerships as central elements. These transformations aim to indicate a growing awareness of the importance of involving recipient countries as active participants in shaping their own development processes.

As described in chapter 2, during the 1980s, a surge in neoliberal aid policies gained prominence advocating for reduced state intervention in favour of advancing free trade and market economies. Nepal, among various other developing nations, faced various economic challenges including sluggish growth, stagnant exports, and a continuous balance of payments deficit which prompted, under the guidance of international financial institutions like the International Monetary Fund and World Bank, the adoption of structural adjustment programs (Shrestha, 2010; Sharma, 2021). This policy shift had far-reaching consequences, reshaping the roles of entities involved. NGOs gained prominence as the state's influence waned – a trend exacerbated by donors channelling resources through NGOs rather than the state. With the state powers and functions curtailed, civil society, in the form of NGOs came to be at the forefront in providing essential services and public goods, gathering legitimacy and experience in many social welfare sectors.

Over time, the shortcomings of the neoliberal approach to aid became evident, leading to a reconsideration of international development paradigms and the emergence of what is termed the "post-Washington Consensus consensus" (Stiglitz, 1998; 2005). This phase prompted contemplation among global donors due to the hardships faced by communities, instigating a discourse on country ownership in developmental initiatives (OECD, 2005; Accra, 2008; Noor, 2022). This concept, in contrast with earlier neoliberal aid policies, aimed to empower recipient countries to lead their development strategies and to foster partnerships based on mutual respect (Noor, 2022).

Ever since the Paris Declaration of 2005, therefore, and the subsequent Accra Agenda for Action in 2008 (see Introduction), contemporary aid discourse focuses on the notion of country ownership. This emphasis underscores the importance of forming development partnerships, coordinating collaborative efforts, and strengthening recipient countries' systems (OECD, 2005; Accra, 2008; Herrick & Brooks, 2018). The overarching objective of these principles is to foster long-term institutional strengthening and ensure that aid efforts align with local priorities and strategies.

Considering the rapid and extensive changes witnessed in contemporary development practice, chapter 4 explores the tensions between past and present mandates, and sheds light on how mental health brokers and translators perform development "success" at a time when country ownership is discursively highly valued.

Brokering evidence-based practice

Another norm and ideal that reshaped global health and development practice more broadly is that of evidence-based practice. Whilst what follows is a succinct summary, chapter 5 will provide a more extensive background to the rise of "evidence" in global health and its central role in the creation of the field of global mental health.

The advent of evidence-based medicine (EBM) originated in the 1970s and gained momentum in the late 1980s and early 1990s, advocating for medical decision-making to be rooted in scientific research. Since then, ever-increasing areas of practice have been rearticulated as evidence-based domains (Evidence-Based Medicine Working Group, 1992; Mykhalovskiy & Weir, 2004).

EBM introduced a hierarchy of knowledge that privileges the quantitative, statistical, experimental, and epidemiological forms of evidence, and especially results from randomised control trials, over other kinds of evidence, knowledge, and understandings (Adams, 2013). This has been critiqued for undermining other forms of knowledge and creating an epistemic injustice (Fricker, 2007). Despite these concerns, the appeal of EBM has persisted, driven by its potential to guide efficient resource allocation and address cost, quality, and access issues in healthcare systems. The fields of global health and global mental health are also embracing these principles, and are now characterised by the need to demonstrate cost-effectiveness and measurable results, with accountability structures mirroring EBM standards.

Chapter 5 sheds light on how two disparate mental health NGOs broker the demand for evidence-based practice on the ground, and reveals the limitations faced by certain organisations conditional on their epistemic frameworks.

Together, the chapters comprising Part II emphasise the active engagement of local actors in performing and stabilising the ever-changing norms and suggest, in line with Mosse (2004), that policy implementation is not a straightforward process guided solely by predetermined guidelines, but rather a laborious, complex and multifaceted endeavour shaped by the agency and practices of various actors involved. These norms merit particular attention because they illuminate different aspects of how brokerage operates: the norm of "country ownership" (Chapter 4) directly affects how state and non-state institutions must position themselves and interact with each other, particularly significant given past aid regimes that historically disempowered the state, while the drive for “evidence-based practice” (Chapter 5) influences which approaches to mental health care receive recognition and resources. The comparison of these norms reveals distinct but interrelated brokerage mechanisms: “country ownership” functions as a structural mechanism shaping institutional relationships and power dynamics in response to historical patterns of state disempowerment, while “evidence-based practice” operates as a technical or epistemic mechanism that establishes criteria for legitimate knowledge and determines which practices receive recognition and resources.

Chapter 4. “*Training time goes in clapping*” – A laborious display of “country ownership”

Introduction

In July 2018, while attending the “closing” ceremony of a mental health training for health assistants in an earthquake affected district, I sat among the trainees in the audience. Before the ceremony started, one of the health assistants asked me whether I enjoyed these events. I was not sure whether he meant the training, or the ceremonies attached to those. He meant the ceremonies. I said I understood why they had to happen, but did not always enjoy them, and asked about his thoughts. As Tennekoon (1988) has also pointed out in the Sri Lankan context, these ceremonies or “development traditions”, as she put it, were expected by everyone involved. But, although it was a tradition, my interlocutor and his colleagues were rather irritated about it. They considered such ceremonies a spectacle (cf. Beeman, 1993 for review of anthropology of theatre and spectacle), and a waste of important time for them to be able to learn, instead, in the training. In this particular case, for reasons that will become clearer later, the “closing” ceremony was taking place *before* the mental health training was over, borrowing time directly from limited teaching time. Throughout the ceremony, I observed the health assistants and Dr. Rikesh (the psychiatrist providing the training) gradually getting more and more restless. After almost two hours of ceremony, Rikesh leaned towards me and whispered, “training time goes in clapping”.

When the health assistant confessed his irritation towards development-related ceremonies, he explicitly blamed the constant need for these on his country’s dependency on non-governmental institutions and foreign aid (cf. Chapter 2 for history of development in Nepal). In hearing the public health worker make a connection between development ceremonies and Nepal’s financial dependency on foreign aid, I got the sense that he believed that if the state was able to fund and organise capacity building activities without external resources and non-governmental organisation (NGO) support, there would be no need for “time-wasting” ceremonies where different parties claim recognition and credit for development work. I assumed he wished for a government that was not realised through NGO activities, which, as Heaton-Shreshta (2002) has argued, are usually regarded as being closely associated with foreign patronage. My interlocutor was not alone in critiquing Nepal’s dependency on aid. In fact, it is a topic that has elicited much scholarly analysis by both foreign and Nepali scholars (Blaikie, Cameron, & Seddon, 1980; Panday, 1989, 2012; Bista, 1991; Khadka, 1994). The country’s dependency on foreign aid was also a topic that often cropped up in daily conversations; animating fierce critiques of Nepal’s political leaders, and eliciting strong emotions that were frequently expressed in idioms of frustration (*dikka lagyo*) and fatalism (*ke garne*). It was very common to hear comments on what people perceived to be an ineptitude on the part of their country’s leaders, or on political leaders’ upsetting and “embarrassing” submission to other nations – “they behave like beggars”, I was once told by a Nepali psychiatrist commenting on the “undignified” ways in which they saw their leaders behave in relation to those of other, wealthier, nations. Years back, in 1997, the Nepali writer Dixit also used the image of beggars in his critical commentary on foreign aid. He wrote:

> "There is no sense in staying on the dole if all it does is reinforce the dependency syndrome. There is no pride in being a country of beggars, which takes anything and everything that is offered by anybody" (Dixit, 1997, p. 186).

Given the ubiquity of these critiques, thus, the health assistant's comment at the "closing" ceremony would not have caught my attention particularly in any other situation. However, hearing him complain about the state's reliance on NGOs to get things done at this event seemed revealing. As detailed later in the chapter, this particular mental health training being provided to the health assistants was described to me as being a "historical" event by a mental health advocate. He explained that this training was significant because it was the first local level state-funded mental health training in the new federal system of government. Indeed, it was the first-time local level government officials had requested and partially funded a mental health training. As such, the capacity building event, and the ceremony attached to it, could have been seen as signalling a shift in the power relations the health assistants were so irritated about, between aid donors and recipients, and between state and non-state institutions. Mental health in Nepal, like in most places around the world, has long been neglected in government, civil society, and community structures (Regmi, Pokharel, Ojha, Pradhan, & Chapagain, 2004; Brenman, Luitel, Mall, & Jordans, 2014; Mishra, Khanal, & Khanal, 2018). Therefore, for local leaders to be allocating resources for a mental health capacity building event was experienced by public health workers as proof of the Nepali state taking responsibility for the welfare of its citizens and communities, and of a new era of government. Yet there were also many non-state actors representing multiple INGOs and local NGOs present at the ceremony of the state-funded mental health training. Indeed, as I will be describing, there had been a lot of labour and resources from both public and non-governmental institutions that went into making this training, and the credit-taking ceremony attached to it, happen. As I will go on to show, this event, representing "government ownership" of mental health efforts was engaged by multiple actors, to multiple ends.

This chapter focuses on the labour and resources from multiple institutions; state and non-state, that went into making this "country-owned" mental health training happen, at a time when "country ownership" was highly valorized in aid policy discourse, as I described in chapter 2 (cf. OECD, 2005; Accra, 2008). Writing about the relationship between aid policy and practice, David Mosse (2005b) convincingly challenges the assumption that development practice is driven by policy. Instead, he argues that practices produce policy by showing how development agencies and actors in development devote a lot of their energy and time in producing and sustaining interpretations of development projects as being reflective of certain policies, regardless of events. Further, he argues that: "development success is not merely a question of measures of performance; it is also about how particular interpretations are made and sustained socially. It is not just about what a project does, but also how and to whom it speaks, who can be made to believe in it" (Mosse, 2005a, p. 158). Whereas Mosse (2004, 2005b) writes about aid policy and the creation and maintenance of development project "success" focusing on the "master metaphor" of "participation" in development narrative, here I concern myself with the aforementioned metaphor of "country ownership".

The choice in focus for this chapter on what happened *around* the mental health training also stems from an ethnographic insight during this event: what appeared to be important about the training was the public recognition of those who were enabling mental health efforts in a post-earthquake and federal Nepal, over and above a concern about the content, quality, or indeed completion of the training itself. While the capacity building initiative might have been seen by those receiving the training as a "failed" development intervention and could potentially be analysed as yet another example of failed development projects in Nepal as many other scholars have done (Panday, 1989, 2012; Ranjitkar, 1996; Dixit, 1997; Leve, 2007), what I offer here is an account of it as a story of "success" (Mosse, 2005b) and a success story in achieving its multiple moral and political goals.

To understand what was at stake in this capacity building event, it is important to situate it within a broader programmatic, political, and discursive background. I begin, therefore, by briefly sketching out the wider context within which the training and ceremony were embedded. The wider context refers to how the training was related to a broader humanitarian project that prefaced it, as well as to how it was embedded within a particular moment of government restructuring and political transition, and within transnational aid discourses. I highlight the latest WHO's "Building Back Better" (WHO, 2013) approach to mental health and psychosocial support (MHPSS) in emergency settings and current international development norms with regards to the principle of "country ownership" of development strategies and plans (OECD, 2005; Accra, 2008). This discursive background provides us with a sense of what was being promoted as being the "right" ways of doing humanitarianism and development at the time of my fieldwork and research. This background will show that the dominant moral and aspirational discourses had to do with trying to improve aid effectiveness by shifting from a relief mindset to one of "sustainable development" by promoting, and enabling, "country ownership" with the state at the centre of it. Then, I narrate the journey from Kathmandu to the training district, reflecting on how, in practice, and because of the previous aid regime and norms, the roles and responsibilities of state and non-state institutions are blurred (Gupta, 1995) and co-dependent. This will set the stage for the display of a shift in ownership over mental health efforts from NGOs to the state conducted by the many stakeholders present at the "closing" ceremony. Finally, I narrate the ceremony with which I began this chapter, to shed light onto what was at stake for the different institutions involved in this training. I suggest that under current aid regimes and development norms, state and non-state institutions are mutually dependent on one another to display, concurrently, "good" statehood and NGO-hood.

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My own involvement in the mental health capacity building event started three months earlier, when shortly after the third anniversary of the 2015 earthquakes in Nepal, Rikesh (a psychiatrist) and I were sharing a cold Tuborg beer near the hospital where he holds his private clinic. He received a phone call from the executive manager of a mental health NGO for which Rikesh is a technical advisor. Rikesh was asked to teach the two last days of a six-day-long mental health training for public health assistants in an earthquake-affected district. After hanging up, he asked me whether I would like to shadow him during the training, as he imagined it could be of value for my research too.

The training Rikesh would help deliver was based on the WHO's mental health gap action programme intervention guide (mhGAP-IG) training for non-specialised healthcare workers. This is a tool designed to aid in the detection, diagnosing and management of common mental disorders. It was also based on other locally adapted and state endorsed training manuals and treatment protocols. In so being, the capacity building event was part and parcel of the global mental health and national projects aimed at scaling up evidence-based mental health services by means of task-shifting and integration of services into primary health care. Yet the training was also an outcome of a wider humanitarian project I call here the NeighborNurture project, which began post-earthquakes, in November 2015. Although the training took place three years after the earthquakes, they were a direct product of the resources, attention, and interventions brought by an understanding of the earthquake as constituting a humanitarian emergency and its associated moral call, and imperative, to intervene (Boltanski, 1999; Fassin, 2011).

I begin, in the following section, by briefly offering the programmatic and political background to the mhGAP-based training. My account of the wider NeighborNurture project is based on an interview with Naya, the local project manager at one of the humanitarian INGOs involved, and on the project dissemination materials. Although the project was designed to provide support to specific and targeted communities (i.e. earthquake-affected) instead of to the national population, the community-based mode of intervention and its focus on building the capacity of public health workers evidences commitments on the part of the I/NGOs involved to work through, and strengthen, country systems for the longer-term.

From providing relief to enabling "country ownership" in a new federal structure of government

The NeighborNurture project was implemented in six earthquake-affected districts thanks to a partnership between two humanitarian INGOs and two local implementing NGOs. Each implementing NGO focused on the implementation in three districts. The duration of the project was initially scheduled to last for a year and a half and was envisioned, and budgeted, as an awareness-raising and capacity building project to encourage community-led mechanisms for psychosocial support at the grassroots level.

There were, initially, two main components to the project. One component was to train Female Community Health Volunteers (FCHVs) and Auxiliary Nurse Midwives (ANMs) in basic MHPSS. FCHVs are women who volunteer to provide basic health services and health education at the grassroots level and act as a bridge between the community and the formal healthcare system (cf. for important critiques around the lack of remuneration of FCHVs in Nepal see Swechhya and colleagues, 2014, and Panday and colleagues, 2017). ANMs, on the other hand, are healthcare professionals that work at the primary healthcare level who receive formal training in nursing and midwifery. The FCHVs and ANMs received training that focused on various MHPSS aspects, including psychosocial concepts, mental health issues, communication skills, coping, resiliency, self-care, and the utilisation of a community informant's detection tool to identify people with psychosocial problems in the community. The aim of this training was to teach them how to provide basic level psychosocial care and how to facilitate referrals to more specialised care when needed. The second, and interrelated, component of the project was to generate awareness, and try to reduce the stigma attached to MHPS issues in the earthquake affected communities where the FCHVs and ANMs had been trained to encourage help-seeking behaviour. For this, the NGOs used Forum Theater, a form of participatory street theatre that has commonly been used as part of social change projects and development interventions in Nepal by I/NGOs and political parties alike (Mottin, 2017) (cf. Chapter 2). After the awareness-raising activities, where more than a thousand performances took place in different public spaces such as markets, schools and bus parks in the earthquake-affected communities, there was a big upsurge of cases of MHPS issues identified and referred (cf. a topic that I further discuss in chapter 6).

Naya, the project manager of one of the humanitarian organisations involved, informed me that there had been more than two thousand cases of people with mental ill health identified, and only three hundred of those individuals had been attended to or dealt with around the time that the project was scheduled to end. Therefore, she said, feeling a "moral obligation", the project managers got extra funding to extend the project for six months and start a case response component to the project. For this, they mobilised fifteen psychosocial counsellors that had previously been trained by the implementing NGOs in the six districts to follow-up the cases and provide individual, family and group counselling sessions as well as referrals to more specialised care when needed. The longer-term problem, however, remained. As Naya explained, all these efforts were possible thanks to "earthquake money" and those resources, and the care they enabled, were going to eventually end.

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There is a consensus among critical scholars of humanitarianism and humanitarian medical practitioners alike that humanitarian emergencies generally engender short-term care (Redfield, 2005; Jones, 2017). Furthermore, critics of humanitarianism have raised important social and political questions around the "mobile sovereignty" (Pandolfi, 2003) that allows humanitarian actors to move across borders, and operate in different contexts without being bound by the legal or political frameworks of the countries in which they are intervening. However, at the time of the NeighborNurture project, these critiques had already influenced aid discourse and practices and there were powerful calls from within the related fields of practice to try to move from relief or shorter-term aid to "sustainable development" (cf. Chapter 2).

In the humanitarian field, current rhetoric is around trying to transcend the "humanitarian-development divide" and to shift the goal from being that of "delivering aid" to that of "ending need" by reinforcing local systems (Secretary-General, 2016, p. 28). In the same vein, the most recent approach advocated from within the subfield of MHPSS in emergency situations is to try to "build back better" sustainable mental health care systems after emergencies (WHO, 2013). This relief-to-development approach asserts that "the surge of aid, combined with sudden, focused attention on the mental health of the population, creates unparalleled opportunities to transform mental health care for the long term" (WHO, 2013, p. 4). Here again, the said goal is to use humanitarian relief in ways that could enable longer-term mental health reform. In the broader field of international development, as I noted above, a central principle or “master metaphor” (Mosse, 2005a) underpinning current norms that can, in theory, better allow to “build back better” or “end need” is that of “country ownership”.

In countries that are deeply dependent on foreign aid such as Nepal (Sharma, 2021), shifting global aid regimes and the norms and forms of development they promote and demand (through conditionalities, for example) greatly influence the role, legitimacy and capacity different institutions (e.g. state and non-state) have in development. This is because of the underlying power asymmetries between those who can provide resources and those who receive them. The current discourse in international development around the donor-recipient relationship, which aims to distinguish itself from the previous aid system, revolves around the concept of development “partnerships” (cf. Chapter 2). In this context, development donors and official documents widely support the idea of “country ownership” (cf. OECD, 2005; Accra, 2008). However, some have suggested that aside from the shift in language, little has changed in terms of the important asymmetries that underpinned the problem of country ownership to begin with (Buiter, 2007). What this chapter suggests is that what has changed under these new development norms is what is considered, in Monica Krause’s words, a “good project” (2014).

In her empirical work, Krause (2014) has shown how managers of the largest Western relief NGOs produce projects and strive to make what she terms “good projects” that can sell, just as any other commodity, in a “quasi market where donors are consumers” (Krause, 2014, p.4). She argues that humanitarian relief has historically been a form of production that has the “project” as its primary output. Under current aid regimes, the “good project”, as Brown and Green reminds us, “is no longer a standalone endeavour […] development requires changed forms of organisation, which can demonstrate the progress of initiatives by making them visible as sets of activities which are internal to, and integrated within, national systems” (Brown & Green, 2017, p. 48).

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In accordance with these discourses and its related moral mandates, the INGOs and NGOs involved in the humanitarian project in Nepal had wanted to be able to secure some degree of “government ownership” over the mental health efforts they had begun post-quakes before phasing out the project completely. To be able to satisfy longer-term visions and strategies, they added a final advocacy component to the project. Whilst there had been a high level of buy-in from the state for the NeighborNurture project (the district public health office had granted permission for the NGOs to coordinate directly with the health post in charge to send the FCHV and ANMs to the training), the NGOs advocated for more commitments from the local leaders to try to pass on “ownership” and “responsibility” to the state. Having proof to have enabled “government-owned” initiatives would count as a “success” for the I/NGOs.

The added advocacy component to the NeighborNurture project was designed by the INGOs and NGOs with Nepal’s political transition into a federal structure in mind. In fact, the local government reforms were central to the advocacy strategy used by the I/NGOs. The post-earthquake context together with the restructuring of government were seen as an important moment of opportunity to advance the mental health agenda.

As outlined in chapter 2, after nine years of being in the making, and driven directly by the earthquakes, Nepal enacted its long-awaited new Constitution in 2015 which formally marked the transition from a constitutional monarchy and Hindu state into a secular and federal democratic one. As noted earlier, the Constitution carried significant structural and symbolic significance.In terms of structure, it indicated Nepal's shift from a unitary government to a three-tier governance system, encompassing national, provincial, and local levels of governance. This restructuring aimed to decentralise power, affecting resource distribution and political authority. On a symbolic level, the new Constitution marked the dawn of "Naya Nepal" (new Nepal) (Sharma, 2021). This indicated a departure from previous government shortcomings and marked the beginning of a new era focused on building a welfare state.

In 2017, the first local elections in the country in two decades took place and signalled to Nepali citizens and to the world that federalism was being implemented. The political move towards implementing federalism meant that there would be a lot more decision-making authority, political power and fiscal autonomy in local governing bodies – powers that local level leaders had not had before 2015. In anticipation of this shift, those involved in the NeighborNurture project viewed it as a good time to advocate for mental health to be included in local government agendas and budgets. Local leaders had been elected for a five-year term, thus from the NeighborNurture's perspective, it was a good opportunity to integrate MHPSS at the local level for a longer-term commitment. In this last component of the project, what the NGOs were advocating for was that instead of NGOs looking for the permission from the state to provide trainings and funding for care, for the local government to take responsibility for the mental health needs in their communities and allocate some budget for the capacity building of public health workers and for the continuation of the work the psychosocial counsellors were doing as part of the humanitarian project.

One of the chief results from the added advocacy component was the commitments from the newly elected local leaders of two rural municipalities of an earthquake-affected district to partially fund mental health trainings with their current budget, and to allocate resources for MHPSS for the following year. The mhGAP-based training to which I was invited was one of these local level state-funded mental health trainings. In so being, it satisfied current international development norms around "country ownership". It was also the first partially state funded mental health training in the new federal structure of government, potentially signalling a new era of government, where public mental health provision would be part of the "New Nepal".

Having presented the wider programmatic and political context within which the mhGAP-based training and ceremony were embedded, I now turn to ethnographically narrate the journey from Kathmandu to the training district. I reflect on how, in practice, the roles and responsibilities of state and non-state institutions remained entangled, and blurred (Gupta, 1995). This will set the stage for the performance acted out by state and non-state actors and institutions in the "closing" ceremony that ostensibly signalled a shift in ownership over mental health policy-making in Nepal.

The journey & an entangled service infrastructure

It was early July 2018. Monsoons were causing what have become yearly disasters of flooding and landslides across the country, and the road we had to travel on was in very fragile condition.

The NGO requested that Rikesh and I set off a day earlier than planned to be able to reach safely and in time. The organisation provided us with a big SUV and a driver. During the long and bumpy journey, I learnt that the NGO had three SUVs and only two drivers. The cars had come with MHPSS projects after the earthquakes, and whilst they do not use the third car, getting rid of it involves enough red tape for them to prefer keeping it, unused. I saw the third car as the material legacy and waste of development resources inherent in the "project-time" (Benton, Sangaramoorthy, & Kalofonos, 2017) within which most mental health care throughout the country had worked for decades. Since the 1990s, most mental health efforts were carried out by NGOs working with time-bounded projects (cf. Chapter 2). However, now many of the same organisations were ostensibly trying to militate against that way of working and trying to hand over the labour and responsibility of MHPSS sustainably, to the state.

The two days of training were scheduled for Sunday and Monday. We left on Saturday, the only official day off during the week in Nepal. Before leaving the capital, however, we were to go to Kanchan's home – the NGO's lead psychiatrist's – to pick up a box of psychotropic medications to take with us to the training district. The NGO was not paying for the drugs, but was transporting them. This moment exemplified, for me, the complex brokerage work NGOs perform in Nepal's mental health system. While the NGO was not paying for the drugs, they were literally and figuratively bridging gaps in the state healthcare system – physically transporting state-purchased medications while also mediating between state procurement challenges and local delivery needs. This material act of brokerage, where an NGO vehicle carries state medicines, is a concrete instance showing the broader entanglement of state and non-state actors in mental health care delivery. Some of the drugs we were to transport had been included on the government's Essential Drugs List (EDL) only after the quakes and it was the first time the government was purchasing them. In each country, the medicines on the EDL are medicines that are believed to be those that best satisfy the priority healthcare needs of the population (Laing, Waning, Gray, Ford, & Hoen, 2003). The drugs are selected based on disease prevalence rates, efficacy and safety evidence and comparative cost-effectiveness and governments are required to provide them free of cost (ibid). Thus, the aim of the EDL is, in theory, to safeguard the accessibility and affordability of essential medicines to populations and are understood as being central to Universal Health Coverage and Sustainable Development goals (Wirtz et al., 2017). The reason these essential drugs were travelling beside us was that the procurement of these essential and free drugs is not always successful and became less so during government restructuring and transition to a federalised system. The roles and responsibilities within the chain of drug supply between the federal, provincial, and local levels were not fully clear. To make sure the trainee public health assistants would have access to the medicines after the completion of their training, the pills were to travel beside us. This was, to me, a significant indication of how the state's responsibility of drug provision is deeply entangled with NGO practices and highlighted how informal infrastructural networks support the state apparatus: here, the state was reliant on an NGO to transport and protect the drugs to reach a partially state subsidised training. Upon reaching Kanchan's home, he greeted us in casual clothing surrounded by his extended family. He passed the box of medicines to me through the car's window and mentioned he hoped I would enjoy the training because it was "a historical one".

Rikesh was not fully aware about the wider picture and project within which his assigned training was embedded. He was accustomed to providing trainings for the NGO and had not questioned whether this training was any different than others he had given in the past. We collectively and progressively put the pieces to the puzzle together. I asked Kanchan why he saw it as being "historical", given that the NGO had been using mhGAP since 2011. "It is the first time the local government is organising it. *They asked us* [my emphasis] for the training, instead of the other way around" he explained to me. What Kanchan was emphasising to me with this formulation "they asked us" was that, as previously explained, for the first time it was government officials asking for, and partially enabling, a mental health capacity training as opposed to what NGO staff were more accustomed to, which was having to request the government for permissions and endlessly nudging and incentivising government officials to notice and attend their activities. However, none of my interlocutors commented on the irony in the fact that an NGO was compensating for the state's challenges with drug procurement for government health workers to have access to essential medicines while also proclaiming how historic it was that the government is finally taking ownership over mental health care.

It took us more than five hours to drive about 50 kilometres. Upon arrival at the hotel, we were welcomed by Jeevan (the NGO's district coordinator) and Ganesh, another psychiatrist who had provided the four first days of the training. Ganesh and I had met at a public hospital where he works in Kathmandu, as I spent time shadowing the psychiatric team as part of my research (cf. Chapter 3). He was, however, surprised to see me there and, I sensed, a little uneasy. This was confirmed to me when he quickly and explicitly asked me not to mention his involvement with the training to his boss if I were to speak to him. I assumed his discomfort had to do with the fact that I had, in a sense, caught him moonlighting – giving the training on his leave-time from the hospital, his boss unaware. However, after I reassured him that I would keep his involvement confidential, he said: "you know him, he likes to do it all himself". This made me think that perhaps it was not the formal rules about whether he could or not be giving this training whilst on leave that bothered Ganesh. In fact, in practice it is very common for psychiatrists to undertake multiple and diverse lucrative jobs at once such as trainings for NGOs, private clinics, and satellite clinics in more rural areas. Instead, what seemed to preoccupy Ganesh was how his involvement with the NGO would be interpreted on a more informal level by his boss. I had personally met Ganesh's boss many times before, as I met him in 2014 when I first lived in Nepal and was aware of his high professional ambitions as well as his ambitions for the Nepali state and his protection over psychiatric expertise. Ganesh appeared, to me, to be worried about how his boss would interpret his involvement with the training with regards to his loyalty to his boss's personal, professional and national ambitions. Ganesh's situation revealed the complex position of medical professionals who must broker between different institutional loyalties and approaches to mental health care. His anxiety about his boss discovering his NGO work illustrated how individual practitioners must carefully translate between state healthcare aspirations and NGO-led implementation, while navigating professional hierarchies and competing visions for mental health care in Nepal.

Like many of the more senior psychiatrists in the country, Ganesh's boss had been one of the very early and few practising psychiatrists in his country and wanted to be known and respected for being a long-standing key face and force behind mental health efforts in Nepal.

Whilst there are still few psychiatrists in Nepal, the numbers are increasing. According to an article published in 2021, there were 200 psychiatrists practising in Nepal, compared to 39 in 2008 (Rai, Gurung, & Gautam, 2021). After many years working in mental health care and advocating for the importance of psychiatry's expertise, some senior psychiatrists find the increasing competition, especially at a time – post-earthquake – when mental health is receiving more national and international attention personally very challenging. Furthermore, Ganesh's boss is the head of the psychiatric department in a public hospital and often spoke about wanting Nepal's health system to be strengthened by public institutions like the one he works for, rather than by the "technical support" of NGOs. As explained earlier in the thesis, the earliest psychiatric services initiatives in the country had not been part of early health development programs but were sponsored by His Majesty's Government during the panchayat government (cf. Chapter 2). These were hospital-based initiatives and were headed by foreign-educated doctors just like Ganesh's boss. Most doctors were trained abroad, mainly in India (Upadhyaya, 2015), as well as Rusia (personal communication), until Tribhuvan University Teaching Hospital opened. During my time shadowing Ganesh's boss, I wondered whether his preference for his country's health system to be strengthened by public institutions instead of by NGOs was because he wanted the hospital he worked for to be recognised for the work they do at a time of enhanced moral stakes, or whether it was more of a nationalist sentiment. In either case, psychiatrists in Nepal, as elsewhere did have an ambivalent relationship towards mental health NGOs, as many psychiatrists worked for NGOs but also felt strongly about protecting their ownership of mental health expertise.

As in many other low and middle-income countries, mental health NGOs in Nepal promote different understandings with regards to what constitutes mental ill health and different ideas on how it is best to provide care than those promoted by psychiatry. Furthermore, several mental health NGOs, such as the ones involved in this training, follow an approach advocated for by the WHO and the Movement for Global Mental Health in the name of manpower resource shortages, known as "task-shifting" or "task-sharing" (WHO, 2008). Task-shifting has been defined as "the process of training primary care and community health workers to assume some health care responsibilities traditionally delivered by specialists" (Kohrt & Mendenhall, 2015, p. 255). At the mhGAP-based training, two psychiatrists (first Ganesh, and then Rikesh) were training non-specialised health workers to diagnose and treat mental disorders at the health post level. Several scholars have observed a professional resistance from the part of psychiatrists to delegating their expertise with less qualified health workers, feeling that their expertise is, in some way, diluted (cf. Van Niekerk, 2008, for a case in South Africa Agyapong; Osei, Mcloughlin, & McAuliffe, 2016, in Ghana;). Global mental health is in fact reframing the public health role of psychiatrists in Nepal and elsewhere as being one of primarily capacity building leadership and of treating the most severe cases (Patel et al., 2018).

With this backdrop, Ganesh might have felt "caught" in an awkward position and worried his boss would interpret his actions as being disloyal to him as his senior, to psychiatric expertise and to his nation. Here again, the ambiguity with regards to whether the training was meaningfully a state initiative is put back into question. Despite this event being promoted as a state training, the specialists providing it were selected and paid by the NGO, perpetuating the centrality of NGOs in the promulgation of the mental health agenda in Nepal.

Ganesh informed Rikesh and I that there were only six health assistants being trained but that they were very enthusiastic. In Nepal, where 79% of the population lives in rural areas (World Bank, n.d.), health-posts are the first institutional contact point for basic health services and are therefore the back-bone of the national health system. The entire district where the training was taking place is composed of a total of ten rural municipalities and two urban municipalities. Each health assistant present was in charge of their health-post, and together, the six of them covered the area of two rural municipalities. We sat together in the hotel lobby for a few minutes before Ganesh took the same SUV back to the capital.

Moments later, another man came into the lobby to meet us. He was the District Health Coordinator (DHC). In every district, there is a public health office that works under the Ministry of Health and the head of the public health office is the DHC or "head chief" who is a bureaucrat appointed by the central government. With the DHC, the main topic of conversation and of concern was the "closing ceremony" with, and for, the newly elected local leaders who had requested and enabled the training. The logistical conundrum had to do with the fact that the local leaders had another ceremony to attend for retiring FCHVs aside from the ceremony related to the mhGAP-based training. The leaders wanted to join these two events and schedule the ceremony for Monday morning, before other commitments. This meant that the ceremony would have to happen before the mental health training was over. The relative importance of the interruption of the training to allow space for the ceremony, however, was not discussed. Instead, the change of the name from "closing" to "sharing" ceremony was debated, as the ceremony would indeed not be closing anything. During the exchange, the importance of ceremonial activities attached to development related events was taken for granted.

As requested by the local government officials, therefore, the "sharing ceremony" took place on Monday morning. The health assistants, Rikesh and I had had a full day of training on Sunday. Rikesh had finished the first day of training by asking the trainees to revise what they had learnt in the last few days and come back the following morning with clarification questions for him. In addition to Rikesh and Jeevan from the NGO, the newly elected local leaders, the trainees and myself, there were another two people from one of the INGOs involved in the advocacy work behind the training that had come from the capital with their own SUV and driver on Sunday, to attend the ceremony.

Displaying a shift in ownership over mental health efforts

Rikesh and I reached the health-post-cum-training centre at nine thirty in the morning, about the time the "sharing ceremony" with all stakeholders involved was scheduled to start. The plastic chairs from the training room upstairs were set up downstairs together with wooden benches facing a large banner with the training's name, and the government and NGO logos, under which government officials would be sitting. Whilst Naya was taking a few photographs for the INGO's website, and Rikesh was skimming through the substance abuse slides, I was chatting more informally with the health assistants about their thoughts on development ceremonies. After some time, Rikesh suggested we again take the chairs upstairs and started going through the questions he had asked each trainee to prepare, as the ceremony was starting late and there was "no time to lose". We barely had time for a few trainees to go through some of their questions and doubts. Then, the training was interrupted; and we again carried the chairs downstairs and set them up for the ceremony.

The DHC was the master of ceremony. He had made note of what activities should be performed in what order and of his own speech, following a cultural script I had witnessed at other events on how these ceremonies should be performed. A few bags filled with traditional ceremonial scarfs (*khatas*), tokens of love, red *tikka* powder and flowers were beside him. The ceremony commenced with the lighting of a candle, followed by a quick round of introductions by those sitting at the front. Those were the chief administrative officer (bureaucrat), three elected local representatives (the vice chairperson of a rural municipality and two ward chairpersons) and two representatives of one of the INGOs involved. Everyone received *khatas*. After the introductions and exchange of material symbols of blessings and gratitude, the speeches began, each guest taking their time in turn. At the beginning of each speech, everyone addressed all of those present first, almost in an enumerating fashion, before emphasising points they felt were important such as the need for more and continuous trainings, as well as supervision, post-training. During the round of speeches, people kept arriving and many of those present, including the local leaders, were busy on their phones. The joining of two separate events for the schedule ease of the local leaders made it hard for some of them to orient themselves at times. During their speeches, however, some did manage to speak eloquently about the difficulty in identifying mental health issues and the importance of responding to MHPSS in their community. One of the leaders explained to the audience, "our internal world is like the software, but we only see the hardware". He was trying to convey an understanding that mental health, although invisible and pertaining to our internal world, is as essential to people's lives as what *is* visible – the health of bodies. To make this point, he chose to use a computer analogy wherein the material and visible components – the hardware – cannot function without the proper functioning of the invisible part – the software. Other government officials, however, were not fully discreet in having to check and read the title of the training off the banner behind them and one of the leaders mistakenly spoke about the "sharing training" instead of the mental health training.

There was a striking contradiction between Kanchan's (head psychiatrist of local NGO) description of this event where the state is ostensibly taking ownership over mental health efforts as being a "historical" one on one hand, and the levity with which those who embodied "the state" were engaging with what was going on, on the other hand. Whilst government officials were putting on a display of ownership, they also did not appear to be particularly interested, or following the proceedings closely. I wondered who this event was "historical" for, what its description as "historical" signalled with regards to mental health's prioritisation in Nepal, and what the local embodiments of the state had to gain from it all. In other words, where did the value of this performance lie, and for whom?

Mental health has always been marginalised within the global public health agenda, and mental health advocates and professionals are often marginalised within health systems and public debates. Given its relative power position with regards to other health issues, getting public recognition of the importance of mental health was very important for those who have been working in mental health for decades such as the local NGOs involved in the NeighborNurture project. Having their efforts not only publicly recognised by government officials, but taken up by them with the ostensible intention to continue building on their efforts, was extraordinary. However, it was not “historical” in the sense that this particular event was indexing a promise of a future cascade of state commitments to fund mental health efforts. In fact, it was “historic” because local-level government commitments towards mental health efforts had not happened before. Thus, it was not that mental health suddenly became important for the state. Rather, the fact that this was being described as “historic” was a clear indication of the tokenistic nature of the state's engagement with mental health efforts. If indeed the precise topic or content of the training was not what was really at stake for the local leaders, as the training might as well have been a training on “sharing”, there were certainly other political stakes involved in this development-related activity.

Once the ceremonial activities concerning the mental health training were performed, it was time to switch to the adjacent (and unrelated) cause of reunion: an incentive-giving ceremony from the state for retiring FCHVs. Each FCHV was called in turn to go up to collect the money. Almost two hours of ceremony went by. After the distribution of incentives and some speeches on their side were given, it was time for the distribution of several material goods for the health assistants. In addition to their own tokens of love, the health assistants received a training completion certificate and mental health registers. These tools and technologies were provided by the NGO giving the training. The mental health registers were to be used by the health assistants to keep track of the issues patients present in their respective health-post, demand the purchase of essential medicines and input data onto the Health Management Information System (HMIS). It was also a way for the NGO to collect data for other mental health research projects and keep the funding coming. This double intent was something Rikesh was aware of, and highly critical about, “I do fear sometimes about how they [the NGO] think, you know, what comes first: research or service? But this is how it works”, he confessed to me (a critique I analyse in detail in the following chapter, chapter 5). The training completion certificates, on the other hand, fulfilled the function as the official proof of prescription licence for the trained health assistants and are strong symbols of the state and its power. Here again, the role of the state and the NGO is blurred and co-dependent. Thus, although this training was deemed “a historical” one for it being requested by state actors and partially funded by them, much of the infrastructure supporting MHPSS work (e.g. trainers, registers, certificates) is still funded by non-state organisations and actors. The NGO staff’s brokerage work was particularly evident in how they managed to make the local leaders appear as the primary drivers of mental health reform, even as the NGO provided most of the infrastructure. This required careful behind-the-scenes coordination to ensure the ceremonial display of state ownership aligned with both local political needs and international development norms around government leadership.

After many pictures, and with our hands still tingling from clapping, the health assistants and I carried the plastic chairs back up again to resume the training. Rikesh was clearly frustrated, and his frustration was visible moments after he had resumed the training. A couple of the trainees stood up momentarily to give up their chair for someone else who was coming in through the door. Rikesh had his back to the door and had not had the chance to see who was coming into the room before telling the health assistants "no, you sit". It was, in fact, his friend Naya from one of the INGOs involved that was wanting to observe some of the training. On seeing it was her, Rikesh quickly apologised for his reaction and explained "I am just very tired of this *thulo maanche* ("big people") business".

Multiple and entangled stakes

As described, this training for health assistants that took place in a rural municipality of an earthquake-affected district and represented "government ownership" involved a lot of work and resources from a multiplicity of institutions; both public and non-governmental. The political stakes were also multiple.

Seen from the wider humanitarian project perspective, this training was the culmination and successful result of their added advocacy component that sought to achieve commitments from the newly elected local leaders of government who had recently got more power due to the change in political structure, around addressing the MHPS needs in their communities. Indeed, the advocacy efforts from the implementing NGOs managed to sensitise the local leaders about mental health issues by carefully translating global mental health priorities into the language of local governance and development. Through persistent behind-the-scenes coordination between mental health specialists, international donors, and local officials, they convinced local leaders of the need to address these issues in their communities, resulting in two rural municipalities allocating funds for MHPS trainings for government health workers This delicate brokering work – making mental health legible to local government while making government involvement legible to donors – allowed NGOs to position their handover of responsibility to local government as evidence of their commitment to ensuring longer-term reduction of suffering and sustainable care through state ownership. Vis a vis donors, and with an understanding laid out by Krause (2014) that humanitarian relief organisations confront a market of donors who desire to relieve "distant suffering" (Boltanski, 1999) but also expect results; their job was a job well done. Under current aid regimes and development norms, the INGOs and NGOs were displaying "effective aid" by displaying their aspiration for government-ownership. For the implementing NGOs, the success of their involvement reinforces their partnership relationships with the well-resourced INGOs. Additionally, they also embedded a research component that appeals to a different type of well-resourced and already established partners such as universities or global mental health research consortiums (cf. Chapter 5). Finally, the NGOs reinforce their "technical expertise" legitimacy in providing the training for government health workers and strengthening their relationship with the government to implement future projects.

Following Mosse's (2005a) approach to development and to development "success" as practice, the display of development and of its "success" for it to be recognised by others is central to its reality. And such displays where different actors proclaim the credit for development activities and successes is not new in Nepal. Indeed, it was commonplace to see the tussle over recognition for having brought in NGOs to do health related work and development projects between communists and the different political parties post-panchayat regime (Ramirez, 2000). However, the performance described here is not of NGOs taking claim of what they are doing but rather of the opposite, of relinquishing ownership and power, and of supporting the state to reclaim its role as a legitimate provider of development and welfare. There are two possible and not mutually exclusive readings here. One is that the NGOs want to demonstrate that they managed to get the government to recognise and take up their agenda. The other is that INGOs are competing in a donor market where they have to put a lot of work in to demonstrate that they are *not* in control of the projects they are running and that it is not their own agendas they are advancing, even as they are asking for funding to do this work and to be able to continue their programs and offices. Both readings however, suggest that it is not a tussle over power or sovereign responsibility between state and non-state actors, but a joint and labour-intensive performance and narrative of "success".

The stakes involved for the political leaders in requesting and enabling this mental health training remain more opaque. Given my positionality, because I arrived and left the training site with the NGO, and that the government officials were busy with the ceremony and communicating on their phones, the perspectives of the local leaders embodying the state and country ownership were inaccessible to me and are missing from this account. However, other scholars writing in the context of Nepal have argued that ever since the 1950s, the Nepali state has sought legitimacy and authority through development (Sharma, 2021) and its rituals (Adhikary, 1996; Gellner, 2015). Tennekoon (1988) argues, in the case of Sri Lanka, that these development celebrations and rituals of development are not just politics in terms of the legitimation of state power, but of personal politics and that maintaining a visible public profile through development celebrations is important for electoral politics. Tennekoon's account resonates widely in the Nepali context too, and perhaps also with Rikesh's exasperated comment on "*thulo maanche"* business. What Rikesh's comment could have indicated was his personal reading of the local leaders' endorsement of mental health efforts and their presence at the "closing" ceremony as a performance with the ultimate aim of increasing their electability and strengthening their political affiliation and patronage networks, as other scholars of Nepal have written about (cf. Sharrock, 2013; Sharma, 2021).

Given the post-earthquake context, the newly elected local leaders being the first to provide such a training could be interpreted as a public demonstration of their concern for, and involvement in, the welfare needs of their citizens and communities. On a personal politics level, the local leaders were embodying the new state and came with more power and resources than previous local representatives. I was told by the NGO's advocacy officer that worked directly with the government officials that this renewed level of responsibility and power meant the local leaders felt more pressure to be seen as legitimate keepers of public interests and welfare, and providers of *bikas.*

Nepal's national health system continues to be reliant on foreign aid and NGO practices and yet both state and non-state actors put a lot of resources and efforts into displaying a shift in ownership over mental health work, as though going from non-state to state institutions. I have suggested that the "master metaphor" of "country ownership" managed to enrol state and non-state actors' and institutions' interests in this short post-earthquake mental health training for public health workers – all actors involved working towards performing "country ownership".

Whilst the material presented in this chapter speaks beyond the confines of global mental health, to demonstrate the enactment within a broader development spectacle, even as the language and politics shifts to country ownership, it is important to also consider how all of this matters, for the evolving mental health field in Nepal. As stated above, one may be inclined to read the material presented here as yet another example of "failed" development, and therefore believe it has no consequence for the evolving mental health field in the country. However, an alternative perspective is to consider how this performance of country ownership of mental health efforts may be suggestive that mental health discourse has become integrated into the development lexicon and framework of the "Naya Nepal" state; and how this integration may have rippling effects in various aspects of Nepali society (cf. Chapter 6 for changing aspirations and career prospects of the urban youth in Nepal).

Conclusion

Current aid regimes and international development norms are requiring development strategies, plans and programs to be "country-owned" by those that receive aid. This chapter has shown what "country-ownership" looks like on the ground in the context of Nepal where aid regimes that have come before can be seen as being responsible for historically disempowering the state and public institutions. The ethnographic evidence – from NGO vehicles transporting state-funded medicines to psychiatrists navigating between public hospitals and NGO roles – demonstrates this historical disempowerment and continued entanglement of state and non-state functions.

This chapter highlights the fact that "country ownership" is laboriously orchestrated through coordinated efforts of government and non-governmental actors. This was evident in the intensive behind-the-scenes work required to stage the ceremony – from NGO staff's careful coordination with local leaders to merge two separate events, to the complex logistics of ensuring essential medicines reached the training site, to the provision of mental health registers and training certificates. Even the interruption of actual training time for ceremonial purposes showed how displaying ownership took precedence over the substantive work of capacity building.

Displaying development "success" in an era where "country ownership" is discursively highly valorised involves coupling the interests of I/NGO actors even more closely with those of governments actors, and vice-versa. This was evident in how the training was framed as "historical" by mental health advocates because local leaders had requested it, even as NGOs provided most of the infrastructure – from the trainers to the mental health registers. The contradiction between this framing and the actual engagement of state officials reveals how both sides worked to produce interpretations of the training as reflecting country ownership, regardless of the minutiae of the supporting arrangements.

State and non-state institutions are mutually dependent on one another to display, concurrently, "good" statehood and NGO-hood. The ethnographic material shows this mutual dependence in action: NGO staff carefully managing the ceremony to make local leaders appear as drivers of mental health reform, while local leaders' participation – however partial – allowed NGOs to demonstrate their commitment to government ownership to donors. While the training ostensibly represented a transfer of power from NGOs to the state, the ethnographic material suggests it may have been more of a joint endeavour, with each party enabling the other to meet their institutional requirements under current aid regimes.

As we will see in the next chapter, the blurring of boundaries between these two domains of actors has raised a host of ethical and economic challenges. In particular, the chapter that follows highlights the impact of evidence-based practice in global mental health and the promotion of global research partnerships on mental health NGOs in Nepal. As we will see, the privileging of certain forms of knowledge production and the increased focus on generating scientific evidence for the GMH project has led to an enclosed and circular funding mechanism that favours certain models of care over others. Ultimately, the blurring of boundaries between government organisations and NGOs has profound implications for the ways in which we understand and practice international development. It raises important ethical questions about the relationship between research and service provision and the uneven distribution of resources and power within the aid regime.

Chapter 5. “Nepal is turning into a research lab”. Evidence, relationships & the funding for mental health care

Introduction

I called Sachit, a psychologist, one day to check in with him about his job situation. The last time we spoke, he was feeling anxious – the project he was working on as a program manager at an international non-governmental organisation (INGO) was finishing soon, and he was unsure when he would get another job opportunity. Sachit knew he had been very fortunate to be in employment for two consecutive years. Before his current position, he had only been able to get contracts for a few months at a time. Non-governmental organisation (NGO) staff workers in Kathmandu are constantly having to come to terms with the uncertainty and anxiety that accompanies their precarious work situation as their financial stability is dependent on donor-funded projects. I was happy to hear that Sachit had found an opportunity to support a new research project at one of the mental health NGOs he had previously worked for, and where he had developed some scientific research skills as part of the organisation’s commitment to local research capacity building. This new job would last for about a year, working for a project investigating the acceptability of using a new technology to identify healthy and risky behaviours associated with youth mental health. “That’s great you found a new job!” I exclaimed, before remarking that I had not heard about that project before. He laughed, and said, “it is hard sometimes to keep track, isn’t it? Nepal is turning into a research lab”. Hearing him say those words struck me, as it was certainly not the first time Nepal had been described as a metaphorical laboratory.

In the early nineties, the director of the U.S Agency for International Development’s (USAID) Mission to Nepal, Kelly Kammerer, famously wrote that “exploring the history of the U.S economic assistance program in Nepal is like being in a development laboratory” (Fujikura, 1996, p. 271). As the anthropologist Fujikura rightly notes, it is easy to imagine that to American social scientists, economists and administrators in the 1950s and 1960s, most developing countries would have been viewed as “potential laboratories for the ideas and agencies of the project of ‘development’” (Fujikura, 1996, p. 271). He remarks, however, that Nepal had an exceptional pull on foreigners’ imaginations as a desirable place for their experiments (Fujikura, 1996). Foreigners were captivated by the idea of being able to test what they believed were the best approaches to planned development in what they saw as a “blank slate” given their assumption of Nepal having been completely isolated from the modern world until the 1950s. Writing about health developments in Nepal, both Justice (1989) and Pigg (2001) have similarly argued that Nepal served as an experimental site and test case for different development concepts and practices promoted by international policymakers. According to Justice (1989), Nepal’s rural health program in the late 1970s was a test case for how to bring about integration of vertical projects to provide basic health services and incorporate the concept of primary health care. And, in the second decade of the AIDS epidemic, when reported HIV/AIDS cases were believed to be low in Nepal, prevention efforts were also tested out in the country (Pigg, 2001).

Was this also what Sachit was implying when he described his country as turning into a lab for mental health research? That Nepal is still being used, as it was suggested in the early nineties, as a testing ground where outsiders put into practice their theories and test their ideals? Or did he mean it in a very different way, highlighting the ever-increasing central role Nepali mental health actors, such as himself, and local mental health NGOs are playing in the production of scientific knowledge about mental health? After saying goodbye to Sachit, I wondered what it was about his dispositions, connections and skill set that had afforded him, as opposed to other candidates, another job opportunity in the metaphorical mental health research lab, and I pondered the same about myself – we are both, after all, actors in the broader sphere that make up Nepal's mental health research "laboratory".

This chapter explores the impact evidence-based practice in GMH and the promotion of global research partnerships has on what mental health NGOs in Nepal do, and on the opportunities they have. In the last fifteen years, GMH has emerged as a new evidence-based field of research and practice for which Nepal has turned into a key site of knowledge production. The project that Sachit was asked to be part of was one among many other research projects carried out by mental health NGOs in Nepal in partnership with development agencies and universities mainly located in high-income countries (HICs) that are testing, evaluating, and generating evidence for concepts and practices advocated by GMH practitioners, to be used in Nepal, and around the world. Importantly, GMH research funds have been enabling much of mental health policymaking and practice in Nepal but are flowing inequitably across local institutions; an inequity that hinges on local institutions' epistemic orientations and their contingent networks.

In what follows, I first provide a background to the emergence of evidence-based medicine (EBM) and evidence-based policy making (EBPM), its impact on global health practice and its central role in the creation of the field of global mental health. I explain how GMH became an evidence-based field and how GMH advocates successfully made the case, through the kinds of evidence privileged by EBM, for increased funding for mental health research and for increased research capacity building in low and middle-income countries (LMICs). Then, I begin to explore the impact of the increased global discourse on mental health needs in LMICs, the research agenda put forth and the promotion of global research partnerships in Nepal by exposing local critiques towards the research activities that are taking place locally. The critics are local mental health advocates and professionals that view research as an exclusive and extractive practice that is granting too much power to foreigners to interfere with – or have influence over – national policymaking. They are individuals that have seen their professional trajectories and ambitions influenced and challenged by the research agenda in GMH and who work for institutions that are ostensibly unable to access the same amount of resources for their programs or have as much policy influence as other local institutions with foreign academic networks, that do experimental research and generate scientific evidence for the GMH project. I take these local actors' grievances as an important point of departure and a call for the investigation that concerns the rest of the chapter; that is, for an analysis on the extent to which the GMH research agenda is shaping mental health developments in Nepal and the possible unintended, unanticipated and localised consequences of the entanglement of GMH research funds with possibilities of policy influence and care provision. I continue by exploring the validity of the local critiques through two case studies of mental health NGOs working in Nepal: Transcultural Psychosocial Organization (TPO) Nepal and Chhahari Nepal for Mental Health (CNMH). Both institutions included research as a foundational pillar to their organisation but have different orientations towards knowledge and the purpose of its production, including a different emphasis on generating knowledge that can guide mental health policy and practice everywhere. It is not the aim of this chapter to assess which one of these orientations is "good" or "bad", but rather to provide examples on how local epistemic projects are intersecting with the evidence based GMH enterprise and a reflection on the implications that the research orientations of local institutions have in the era of EBM and GMH.

I argue that institutions with an already existing intent to generate scientific evidence and peer-reviewed publications that can feed into the GMH knowledge base have become the primary recipients of GMH research funds. This forms an enclosed and circular funding mechanism that affects different institutions' political power, access to future funding, and other forms of prestige. The dominant epistemic position of institutions that have the intent of producing scientific knowledge serves to favour certain models of care over others that are promoted by institutions with different orientations towards knowledge production. Further, I suggest that mental health NGOs with less generalisable, scale-able and "global" knowledge production aspirations are also, increasingly, seeking out partnership opportunities with academic institutions based in HICs and directing efforts into research-*related* activities, including, for instance, the hosting of foreign students and researchers, to access resources that are used to continue providing care. This raises an important set of ethical questions concerning the increasingly blurred boundaries between research and service provision and leads us to revisit the issues flagged by the critical voices in the field with regards to research beneficiaries.

The rise of "evidence" in global health and its central role in the creation of global mental health

Evidence-based everything

The advent of evidence-based medicine (EBM) has been attributed to efforts by clinical epidemiologist Archie Cochrane in the 1970s in the United Kingdom and in the late 1980s and early 1990s, to another group of clinical epidemiologists in Canada, that sought to herald a new "paradigm for medical practice" in which scientific research evidence became the fundamental ground for medical decision-making. Since then, ever-increasing areas of practice have been rearticulated as evidence-based domains (Evidence-Based Medicine Working Group, 1992; Mykhalovskiy & Weir, 2004). What was novel about the EBM approach was not the claim that clinical medicine must be based on evidence, but rather the notion that all kinds of decision-making should be based on evidence of a particular kind. And it is this notion that has permeated not only several clinical practices, extending the notion of EBM to the broader evidence-based clinical practice (EBP), but to several non-clinical public policy areas where policymakers are increasingly encouraged to engage in evidence-based policy making (EBPM) – that is, to develop and justify policies based on scientific knowledge and "evidence" rather than political ideologies (Klein, 2000; Behague, Tawiah, Rosato, Some, & Morrison, 2009).

The original ambition of the EBM framework was said by its proponents to be to improve health care delivery and outcomes. The underlying logic and assumptions were that health outcomes could be improved if there was a stronger "scientific" foundation to clinical decision-making and practice. That is, if all clinical decision making and practice was based on the most reliable type of scientific research and evidence. Importantly, while evidence can take many forms, EBM produces a hierarchy of knowledge that privileges the quantitative/statistical, experimental, and epidemiological forms of evidence, and especially results from randomised control trials (RCTs), over other kinds of evidence, knowledge, and understandings (Adams, 2013). This hierarchy is commonly represented in a pyramid with systematic reviews of trial evidence and RCTs at the top, and expert opinion and observations at the bottom. Following EBM's logic, then, only certain research methodologies can produce the ideal type of knowledge that should drive decision-making and practice, which is knowledge that is "objective", "certain" and "reliable", and those scientific methodologies are epitomised in the RCT. The forms of evidence privileged by the EBM framework have come to constitute the gold standards in increasing areas of policy and practice, "the rock bottom to which new candidates for standards are compared" and which "defines the truth" (Timmermans & Berg, 2010, p. 27). This hierarchisation of types of evidence and knowledge has been critiqued by social scientists as being liable to create "epistemic injustice" – that is, a "wrong done" to a person or group of people "specifically in their capacity as a knower" (Fricker, 2007, p. 1), because it grants epistemic privilege to some individuals or groups of people over others. In favouring specific types of evidence (e.g. quantitative, statistical, etc.) other forms of knowledge (e.g. qualitative or experiential) are discredited as irrelevant and/or untrustworthy and subsequently marginalised.

Despite these critiques, the appeal of the EBM framework and the RCT model for increasing public policy areas has been powerful not only for what it affords in terms of "truth" claims for those who use it but also because of its purported promise to provide an effective, value-neutral, and apolitical way of guiding domestic and foreign investments. Supporters of EBM believe that using it can address problems of cost, quality, and access that torments health care systems everywhere by creating a consensus on "best practices" based on data and research that will ultimately eliminate "unnecessary", "unproven", and "ineffective" health care. Like that, the EBM framework ostensibly sets a reliable way of evaluating the efficacy of interventions and policies. It becomes a way of testing current policies and practices and of sieving through what is proven to "work" and what is not and guide public and private resource allocations in an impartial and effective way. In the field of development economics Abhijit Banerjee, Esther Duflo and Michael Kremer were awarded the Nobel Memorial Prize in Economics Sciences in 2019 for their experimental and evidence-driven economics approach to fighting global poverty in which conducting RCTs was at its core (cf. Banerjee & Duflo, 2011). Another area of practice that has widely embraced the promises of such a "legitimating strategy" (Lambert, 2006, p. 2636) and which concerns this thesis is the field of global health.

No global health without (generating) evidence

It would seem symptomatic of the expansion of EBM's logic and the embrace of the scientific method within public policy areas that within a couple of decades, research went from being a neglected powerful tool for health and development equity to becoming the *sine qua non* of all international health and development action. In 1990, the Commission for Health Research for Development (an independent international initiative with the aim of improving health and development in developing countries) published a report entitled *Health Research: Essential Link to Equity in Development* in which the authors stated that scientific research was a powerful tool to overcome health and development disparities that had until then gone under-recognised and neglected (Commission on Health Research for Development, 1990). Fifteen years after that, increasing numbers of high-profile international organisations were publishing reports with similar statements. The Global Forum for Health Research's 2005 report proclaimed, "*No Development Without Research"* (Nuyens & Global Forum for Health Research, 2005), language reflected again in the World Health Organization's 2012 health report "*No Health Without Research"* (WHO, 2011). Just as crucial as the EBM movement advocated for scientific research and evidence to inform decision making in the clinic, health research is highlighted in these international reports as being the essential basis for health, development, and for achieving equity in both.

The extent to which the field of global health has not only embraced EBM principles and practices but has institutionalised them led medical anthropologist Vincanne Adams to describe the field in 2013 as having been transformed into "an experimental research endeavour" where "good science" equals "good global health" (Adams, 2013, p. 34). Certainly, the demand for evidence-based interventions has spread to become, if not standard practice, at least a widely enough entrenched notion for one to be able to claim, in keeping with the language used above, that there is today no global health without research and the generation of scientific evidence. In great part, this has been due to the increasing pressures to satisfy donors' concerns around aid effectiveness and accountability conditionalities (Sharma, Khatri, & Harper, 2018). EBM standards of evaluation, with its production of "objectivity", offered a way of institutionalising donors' demand for more accountability. One of the defining, and neoliberal, characteristics of the landscape of *global* health vis a vis its predecessor *international* health is that aid recipients are required to demonstrate cost-effectiveness (value for money) and impact (measurable results) of projects and programs through scientific evidence (Biehl, 2013; Packard, 2016). These accountability structures using EBM standards that are central to global health practice have been said to shape how global health is done in profound ways: altering the way problems are defined and prioritised, and interventions implemented and evaluated (Sharma et al., 2018).

In evidence-based global health where research and evidence are required to guide action, advocacy also needs to be articulated in the language of scientific evidence. In the following, I briefly trace the emergence of an evidence-based approach to mental health service development focused especially on LMICs that kindled an ostensibly "new" global health field of research and practice called global mental health. I explain how global health research-practitioners successfully made the case, through the kinds of evidence privileged by EBM, for increased funding for mental health research and for increased research capacity building in

LMICs. Building on existing work, I want to suggest that the trope and the production of "evidence" has been central to the creation and perpetuation of the field and project of global mental health.

Global mental health – a field created and perpetuated by researchers through scientific evidence

Today global mental health appears to be a fully-fledged and distinct academic discipline and area of concern and practice. There are ever increasing amounts of dedicated textbooks (e.g. (Patel, Minas, Cohen, & Prince, 2013; Kohrt & Mendenhall, 2015; White, Orr, Read, & Jain, 2017; Escobar, 2020; Dyer, 2021), journals, training programs, advocacy platforms, institutions, and funding streams lending credibility and legitimacy to its coherence and stability. GMH champions such as Professor Vikram Patel have traced certain roots of this field to the birth of cross-cultural psychiatry and international mental health in the early twentieth century (Prince, 2013). More often, though, it is the World Mental Health Report (Desjarlais, 1995) and the WHO's first World Health Report dedicated to mental health entitled *"Mental Health: New understanding, new hope"* (WHO, 2001a) that are cited as being key influences for the field of GMH. Further, it is a series on GMH published in 2007 by the *Lancet* that is commonly referred to as the field's inaugural series. The *Lancet* is a world leading journal for general medicine and global health that periodically publishes a thematic series of articles where evidence is synthesised and used to call for action. These series serve to anchor disparate views, acting as a point of stability and reference for the mobilisation of resources. It may be precisely because of their function and the centrality of evidence to global health endeavours today that the birth of GMH is so often pinpointed at the publication of the 2007 *Lancet* series.

The Lancet GMH Group was composed of leading scientists, public health professionals, mental health advocates from UK-based academic institutions and the World Health Organization (WHO) who came together to provide what they called "evidence for advocacy" and make a call for action to scale-up the coverage of evidence-based services for mental disorders worldwide, especially in LMICs (Chisholm et al., 2007). The series was composed of six papers that drew on the forms of knowledge most valorised in the hierarchy of knowledge that emerged with EBM: namely, on systematic reviews and randomised research designs; and on psychiatric epidemiological studies using standardised diagnostic instruments in order to emphasise the magnitude of the problem(s) at hand; highlight the best technical solutions available, guide decision-making and resource-allocation and establish actionable goals and research priorities. The problem at hand, they proposed and argued based on scientific evidence, was the neglect of mental health worldwide and the disparity in the "treatment gap" (that is, the difference that exists between the number of people counted as needing mental health care and those receiving it) between HICs and LMICs. And this inequity, which they viewed as being at once a moral, political, and operational problem, required urgent and evidence-based action. It is important to note that many critiques have been offered with regards to the notion of a global "treatment gap" as it ostensibly ignores observations by medical anthropologists and cultural psychiatrists of culturally specific forms of suffering, coping, care and resilience (cf. Ecks & Basu, 2009).

At the time of the 2007 *Lancet* series, the authors argued that there was enough valid evidence from LMICs to justify the call to scale-up a basic package of services for four mental health conditions (schizophrenia, bipolar affective disorder, depressive episodes, and hazardous alcohol use as a risk factor for disease) and that there should be no delay in action on grounds of scarcity of evidence. But they also highlighted, echoing earlier concerns in global health, an important "evidence gap", also known as the "research gap" or the 10/90 problem, which was stunting the development of evidence-based health policies and practice in LMICs more generally. They stated:

> "Only 10% of the world's medical research addresses the health needs of 90% of the global population who live in LMICs. The adverse effect of this gap is potentially greater for mental health, which is heavily influenced by sociocultural factors and for which current practice and evidence is dependent on cultural norms from high income countries, especially Europe and the USA. Three recent studies have reported that only 3-6% of mental health research in high impact and indexed medical journals was coming from LMICs." (Chisholm et al., 2007, p. 1245)

And like that, the Lancet GMH Group framed an important operational barrier to service development in LMICs as a problem about knowledge (or lack thereof) of a particular kind. Indeed, the fact that the number of research publications in high impact and indexed medical journals is taken as a proxy to prove an evidence gap indexes an understanding that it is only the kind of knowledge that can be published in such journals that counts in guiding action and mobilising resources. Further, the authors highlighted the potentially even greater lack of knowledge about mental health needs of people living in LMICs relative to other health needs due to the Euro-American centric nature of the existing evidence base and the important influence social and cultural factors have on mental health. In line with EBM's principles and logic, the evidence gap needed rectifying through more research, if sound and responsible policies and practices were to be developed in LMICs.

To begin addressing the evidence gap, the 2007 Lancet GMH Group conducted an initial priority setting exercise to identify the specific gaps in the evidence-base in GMH and set research priorities focusing on four disorders: schizophrenia and other psychotic disorders, major depressive disorders and other common mental disorders, alcohol abuse and other substance abuse disorders, and child and adolescent mental disorders. These disorders were selected on the basis that they are major contributors to global burden of disease and there were known cost-effective interventions. This first priority-setting exercise suggested that research funding should focus on research to develop and evaluate mental health care that can be delivered by non-specialist healthcare workers and determine whether health systems can provide these interventions in routine healthcare. Strategies previously used in global health, such as task-shifting, namely the process where specific tasks are moved where appropriate to non-specialists with shorter trainings and less qualifications to make more efficient use of the limited specialist human resources available, required "proof of concept" for the GMH agenda. In turn, this meant there was a need for a stronger evidence-base, not only with more randomised controlled trials but more implementation research guiding the integration of evidence into health-care policies and practices. Since the initial priority-setting exercise, many others have taken place (cf. Sharan et al., 2009; Tomlinson et al., 2009). Most notably were the

Grand challenges in GMH, where the need for research-generated information for discovery and delivery science "to provide programme planners, clinicians and policy-makers with effective care packages" emerged as a leading challenge (Collins et al., 2011, p. 28-30). And so, the field of GMH emerged as an evidence-based field for which the trope and the production of evidence was central to its creation.

To make progress in addressing the research agenda that would allow the production of the appropriate and necessary evidence to inform the development of evidence-based guidelines and their implementation into policy and practice, GMH advocates emphasise the centrality of research collaboration through partnerships and networks (Collins, Tomlinson, Kakuma, Awuba, & Minas, 2013; Patel et al., 2013).

The notion and ideal of "partnerships" emerged in the field of international development before influencing global health discourse and practice (Herrick & Brooks, 2018). The history of "partnership" as an ideology and a modality of development assistance has been traced back in the international development literature to 1969 when the Pearson Commission on International Development evaluated the effectiveness of the World Bank's development assistance in the twenty years prior and promoted partnership work for future work of the Bank in their report "*Partners in Development"* (cf. Maxwell & Riddell, 1998; Harrison, 2002; Mercer, 2003). Discourses of "partnership" and "participation" became part of a new ethic and orthodoxy promoted within international development as a break and move away from the past which was characterised by the economic development policies of structural adjustments and their conditionalities that had positioned donor and recipient in a relationship of unequal exchange (Mercer, 2003). This new ideology that foregrounded values of equity, collaboration, and mutual respect between donors and recipients was to signal an ostensible transformation in North-South relations and global governance (Abrahamsen, 2004; Andersen & Jensen, 2017). In global health, the partnership modality of funding and working emerged in the 1990s and was initially applied to vertical interventions to address single diseases such as HIV/AIDS, TB, malaria and child and maternal health but is increasingly used to fulfil health systems strengthening mandates and global health workforce issues (Herrick & Brooks, 2018).

Research collaborations and academic partnerships across high and low resource places are also embraced by global health practitioners and policymakers as being the best way to address the evidence gap on mental health in LMICs. They are seen as important to answer key and complex questions in the field, access funding, influence policy, ensure interventions and policies are relevant, feasible and ethical, and to build research capacity in LMICs (Collins, Insel, Chockalingam, Daar, & Maddox, 2013; Kohrt et al., 2014).

Prior to the 2007 call for greater investments in building the GMH evidence base, a few funding agencies had already begun addressing the need to invest in building research capacity in LMICs, for instance, by requiring projects to allocate a certain amount of time and resources to capacity-building efforts (e.g. The UK Department for International Development's Research Programme Consortium), or to focus their efforts on enhancing LMICs' capacity for applying research findings into policy making (e.g. the WHO Alliance for Health Policy and Systems Research). Since then, a wider range of funding bodies including several bilateral agencies such as the UK Department for International Development, the Canadian International Development Research Center and Grand Challenges Canada; multilateral agencies such as the

WHO and the European Commission; research institutions and private donors like the Wellcome Trust, the Gates foundation, and the US National Institute of Mental Health are increasingly allocating resources toward GMH research projects. There are also wider international, and intersectoral alliances of mental health research funders being created to leverage the collective funding efforts from charities, philanthropies, public figures, and industry to achieve "greater impact" (e.g. The International Alliance of Mental Health Research Funders https://iamhrf.org). Over the last fifteen years, these investments have enabled a greater number of research trials conducted in LMICs, the establishment of collaborative hubs for research excellence (cf. the National Institute for Mental Health five-year initiative for Collaborative Hubs for International Research in Mental Health), and multi-sited implementation research studies exemplified by the DfID funded "PRogramme for Improving Mental health Care" (PRIME) and the "Emerging MEntal Health Systems in Low- and Middle-income countries (EMERALD)" project funded by the European Commission.

In the following, I begin to explore certain impacts of this increased global discourse on mental health needs in LMICs, the promotion of global research partnerships and the increasing investments in GMH research in Nepal. It is within this wider context I have described that mental health NGOs in Nepal are working and within which people like Sachit – the Nepali psychologist we met at the start of the chapter – are looking for work. As explained at the outset of the chapter, Sachit's work opportunities were directly shaped by the GHM research agenda. In his case, the previous exposure and experience he got doing experimental research meant that was offered another job to continue supporting the production of evidence for the GMH knowledge base. However, other local mental health actors experience the wider context within which their advocacy efforts and work takes place very differently. It is to their voices that we now turn to.

Local grievances: research experienced as an exclusive and extractive practice

Speaking to Nepali mental health advocates and professionals about their perceptions of mental health research activities rapidly suspended the seemingly unproblematic arguments about the unequivocal benefits of research for equity in health and development that are stated so assertively and ubiquitously in international reports. The conversations opened a space of critical reflection on how research agendas and activities are intersecting with the lives of, and experienced by, differently positioned actors. The voices I briefly sketch out here are the more critical voices in the field, as they raise ethical and practical issues that are important to consider at a time when bilateral and multilateral agencies, research institutions and private donors are (albeit, slowly) increasing the resources they allocate towards GMH research projects.

Research activities are not always perceived as a public good by mental health advocates and professionals working in Nepal. The reservations they express are about the exclusivity of the practice, the extractive approach of most of it, and about whose agenda and interests they believe mental health research carried out in Nepal has, so far, satisfied and benefited. An advisor at a mental health NGO also described it as a "sad irony" that the organisation she was associated with was able to access resources in the name of research, but not when applying for resources to support their long standing program. She felt research funding was diverting resources from much needed services.

Often research was described as a foreign-led and foreign-benefiting endeavour – an activity carried out, thus, by a certain kind of "other" who sits on the privileged side of existing global power structures with easier access to resources and international travel. A Nepali psychiatrist practising in Kathmandu said, "the whole concept of research in Nepal is foreign-driven" and "researchers come for their own purposes". Even though he was also engaged in training to establish himself in the field of mental health research by pursuing a doctorate from a university in a foreign country, he remained critical of foreign researchers whom he believed were often the real beneficiaries of research done in Nepal. I felt there was a certain contradiction between the critique my interlocutor was expressing, an echo of historical critiques regarding the real "beneficiaries" of development in Nepal (cf. Chene, 1996) and his personal experience, and reality, of being a local researcher himself. This incongruence could be interpreted as being symptomatic of the rapid social changes taking place in Nepal and perhaps indicate the need for a more nuanced understanding of the power dynamics within research.

Another local mental health advocate who had dedicated his life to advocating for mental health care improvements within a human rights framework and who felt his advocacy efforts were undermined by other institutions with foreign academic networks, also saw mental health research in Nepal as a foreign-led enterprise. However, he blamed "the Nepali system" and certain "undignified" cultural practices of bureaucrats and universities alike for enabling and perpetuating such an unequal endeavour. In his own words:

> "They [a local mental health NGO doing GMH research] have back-up, more than eight or nine universities based in Europe and in the US. They design the research there and then they conduct it here. It is cheaper here and there are no strict rules like in Europe in terms of approaching respondents. It is also easier for foreigners with back-up from foreign universities to come to Nepal, take some government bureaucrats, give them consultancies and night by night, day by day, and of course they [the government] will endorse whatever they [researchers] propose in the country…in the country where I was born and raised, in the country that I care about, and that I am loyal to. I do not blame anyone – it is the Nepali system. I wish our system would be stronger and that foreign and Nepal universities had more dignified ways to make the relationship equal balance."

Somewhat akin to the ideal approaches to planned development in the 1950s, this advocate saw mental health research as being conjured up elsewhere, "they design the research there", and put into practice in Nepal, "and then they conduct it here". He suggests a lack of research ethics in a comparatively less regulated legislative environment, denounces the unequal balance between academic "partners" and resents the power scientific research grants foreigners to shape national policy making. His sentiments and critiques are not unique. They resonate loudly with critiques put forth by critical global health and development scholars who have also highlighted the inherent inequalities and ethical tensions in North-South "partnerships" (Crane, 2010; Sharma, Khatri, & Harper, 2016; Citrin et al., 2017).

Mental health research activities were seen so much as being a foreign venture that in telling me about his plans for his organisation, a local psychologist and founder of a new mental health NGO said he was planning "to conduct a summer camp in Nepal for foreign psychologists and researchers" and explained that he was "searching a few connections with university professors in the US" as he was convinced that if he had a good connection with one or two university professors they would send their students for research "and then the community can get service". Thus, "building a good connection" with foreign scholars, entertaining them, and providing the right environment for them was a strategy he had come to understand as being a viable way to get funds that could trickle down and be used to provide services to the community. This psychologist was actively and strategically positioning himself to broker between university professors with their potential research funds from HICs and the local communities and their needs. Another psychiatrist, now retired, reflected on her experience and feelings of being an informant for a number of foreign-led research projects, commenting on the extractive nature of it. She said,

> "They are students who came here, attached to the department of health. And I am very friendly, you know, and naïve, so I had all these expats coming, first for half an hour, they nipped my brain for one hour and after I said…wait a minute, what is happening here? Why are you here? They are taking everything out of me, and I am drained, you know, emotionally, having to talk, talk, talk and I have pending things which I need to attend to myself that no one else is going to do for me. So, I started declining. I have seen such behaviour with my own eyes, people will go and take out the thing and do like that (she dusts off her hands) and then in their CV they will write you know, on that basis they will get a good job and then they will come back to Nepal because they are Nepal specialists now, you see?"

Taken together, these grievances raise important ethical and practical concerns that speak directly to global mental health practitioners themselves who aim to move from "science to action" (Patel, 2012), establish equitable collaborations in global research partnerships (Ruiz-Casares, 2014) and to strike the right balance between generating knowledge and enabling appropriate and sustainable care (Patel et al., 2013). Moreover, more recently, GMH practitioners have also been increasingly questioning and reflecting on what "equitable" may mean within a decolonial framework (Khan et al., 2021; Khan, 2022). I take these grievances as a motivation to further an analysis of the possible unintended consequences (Mosse, 2005a) of the GMH research agenda, and its effects on policy making and care practices around mental health in Nepal. The following section will take institutions and their research practices as the unit of analysis and further explores the validity of the outlined critiques. As I will go on to show, local mental health NGOs in Nepal increasingly find themselves acting as brokers between multiple worlds: translating between global mental health research priorities and local care needs, between international evidence standards and local forms of knowledge production, and between foreign funders' requirements and local organizational sustainability.

Two cases of mental health NGOs and research practices in Nepal

The case studies I present below describe two diverse mental health NGOs working in Nepal, Transcultural Psychosocial Organization – Nepal (TPO Nepal) and Chhahari Nepal for Mental Health (CNMH), that advocate for distinct modalities of care and have different orientations towards knowledge and the purpose of its production. TPO Nepal promotes a psychosocial approach to mental health and was born out of a large international humanitarian institution with a positivist approach to knowledge and pragmatic attitude towards research that was developed with the primary intention to generate scientific knowledge that could travel – with adaptation – to guide mental health policy and practice everywhere. CNMH advocates for a social model of care and illustrates a different orientation to knowledge and its production; one that stemmed from the desire of the founder to be a "reflective practitioner", to establish her NGO as a "learning organisation" and to foster critical thinking and a learning environment. In what follows, I trace both institutions' histories to explain how each institution and their epistemic projects came to intersect in particular ways with the evidence based GMH enterprise. I argue that research orientations have power implications in the era of evidence-based global mental health.

The data I draw from comes from information available on the respective mental health NGOs' websites, and documentation including research publications, as well as from interviews with the NGOs' staff. In narrating the institution's histories, I review some of the organisations' academic outputs as well as internal documents. In my descriptions of CNMH I also rely on insights drawn from my own observations from when I volunteered for the organisation during fieldwork – a level of direct engagement I did not have with TPO Nepal.

As discussed previously (cf. Introduction), it is important to note the differences in my engagement with and access to these two organisations, as this shaped the data and analysis I present. My relationship with CNMH was more direct and sustained – I volunteered with them during fieldwork and had extensive opportunities for participant observation of their daily operations. This provided rich ethnographic data about their organisational culture and approach to knowledge production. In contrast, my understanding of TPO Nepal comes primarily from interviews, document analysis, and their extensive publication trail. While I had some interactions with TPO Nepal staff, I did not have the same level of embedded access to their daily operations.

These differences in access reflect broader patterns in how organisations position themselves within Nepal's mental health system. Smaller NGOs, like CNMH, operating primarily at a local level, often maintain more open and permeable institutional boundaries. In contrast, larger organisations like TPO Nepal, with their established international partnerships and significant policy influence, tend to maintain tighter control over how their work is represented and documented. While my reliance on formal documentation for understanding TPO Nepal means I necessarily analyse their carefully curated institutional narrative rather than the complex daily realities that ethnographic observation can reveal, this methodological constraint itself illuminates important dynamics about institutional authority and knowledge production in Nepal's mental health system. The very ways that different organisations manage their visibility and accessibility to researchers reflect their relative power positions and their distinct approaches to producing and sharing knowledge.

TPO Nepal: Embracing positivism and pragmatism to promote psychosocial care in Nepal and around the world

Foundations: networks, epistemologies, and goals

The roots of TPO Nepal can be traced back to what were two separate Netherlands-based INGOs: HealthNet International and TPO, which merged in 2005. HealthNet International had been accumulating knowledge and experience in strengthening healthcare systems in war-affected contexts since 1992. TPO (previously IPSER: International Institute for Psychosocial and Socio-Ecological Research) was established by Prof. Joop de Jong, a European psychiatrist and scholar, and became the largest relief organisation specialising in mental health and psychosocial (MHPS) care for trauma affected populations in conflict and disaster settings. Together, they became HealthNet TPO: an NGO and global aid agency, with TPO's founder as chief executive. HealthNet TPO now focuses on developing and implementing evidence-based interventions to strengthen the health of populations in distress and leans on an approach informed by its leader's inter-disciplinary background, combining insights from his psychiatric, epidemiological, psychotherapeutic, and medical anthropological academic training, as well as from his practical experiences as a humanitarian working in conflict settings across Africa and South Asia. HealthNet TPO follow what they call a public mental health paradigm seeking to develop sustainable, culturally appropriate community-based psychosocial support systems. They attempt to:

> "capitalise on opportunities that arise in the context of limited human resources and inadequate infrastructures in order to build systems of care that focus on accessible, acceptable and effective community services. It uses operational and scientific research to develop effective, evidence-based, and context-sensitive models of care in complex emergencies and works on capacity building geared towards sustainability" (Patel et al., 2013, p.18).

TPO's first intervention in Nepal was in the mid-1990s and was justified by the understanding that two complex emergencies, the Maoist insurgency and the Bhutanese refugee crisis, would cause collective traumatisation and an increase in human rights violations (cf. Chapter 2). Initially, they worked in partnership with the Center for Victims of Torture (CVICT), a local NGO established in 1990 by the Nepali medical doctor, Bhogendra Sharma, to prevent torture and rehabilitate torture survivors. Together, CVICT and TPO provided medical, legal, and psychosocial rehabilitation programs to populations affected by political violence whilst simultaneously carrying out population-based epidemiological studies (Shrestha et al., 1998; Van Ommeren et al., 2001) and testing and preparing instruments for transcultural research (van Ommeren et al., 1999, 2000). From the initial focus on torture survivors and refugees, they expanded their target group to other groups suffering from human rights violations and trauma, particularly children and women. Their collaborative efforts were facilitated by the availability of donor funding for psychosocial support in humanitarian and conflict-affected settings focusing on treating trauma (Seale-Feldman, 2019).

CVICT and TPO shared a vision and mission to institutionalise psychosocial counselling through guidelines and training curriculums (Jordans, Tol, & Sharma, 2003; Jordans & Sharma, 2004) and integrate the modality of care into existing systems of care in Nepal. They saw psychosocial counselling as an essential component that was missing from a holistic care system, and that needed to be developed. In a paper published by scholar-practitioners working for CVICT and TPO in 2003, they state:

> "Counselling is clearly only one element of overall care. Though the emphasis in counselling lies on helping the client with alleviating distress directly through the counselling sessions, it acknowledges that other agents of care are vital in recovery or healing, namely the family and other community structures (such as the school, women's groups). Such primary agents of care should be the fundament of the care pyramid. Nevertheless, one needs to simultaneously plan interventions for a certain percentage of the experienced problems that cannot be dealt with at this basic level but do not directly need specialised care either (the top of the care pyramid; doctors, psychiatrists, psychologists). It is exactly between these two levels that the training programme aims to put care interventions in place." (Jordans et al., 2003, p.19)

Already in 2003, TPO and CVICT practitioners were referencing the image and notion of a "care pyramid" that is divided up broadly in three to four levels of care going from the first level at the base of the pyramid representing the largest number of people in society that will require non-specialized support, to the highest level at the top of the pyramid representing the smallest proportion of people that will require the most specialised mental health care services. In 2007, this "care pyramid" became a central notion, image and guiding principle enshrined in international guidelines for mental health and psychosocial support in emergency situations (IASC, 2007) (see Figure 1).

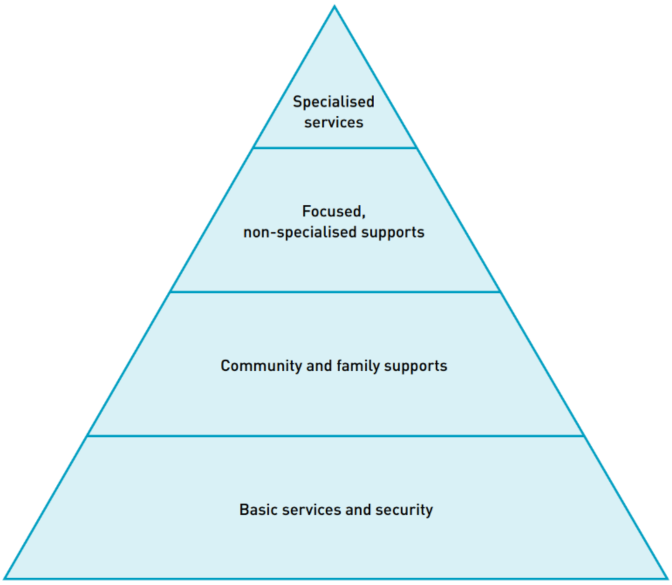

Figure 1. Intervention pyramid for mental health and psychosocial support in emergencies (IASC, 2007, p. 12).

Back in 2003, CVICT and TPO acknowledged that there were many other organisations working in Nepal that were claiming to already provide "psychosocial counselling" services within their programs but argued they "rarely corresponded to the common notion of what psychosocial counselling *should be* (my emphasise)" followed by a reference to an internal document produced by UNICEF which described a situation analysis of counselling in Nepal (Jordans et al., 2003, p. 18). Although deemed inadequate or incomplete, CVICT and TPO took the already existing efforts to provide psychosocial counselling as indexing a growing need for skilled counsellors and for "adequate training programmes" to train them; an endeavour they went on to undertake (Jordans et al., 2003). In 2004, internal accusations of corrupted practices within CVICT precipitated TPO to break away from CVICT and a year later, TPO Nepal was officially established as an independent organisation, remaining in close affiliation with HealthNet TPO and their international psychosocial model.

TPO Nepal was established, then, in 2005 by a team of foreign humanitarian scholars linked with Netherlands-based HealthNet TPO, and Nepali mental health advocates. Since its inception, TPO Nepal has mostly been run by local staff, but European and American scholars have always played a central role in securing funding for the continuation of the NGOs' activities. Although this is changing over time, initially it was also the foreign humanitarian scholars who brought with them the "technical knowledge" and "expertise", as well as the international influential networks they had established through working with Healthnet TPO, that facilitated the production of scientific research. The Nepali NGO's mission was closely aligned to the INGO they had ostensibly separated from; namely, "to promote psychosocial well-being and mental health of children and families in conflict affected and other vulnerable communities through development of sustainable, culturally-appropriate and effective community-based psychosocial support systems" (TPO Nepal, 2010, p. 1). Further, they worked on what they called an integrated program, with five separate but interlinked areas of practice (see Figure 2).

Research: on psychosocial needs, existing systems of care, effectiveness of interventions

Intervention design: culturally-appropriate, community-based and sustainable

Building capacity: of community members and staff of local organizations to provide psychosocial care and support

Psychosocial service provision: individual, family, group counseling, self-help and support group facilitation, class-room based interventions

Advocacy: on mental health issues and policy

Figure 2. Figure depicting the integrated program of TPO Nepal (TPO Nepal, 2010, p. 2)

Embedding research into programmatic funding and creating an evidence base for psychosocial care and counsellors

Underlying TPO Nepal's efforts is a conviction that research and intervention should go hand in hand and inform one another. A senior past member of the organisation explained to me that from their first funding proposal, they decided to insert a research component into it. This allowed them to provide a psychosocial care program for children affected by armed conflict whilst concurrently conducting an RCT. He explained where the research emphasis for TPO Nepal came from:

> TPO Netherlands was started by the academician [sic] Prof. Joop de Jong. And this professor already had this concept that we have to do research. When [TPO Nepal founder] came to Nepal we discussed, you know; if we do pure research organisation it is not going to help, because we also need a program. So, we discussed, we wanted to do program and research side-by-side, so that program should support the research: generating data, new research questions, and the research evidence should support program and policies. So that was the concept. And in our first program we did a randomised control trial on the classroom-based intervention.

From the way he describes the initial conversations about the vision and mission for TPO Nepal, it appears as though there was the possibility for TPO Nepal to become a "pure research organisation", but that they felt that it would have been difficult to justify on moral grounds given the community needs for services. What is clear is that from the very beginnings of TPO Nepal, the will, intent, and possibility of carrying out scientific research, including RCTs, was present and central to the institution's agenda. The logic was that doing research on the interventions they offered to communities would generate scientific evidence to (hopefully) support the efficacy of the programs they were offering and thus validate the intervention; and that the intervention itself would support the continuation of the research endeavour. Indeed, the conversation my informant was recalling and relaying to me seemed to have revolved more around the pursuit of evidence than the pursuit of health outcomes.

From their first RCT intervention onwards, my informant explained,

> We made sure that in every program, we inserted the needs assessment component in the beginning, and then some kind of final evaluation or project evaluation or qualitative study in the middle. So, depending on the donor, some didn't like the research at all, so we had to compromise, but most of them liked it and we continued the program proposal with a small component of research [...] And then because of our track record, doing small, small research, that brought us in connection with universities. In 2010 we were able to collaborate with big universities like King's College London, and others, so we were able to have research grants but having the program inserted. So just the opposite. Because we thought look if we just do research program, you know, theoretical program, that is not going to help anyone and for our sustainability also it is not good, so we did the opposite of what we were doing before.

From 2005 to 2010 TPO Nepal worked by inserting a research component into programmatic funding, building their research capacity and publication track record. It is interesting to note that my informant explains how some donors were not open to the research component the NGO was proposing as it seems counter-intuitive considering the increasing demands for impact and outcome evaluations from funders. TPO Nepal became skilled brokers between global research demands and local program implementation. Their staff translated global mental health research priorities into locally feasible interventions, while simultaneously translating local practices into the forms of evidence required by international donors and academic partners. By wanting to add a research component into programmatic funding, TPO Nepal were tapping into an ambiguous space where the boundaries between program and research were blurred and did not fit into the previous frameworks used by donors that were either solely focused on programming and impact or donors interested in research, potentially falling out of the purview of either. My informant explains how TPO Nepal's publication track record later served to position themselves favourably when GMH research funding became increasingly available after the call for more investments in evidence based GMH practices. Until 2010, 48% of TPO Nepal's costs were associated with programs and only 5.6% went under the heading of research (TPO Nepal 2010 Annual Report). This changed drastically over the years, and in 2018, 26% of TPO Nepal expenses were accounted for by program costs and 36% by research activities (TPO Nepal annual report, 2018). Initially, TPO Nepal was funded mainly by Save the Children US and UNICEF and, with a staff of less than 20 people and a budget of around 50 thousand dollars, they provided psychosocial care to children and families affected by political violence (e.g., Internally displaced people; children associated with armed forces and armed groups). With the support of their main donors, they continued to expand their psychosocial interventions to different groups including victims of sexual violence/survivors of gender-based violence, children and families affected by HIV/AIDS, trafficking survivors/commercial sex workers, victims of emergencies, disabled children and families, and human right workers. These were all stand-alone interventions.

Research funding enabling policy implementation and service delivery – Embedding psychosocial care and counsellors into Nepal's health care system

From 2011, TPO Nepal's main source of funding changed as the organisation's epistemic project began to intersect with that of the evidence based GMH enterprise and they became Nepal's country-based research and implementation partner for large-scale cross-country global mental health research consortia. Due in part to these consortia, and the ideological shifts in aid modalities at the time, TPO Nepal changed from working through stand-alone interventions to working in closer collaboration with the government focusing on health systems strengthening and sustainable development. What the implementation of these consortia and other subsequent cross-country research projects[1] certainly meant for TPO Nepal was that they became an important node for the GMH network as they translated GMH

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[1] e.g. "Mental HEalth Beyond facilities (mhBEF)", "Problem Management Plus (PM+)", "Optimizing Provider Attitudes and competence in Learning mental health systems" (OPAL) and "HEalth Action in ScHools for a Thriving Adolescent Generation (HASHTAG)"

strategies into practical and operational mechanisms. In this role, TPO Nepal performed crucial brokerage work between global mental health research agendas and local implementation. They translated global research protocols into locally feasible interventions, converted local experiences into forms of evidence legible to global audiences, and mediated between international funders' requirements and ground realities. This brokerage position required constant navigation between different epistemic frameworks and institutional demands. I will also suggest, through the brief example of the first GMH research consortium implemented in Nepal, that the implementation of these consortia has helped establish TPO Nepal as a dominant institution locally.

The first GMH research consortia in Nepal and implemented by TPO Nepal was called the "PRogramme for Improving Mental health Care" (PRIME) which ran from 2011 to 2019. PRIME was designed and funded as an implementation research project which means it was a project intended to generate scientific evidence of methods and strategies that facilitate the uptake of evidence-based policies and practices into routine practice. PRIME's goal was to develop and evaluate a strategy for the integration of mental health into primary healthcare for priority mental disorders (based on the WHO's mental health gap action program) in five LMICs including Nepal (Lund et al., 2012). It was set up as a Southern-led consortium led by a centre at the University of Cape Town, with academic research institutions and NGOs in five countries, including Nepal. The PRIME team included support from international partners such as the WHO and renowned UK-based institutions like the Center for Global Mental Health, King's College, Basic Needs, and the Perinatal Mental Health Project at the University of Cape Town.

The country-partners were said to be chosen according to the consortium's strategic need for diversity in contexts that would enable fruitful cross-country comparisons, and because of the presence of research institutions in each country with "a strong, established track record demonstrating their capacity for carrying out research" and that had "forged strong local partnerships involving the Ministry of Health, other academic institutions, and non-government organisations" (Lund et al., 2012). The compliance to these criteria was perhaps what my informant was referring to when he explained that it had been TPO Nepal's research and publication track record that had enabled them to access bigger research grants within which they did a lot of interventions. Whilst TPO's Nepal's pre-existing relationship-building work with local stakeholders and their proven ability to produce scientific research were no doubt crucial to being able to access GMH research funding, it should not be forgotten that prior to and underlying their proven capacity, was a particular epistemological orientation and epistemic project of the scholars and practitioners involved in HealthNet TPO/TPO Nepal. They held a particular understanding, in accordance to evidence-based practice, of what type of "evidence" counts in guiding mental health policy and practice, as well as the intention to generate the scientific knowledge to guide such policies and practices; an epistemic orientation and project that aligned with the research agenda of the evidence based GMH project.

Each country-based academic partner involved in PRIME partnered with their respective Ministry of Health (MoH). The partnership with the MoHs was important not only to be able to ostensibly align research questions with national policy priorities but for the academic partners to be able work through different levels of government structure (health organisation; health facilities and community) and fulfil the aims of PRIME of setting up a district demonstration site and ensure governments' up-take of the PRIME results and best practices. TPO Nepal's relationship with the Ministry of Health exemplified their complex brokerage role. They had to translate between global mental health frameworks and national policy priorities, broker between international research requirements and local government processes, and mediate between different institutional timelines and accountability structures. This work involved not just technical translation of interventions, but careful navigation of political relationships and institutional hierarchies.

PRIME was divided into three phases: an initial "inception" phase where country-based academic partners drafted, in collaboration with the MoH, a mhGAP-based district mental health care plan (MHCP) comprised of evidence-based intervention packages to be implemented at community, health facilities and health service organisation levels (Lund et al., 2012). All the MHCPs included elements of raising awareness, improving detection, improving access to treatment, recovery, and other systems-level interventions that would enable the services to be delivered. In the second phase, the MHCP was implemented, and its feasibility, acceptability, and impact evaluated (Lund et al., 2012). Finally, in the third phase, the plan was scaled-up either district wide or to other districts, and again evaluated (Lund et al., 2012).

In Nepal, within the parameters of this research consortium and enabled by its accompanied resources, a MHCP comprised of twelve evidence-based packages targeting psychosis, depression, alcohol use disorders and epilepsy was developed and agreed upon with the Ministry of Health and Population (MoHP) and implemented in district-wide in Chitwan, a district in the southern plains of the country, through the government structure. Over the course of developing and implementing the MHCP, TPO Nepal placed itself at the forefront in designing, adapting, validating and implementing intervention packages; developing, piloting and validating tools (e.g. Community Informant Detection Tool, CIDT), scales (e.g. the Enhancing Assessment of Common Therapeutic factors rating scale) and questionnaires (e.g. Patient Health Questionnaire, PHQ-9); standardising training manuals and training packages, training thousands of government primary health and community workers, and guiding policy development. Moreover, they generated evidence at every step of the development, the implementation process, and the evaluations (outcomes and process), of the strategy to integrate mental health into primary health care and published their findings and experiences widely in top tier journals[2]. All these efforts and recognised achievements reinforces the institutions' social prestige and status and its political influence and power. The resources and formal partnerships with government made for important mental health system strengthening outcomes such as the capacity building of thousands of government primary health care workers[3]; the establishment of referral pathways and the addition of six psychotropic medications added to the country's essential drugs list, that are credited to TPO Nepal's efforts. Finally, TPO Nepal also leveraged their involvement in PRIME to integrate elements of the

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[2] E.g. *The British Journal of Psychiatry; BMC International Health and Human Rights*; *BMC Psychiatry*; *Conflict & Health*; *Behavior Research and Therapy, PLoS Medicine, PLoS ONE, BMJ Global Health.*

[3] Three types of primary health care workers were trained: prescribers (i.e. the group that is mandated to prescribe medicine); non-prescribers (healthcare providers that are not mandated to prescribe medicines) and Female Community Health Volunteers (FCHVs).

modality and model of care they advocate for into the MHCP. In the paper that describes the development and the pilot testing of the MHCP in Nepal, Prof. Jordans and his colleagues explain:

> "…the plan involves a new cadre of community counsellors that serve to bridge the gap between community-based care and facility-based care. This service delivery agent can safeguard and bolster the psychosocial care function within the overall care system. It should be noted that this is a new position within the Nepal health system, thus requiring significant additional resources. At the same time, extensive experience in community psychosocial interventions by TPO Nepal should ensure the feasibility of including this care package within the overall MHCP, at least initially" (Jordans, Luitel, Pokhrel, & Patel, 2016, p. s27).

Over the course of PRIME, TPO Nepal generated further evidence on the benefits of involving community counsellors into the overall care system which serves to further advocate for their policy interest. Four years after the initial description of the MHCP, another paper was published describing the process of implementation of the MHCP and its evaluation in Nepal in which the need for community counsellors to look after psychological interventions in the community resurfaced, this time based on robust scientific evidence (Luitel et al., 2020). The authors write:

> "A randomised control trial embedded within the PRIME cohort study demonstrated that a psychological intervention (i.e. HAP) delivered by community-based psychosocial counsellors increased treatment effects for depression compared to those who only received mhGAP-based services in primary care." (Luitel et al., 2020, p. 9).

Furthermore, the need for a separate cadre of psychosocial workers was highlighted as a key lesson learnt from PRIME for future integration of mental health services within primary care in Nepal (ibid). It could be said that the research outputs were being used to support pre-existing policy interests.

Once the research funding finished, and the NGO-supported project was phased out; the government lacked the financial resources and/or political will to sustain – never mind scale up – the implementation. However, the expertise, evidence, tools, and manuals generated by these projects gained a lot of traction and are used to demonstrate "success" and impact of the project.

In Nepal, PRIME results and best practices were used to inform the community mental health care treatment package (PHCRD, 2017a), a standard treatment protocol for mental health services into primary health care (PHCRD, 2017b) and the development of many training materials (Luitel et al., 2020). With technical support from TPO Nepal, there were four modules for mental health and psychosocial training that were subsequently standardised by the National Health Training Center (modules 1, 3 and 4 had a psychosocial focus for non-prescribers, and module 2 is used for the training of prescribers focusing on pharmacological intervention). These modules then form the basis upon which many trainings are conducted around the country. TPO Nepal's strong influence is noticeable on many levels within government documents (e.g. community mental package and the standard treatment protocol). The evidence the documents are based on is evidence mainly produced by TPO Nepal; as are the resource materials used such as information, education, and communication materials. TPO Nepal and/or its representatives and experts are acknowledged and highlighted as lead technical advisors by national policymakers. As Sharma and colleagues (2018) noted after they mapped the institutions and networks involved in getting the use of misoprostol for the prevention of postpartum haemorrhage into national policy in Nepal, sustained lobbying and getting the "right people" on board can be as important drivers in influencing state policy as the quality of an intervention itself. They argued that the quality of relationships and networks were as important, if not more so, than the quality of evidence and that there is a lot of investment that goes into making the research visible to politicians and policy makers. Thus, one may view the relationship-building that takes place under the auspices of large global mental health research projects between national policymakers and TPO Nepal as having important consequences with regards to state policy influence. The insights and evidence presented in this chapter provide additional support for this argument.

PRIME is but one example of the many subsequent GMH research consortiums and cross-country research projects TPO Nepal has gone on to implement and through which they continue to establish their dominance in the field of MHPSS in Nepal. In fact, to date, TPO Nepal has been the exclusive implementation agency and research partner for GMH implementation research conducted in Nepal. Fifteen years after they began working, TPO Nepal now employs between 100 and 400 staff depending on the country's situation (increasing substantially in the aftermath of a crisis) and operates with a budget of up to 1.5 million USD. They receive funding from powerful institutions such as the United States' National Institute for Health Research and the National Institute of Mental Health, the Bill & Melinda Gates Foundation, the European Commission, the Wellcome Trust and the UK's Foreign, Commonwealth and Development Office and the Medical Research Council. They are partners with many UN agencies (e.g. UNICEF and UNHCR) humanitarian organisations (e.g. International Medical Corps, USAID, IsraAID, Americares, Australian Aid, Red Cross, Cordaid) as well as with many development organisations (e.g. WHO, Terres des hommes, Save the Children, The Asia Foundation) and academic institutions (e.g. Duke University, McGill University, King's College London, University of Liverpool and Yokohama City University).

The brief institutional history and case study of TPO Nepal is illustrative of the potential synergies that can, and are, created between the GMH research agenda and some local mental health institutions working in low resourced settings. However, it also flags the fact that these synergies may be contingent on the epistemic frameworks within which the institutions operate, their research orientations and their networks. Indeed, the affinity between the knowledge and research orientation of practitioners involved in HealthNet TPO/TPO Nepal with the GMH evidence-based endeavour has made, on the ground, for one local institution to become the primary (and exclusive) recipient of funds for GMH research. Because GMH research donors are investing in implementation and service delivery research projects that are looking for the public health impact of science (that is, for the uptake of research findings and other evidence-based practices into routine practice), the power implications for who receives these resources (with the accompanied accountability mandates for "real-world" impact) and who does not, are very important to consider. As shown in chapter 3, there is a great diversity in the modalities (and service delivery models) of care being advocated for by different local institutions in the mental health system in Nepal. With research funds enabling much mental health policymaking and practice in the country, one may assume the privileging of one local institution over others affects who gets to influence what moves into state policy, and risks affecting the advocacy and care efforts of other institutions practising/promoting a different modality of care because of their disparate epistemologies and/or epistemic projects.

In what follows, I explore further this risk and assumption with the following contrasting case study. I present the case of Chhahari Nepal for Mental Health (CNMH), a small local mental health NGO with a different orientation towards research and distinct ideas about the purpose of knowledge production. How has CNMH and their own epistemic project intersected with the evidence-based GMH project? Are their practices and opportunities being thwarted by the GMH research agenda? And if so, in what ways?

Chhahari Nepal for Mental Health (CNMH)

Foundations: networks, epistemologies, and goals

CNMH was formally registered as an NGO working in the field of mental health in 2009. They began, and remain, a small organisation with four members of staff operating with an annual budget of between 12.5 and 15 thousand pounds, and financially reliant on individual donors in Nepal, Europe, and Australia, mainly from the personal networks of the founder, Anna. They aim to provide a social model of care for the urban poor living with mental health problems and their family members through home and street visits; a day care centre they call the "welcome centre" and to provide financial support for treatment expenses which often include psychotropic medication. The reach of their support is limited to the local area around the organisation's office in Lalitpur, the southern district of the Kathmandu Valley.

The roots of CNMH can be traced back to 2003 when a few individuals, who were concerned for homeless people living in their area with poor mental health, informally formed a group with the intention of providing some sort of support. Among one in this small group of otherwise local people was Anna, a long-term expatriate originally from the United Kingdom (UK), and the main force behind the ideation and establishment of CNMH. After working in social work and community mental health rehabilitation programs in the UK, Anna moved to Nepal in 1990 and lived there full-time for over thirty years. Anna's first involvement with mental health work in Nepal was in the late 1990s and her experiences would go on to inform certain aims of CNMH. Her first experience with mental health work in Nepal was with an NGO called MaryKnoll Nepal that would later become the Aashadeep Rehabilitation and Treatment Center. As noted in chapter 2, MaryKnoll Nepal/Ashadeep were pioneers back then in the field of mental health. They were working to release and rehabilitate women who had been locked and abandoned in jails with no criminal offences, solely on the grounds of having a mental health problem (Robertson, 2001). The efforts and networks of Aashadeep resulted in an informal agreement with the directorate of jail administration to stop the imprisonment of those living with mental health problems without criminal offences. However, the resources that had been designated to keep them in jail were not re-allocated to provide alternative care and there was a growing number of people with mental health problems living on the streets, without access to food, treatment or shelter (Robertson, 2001). After Anna's involvement with Aashadeep, she began two personal and inter-related projects: she started a PhD in transformative learning and development practice and, in 2003, in response to the needs of people living with mental health problems on the streets, started "Chhahari Nepal". At first, Chhahari Nepal was registered as a project under the auspices of the Jesuit Saint Xavier's Social Service Center where Anna was part of the faculty in the social work department. The aim was "to advocate for the development of mental health services alongside promoting the rights of mentally ill men and women" (CNMH, 2011, p.1).

Anna's interest in transformative learning theory, a theory of adult learning formulated by the American sociologist Jack Mezirow in the late 1970s, sits at the heart of what became CNMH. Transformative learning theory is defined as "a process by which we transform problematic frames of reference (mindsets, habits of mind, meaning perspectives) – sets of assumptions and expectations – to make them more inclusive, discriminating, open, reflective and emotionally able to change. Such frames are better because they are more likely to generate beliefs and opinions that will prove more true or justified to guide action" (Mezirow & Taylor, 2009, p. 92). Informed by this adult learning theory, Anna wanted CNMH to become a "learning and responsive institution" and to foster what she terms a "reflective learning environment" where emphasis was placed on critical self-reflection, learning from experiences, and adapting practice accordingly. Conducting research was one way of satisfying those aims, and to guide the organisation's practice.

To determine the NGO's mandate, strategies and activities, Anna commissioned a couple of studies using qualitative research methodologies, such as document reviews, interviews and case studies. These studies aimed to assess the existing mental health institutions in the Kathmandu and Lalitpur districts, avoid duplication of efforts, and develop a referral system. The studies revealed that mental health services were largely inaccessible to poor individuals, outreach services were limited, collaboration and referrals among institutions were lacking, and more emphasis was needed on awareness and advocacy activities (Poudyal, 2005). The findings were used to inform CNMH's ensuing aims and activities, were written up in a report format, shared in a workshop with the stakeholders that had participated in the study and published on their website. As opposed to the studies carried out by TPO Nepal, the research findings from these studies were never intended for a broader scientific audience nor for a broader marketplace. The knowledge generated was for Chhahari Nepal, and the wider local mental health community.

The Chhahari Nepal project that then turned into an official NGO, CNMH, in 2009 developed at a slow pace. The few people involved worked on the project in their spare time as volunteers and there were limited sources of funding. From 2005 to 2009 they worked on a few awareness-raising activities and on trying to establish working relationships with other local institutions, mental health advocates and professionals, as well as more official partnerships with international NGOs. In 2006 they signed a memorandum of understanding with the international mental health and development NGO Basic Needs UK, and in 2008 they also became a charity partner at the Kathmandu Marathons: a platform they use on a yearly basis to simultaneously raise funds for the NGO, and awareness about the cause of mental health care.

In 2011, CNMH began to work more regularly and directly with people living with poor mental health on the streets. And they did so in the name of a one-year "outreach action research" pilot project they called the "Street Project". The goal was to gain a better understanding of the experiences of homeless people living with mental ill health in Lalitpur and document these experiences, to evidence the gaps in existing health and social care systems in the country, and for CNMH to go on to develop programs and activities that would be more tailored to the community's needs. The funding for the pilot project came from a UK based church where Anna's brother was the minister at the time, and the project staff were recruited from the Nepali Isiai Mandali (NIM) church network in Kathmandu. To gain this "better understanding", CNMH's staff first sought people out who they believed could benefit from some support. Then, they slowly built and maintained relationships with them (e.g. visiting them regularly, listening to them, providing them some food and clothing if needed, etc.), gradually building (mutual) understanding and trust and assessing their physical and mental needs. If the person was open to CNMH's support, they would try to link them with existing service providers as well as locate and support their family members in their caring efforts. The stories of the people they encountered during the "Street Project" were written up in a report format (CNMH, 2012). The report states to provide "evidence of the poverty and societal exclusion of the mentally distressed men and women who were contacted by The Street Project" and to "identify a set of advocacy issues based on the analysis of these experiences" (CNMH, 2012, p. 1). With what CNMH term an "action learning approach" and building directly from the lessons learnt from the "Street Project", they began providing what they believed to be a more sustained and holistic support including informal counselling, financial coverage of medical costs and social support through a day care centre called the "welcome centre". In sum, the knowledge they derived from the research process was used to inform CNMH's practice, and the evidence was thought useful to highlight key advocacy issues: making a case, for instance, for the importance of looking at issues such as poverty, exclusion, and gender-based violence in the context of mental health care.

In 2014, when I first encountered CNMH as a volunteer, Anna proposed an ethnographic research project for me to undertake. It turned out that many of CNMH's "clients" ("Client" is the word CNMH has chosen to describe the people they work with) came from an area in Patan that was home to many low caste Newars. CNMH had been wanting to provide additional support in their community but were at a loss as to how best to support them. Anna suggested I investigated the social determinants of mental ill health affecting people's lives in the area and that I put forward informed suggestions for CNMH's future work with the community. Thus, at that time, research was still mainly carried out with the same objectives in mind: to inform their practice to better support the local community. That was also the initial context in which I began to assume the role of a foreigner doing mental health research in Nepal, a role that I have become increasingly uneasy about.

Partnership with a HIC-based academic institution – on hosting academics and doing research

When I returned to Nepal, and to CNMH, for my doctoral research a few years later, in 2017, CNMH remained a very small organisation, doing what they trust is good quality and meaningful work for a small number of clients and their families in the local area. However, some things had changed in the interim. On one hand, the field of GMH was burgeoning, and mental health research and mental health research capacity building in LMICs was an attractive endeavour for donors. On the other hand, Anna had finished her doctorate and had become an honorary fellow at the University of Edinburgh and CNMH had become a research partner of the university in 2016. Since that institutional partnership was established, CNMH's few members of staff were dedicating a lot more time and resources accommodating and facilitating research-related activities. The purpose of enabling research projects had taken on additional significance for the NGO – the possibility of accessing a new source of financial resources for the continuation of the NGO, as they were included in research grant proposals submitted by the HIC-based university faculty members.

In what follows, I describe two different dimensions and transformations resulting from the partnership between CNMH and the University of Edinburgh: namely, CNMH's yearly hosting of postgraduate students from the university doing their placement-based research dissertation projects in Nepal, and the successful application for a "pump-priming" grant from the UK's Medical Research Council in name of (future) global mental health research. Whereas the foreign student placements seem to fit easily within the initial transformative learning goals of CNMH, the MRC funded project appeared to pull CNMH momentarily into a different direction and framework than that initially envisioned and anticipated. In describing these two different aspects of the institutional partnership, I foreground the voices and experiences of those working for CNMH: the "host" and "southern" institution in this partnership and offer nuances to the literature on North-South research partnerships.

Student research-based placements

CNMH had, since their early days, hosted and mentored local social work students that volunteered from St. Xaviers College, as part of their bachelor degree. Building on, and adding to this experience, as part of the partnership with the University of Edinburgh, CNMH began, in 2016, to host a few masters students from the foreign university on a yearly basis. The students from the University of Edinburgh come from disciplines of international development and global health policy, and travel to Nepal for a month or two to do their placement-based research dissertation projects. A few titles of these projects include: "Shaken to the Core: Experiences of mental health and psychosocial service delivery one year after the 2015 Nepali earthquakes", "Interactions of Poverty and Mental Health: A Case for Local Perspectives and Community Health Care in Lalitpur, Nepal" and "A qualitative analysis of Chhahari Nepal for Mental Health's social model approach as an effective social care support model for low-income men and women experiencing mental health problems in the Lalitpur district of Kathmandu, Nepal. The students are mentored and supported through their learning and research process in Nepal by Anna and Dhriti, CNMH's program manager. The students pay for their travel expenses and can apply for funds to pay for a translator, if needed. CNMH does not receive any direct payment from the university to host the students. Rather, the placements are designed as a *quid pro quo* with the local NGO defining the project based on identified needs, selecting the students, and receiving a research report.

Anna mentioned how fortunate she believed the placement arrangement between both institutions was, for everyone involved. She thought that for the students of the University of Edinburgh, having the opportunity to get exposure and gain experience in a different cultural context to their own was a huge privilege that would greatly benefit their personal and professional growth. Anna's view is consistent with some studies on the benefits international medical electives, volunteer tourism and study abroad programs in global health confer to students, which also suggest that cultural immersion, service or contextual learning, can result in positive personal and professional growth (Gard McGehee, 2002; McGehee & Santos, 2005; Smith & Weaver, 2006; Lyons & Wearing, 2008; Conroy & Taggart, 2016). On the other hand, other scholars have presented contrasting perspectives, arguing that sending students primarily from North American academic programs to LMICs for practice placement can perpetuate a new form of colonialism (Janes & Corbett, 2009). These perspectives shed stark light on global inequalities, as seen also in Wendland's (2012) study on clinical tourism in a training hospital in Malawi. In addition to the personal and professional benefits Anna saw for the students, she also viewed the placements as being a way to support the human resource-constrained organisation and Dhriti, whom she described as being "constantly overstretched". Finally, the placements, she said, also provided the "opportunity for opening up and look[ing] at the social approach [to mental health care]". I interpreted her formulation as indicating the fulfilment of a desire she had of taking time out and distance from the everyday operations of the organisation to document and reflect upon the organisation's approach to mental health care. Thus, I sensed Anna was appreciative of the students' placements not only for the extra help they could provide CNMH's staff with, but for the opportunity the placements presented to formalise and institutionalise a time and space for shared reflection on CNMH's form of care. Anna also appreciated the fact that CNMH had a significant amount of control over what sort of research questions and projects were being carried out. She liked to think that every individual project was building upon one another and envisaged a day when all the research carried out in and on CNMH could be pulled together. She hoped this "pulling together" of evidence would enable CNMH to put forward key points for advocacy. This, in turn, she speculated, could be useful at the Ministry of Health for Dhriti, who Anna described as being a lonely voice over there vis a vis most other local mental health advocates who, she was convinced, subscribed to a narrower medical model of understanding mental ill health and of practising mental health care. The "Street Project" that was carried out earlier on in CNMH highlighted advocacy issues around poverty and social exclusion of those living with mental ill health. With the evidence gathered from several projects and reports done by the students on placement, this time, Anna envisaged being able to advocate for a social approach to mental health care such as the one that CNMH practices.

The only thing I heard from Dhriti on the topic of the students' placements in everyday conversations was that there had been some initial disagreements amongst the board members as to whether CNMH should ask for funding from the university or not, and that the placements took away a lot of her time and energy. But a different picture emerged when I asked Dhriti if I could speak to her a little more extensively on the topic in the context of an interview. The placements, she said, did take a lot of her time and energy. She wanted to support the students in their learning experience and research process but equally as important, she wanted to make sure the students felt comfortable and happy during their time in Nepal. She helped them with a lot of practical matters such as finding places to live during the duration of their placement, orientating them to the culture, provided them with relevant local contacts for their research and often directly scheduling the meetings for them, listening to them, and talking through any issues the students faced during their research process. When the students were in Kathmandu, therefore, she engaged in a lot of hidden labour; labour that was all-consuming, and that took time away from other aspects of her job. On the other hand, the students did other types of work that was also integral to CNMH's learning and advocacy goals. In line with Anna's views, Dhriti also seemed to view the students as helping with the human resource constraints of the organisation:

> "We are a small organisation and do not have the human resources to look at and document all the aspects of our work that we would like to. So, the students from Edinburgh university who have the capacity and time to do this research help us in documenting our work. It saves our time as well because we are not many staff and we cannot do everything. It divides our work for free, you know."

Having others with time and capacity to do research for, and about CNMH, helped with the organisation's advocacy goals. Having evidence, Dhriti believed, was useful to show to the government, which was important because, "at the end of the day", she reflected, "it is our government that needs to implement things that are going to affect the people of Nepal". And it was through evidence that important messages could get across to Nepal's policymakers. The most relevant research projects for her were those that provided detailed documentation of both the lived experiences of CNMH's clients and their families and the successes of CNMH's way of caring. It was through this documentation, and "evidence of success", that a stronger case could be made for the need for a broader understanding of mental ill health and mental health care than that offered solely by the dominant medical model. She put it like this:

> "Mental health is looked at in a medical sort of way, you just go to the doctor or have medication and you will be fine. But there is no understanding of people with mental ill health needing someone to talk to for instance, or that their family members also need support to care for others. We want to demonstrate that 'look, our client goes to the hospital to seek support but then the carers also need support to support the person with mental health problems, and they need interaction with others, and get-togethers, and things like that'. We want to collect the evidence to say look these are the gaps that would be good if our government could address."

The concept of "evidence" here appears to be somewhat different from that purported by evidence-based practice advocates presented at the beginning of the chapter. Whilst CNMH embraces the fact that "evidence" is needed as a means to influence policy-making, the organisation's preference for "success stories" also has implications for the concept of evidence and typifies the ongoing debates around what counts as reliable and valid "evidence" (Kirmayer, 2012).

Dhriti identified another important advantage of the student's research projects - it provided CNMH's staff with an opportunity for ongoing internal learning, reinforcing the organisation's commitment to transformative learning culture. She did not conceive of the learning she valued in terms of "capacity building", as much of the literature on North-South institutional partnerships has. What she valued was getting to learn "even more" about the clients she engages with daily through the students' research reports. She explains that there are some questions that the students ask, and some of the answers they get, that CNMH staff "just never thought of asking" and that because of that, "new things come up" – illustrating again the core value to the organisation of constantly learning. Dhriti also found that within the context of research, she did not only learn more about the clients she worked with but also about the constantly changing political and legal context within which CNMH's works takes place. "The political scene in Nepal is always changing, and in the last year for example, so many things have changed with restructuring" she explained, "there are many things we do not know in detail". During the political transition, CNMH designed and proposed a research project that sought to clarify what were the role and responsibilities of the different tiers of government with regards to mental health governance and services in the newly federalised system. On a more personal level, Dhriti shared that in seeing how students described and articulated the work carried out at CNMH, and how they situated CNMH's approach within and amongst other ways of working in mental health in Nepal and around the world, helped her better appreciate the unique value of CNMH's approach and how it fits into the larger mental health care landscape. As a result, this made her a lot more confident in presenting and explaining CNMH's work to others. In her own words:

> "When I started working in CNMH they had their vision, mission, and this and that but after working on actual cases and after the research, it all made sense. The research was helpful also for me in explaining to other people, it made me more confident to present".

Indeed, learning from students, Dhriti felt she was able to draw upon her broader understanding of the GMH context to clearly communicate the significance and impact of CNMH's work to a wider audience. For Dhriti to place value on her increased knowledge about the broader context within which CNMH operates, and on her ability to effectively communicate the uniqueness of the organisation she works for, hints perhaps at particular demands of the current labour-market within which she works, and the skills that are valued within it.

Together, the views Anna and Dhriti shared with me on the placements of foreign students in CNMH were mostly positive and pragmatic. The placements seemed to mean "free" extra human resources for a small organisation. They also meant the possibility of building an evidence base on the gaps of current mental health care practice and on the potentialities offered by a social model of mental health care; an evidence base that could be used to advocate for a social model of mental health care in Nepal. Furthermore, the process of research itself and the reports resulting from these projects were valued by Anna and Dhriti for the possibilities they enabled for personal and institutional learning. Thus, whilst the research placements offered no direct funds to the organisation, they were important resources for the organisation, fit well with CNMH's commitment to learning and fulfilled CNMH's advocacy goals and their low cost and small-scale North-South collaborative resourcing model.

As a point of comparison, I now turn to describing another way in which the southern and northern institutions' agendas intersected, explicitly in the name of GMH research. This time, the collaboration brought significant funds to CNMH. The process to obtain the funds felt less congruent to the institutions' mission, yet once the funds had been secured, the GMH research funding allowed CNMH to cover their operational costs for a couple of years and continue providing care in the way they thought was best for their clients.

"Pump-priming" funding for (future) global mental health research

I was working with CNMH when an application process started with the University of Edinburgh for a GMH grant from the Medical Research Council (MRC). The purpose of the call they were working on was to provide institutional "pump-priming funds", to lay the grounds for future large scale, multi-disciplinary, cross-country GMH research bids to address issues of primary relevance to LMICs, including capacity building. Although with a view to be of relevance and future benefit to LMICs, the applicant institution had to be led by a UK research organisation with partners in LMICs. The proposals were to be up to twelve months in duration and applicants were encouraged to set out long-term research plans, including plans for developing sustainable UK-LMIC partnerships, but also to place those plans in the context of past or on-going research. To access the funds, therefore, it was important for the lead applicant, a HIC-based academic institution, to have institutional relationships with LMIC-based institutions and for institutions in LMICs to partner with HIC institutions. On a more minute level, what this often means is that accessing funds such as those available through the MRC boils down to having cultivated personal relationships across asymmetrically resourced places. These relationships are important for both parties, with higher stakes for those based in LMICs.

At about the time that the GMH MRC call was released and published, some faculty members across social and medical sciences at the University of Edinburgh were building a network at the university of scholars with a shared interest in GMH research across disciplines, schools, and departments, to enhance interdisciplinary work and create opportunities for research collaborations. With funding bodies financing increasingly ambitious and inter-disciplinary proposals for mental health research, one of the drivers in creating a university-wide GMH network was to try to enhance the possibilities of accessing such resources. During a research idea generation workshop held by this GMH network, an initial proposal idea for the MRC call was put forth and a bottom-up agreement on who would lead in pulling together a bid was reached between the attendees. At a later stage, a more top-down approach was taken by senior figures within the university that appointed a different lead on the bid from within the medical school of someone who had a track record of MRC funding. This intervention did not only create an initially unpleasant working experience for some, but also reaffirmed the dominance of some ways of knowing over others and laid bare the market logic at play in higher education institutions.

Eventually, a group of psychiatrists, clinicians, social scientists and informaticians put together a mixed-methods and interdisciplinary proposal for the "pump-priming" GMH MRC call. Each faculty member brought to the table their existing connections and partnerships with institutions in different LMICs. Indeed, within these collaborations, faculty members' value often lies in the partnerships and connections they bring. This, in turn, influences who the University of Edinburgh partners with locally. The MRC group debated the optimal number of partners, and the inclusion or exclusion of different local partners based on the coherence of their presence in the overall proposal strategy (e.g. regional diversity; comparability across population sizes, etc.) and interpersonal commitments. The final local partners chosen were based in Malawi, Costa Rica, India and Nepal. The proposal they submitted offered to create a network for the study of genetic, developmental, and environmental factors of psychological resilience in LMICs. "Resilience" was a broad goal and project under which the diverse group of scholars with their different approaches and research interests, and their partners based in very diverse contexts, could work together. Under this broader theme of psychological resilience, they divided activities around three main areas of interest that built on previous work carried out with each country partner: familial factors in Costa Rica, maternal mental health in Malawi and community mental health in Nepal and India. In each country, activities were divided into a couple of workshops: an initial multi-country collaborative development workshop and a later dissemination and future funding development or grant writing workshop; some formative studies that could include, for example, mapping and scoping exercises in potential study sites, doing a pilot or acceptability study and/or writing up case studies; and finally, public engagement activities. As part of the capacity building intention and mandate of the grant, in every LMIC at least one local research assistant would be employed by the local partner institution to conduct the formative studies.

Anna was part of the grant application as an advisor and research lead of CNMH. However, her position on the grant was somewhat ambiguous due to the MRC requirement of utilising existing employed resources. In accordance with this requirement, Dhriti was officially registered as the Nepali Principal Investigator for the health research council. Anna felt ambivalent with regards to CNMH's involvement in the GMH grant from the beginning. It created what she called big dilemmas for her, as a "reflective practitioner". On one hand, she said the scale and approach did not match the vision or values of CNMH. The scale was overly ambitious, and the constant need to do cross-country endeavours including countries with profoundly different contexts, unsound. Further, Anna confessed feeling uncomfortable and disappointed with some aspects of the process of application itself. Without giving me a particular example, she said that it had become very clear to her during the process of application that the university had little knowledge as to how their LMIC-partner NGOs operate. On the other hand, Anna knew that if awarded, the resources CNMH would receive from the grant would cover the operational costs of the organisation for some time, enabling them to continue providing the care they provide to their clients and their families. Further, a large proportion of the grant resources were budgeted for international and national travel and subsistence, enabling several regional meetings between University of Edinburgh researchers and the country partners. In practice, what was important about this, for Anna, was the prospect of her and Dhriti to be able to meet more often in person with one of their international collaborators with whom they were working on a longer-term project she felt was important for CNMH around documenting CNMH's approach to mental health care. Furthermore, Anna mentioned another achievement resulting from this partnership. She expressed her satisfaction in witnessing the lead psychiatrist involved in the project actively advocating for and discussing the social approach to mental health care during a session at the Nepal Health Research Council (NHRC) – a council that has traditionally emphasised science as the sole source of objective truth and has often displayed resistance towards ideas rooted in social sciences.

The University of Edinburgh's MRC proposal was eventually successful, and the first multi-country team meeting took place in Kathmandu at the end of February 2018. The occasion of the visit of the university's investigators as well as some partner representatives from Costa Rica, Malawi and India to Nepal was used to organise a launch event for the network, and for a three-day long collaboration development workshop. This was the biggest grant and project CNMH had ever been involved in as a partner. And, although CNMH was used to hosting foreigners; hosting a group of about ten foreign researchers at once while acting as a broker, facilitating connections between the foreign mental health researchers with an interest in working in a low-resource setting and the local mental health community, and preparing presentations to contribute to the wider discussions, was a lot.

CNMH's staff, board members and volunteers had barely had time to recover from their involvement with the first international mental health conference held in Nepal (cf. Chapter 6) which had ended just a few days before. And were already busy preparing PowerPoint presentations along with organising the travel, accommodation, and catering logistics for the group of academics who were visiting for four days. Indeed, CNMH's staff performed intensive brokerage work during the MRC grant visit – coordinating between foreign researchers, local mental health stakeholders, government officials, and their own organizational needs. This involved translating their social model of care into terms that would appeal to biomedical researchers, while also translating the researchers' interests into meaningful connections with the local mental health community.

An important aim of the visit was to establish connections with the local mental health community, get a feel for how things worked in the country, and to get a clearer idea as to whether future large-scale, multi-disciplinary and cross country GMH research projects would indeed be feasible. To facilitate that, CNMH first invited all their local mental health contacts to the network's "launch event" hosted at a high-end hotel (another development ritual, as argued in Chapter 4) in Kathmandu where they were all informed as to the aims of the year-long project and were invited to mingle.

At the launch event, in addition to the network team, there were a few representatives of other mental health NGOs, some mental health professionals, and a couple of national policymakers present. In addition to the informal networking that took place during the launch event, CNMH staff and board members planned several visits for the researchers: visits to a few public hospitals, universities, research laboratories, and national regulatory bodies such as the planning commission and research council. In the thick of the experience, I recall people working at CNMH commenting on how exhausting they were finding the researchers' visit and how challenging it was to accommodate everyone's interests and needs. Some members of staff were confused as to what the project was all about and whether there was potential for obtaining more resources later on. They all worked, nonetheless, knowing that some resources for the organisation and their clients were to come. In fact, CNMH eventually received funds that covered two years of their operational costs. Further, CNMH hired a research assistant to do the "formative study" of the network grant which involved doing a piece of ethnographic work on CNMH, which they hoped to be able to publish someday. Finally, on the back of the work done with the MRC grant, they obtained some more money to do some "knowledge exchange" work which enabled CNMH to produce a short documentary about their organisation, adding to their promotional material. Importantly, the MRC grant, and the successful completion of the project, also helped sustain relationships and partnerships that may help ensure CNMH's services again in the future. These dilemmas that small NGOs face, having interests diverted to access funds is part and parcel of the political economy of funding.

Conclusion: re-visiting local grievances

The ethnographic material presented in this chapter reveals how the global mental health research agenda shapes mental health care provision in Nepal in profound and systemic ways. Through detailed case studies of two contrasting mental health NGOs -TPO Nepal and CNMH - the data demonstrates how institutions' epistemic orientations and networks fundamentally influence their access to resources and ability to influence policy.

The case of TPO Nepal illustrates how alignment with GMH's evidence-based framework creates self-reinforcing cycles of influence. Their early commitment to generating scientific evidence positioned them to become Nepal's primary recipient of GMH research funding. This in turn enabled the production of more evidence, establishment of stronger government partnerships, and shaping of national mental health policy. The ethnographic material indicates this is not just about single research projects, but rather shows how certain forms of knowledge production become systematically privileged, creating lasting structural advantages.

CNMH's experience reveals the complex ways smaller organisations must navigate this system. Despite their different epistemic orientation focused on local learning rather than generalisable evidence, the organisation has been gradually drawn into GMH research activities - hosting foreign students, partnering with UK universities, applying for research grants - not because of shared GMH epistemic premises but because research engagement has become necessary for organisational survival. The detailed ethnographic account of their MRC grant experience demonstrates how even organisations committed to alternative approaches must participate in evidence-based frameworks to access resources.

These findings challenge simplistic critiques of mental health research in Nepal as merely foreign-driven or extractive. The ethnographic evidence points to more complex dynamics where local institutions actively engage with global research agendas, but in different ways shaped by their epistemic orientations and networks. TPO Nepal's case demonstrates how local organisations can become dominant players through alignment with global epistemic frameworks. CNMH's experience reveals how others must strategically engage while trying to maintain alternative approaches.

The implications extend beyond these individual organisations to raise fundamental questions about how mental health care is conceptualised and delivered in Nepal. The privileging of certain forms of evidence shapes what kinds of interventions are seen as legitimate and reproducible. Organisations focused on social approaches or local learning must increasingly frame their work in terms of generalisable evidence to access resources. This creates systemic pressures toward standardisation and away from context-specific or relationally-focused care approaches.

Further, the findings highlight how the boundaries between research and service provision are increasingly blurred in Nepal's mental health system. Research funding has become a primary mechanism for enabling care delivery, while care provision increasingly must generate evidence to justify continued support. This raises important ethical questions about consent, experimentation, and the responsibilities of care providers that extend far beyond individual research projects.

Finally, the ethnographic material reveals how global mental health research practices are reshaping professional opportunities and career trajectories for Nepali mental health workers. From Sachit finding work opportunities through research projects to Dhriti navigating institutional partnerships, engagement with global research increasingly determines professional possibilities. This reflects broader changes in Nepal's mental health system as it becomes more integrated into global networks and frameworks.

These findings emerge directly from detailed ethnographic observation but point to durable features of Nepal's evolving mental health system. They demonstrate how global epistemic frameworks shape local realities not just through individual projects or partnerships, but by fundamentally restructuring what kinds of knowledge and practice are valued and fundable. The following chapter explores how these dynamics affect the aspirations and opportunities of Nepal's urban youth as they pursue careers in mental health.

Part III – PSYCHOLOGICAL KNOWLEDGE AND SOCIAL TRANSFORMATION

Having examined how institutional actors navigate and stabilise Nepal's mental health system through key aid norms in Part II, Part III, comprising chapters 6 and 7, moves beyond the brokerage dynamics explored in previous chapters to explore how psychological knowledge circulates and transforms within Nepal's broader social fabric through specific channels like public radio programs, mental health education initiatives, and professional training programs. Through ethnographic analysis, these chapters reveal how Nepal's mental health system serves as a crucial site where global psychological knowledge is "Nepalised" and integrated into local aspirations for modernity and development. Specifically, these chapters examine how individuals with varying positions in society, especially by virtue of their socioeconomic status and gender, engage with and transform psychological knowledge within this system, and how this engagement impacts both their own identities and broader social change in Nepal.

Chapter 6 explores these questions by focusing on mental health professionals engaging in the dissemination of public mental health knowledge. Further, the chapter explores what intended audiences and imagined subjects these discourses are directed to and suggests that by localising psychological knowledge in Nepal and presenting it as a vital part of modernity and nation-building, brokers are actively seeking to shape individuals' identities. In this process, they seek to inspire others to acknowledge the significance of psychological knowledge and the need for psychological well-being within the broader framework of modernisation.

Chapter 7 then focuses on the effects of subjectivation, where mental health is an integral part of modernity, in shaping new professional identities. Based on twenty-eight semi-structured interviews with a group of young urban middle-class individual educated in psychology, I argue that these individuals not only use their education as a means to construct their own sense of self, but also perceive a responsibility to disseminate psychological knowledge for the betterment of others and the pursuit of social transformation. These psychology-educated individuals regard psychology knowledge as an essential tool for leading a fulfilling life, embracing modernity, advancing in their careers, and contributing to the modernisation of Nepal as a nation. Nevertheless, chapter 7 also highlights the tensions that arise between the promises associated with the modern ideal and the necessity of navigating the slower-changing operating modes embedded within society.

Together, these chapters highlight the central role brokers have in "Nepalising" psychological knowledge for the process of social change in the pursuit of modernity.

Chapter 6. Public Mental Health Knowledge: Messaging Strategies and Development Discourse in Nepal

Introduction

This chapter focuses on public mental health knowledge in Nepal, specifically, examining how mental health knowledge is disseminated through psychoeducational activities. I analyse what kinds of audiences these activities imagine and target, and how their messages are constructed and delivered in a society where the ideology of modernisation and *bikas* – development – is deeply ingrained (Pigg, 1992) (for effects of formal education in psychology see next chapter; chapter 7).

To examine these questions, I take a close look at three psychological educational activities. The analysis centres on examining the messaging strategies, discursive frameworks, and intended effects of these psychoeducational activities, rather than on the reception or uptake of such discourses by the intended audiences. Throughout the chapter, and in accordance with previous anthropological scholarship working in the context of Nepal (cf. Pigg, 1993; Fujikura, 2001), I suggest that, while psychoeducational efforts may be designed or intended with the aim of "educating", "raising awareness", "reducing stigma" or "increasing basic community capacity", their messaging strategies reflect broader ideological frameworks. Specifically, I analyse how these activities construct and promote particular ways of understanding mental health that align with existing ideologies of development – *bikas* – and modernisation. The messages position their audiences as potential adopters of these "modern" approaches to mental health, while framing mental health care as both desirable and necessary. This messaging may contribute to increasing demand for mental health services, though examining the actual impact is beyond the scope of this analysis.

Psychiatric lessons and referrals on FM radio

It is an early spring morning in 2018, and Dr. Rajendra – a high caste Hindu psychiatrist based in Kathmandu – is the guest speaker on a call-in FM radio show dedicated to mental health on Radio Kantipur. The radio is an important popular medium of entertainment and information in Nepal, where a large portion of the population has access to some form of radio, whether through a traditional radio set, or through other means such as mobile phones or the internet. It is also one of the main mediums of information for people living in more remote areas, where access to other forms of media, such as television and the internet, is more limited (Wilmore, 2008). Estimates suggest that more than half of the population listens to the radio every day (Acharya, n.d.). In addition to shaping public discourse and popular culture, the radio has also played a significant role in promoting different ideologies in the country (Kunreuther, 2012).

It has been employed for various purposes, such as disseminating political propaganda during the Maoist insurgency, wherein both the government and the Maoists utilised the radio to spread their respective ideologies. It has also been used for cultural and religious promotion, as well as for raising awareness about health and social issues, as is the case here.

Radio Kantipur is owned by Nepal's biggest media house: Kantipur Media Group. It is one of the oldest, largest, and most popular commercial FM radio stations in Nepal with extensive coverage and listeners across the country. On the radio's website, they claim to reach 75 percent of the population (Acharya, n.d.). Radio Kantipur has been broadcasting *manasik swasthya ma koshish* (effort on mental health) since 2016, in collaboration with the disabled persons' organisation called KOSHISH. Right after the 2015 earthquakes, Radio Kantipur had started a program called "*prayas*" (effort) – a music show, with the intention to uplift the communities affected by the earthquake. "*Prayas*" was created to bring some entertainment to the communities, and to allow some space for conversation with artists on how they were coping during the shared challenging times. The news chief of the radio station told me that after seeing the overwhelming response to that show and how much it resonated with the listeners, the radio station decided to start a program dedicated to mental health, and launched *manasik swasthya ma koshish.* It is a program that runs once a week where different guests are invited to talk about mental health and start a conversation in the public sphere, to educate and support people in their recovery. Once a month, a psychiatrist is invited to speak about mental health related topics, and to provide brief consultations to listeners calling in. After the radio station's experience with the program, the manager said that even if KOSHISH were to terminate their contract with Kantipur, they would continue the show, as they now view it as part of their corporate social responsibility. "It has been awareness raising for us too", he told me – a comment that, to me, indicated the development ethos ingrained in Nepali society resonating beyond the NGO-sphere, and into the private sector. What I provide in the following is an English translation and an analysis of the original *manasik swasthya ma koshish* show broadcasted in Nepali.

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Dr. Rajendra is introduced as a *manasik rog besaysagya doctor* – literally, "a mental illness specialist doctor", a psychiatrist – and is asked to explain to the audience what types of problems are referred to as mental health problems (*manasik swastha samasya bhaneko kasto samasya ho?)*, how to identify the signs and symptoms of such an illness (*yo rog kasto khalko ho ra yeska lakxan haru kasta khalka hunchhan?)* and to inform the audience about where to get treatment for this type of illness (*yo rog ko upachar kasari garna sakinchha?).* In being invited to share his knowledge on mental health, the psychiatrist is placed in the position of an educator for the public – an authority legitimised by his biomedical knowledge and clinical experience.

The psychiatrist begins by emphasising that "people have to understand that mental illness (*masasik rog)* is not a single type of illness, and consists of many different types of problems". He says that it is due to a "lack of knowledge" (*aagyanta nai ho)* that the common perception when one hears about mental problems (*manasik samasya),* or heart-mind problems (*manko samasya),* is that all types of mental illness are the same, and that being mentally ill means "walking around on the streets without clothing on, looking dirty, and talking nonsense". He continues by saying that severe mental illnesses (*kada khalko manasik rog haru)* are only the most extreme and are rare, “only a few percentages [sic], around 2-3% of mental illnesses are very complicated and people can lose control of the body”. “The rest of all cases are normal illnesses (*samanya khalka rogharu)*” he says, “like having so many thoughts on the mind, excessive worrying, not having energy to work, tense muscles and feeling pains in the body, having trouble falling asleep and overthinking small things.” These, he says, are all symptoms of what must be understood as mental health problems (*manasik samasya).* Thus, setting the tone for the rest of his interview, and central to his pedagogical approach (as well as attesting his pedagogical capacity), the doctor’s discourse emphasizes a pervasive “lack of knowledge” in society fueling a common misperception about what it means to be mentally ill. The messaging technique is significant: in identifying a “lack of knowledge” in society, Dr. Rajendra’s discourse deliberately echoes and reinforces a powerful local development narrative that has historically equated “ignorance” and “not understanding” with “villagers’” awareness and consciousness (Pigg, 1992). Through this discursive strategy, Dr. Rajendra positions himself and his knowledge with the ideology of *bikas*, speaking from a position of an urbanised and cosmopolitan elite. In doing so, the discourse is concurrently informing the audience about a new way of understanding mental ill health and about what a *bikasi* – modern – person says and does about mental health. This dual messaging represents another strategy for framing mental health knowledge within existing ideologies of modernity and bikas (Pigg, 1995, 1996). The host then asks the psychiatrist about the treatment options for these problems. The psychiatrist explains that every mental illness (*manasik rog)* has a different treatment:

> “In the same way that often we cannot conclude exactly why fever happens, as it can arise from a common flu, HIV, tuberculosis or even cancer, heart-mind problems *(maanko samasya)* also have various types of problems, and every single problem (*pratek samasya ko lagi)* has a treatment based on the issues.”

He then makes a distinction between what he refers to as *kada kahlko rogharu,* severe types of illnesses, and *naram khalko rogharu*, mild types of illnesses. For the mild and more common mental health problems, he says, many people do not have to take medication, but some have to take medication for periods lasting anywhere between eight weeks to one year. He adds that it is only in the more severe cases that a stricter treatment may be required with longer-term medication. He then emphasises “it does not mean that when you are diagnosed with a mental health problem (*manasik samasya*) that you have to take medicine throughout your life”. After a couple more questions, the doctor feels it is necessary to reiterate that it is important to understand that *manasik samasya* or mental health *problems* [my emphasis] and *manasik rogharu* or mental *illnesses* [my emphasis] are two different things but, he says, in both cases “a person has to consult with a specialist about the problem” (*samasya ma pani bisaysagya ko sallaha chainchha ani rog ma pani upachar chainchha).*

To clarify the distinction between a mental *illness* and a mental health *problem,* he gives an example:

> “When a student is going to take an examination, it is natural that the student feels nervous, but if that nervousness leads him to not deliver his exam and cannot write his answers, then we have to take that situation as a problem (*rog nai ho ani samasya ho*)”

And continues:

> "It is normal that several types of feelings develop in our mind depending on the situation. People grieve in sad moments of life, feel fear when something scary happens. If these types of feelings increase higher than the natural level, we consider it as a mental health problem (*manasik samasya bhaninchha).* If feelings start to affect daily routines like a person not being able to go to work or it starts to affect social life, then it is considered for a mental illness *(manasik rog bhanchhau)*".

In response to the examples given by the doctor, the host decides to share a personal experience. She recalls once during an examination where she "could not write and fainted" but says that at the following examination it did not happen again. She asks how long these problems or illnesses last, what the standard measurement of these are, and related to her personal example she wonders, "how do I know this type of symptoms is a mental illness *(manasik rog ho ki hoina)*? How should I understand this situation? (*yo kasari bujne ta dr sab?)*".

The psychiatrist answers:

> "If people have experienced that type of problem, then it is simple and easy that you have to consult with a psychiatrist. You should not ignore such signs and symptoms, because you might have other symptoms as well. Consulting with a psychiatrist does not mean you have to take medicine. Consultation helps to increase quality of life, to increase productivity, and to reduce complications. Consulting with a doctor is important to good management of life. Also, it is very common in our society that people try to hide problems and sickness, in some cases people are not even allowed to leave the room. People are afraid to take treatment and take medicine. These types of problems are taken as taboo."

After a short commercial break, the host asks the doctor whether he could go over once more what the baseline is for a mental health *problem* and a mental *illness*.

Dr. Rajendra explains:

> "Every matter that affects life tends to reflect on our feelings and it has the ability to make you worried and sad in certain phases. These worries should gradually decline with the passing of time and the person should continue their normal routines of life. However, in some cases, the person takes the situation very heavily, always thinks about it and can't get back to normal life. For example, the feelings in the mind are affecting study, normal work routines, and the person is not able to sleep at night. If someone is facing such a situation, then we must understand that the person needs treatment (*tya samasya chha bhani bujna paryo)*. In general, or in a very simple way, mental health problems (*manasik swastha samasya haru)* result from excessive thinking of the same thing which is hampering the daily life of a person. Neighbours and family members also begin to indicate that the person is overthinking small things, they report the person is getting very annoyed, angry, and not wanting to talk with others. This can also indicate that a person needs treatment. They should seek a solution to the problem (*tyo samasya ko samadha khojna paryo)*."

Finally, the doctor feels it is important to explain one last thing. "There is another important thing", he says, which is that:

> "Many people are taking 'anxiety disorders' [said in English] as their habit (*bani)*, so many people are believing 'I am like this since my childhood. I take

> everything seriously and it has been like this from childhood. So, I don't have a problem'. For example, they think 'I am very much a moving person, I cry about very small things', or 'he is a very angry person since his childhood', 'he gets very annoyed with anything because he is always like that'. So, this kind of habit might be a mental health problem (*manasik samasya)* and there are huge chances of developing a mental illness. But there is a cure for every problem (*yo chai manasik samasya pani huna sakchha)*."

After the doctor's note on potentially dangerous thinking "habits", there is time for three call-ins from the audience. The first caller draws from an example that Dr. Rajendra gave on what may constitute a sign of a mental health problem:

Caller 1: I often get moved easily; my tears come out about very small things that happen in my life. Is it any type of mental health issue? *(sano sano kuro ma mera aau aacuchha, dherai maanma kura khelchha, tyo chai k hola?)*

Dr. Rajendra: Do you get hurt by others in very small incidents? **Caller 1:** Yes **Dr. Rajendra**: do you feel small problems as big problems and think about it all the time?

The call then gets disconnected. The psychiatrist warns the audience that he cannot simply conclude someone has a mental illness knowing a few symptoms, and advises the caller to go to a psychiatrist for a consultation: "a person needs to share their things to the doctor and keep talking about it" (*afno kura daktarko ma raknu parcha. Kura gardai janu parcha – kura haru gardai gayo bhane)*. In consultation, he says, "we get deeper by talking and asking clarification questions and the patient can gradually start to share their problem *(bistarai aafno kura haru rakhna)*". He explains that there are no fixed symptoms and signs, and that symptoms can also change person to person. He advises the first caller to go to see a psychiatrist as, he admits, "when I listened to her, I felt she had some psychological problem *(wahale tyo ekuta prasna sode pani aru pani maanko samasya hary chhan bhanne malai lagisakyo)*" but reassures her "the problem has a solution as well" (*yesto samadhan chha*), and says "she can go to the nearest health service centre or she can consult with a psychiatrist if it is possible *(najik ko aafno swastha karmi aajha manasik rog bisaysagya haru lai gayera vetnu vayo vnaye)*. There will be a solution to her problem and it can be easily treated".

Shortly after, another call is answered:

Caller 2: Whenever something wrong happens, I feel very much scared and my heart beats very fast as I feel I am having a heart attack. It happens often, and every time I feel the same.

Dr. Rajendra: So, when you have that type of attack, do you feel like you are going to die or feel very scared? Do you feel agitation, nervousness, dizziness, wanting to go to the hospital and after some time, these feelings come back to normal? **Caller 2**: Yes, **Dr. Rajendra**: this type of attack is known as a panic attack. This is due to an extreme fear of something. This is not any kind of physical problem; this is a psychological problem. Many people visit several doctors, cardiologists, and different specialists; however, the problem is never solved.

Caller 2: Yes, I have consulted with a cardiologist and done ECG and ECHO, but my problem has not been solved, and the cardiologist concluded my reports are normal.

Dr. Rajendra: You must understand it this way, of course there is some issue, but not an issue in your heart, but a big problem in your heart-mind *(mutu ko chai samasya hoina tara maanko chai thulo samasya ho)*. But you do not have to worry even though I said it is a big problem. This kind of illness *(yesle dukkha dine samasya ho)* gives trouble in life. It has no risk of life or potential to have big damage to your body, but it makes your daily life more difficult. This problem has a very simple treatment. You should consult your nearest psychiatrist *(maanko doctor haru lai vetny vayo bhanye)*. There is no specialist available in your district, but you can go to another district (8 hours drive from where the caller is calling from) or yet another (10 hours drive).

The last call-in says:

Caller 3: I have a problem that I do not have confidence in anything. For example, if I just change my clothes, I feel I have not done it. I just turned off the gas stove, but I am not sure if I turned it off or not. While talking with someone I do not feel confident. I feel like I cannot control myself.

Dr. Rajendra: This is also not a big problem *(yo pani samasya chai thulo samasya hoina).* This happens when you have so many feelings on your mind. You have to understand, suggestions given through the FM are not a treatment. This is just to help find out the problem. Your problem is a very common psychological problem (*yo pani ekdam common samasya ho dekha pari rahane samasya ho)*. This has a solution also, if you have so many feelings on your mind that leads you to not concentrate on other activities. You can consult with any psychiatrist near you *(kunai pani manasik bishaysagya lai sallaha line)*.

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As suggested by the transcript of the radio show, the psychiatrist sets out to teach the audience about the way mental health specialists understand mental ill health. To do this, his discourse centers on rectifying what he identifies as the common yet “mistaken” understanding in society at large, which is that being mentally ill *always* means behaving in ways akin to madness. Instead, his message emphasizes that mental illness consists of many different types of problems with varying degrees of severity and chronicity. Anthropologists working in rural areas of Nepal three to four decades ago highlighted and emphasised the weight that idioms around “not understanding” and “wrong beliefs” carried in Nepali society (Stone, 1986; Pigg, 1992, 1996). In 1992, Pigg persuasively showed how these idioms served to create a conceptual polarity between the village/villagers and *bikas* – development – and argued that it was a polarity against which people in Nepal used to orient themselves in national society. Despite the substantial social changes that have occurred in the country since those anthropological analyses, and the distinct context in which Dr. Rajendra is broadcasting his lessons, his discourse continues to employ and emphasise on idioms around knowledge to draw another marker of social differentiation. Here the psychiatrist’s discourse draws a rhetorical distinction between the *majority* in Nepali society, whom his narrative characterises as having a mistaken understanding of mental ill health (that being mentally ill always means being “mad”) and the select few that, like himself, have the correct understanding (i.e., that there are many types of mental health problems with different degrees of severity and chronicity). While placing his knowledge in opposition to that of the majority of people in Nepali society, his discourse does not reproduce wholesale the social distinction and markers of differentiation exposed by Pigg's work (1992) between "villagers" and *bikas*. Rather, his discourse creates an understanding of *bikas* as existing on a continuum, where there are varying degrees of *bikas*. Indeed, his discourse resembles an evolutionary model of psychological development wherein individuals are understood to progress through various stages of development. Through his narrative, the psychiatrist places himself at the higher end of the *bikas* continuum, contrasting his expert awareness and understanding of mental health to that of almost everyone else's in society – including that of his fellow urban, educated counterparts as signalled through his discussion of examination anxieties. The psychiatrist's message presents the endorsement of his knowledge and understanding of mental health and mental ill health as a marker of social differentiation. Furthermore, given that even some of the most highly educated people are presented as having a "mistaken" understanding, rather than this "lack of knowledge" being framed a sign of social difference in educational terms, it is constructed as marked in terms of the absence or presence of a certain kind of morality, as I now go on to suggest.

Over the course of the radio show, Dr. Rajendra does not educate the public about the existence of mental illness in society, as it is not a novel nor unfamiliar form of illness in the same way that HIV/AIDS (Pigg, 2001) and tuberculosis (Harper, 2006) were when they were first recognised. Indeed, mental illness is already known to the public – it is known as a highly stigmatised form of suffering that is equated or related to madness, chronicity and irremediability. Thus, rather than teaching the public about the existence of mental illness in society, what the doctor tries to do instead is to make a distinction between the more severe and rare cases of mental illness, and the more common and mild cases of mental health problems. To do this, he makes a very slippery distinction between *manasik rog* (mental *illness*) and *manasik samasya or manko samasya* (mental health or "heart-mind" *problem*) and adds diversity to the types of problems falling under mental ill health.

In the early days of medical anthropology, anthropologists made a clear differentiation between illness and disease (Kleinman, 1978, 1980). Illness referred to the personal and subjective experience of living with a health condition, encompassing the social, cultural and emotional aspects that might go unnoticed by medical professionals. Disease, on the other hand, pertained to the biological and physiological aspects of a health condition, including observable signs and measurable symptoms identified by medical practitioners - disease represented the doctor's objectified diagnosis. Although this distinction has been considered heuristically useful for understanding health conditions, the discipline has since moved beyond it due to how it reified the objective and subjective realms. Later, working in the context of Nepal, Korht and Harper (2008) argued that one explanatory displacement strategy involved attributing issues to bodily causes as identified by mission doctors, while another strategy focused on community-based interventions.

Dr Rajendra, in a similar but distinct manner, was also offering an explanatory displacement. Trying to militate against the fear, shame and stigma people often attach to the label of being mentally ill, he explains that more often than not, mental ill health has nothing to do with madness – reifying a particular stigmatising image of a "mad" person. The severe (albeit rare) case of mental *illness* is reified as being epitomised when "one can lose control of the body" and is presented as potentially being a *kada samasya,* a "severe problem", that can be "complicated" and might require to be treated with medication for some time. Mental health *problems*, on the other hand, are represented as normal illnesses, that are a lot more prevalent in society, and that although "can give trouble in life" they are also "not a big problem", and are "normally treated without the use of medication". Importantly, though, the doctor's discourse suggests that if mental health *problems* or "heart-mind" problems go unnoticed by the person affected and are unmanaged, they can develop into an *illness* (e.g., "this kind of habit might be a mental health problem and there are huge chances of developing a mental illness"). In so doing, his message constructs a continuum between "normal illnesses" and a "severe problem", and implicitly utilises the image of a "mad person" as a rhetorical device to haunt people into action. The messaging strategy here operates on multiple levels: while ostensibly focused on awareness-raising, it also constructs particular moral frameworks around mental health. While the doctor's narrative attempts to challenge the degrading portrayal of mentally ill individuals as "mad persons", it simultaneously reinforces that image through its rhetorical structure. Two discursive imperatives emerge from this constructed continuum between *samasya* (problem) and *rog* (illness).

The first imperative constructed is to notice and identify *manasik swastha samasya/manko samasya* (mental health problems/heart-mind problems) in oneself. In the doctor's narrative, being able to accurately read certain signs and symptoms in one's own behaviour, emotions, and character, is necessary to prevent a mental health *problem* from becoming – or escalating into – a *manasik rog,* a mental *illness* that, in its most severe form, can look like madness. This messaging strategy urging to read mental ill health within oneself can be understood as a type of what Michel Foucault termed a "technology of the self" (cf. Introduction) because the individual is encouraged to pay attention to one's inner world, to self-examine, surveil, monitor, and become aware of any indication of the onset or escalation of mental health problems. In the doctor's discourse, the state of "madness" is re-stigmatized and presented as always being an underlying threat of inaction with regards to mental health *problems.*

Throughout the radio show, Dr. Rajendra provides examples of potential signs and symptoms of mental health *problems,* such as "not having energy to work", "overthinking small things" or "having trouble with falling asleep". These are all very common idioms of distress (Nichter, 1981, 2010), in Nepal (Kohrt & Hruschka, 2010; Harper, 2014) and in the wider South Asian context (Kirmayer & Young, 1998), that many likely experience at different moments in their life. The use of such common idioms of distress raises questions about how everyday experiences are framed as potential symptoms – a discursive process that Kidron & Kirmayer (2019) have analysed as potentially medicalising normal experiences, emotions and behaviors. In addition to reframing common idioms of distress as a potential sign, or symptoms, of a mental health *problem,* the doctor's discourse recharacterizes certain personality traits and behaviors. Dr. Rajendra warns that there may be some behaviours or tendencies in a person's character that have come to be understood by the person themselves and by others as being personality characteristics or "habits" (*bani*) such as crying easily, being angry often and getting annoyed quickly, that could all also be related to an underlying mental health *problem* or *illness* but that has gone unnoticed. Finally, the doctor's discourse emphasises that the signs and symptoms of mental health *problems* and *illnesses* are "not fixed" and may vary person to person. In short, while his message promotes the importance of reading mental health *problems* in oneself, it also conveys a sense that being able to read these *problems* accurately is a highly nuanced and complex process that ultimately really requires consultation with a skilled clinician who can do this effectively, reinforcing the power of psychiatry over the individual (cf. Introduction on Foucault's "technologies of power").

The first discursive imperative to notice and identify mental health *problems* in oneself therefore ultimately leads to, and links with, the second imperative the doctor's discourse constructs throughout the radio show, which is the imperative to act – to "seek a solution to the problem". The main behaviour and action that the psychiatrist recommends and promotes is for individuals to share their problems and concerns with a psychiatrist. The doctor lists many reasons for, and benefits to, this practice of self-disclosure with a psychiatrist. In Dr. Rajendra's narrative, consulting with a psychiatrist is presented as enabling one to clarify and know whether one's behaviours, emotions and personality traits are signs or symptoms of mental ill health; unearth other potentially existing signs and symptoms that are unknown to the individual but likely identifiable by the psychiatrist; increase one's quality of life, productivity, and life management; prevent or reduce future complications (i.e. preventing from going mad) and get treatment if necessary. Thus, self-disclosure and revealing one's inner state to a clinical practitioner is constructed in the discourse as necessary to accurately identify mental health problems in oneself (i.e knowing truth about self), assess and identify one's risk of developing a mental illness, and receive the proper treatment if necessary and be able to heal – "there is a cure for every problem" he says. This practice of disclosure that Dr. Rajendra's discourse encourages individuals to adopt with a psychiatrist can be understood, as Hunt (1997), Nguyen (2010), and more recently Whitacre (2021) have theorised in the context of HIV/AIDS, as a type of "confessional technology" – an exemplar of "technologies of the self" (Foucault, 1988).

Once the psychiatrist has taught the lessons he sought to, the audience is given a glimpse into the process of self-disclosure with a psychiatrist through the three brief call-in consultations. The client-psychiatrist interaction that the psychiatrist's discourse is encouraging people to seek out in their lives, is briefly enacted publicly. In these short interactions, each caller in turn publicly self-discloses, sharing a snippet of their personal experiences that they suspect and/or worry may be a sign of mental ill health (e.g. feeling moved easily; feeling scared and as though they are having a heart attack; not having any self-confidence). These instances of public self-disclosure already imply that some form of self-surveillance has taken place within the individual. Once the individual has self-disclosed, the psychiatrist in turn showcases his skills and expertise by asking clarificatory and suggestive questions, for example: "do you get hurt by others in very small incidents?", "do you feel small problems as big problems and think about it all the time?" – exhibiting his understanding and then offering a course of action and solution. These brief and syncopated interactions are a sort of public testimonial. In the same way that, in Christianity, public testimonials are intended to inspire and encourage others by sharing their own moments of revelation, growth, and transformation, these interactions serve as a public testimonial of the type of modern subjects the callers and the psychiatrist represent, and encourage individuals to engage in self-surveillance and seek professional help. In other words, the social message that is being conveyed through the brief call-in consultations is how to understand and act with regards to mental ill health in a way that a person on the higher end of the *bikas* continuum would, and does.

The mental health and social messages that Dr. Rajendra imparts on the radio constructs an understanding of the self as potentially needing psychiatric consultation and care. This messaging has the potential to shape how people conceive of their life problems and what they should do about them. Ultimately, this discursive framing around the self and mental health problems could contribute to an increase in the perceived value and demand for psychiatric expertise, as Liecthy (2010, p. 48) has described in terms of the production of "needing subjects". Although my research focuses on the discursive and identity/ideological impacts of psychoeducational activities, it is important to reflect on these findings within the wider context of increased material availability of psychopharmaceuticals in the country, as highlighted by other scholars (Harper, 2014; Upadhaya et al., 2018; Ecks, 2022) and research done by Nepali mental health NGOs (Upadhaya et al., 2018). Despite Dr. Rajendra's assertion that consultation with a psychiatrist does not mean having to take medication, other scholars have highlighted that, in the South Asian context, rarely do patients leave a psychiatrists' consultation room without a drug prescription (cf. Nunley, 1996, for an Indian case). This suggests that "needing subjects" – individuals who understand themselves as needing mental health consultation – may become pharmaceutical subjects in consultation with a psychiatrist. Finally, it is also important to acknowledge that whilst Dr. Rajendra recommends for everyone who may be experiencing some distress to consult with a psychiatrist, there are still very few psychiatrists in the country, i.e. 200 in 2021 (Rai et al., 2021). The more likely course of action would be for people to access primary care settings where the default treatment for mental ill health continues to be psychotropic medication (Kohrt & Harper, 2008; Ventevogel, 2014). Thus, Dr. Rajendra's messages form part of a wider movement towards the over-prescription and consumption of pharmaceuticals.

In sum, the lessons and actions the doctor encouraged were focused on the self: how to read signs of mental ill health in the self, how one should act if those signs are present in the self, and what type of self one is, if one understands and acts in the ways the doctor is suggesting. In my analysis, I have argued that the discourses espoused and promoted by the psychiatrist, situated within broader development narratives in the country, have the potential to shape understandings and perceptions of mental health, the self, and the value of psychiatric expertise. Specifically, the messaging constructs the possibility for individuals to: a) transcend, to a certain extent, the stigma associated with mental illness by readings mental health problems within oneself and taking the responsibility for one's own well-being; b) engage in public self-disclosure and seek clinical treatment in order to regulate behaviour (by being diagnosed, treated and normalised); c) place trust in the psychiatrist's theories and expertise, and by extension, in the knowledge and institutions of medicine; d) see problems as being in the domain of the individual and their mind rather endorsing *bhut/pret* explanations (Seale-Feldman, 2022) that understand the problem as more relationally situated. Additionally, the discursive framing has the potential to contribute to the transformation of individuals into pharmaceutical selves (Ecks, 2022), where issues being constructed as within the individual domain lead to consumption of medicine as the solution. Further, Dr. Rajendra's intervention on the radio should be understood as a didactic one, in that it was intended to teach about mental health, but it also conveyed ideological, social, cultural and moral messages to the audience. The doctor did not only teach the audience about a mental health specialist's understanding of mental ill health, but also imparted messages about modernity and morality. It is not incidental that Dr. Rajendra has a privileged social status and position in Nepali society – he is a highly educated individual who belongs to the middle class and comes from a high caste background. Furthermore, his psychiatric knowledge is in alignment with institutions of *bikas* such as medicine and science. Dr. Rajendra's discourse teaches the audience about the ethical and moral values with regards to mental health that ostensibly should/ought to be part of a modern society. The doctor's positioning and messaging construct him as embodying a certain type of person with higher levels of modernity and development, characterised by a higher level of consciousness and morality, one that is presented as going – to a certain extent – beyond stigma, and demonstrating a specialised knowledge and understanding.

In the next ethnographic section, I describe and analyse the messages imparted by a community based psychosocial training that was delivered by a faith based mental health NGO to Christian farmers in an earthquake affected district. The training aimed to teach "basic trauma counselling skills". In some ways, the data that follows reinforces my previous arguments that the messages imparted by psychoeducation teaches a discourse of self as one that is amenable to mental health consultation and care and teaches about the beliefs, discourses, and practises modern subjects have in relation to self and mental health. In this case, however, the mental health teachings were not delivered by a psychiatrist over the radio but were instead delivered in a church by Christian individuals, backed by a Christian NGO. I will show how the community based psychosocial training embedded mental health teachings within Christian teachings and suggest that they were infused with Christian ethics and morality. The program not only focused on providing practical skills but also integrated Christian teachings and values. Furthermore, as it will become clearer, the Christian farmers were not just informed – as the public was taught through the radio – about potential mental health symptoms that they themselves may experience and the goals were not only to educate about common mental health problems assumed to be widespread in communities. Rather, the training was targeted at community members without an explicit need themselves and aimed to equip community members with basic therapeutic skills to monitor and care for others. In the following, I suggest that the messages the trainees received during this training were that they can, and should, particularly in their capacity as caring Christians, identify mental health issues in their communities and provide basic psychosocial support.

Christianising mental health monitoring and care

On a cold November morning, leaving my shoes behind on a rack, I climbed two stories of a big concrete building and walked into a church for the first time in many years. Whilst Christianity remains a minority religion in Nepal, it has seen a significant growth, especially among the younger generation and socially and culturally marginalised groups (Gibson, 2017; Poletti, 2022). This church was different to any I had been to before – it was a very spacious hall, sign-posted by a cross on a poster. Soft background music was playing when I arrived, and a group of people were sitting down on the floor facing two trainers from a Kathmandu faith-based mental health NGO. The trainers were Bhavana and Deepak. The two middle-aged and urban-based Newars had travelled from Kathmandu to a village development committee in a district in an eastern hilly district which had been affected by the 2015 earthquakes, to deliver the training. The NGO's goal in providing this training was to increase community mental health knowledge around trauma, grief, and stress, and to increase the number of people that could provide basic psychosocial support in their communities.

The history of community-based trainings in Nepal dates to the early 1990s, when several NGOs and development organisations started to implement such programs with the aim of empowering local communities, particularly women and marginalised groups, by providing them with the skills and knowledge deemed necessary to improve their livelihoods. The number of training programs and the rate of expansion of these increased rapidly after the end of the civil war in 2006 when the government, along with several development organisations, began to implement programs aimed at promoting peace and development in the country (cf. Chapter 2). These programs often included components related to community-based training, with a focus on building the capacity of local communities to participate in the country's development process. As Pigg (1995) has argued, training programs are common features of the wider world of development and modernity in Nepal. In mental health, community-based psychosocial trainings are also a common avenue by which mental health NGOs reach communities to raise awareness and build basic capacity.

The twenty-some parish members present at the training were a mixed group of men and women, some young and others more senior individuals. The trainers were busy with final preparations when I went up to a makeshift registration desk displaying a sign written in English and Nepali and received a name badge, a training manual, and a couple of pamphlets from other faith-based mental health NGOs in Nepal. Although the English signage seemed superfluous, given that no one else present aside from myself was likely to benefit from it, it served as a stark reminder of the broader institutional context in which the training was situated, namely that of *bikas* or development. Indeed, the use of English had very little to do with functionality and more to do about insisting on the language and ideology of development (cf. Pigg, 1992; Pandey, 2020). The pastor of the church, utilising a common Christian greeting in Nepal, welcomed the participants with the phrase "Jai Mashi!", meaning "victory to Jesus". He then proceeded to deliver an introductory speech that concluded with a communal prayer and group applause, imbuing the training session with a distinctly Christian flavour that, as I will argue, would prove to be pervasive and influential throughout.

Bhavana started the training with the topic of trauma. She explained what constitutes a "traumatic event" and what, she said, is a "normal response" to such events. To explain what a traumatic event was, she took the communal experience of the earthquakes as an illustrative example. The sudden, intense, and frightening experience of the earthquakes coupled with the loss of loved ones, constituted, she explained, a "traumatic event". Events such as these, and others such as having a serious car accident, or a life-threatening illness were also considered traumatic life events. Echoing Dr. Rajendra, Bhavana explained that it was normal for experiences in life to have an impact on people's feelings. She taught that after a "traumatic event", having a "psychological trauma" was considered a "normal" response. In the training manual, "psychological trauma" was defined as "a wound to the psyche or mind". Comparing wounded minds to wounded bodies, Bhavana reassured everyone that just like bodies heal by natural means over time, so do minds. In presenting this comparison of the mind with the body, Bhavana's discourse employed familiar physical health concepts to communicate Western mental health ideas. Her narrative used body-mind analogies that are common in Western mental health discourse, rather than incorporating local understandings of suffering that often emphasise relationships with others, supernatural entities, and the environment(Kohrt & Harper, 2008; Seale-Feldman, 2022). Thus, Bhavana's teachings demonstrate how Western mental health concepts were translated and communicated in this context, reflecting broader patterns of mental health knowledge dissemination that other scholars have documented (cf. Watters, 2011; Heaton, 2013; Fernando, 2014). As many of these scholars have long argued, the Westernization of mental health knowledge can also serve to promote a biomedical model of mental health that focuses on individual pathology and medical interventions rather allowing space for other understandings of mental ill health or alternatives ways of healing. During this training, the discourse used privileged Western biomedical understandings of mental health over other local interpretations of suffering. As medical anthropologist Ian Harper (2014) has observed, within a diverse healing environment, discussions tend to conform to the prevalent discourse of the context.

Bhavana continued her teachings on trauma by giving examples of common experiences people have after experiencing a "traumatic event". Those were: sleep disturbance, difficulties concentrating, changes in thinking and mood, such as being more irritable, aggressive, or angry, and recurrent involuntary memories. Whilst the experiences she listed were similar to the common idioms of distress that Dr. Rajendra had also highlighted as being potential indications of mental health *problems* that would benefit from psychiatric consultation, according to Bhavana, in general, these experiences were nothing to worry about, and experiences that tend to disappear naturally over time. However, she explained that for a minority of people, the experiences can last for longer periods of time and could start to interfere with daily living – resembling more to what Dr. Rajendra was calling a mental *illness* – and that in those cases, seeking help from medical professionals is beneficial. The "normal" experiences she spoke about were also listed in the manual as "symptoms of trauma". And, at the end of the list, a cautionary sentence stated, "if symptoms do not go away in 6 to 8 weeks, consider seeking professional help". Thus, in contrast to Dr. Rajendra's open-ended temporality of normalcy versus illness (a discernment that needed to be made by a psychiatrist), Bhavana's teachings imposed a temporal limit to "normality" - one linked, in all probability, to the International Classification of Diseases (ICD) or the Diagnostic and Statistical Manual of Mental Disorders (DSM), which are highly weighted towards the dissemination of the western mind (Summerfield, 2001; Murphy, 2015). This placing of time on "negative" emotions has been critiqued for being a particularly American notion (Kleinman, 2012). Once Bhavana had explained the definitions and signs and symptoms of non-pathological trauma, it was Deepak's turn to teach about the pathological form of trauma. He taught about post-traumatic stress disorder (PTSD).

Using the language of development and claiming his place on the side of *bikas,* Deepak stated the name of the disorder first in English before providing his Nepali translation: "*aaghat paschaatko tanaab awastha*". PTSD was introduced as a more serious condition that could ensue after experiencing a traumatic event. While Deepak taught that everyone could have a different experience of PTSD, the common symptoms were very closely related to those Bhavana had previously enumerated as being "normal" responses. They included reexperiencing the traumatic event through intrusive or troublesome memories of the event, flashbacks, nightmares; emotional numbness and avoidance, a loss of interest in normal activities and life; increased anger outbursts or irritability, difficulties concentrating and being hypervigilant. The distinction, thus, between the non-pathological and pathological, similar to what Dr. Rajendra also taught, rested on a question of degree, in terms of severity and duration of the distress as well as its interference with everyday living. In the same way that temporal boundaries of normalcy and illness have faced criticism for their association with Western ideologies, the medicalisation of trauma and the discourses surrounding trauma and PTSD that the training was leaning on have also drawn ample scrutiny, highlighting the presence of Western and biomedical perspectives within these discourses (cf. Young, 1996; Summerfield, 1999; Kienzler, 2008; Kienzler & Pedersen, 2012).

The training session continued, focusing next on loss and the grieving process. Soft instrumental music was turned on, setting a solemn mood. Bhavana instructed the trainees to gather in a circle and asked them to participate in an activity. She explained she would read a series of statements aloud, and that those who had experienced the described situation were to step forward towards the centre of the circle. Here, just like the psychiatrist was on the radio, Bhavana also used "confessional technologies" (Hunt, 1997; Nguyen, 2010), aiming to elicit self-disclosure from the participants. In this case, she sought a public confession of personal experiences of grief. Rather than by speaking, like Dr. Rajendra did, Bhavana encouraged the participants to express themselves by physically stepping forward. She proceeded by reading out statements that covered various causes of grief, such as: "you have lost someone close to you", "there has been a separation or divorce in your family", "a loved one is experiencing a lot of suffering" and "you have gone through some traumatic event". Whilst a few participants had shared in previous discussions some personal experiences like those Bhavana was stating, very few were stepping forward for the entire group to witness. Although the format of stepping forward to express personal experiences bears some similarities to certain Christian charismatic and Pentecostal group methodologies or witnessing strategies, where church members may be encouraged to share their personal experiences of faith or where physical gestures such as raising hands or kneeling can be ways of express their emotions and connect with a spiritual experience, the participants, in this case, seemed uncomfortable to make stigmatised issues public. It is important to note, then, that although self-disclosure and confession are central to Christian ethics, there were overlapping cultural, social, and religious norms at play during this training that influenced the uncomfortableness individuals felt with publicly disclosing personal experiences of grief. Bhavana explained that her aim was for the group to appreciate how common it is for people to experience grief and that loss is inherent to our human condition. As opposed to the case on the radio, where a few people did call into the show and publicly self-disclosed certain private behaviours and emotions, here the very teaching point, on how common grief is, was undermined by the lack of participation due to discomfort.

After the group exercise, Bhanava shared a YouTube video from her computer called the "Story of Love". It narrated the story of a close relationship between a bridge operator and his young son and the day when both tried to save many others from an impending rail disaster. In the video, the bridge operator must decide between saving his own son or saving the many other lives of people on the train. He decides to give up his son to save the rest. The video ends with an image of the father holding his son in his arms with a well-known verse from the

Christian Bible: “For God so loved the world, that he gave his only begotten Son, that whosoever believeth in him shall not perish, but have everlasting life” (John 3:16). This is a statement about the love of God and the gift of salvation that is offered through faith in Jesus Christ. “God so loved the world” means that God has great love for all people and all of creation; “gave his only begotten Son” refers to Jesus Christ, who is believed to be the Son of God, sent to Earth to offer salvation and eternal life to humanity; and “whosoever believeth in him shall not perish, but have everlasting life” means that those who have faith in Jesus Christ will not suffer eternal death or separation from God, but will instead have the opportunity for eternal life in the presence of God. Embedding Christian teachings with teachings about grief, Bhavana asked the group to reflect on how the bridge operator responded to the death of his son and to reflect on whether they would all respond similarly. The consensus was affirmative: that everyone cries, feels hopeless, lonely, and angry. There was, in a space permeated with Christian and modernism ideology, again, little pushback with regards to how someone may respond to grief differently.

Deepak built on the created sense of shared humanity and described what the grieving process looks like, leaning on a diagram from the training manual. He made sure everyone understood that it is not a linear journey but rather one with lots of ups and downs. Once the process was described, again an idea of a normal temporality for feelings was sought from the participants. Even though it was acknowledged that the process can fluctuate from person to person, Deepak added that, according to “research”, men need about a year to grieve and heal, while women need double the time. This statement served to both present women’s mental health issues as heightened and to reify sexism as well as ideas of scientific expertise (the ways in which gender difference is enfolded within public psychological education comes up again and will be more explicitly discussed in the final ethnographic section of the chapter). By using a vague reference to scientific evidence, Deepak positioned himself once again on the side of *bikas*. In the same way the trainees had been taught how to discern between “normal” and “pathological” trauma, here pathological or unresolved grief was described as a deviation to the “normal” and natural process, when the process was not completed or when no progress was seen after six to eight months of the loss. Finally, a session on stress followed a similar format. Stress, together with its symptoms, was portrayed as a normal part of life: a way we react to change, physically or emotionally. However, a skillful discernment was to be made between “positive” and “negative” stress. In “positive stress”, they taught, there is a stopping point. Once a challenge or job is done, it is followed with a relaxation response to give the body time to build up the emotional and physical reserves. “Negative stress”, on the other hand, was said to be when the stress response is ongoing and can, in the long run, cause headaches, ulcers and heart attacks.

As described, during the training, Bhavana and Deepak’s discourse focused heavily on distinguishing between “normal” and “pathological” responses to traumatic events and loss, as well as between “healthy” or “unhealthy” coping mechanisms. This messaging strategy encouraged trainees to apply these frameworks when interacting with others, positioning them as community-level mental health monitors.

Once these lessons around how to understand and monitor mental ill health were imparted, the trainees were provided with some “basic trauma counselling skills” by which they could provide an adequate response to suffering others. The tools Bhavana and Deepak taught were good communication, active listening skills and relaxation techniques. As opposed to Dr. Rajendra's project, which aimed to ultimately elicit self-disclosure with a psychiatrist, here Bhavana and Deepak were teaching the Christian trainees how to provide basic support and assistance to those they may encounter suffering in their communities.

To teach about "good" and "bad" communication, Deepak and Bhavana sat facing each other, pretending to have an ordinary conversation. After some time, they exaggerated a few behaviours that made everyone laugh. Every other word Bhavana would say, Deepak would interrupt her, finish the sentence for her, or pick up his phone. In another instance, Bhavana acted very visibly annoyed about having to listen to Deepak talking, barely paying attention to him and yawning. In another scenario, Deepak acted as though he was disregarding Bhavana's problem, "it's not all that bad" and giving simplistic advice "just forget about it", looking at his watch. After a few scenarios, Deepak explained that, while common, these behaviours were clear examples of poor listening skills and that people requiring some support benefit from speaking to someone with "good" listening skills, namely "active listening skills", and basic conversation tools. Good listening, he taught, was to "listen with eyes, ears, mind, body, feelings and spirit", encompassing both verbal and non-verbal skills and making the other "feel safe, deeply respected, attended to, valued and understood". Deepak and Bhavana role-played once again an ordinary conversation where active listening skills were being used. Participants were encouraged to tell the group what verbal or non-verbal cues they could pick up on: "good attention", "soft tone of voice", "patience", "eye contact", "encouragement" were a few examples that came up. This list was then complemented with an explanation about two types of questions: "open questions" which allow for a longer answer, as opposed to "close questions" that only allow for a "yes" or "no" answer and does not invite further conversation. The use of open questions was encouraged as an important tool in a conversation with a therapeutic aim. Finally, the trainers taught a relaxation technique they called "deep breathing" – a technique they were invited to use for themselves and encouraged to teach others in moments of stress.

Meditation is a practice that has a long history and use in Nepal's spiritual and religious traditions, including Hinduism and Buddhism, and is also found in Christianity. However, its adoption in secular and clinical contexts has also brought it into the realm of modern and evidence-based mental health care, particularly with the emergence of "third-wave" behavioural therapies that are gaining an increasingly large evidence base and are seen as cutting-edge approaches to mental health care (Hayes & Hofmann, 2017). In the context of this training, thus, the "deep breathing" exercise may have carried diverse meanings, values, and ideological weight as a practice that is both rooted in tradition and has legitimacy as a modern and scientific approach to mental health care.

As the preceding descriptions suggest, over the course of the training, Bhavana and Deepak taught the trainees to make a difference between "normal" and "pathological" responses to traumatic events, loss, and stress; how to identify the signs and symptoms of pathological responses in themselves and others and offered them tools with which they could support others in their community. These lessons differed from what Dr. Rajendra taught via the radio. Whilst the psychiatrist provided information on how one could read mental ill health in oneself, what

Deepak and Bhavana were encouraging was for the trainees to be attuned, and responsive to the psychological life of others. Being aware of the needs of others and seeking to serve – and care for – them was by no means a foreign concept to the trainees. These ideas of care, love, and compassion are common throughout Nepal and are also promoted within Christian communities and expressed in the teachings of Jesus Christ. By combining therapeutic skills training with Christian principles of service and care, the training's messaging presented mental health support as aligned with Christian values and responsibilities. The messages framed psychological care through religious language and concepts, connecting it to existing Christian teachings about community care. Unlike Dr. Rajendra's messaging which emphasised seeking professional psychiatric help, this training discourse focused on democratising psychological care through a Christian framework. The messages encouraged trainees to act as community resources, sharing these mental health understandings with others in their religious community.

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To summarise, as in the case of Dr. Rajendra, I have suggested that Bhavana and Deepak's discourse went beyond teaching how to discern "normal" from "pathological" expressions of trauma, loss, and grief, and how to provide basic care. Their messaging reflected and promoted a Western discourse of mental health. Dr. Rajendra's mental health, ideological and moral messages were couched in psychological language and development discourse, and this was also evident over the course of the community-based training described. In addition to the ideological power of psychological language, the ideological power of *bikas* and its association with modernisation, Western knowledge systems, and the English language, there were other intersecting forms of ideological power at play. The mental health messages were imbued in Christian discourse and ethics, adding another player to the complex dynamics of the training. The training was delivered in a church by Christian individuals, backed by a Christian NGO to a community of converted Christian farmers. The training infused mental health teachings with Christian teachings and values, emphasising the importance of supporting suffering others. These sources of ideological power are not mutually exclusive, but rather overlap and reinforce each other, creating a complex and dynamic cultural landscape that shapes certain mental health practices in Nepal.

In the following ethnographic section, I reflect on a third and final mental health pedagogical intervention, this time delivered through the medium of forum theatre, also known as "theatre of the oppressed" (Boal, 2000). Forum theatre is a form of participatory theatre that is locally recognized and is widely used as a method of awareness raising in the context of development, particularly in rural areas of Nepal (Mottin, 2010). However, in the case that follows, the forum theatre took place in urban Kathmandu, as part of an international mental health conference. Despite its typical use in rural communities, the performance at the conference had a different audience: that of primarily middle-class and educated Nepalis. The play depicted the story of a village woman who was burdened with inconsolable worry (*cintā*), living with her husband Shambhu and their daughter Nanu. In theory, forum theatre is intended to be a dialogic and participatory form of intervention where the collective experiences and perspectives of the audience are valued and sought after – a place where different understandings and opinions can be openly debated. However, as it will become clearer, the forum theatre I observed – in the doubly staged context of the international conference – was not genuinely dialogical or participatory in form. Instead, it was a highly choreographed and rehearsed performance that effectively erased any uncertainty, ambiguity, or alternative viewpoints, and created a sense of expert community consensus on what is a "correct" understanding and way of responding to a supposedly unequivocal mental health condition in a female villager. The play emphasised the importance for distressed individuals to receive psychosocial support and pharmacological treatment, and for them to adhere to such care and treatments. The messages conveyed underscored the importance of taking action to ensure that individuals receive and adhere to appropriate care and treatment. I also suggest that the use of the female villager as a narrative tool to depict mental health issues and non-adherence to treatment inadvertently perpetuated narratives portraying women as emblematic of suffering and distress (cf. Breuer & Freud, 2009; Burgess, 2016) as well as a portrayal of rural populations as being less educated and less capable of understanding mental health practices. I suggest that this messaging approach reinforced existing urban/rural distinctions in how mental health knowledge was presented and communicated to different audiences.

The performance of community consensus: Forum theatre and urban expertise

The first international mental health conference in Nepal was held in February 2018 at the Park Village Resort in Budhanilkantha, Kathmandu. With a diverse crowd of over four hundred attendees, including government officials, international mental health stakeholders, NGO teams, program managers, researchers, psychologists, psychiatrists, people with lived mental health experiences, advocates, and students, the conference's slogan "Coming together for mental health", accurately reflected one of the main objectives behind its organisation. The conference's primary ideator expressed concerns over the lack of collaboration and fragmentation within Nepal's mental health system and believed that the expert community needed to be more cohesive. She hoped that the conference would be a symbol of positive shift towards collaboration among mental health professionals in Nepal. After two full days of presentations, the conference was coming to an end with a theatre on mental health. The play was part of a wider effort the organising committee had made to include arts, such as song and slam poetry performances, in an otherwise mainly academic conference. It was also an example of many other plays that development and humanitarian organisations use throughout the country for mental health promotion (UMN, 2017; IOM, 2021).

The performance took place outside, in the pleasant grounds of the hotel where the conference attendees sat or stood, forming a circle around the group of drama artists. As is characteristic of forum theatre, before the performance began, a presenter explained that at certain points in the play, he would momentarily pause the action and invite the audience to suggest solutions to the scenario being acted out and intervene in the development of the play. The presenter highlighted the crucial role of the audience in the play's development and emphasised that without the audience's participation, the play would not be able to continue or reach its conclusion.

The play the conference attendees were about to watch and, to an extent, be part of, was an example of countless other community and street plays that have been, and are, performed in Nepal with the double intention to entertain and "educate" communities (cf. Seddon, 1995; Davis, 1998; ; Mottin, 2007, 2010; Holloway et al., 2009). This form of educational intervention has a long history in the country and because theatre, as well as many other artistic forms, such as dance, song and poetry are common modes of expression in Nepal, they have also often been appropriated and used for distinct ideological ends including activism, political opposition, campaigning, and development (Mottin, 2007, 2010). In this case, the lessons the drama artists were aiming to convey were about mental health. More specifically, the play focused on women's mental health; on the familial and societal effect poor mental health in women has, and about the importance of sustaining "appropriate" care and ensuring continued treatment. I turn now to describe the play, before providing an analysis of it.

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The drama began with a woman, Kumari, standing in the middle of the circle, hair dishevelled, hunching her shoulders, looking sad and exhausted, while drum music and singing expressed the incredible amount of worry (*cintā*) she was feeling:

> "worrying and worrying, worry in the heart-mind, household worries, worry about family. No appetite for food, sleep also does not come, always heavy thoughts come to my heart-mind, do not like people around, no energy for work, no one is there to listen, worrying about everything has to be handled alone, worrying and worrying, worry in the heart-mind., worrying and worrying…"

Kumari's body was wrapped with colourful shawls that were being pulled from many directions, by different people. It was a beautiful and telling depiction of the embodied feelings and experiences of women, when trying to attend to everyone else's needs amidst their own. Once the pulling from all directions finished, Kumari dropped to the floor on her knees, defeated. Her husband Shambu walks into the circle. He sees her sitting on the floor, and starts scolding her for not doing any of the household or agricultural chores and walks away. Shambu is initially depicted as an insensitive and irresponsible father and husband, who spends a lot of time drinking alcohol. At first, thus, both the roles and behaviours of women and men are highly stereotyped. The next scene depicts Nanu, Kumari and Shambu's daughter, complaining to her mother that she is hungry and that all the neighbours have already eaten rice, asking why she has not yet finished cooking. Kumari, who is sitting on the floor slowly preparing food, tells her daughter that she is sick and that she does not have the energy to cook. Nanu does not understand why her mother is saying she is sick "when nothing is showing from the outside". Then Nanu is shown not wanting to play with her friends, emphasising the impact her mother is having also on her daughter's wellbeing.

Moments later, members of Kumari's community are shown backbiting and gossiping about Kumari's behaviour, such as not showing any interest in celebrating *Teej* (the "women's festival"). Among those gossiping is Sangita, who then goes back home and tells her husband Harkey about Kumari's situation. Harkey appears to be surprised and disappointed to hear his wife gossiping and reminds her of her own past – when she also experienced similar feelings to Kumari's and got better only after getting support from a counsellor. Harkey is represented not only as a husband that is hard-working (shown to work with the cattle alongside his wife) but as being the wiser one of the two of them. After lecturing Sangita about her behaviour, Harkey decides they need to stop talking, get into action and help Kumari. Sangita goes to speak to Kumari while Harkey goes to find Shambu.

Kumari is then shown sharing her thoughts and feelings with Sangita. She tells her that she has a lot to do but does not feel like doing anything, that she does not feel like eating, does not want to talk to anyone and cannot care for herself or her family - a depiction of illness that underscores a neglect of what may be considered a woman's duty and role in her family and thus a break in social norms. Kumari says she cannot sleep at night and that she just wants to leave everything and die. Meanwhile, Harkey finds Shambu and encourages him to take care of his wife, who, he explains, has an internal and invisible wound that requires love and care to heal. Shambu tells Harkey he is contributing at home, by dropping her daughter off at school and supporting her with the household chores, and asks how he can know her troubles if he "cannot see anything visibly wrong with her". Harkey explains the role of the counsellor, and how useful it was for his own wife Sangita.

Then, all the actors come together to sing a song that informs the audience that Kumari sees a counsellor for a month and that she feels it helps a little; after two months, with the additional support from her family, it is communicated that she is getting better; after four months of taking some medication in addition to the counselling and family support, she is feeling a lot better and is shown to become busy and preoccupied again with household and agricultural chores. After six months, Kumari stops taking her pills, and after seven months Kumari is depicted as feeling as she was before seeking help and treatment.

Once the song finishes, Kumari is portrayed to be engaging in household chores but being very forgetful. Shambu, who is now represented as having understood Kumari's problem and being more supportive, tells Kumari he is going to the market and asks whether she needs anything. He enquires about how much medication she has left. Kumari tells him she is stopping the medication because it is too expensive and she does not need it anymore as she is already feeling much better: she can cook, take care of household chores, and work the fields. In the next scene, Kumari is represented as being sick again.

Only then does the presenter come into the scene and makes the actors pause. He then asks the audience what problems Kumari's family is facing and who is affected by them. The delegates in the audience were fully immersed and felt confident to voice their opinions about Kumari's situation. This engagement and feeling of being drawn into the theatre by mental health professionals in the audience reflects Dr. Rajendra's message in the first vignette, emphasising that educated urban individuals also need to fine-tune their awareness. The presenter encouraged the audience to share their hypotheses and ideas before providing them with the "correct understanding" of Kumari's situation. Then he asked why her problems had returned. The main message was around the importance of continued treatment. Finally, the audience was invited to suggest what could be done to ensure complete treatment. The audience came to a consensus that Kumari needed to restart medication and counselling and adhere to the full treatment for complete recovery.

The audience's recommendations were further affirmed in the subsequent scenes, where a conference participant watching the play was asked to take on the role of a counsellor and provide the appropriate guidance to the actor-villagers. The spectator-converted-actor repeated the same advice and reason the audience had ostensibly agreed upon to Kumari and Shambu. The appearance and dress of the spectator-converted-actor who was embodying the role of the counsellor and wore a formal and professional attire stood in striking contrast to those of the actor-villagers that were dressed in traditional clothing – suddenly also conveying a powerful message about knowledge and class.

After this staged exchange, the spectator-converted-actor returns to her place in the audience and the presenter reappears. The presenter asked for a moment to guide a reflection before ending the play and proceeded to ask several yes or no questions. The questions revolved around whether Kumari shared her problems with her husband, if he asked about them in a caring manner, if Kumari's daughter was aware of her struggles, and if Kumari herself tried expressing her problem with her family. The explicit message the presenter conveyed to the audience was that it is important for people to "open their heart and share their problems with trusted others" – the "confessional technologies" (Hunt, 1997; Nguyen, 2010) used by Dr. Rajendra and Bhavana in the earlier interventions, were at play here again. Despite the mention of medicine throughout the play, the presenter concluded that most problems can be solved by sharing one's problems with trusted others, and that there might be no need for medication.

The presenter marked the end of the play by stating that Kumari's story is just one example of the many experiences individuals face in Nepali society.

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As previously mentioned, the forum theatre performance described diverged from the usual context and target audience of this medium. The audience was primarily composed of middle-class educated Nepalis, in contrast to the more typical rural community settings in which forum theatre is often performed. It was in that sense doubly staged, not just as a pedagogic effort intended to disseminate psychological knowledge, but also an exhibition of this method of imparting knowledge, for the conference delegates. Furthermore, one of the distinguishing features of forum theatre is its interactive nature, which is often praised for its ability to allow people to engage with social issues in a meaningful way, explore different perspectives, and develop new solutions. By contrast, in this particular case, the performance was highly choreographed and rehearsed, with no opportunity for improvisation in response to audience suggestions, as is more commonly expected in the forum theatre format. It is worth noting that the presenter only stopped the play towards the end, ostensibly handing over some control to the audience. However, by this point, most of the story had already been told, limiting the opportunities for audience engagement and input. This also restricted the space and scope for visualising or offering alternative perspectives on the nature of the problem represented in the play or exploring alternative responses to it.

Throughout the play, there were certain tensions and slippages with regards to ideas around the best care for mental ill health. Initially, the play suggests that counselling would be the appropriate course of action for Kumari. Later, it was revealed that Kumari was getting better not only because of support from the counsellor, but also thanks to her family support, and medication. In fact, it is implied over the course of the play that Kumari's recovery is gradual and that she experiences improvement by incorporating various types of support –

highlighting the significance of a multimodal approach for mental health care. Then, the audience is told that when Kumari decides to stop taking her medication, after feeling somewhat better for a few months, she quickly relapses, and it is unclear if she continues to receive counselling and familial support. Thus, towards the end of the play, the focus moves away from emphasising the significance of a multimodal approach to mental health care and becomes more narrowly focused on stressing the importance of adhering to pharmacological treatment, ultimately placing emphasis on medication as the crucial form of treatment (Kohrt & Harper, 2008; Ventevogel, 2014). Yet, right before the end of the play, the presenter makes a point to explicitly reiterate to the audience that most problems can be solved by talking and opening one's heart with trusted others, and that medication may not be necessary at all.

Despite these tensions and slippages, an illusory sense of consensus was created among the audience members about Kumari's issues and the best course of action to support her. It seemed the audience agreed with the specific message the theatre was designed to convey, which was to emphasise the importance of providing psychosocial support and pharmacological treatment for distressed individuals and ensuring adherence to appropriate care and treatment. Arguably, the slight tensions between counselling and medication made it difficult for the audience to question more fundamental assumptions about the nature of mental ill health and limited the consideration or voicing of alternative understandings and approaches.

Considering the composition of the audience, the types of individuals represented by the actors, and the fact that one of the primary objectives for the conference was to symbolise a collaboration, if not coherence, among mental health professionals in Nepal, it is important to reflect on the potential impact of the consensus-making theatre on the audience.

The actors represented composite, typical Nepali villagers, and everything that villagers and village life entails symbolically and ideologically in Nepal (Pigg, 1992). The actors were dressed in traditional clothing, portrayed as doing agricultural work, and following certain rigid social norms around gender. In the same way that Deepak taught trainees that women's mental health problems can be heightened due to various factors, the play also centred on the "problem" of women's mental health. The problems within Kumari's family were simplistically attributed solely to Kumari's mental health problem that ostensibly affected the entire family's well-being, neglecting other potential broader familial, social and cultural factors influences on her well-being. Further, Kumari is represented as not knowing how to understand her own experiences, what to do about it, or about the importance of adhering to medical treatment. This use of the female villager as a narrative tool to depict mental health issues and non-adherence to treatment reinforces the *bikas* narrative that women and rural populations are less educated and less capable of understanding mental health practices (cf. Nepali society and social change section in Introduction). Through the device of having conference delegates participate in directly advising them on what to do about their problems (embodied by the spectator-transformed-actor taking on the role of counselor), the performance reinforced distinctions between urban expertise and rural understandings in its mental health messaging. Furthermore, the ostensible consensus among the conference delegates, on the right course of action, may have also served to strengthen a collective urban/*bikasi* identity among them, who may have perceived themselves as more knowledgeable than their rural counterparts. Finally, and interestingly, throughout the theatre, Harkey is portrayed as a wise and knowledgeable villager who does not only refrain from stigmatising mental health issues but also instructs others on how to support others in need. This portrayal of Harkey suggests and demonstrates the developability of the – male – villager and re-enforces the value of the "developers", legitimating their interventions.

Conclusion: Modernity, Mental Health Discourse, and Market Demand

This chapter has presented and analysed data from three distinct psychoeducational activities to explore the intended audiences and imagined subjects targeted by psychoeducational discourses in Nepal. The activities described are illustrative examples of how psychological knowledge is "Nepalised". I began with an example of a didactic psychoeducational intervention that employed psychiatric discourse to address individual mental health behaviors, framing mental health through professional medical language and expertise. Then, I examined how Christian discourse was mobilised in an interactive training that reframed mental health monitoring as an expression of religious care and duty. Finally, I analysed how popular discourse was deployed in a forum theatre that aimed to build community consensus around mental health care, though this "popular" form was ultimately used to reinforce professional perspectives. This progression – from psychiatric to Christian to ostensibly popular discourse – reveals how mental health messages are adapted and legitimised through different discursive frameworks while maintaining certain core ideas about proper mental health care.

Together, these psychoeducational activities communicate consistent messages about mental health: that certain experiences should be understood through a mental health framework; that these can be identified through specific signs and symptoms (whether in oneself or others); that professional support should be sought; and that treatment adherence should be actively encouraged. While these messages were delivered through different discursive frameworks – psychiatric, Christian, and popular – they consistently promoted particular ways of understanding and responding to distress that aligned with modern professional mental health approaches.

I argue that psychological pedagogical interventions, through the "Nepalisation" of mental health knowledge and their connection with institutions of modernity and *bikas,* introduce and legitimise particular ways of understanding distress. In a society where the ideology of modernisation and bikas is deeply ingrained, these messages may increase the perceived value of psychological knowledge and expertise, potentially generating greater demand for mental health care. Further, I argue that whilst mental health professionals may not intend to generate new subjects, their communication directed toward an imagined modern individual, as per Foucauldian theory, can have the effect of compelling individuals to align with these discourses. This process, known as subjectivation, refers to the process by which individuals actively participate in constructing their subjectivities through self-formation and self-identification with modern discourses of the self (Foucault, 1988). Thus, I suggest that there may be a circular relationship between the discourse of self and its relation to mental health – that is promoted through mental health knowledge and the demand for such expertise.

With this, I am not suggesting that psychoeducational activities are a totalising project that has completely altered the way people in Nepal are understanding and relating to their selves or how they care for others. Rather, I argue that there has been an introduction of particular discourses of self and mental health into the public sphere (that is backed up by locally powerful institutions) that are being taught across different sites and multiple spaces, and that these discourses are present and circulating.

Building on these arguments, the following chapter analyses how higher psychology education serves as a key site where professional development intersects with broader social transformation. Through examining psychology students' experiences, it shows how formal education in psychology shapes not only professional trajectories but also new forms of social consciousness and aspirations for modernity.

Chapter 7. Psychology expertise and its appeal among the young urban middle class in Kathmandu

Introduction

This chapter extends the thesis' exploration of how mental health knowledge shapes individuals and society in Nepal. While the previous chapter analysed how different actors (psychiatric, Christian, and popular) communicate mental health concepts to general audiences through various discursive frameworks, here I shift focus to examine how expert psychological knowledge is transmitted through formal higher education and shapes professional identities.

To situate this analysis, it is important to understand how psychology education has evolved in Nepal, as this history shapes contemporary experiences and aspirations. The field's transformation from philosophical roots to clinical practice mirrors broader societal shifts toward modernisation. Beginning in 1947 at Tri-Chandra College as part of philosophy courses, psychology gradually developed into a distinct discipline (Rana & Shakya, 2022). A crucial turning point came in the 1980s with the establishment of the Post Graduate Department of Psychology at Tribhuvan University, which launched Nepal's first master's program offering comprehensive training across clinical, industrial and military psychology (Joshi & Joshi, 2022). The field's professional identity strengthened with the formation of the Nepalese Psychological Association in 1981 (Adhikari, 2022), and the 1998 launch of Nepal's first M.Phil in Clinical Psychology program at Tribhuvan University's Institute of Medicine marked psychology's emergence as a clinical profession (Rana & Sharkya, 2022). Today, with approximately forty clinical psychologists and multiple universities offering various specialisations, the field represents a new form of expertise in Nepal. As I will go on to show, psychology professionals face ongoing challenges in establishing their professional authority within existing institutional structures and employment markets, even as they actively work to create new spaces for their expertise through entrepreneurial efforts. This evolution from philosophical study to clinical practice provides essential context for understanding how current psychology students position themselves as modern subjects and agents of social change.

To examine these dynamics, I draw on data with a group of young urban middle-class individuals at different stages of their psychology careers in Kathmandu. I analyse the impact of subjectivation on these individuals, and their engagement in subjectivating others. In doing so, I do not claim that psychology education and knowledge are the sole determinants of the identity of the people interviewed, but suggest it is one aspect among many other complex factors that contribute to shaping their life experiences, considering the broader social and cultural context in which this education is situated. Further, it is noteworthy that the individuals interviewed are generally ill-attended to within development discourse – which focuses more narrowly on rural and remote poor populations – and thus what I offer here is a new perspective of the effects of discourses of self-improvement in Nepal.

I begin with an exploration on what psychology education does for the self. Why are young urban middle-class individuals pursuing psychology studies, and in what ways does this change the way they think about themselves? For this, I draw on data from twenty-five semi-structured interviews conducted between May 2018 and October 2018. These interviews were carried out by two psychology master's students at Tribhuvan University who served as research assistants, interviewing their peers. This methodological choice was crucial for examining self-transformation through psychology education. The shared educational and cultural context of the interviewers enabled a more nuanced exploration of how psychology education was influencing student's understanding of themselves and others. The research assistants conducted interviews in Nepali which allowed participants to express themselves more freely while making the research process itself contribute meaningfully to the community being studied. The aspiring psychologists interviewed reflect on their motivations for studying psychology and on the value of a psychology degree and education in Nepal. I suggest that these students are drawn to the promise and power they attribute to the discipline of psychology, of it being able to provide a universal knowledge of self through which they can understand, know, and heal self and others. Further, the students express valuing the knowledge and skills they acquired because of how it transformed the ways in which they understand and relate to themselves and others. In alignment with the modern notion of the self – as a malleable entity open to continuous personal growth and development (Giddens, 1991) – I suggest that psychological education can transform the self into an object that is constantly in need of improvement and that psychological knowledge can serve as a tool or technology for achieving this self-improvement through the process of subjectivation.

Then, I interpret data obtained from interviews I conducted with three psychology graduates who are further down their professional journey compared to the psychology students and who are working within the mental health system in Kathmandu. First, Kamala and Sadik narrate their many projects and endeavours in making psychology knowledge relevant to modern Nepali youth. On the other hand, Amina sees herself as a modern self, who uses psychological tools to challenge traditional gender norms. Together, Kamala, Sadik and Amina do not only provide insights into the transformative impact of psychology education on their own selves, but also into how they are using psychology knowledge for projects of social uplift and reform whilst subjectivating others, and the tensions and consequences that arise from this. I argue that the sense of self that they cultivated through their psychology studies – as a technology of self – encouraged them to adopt entrepreneurial means to become masters of their professional futures. Further, through this process of subjectivation, they adopt characteristics of the "entrepreneurial self", as described by Bröckling (2016). That is, they transform their selves into subjects that are "awakened, self-initiative and self-responsibility" (2016, p. xi) that try to discover "how to be different but in a different way to the way being demanded" (2016, p. 198). This tension shows how this new "entrepreneurial self" is also subject to a "field of force" – or entrepreneurial practices – that pulls individuals in contrary directions all at once. This brings attention to the tensions between the promises of the ideal of modernity and the need to navigate the slower-changing operating modes embedded within society.

The analysis in this chapter draws on two sets of data. The peer-conducted interviews with the current students capture immediate experiences of transformation while the in-depth interviews with the graduates who have established careers allows for an exploration of how this educational transformation manifests in longer-term professional identity formation and social reform efforts. Together, these complementary data sources reveal both the immediate impact of formal psychology degree education on individual subjectivity – as seen in current master's students' self-understanding and aspirations - and its broader role in creating "modern subjects" who, through their professional practice and entrepreneurial initiatives, aim to transform Nepali society.

Aspiring psychologists – Mastering in self and becoming modern self-masters

Ambitions to understand, know and heal self and others

The twenty five students interviewed were in their mid-twenties to mid-thirties and were pursuing a master's degree in psychology at Tribhuvan University in Kathmandu in 2018. Fifteen interviewees were female, and ten male. Most of them had been drawn to the discipline earlier in their life (e.g. +2 or bachelor's degree) and decided to continue their postgraduate studies in psychology. Others did their bachelors in a different subject; in microbiology, engineering, information technology, management, education, or business administration, and decided to change paths. A common reason mentioned by the students for choosing to study psychology was that they had a very strong interest – a fascination, even – in people, and that they wanted to learn about, and understand, people's behaviour, thinking, and mind. This interest in people was, for many students, very closely related to an interest and ambition in understanding, not only others, but oneself.

Whilst they differ in many aspects, the theoretical works of Dumont (1980), Marriott (1976a; 1976b) and Marriott and Inden (1977) on the subject of personhood in South Asia have highlighted that South Asian conceptualisations of the person fundamentally differ from Western notions. Dumont (1980) contrasted the ostensible holistic ideology of Hindu India with the individualistic ideology of the West and argued that unlike Western societies, which emphasise individual autonomy and independence, Indian society placed greater emphasis on the interdependence of individuals, and the maintenance of social harmony through hierarchical relationships (for critiques of Dumont's work cf. Appadurai, 1986). Further, Marriott and Inden (1977) argued that in India individuals are perceived as having a "dividual" self, which is divisible and partible, composed of various social and familial relationships, obligations and identities. This "dividual" self contrasts with the "individual self" that is more generally emphasised in Western societies. This emphasis on individuality seemed appealing to the Nepali students interviewed. A couple of quotes that capture this appeal are:

> "For me, I thought that by studying this I could know the person […] I wanted to understand myself first, my emotions, what I am and who I am… to explore it, finding my own identity and dealing with it." (STUD-8).

> "I felt like I had incomplete knowledge. I knew lots of things, but did not know about self. And I was interested in how the mind works and learning to control the mind." (STUD-11).

These motivations also reveal an assumption of the discipline as being a "science of the individual" (Rose, 1996, p. 19) that could provide a universal knowledge of self, and through which they could "know the person", learn "how the mind works", as well as provide objective insights into one's own identity. The students were fascinated and drawn to the idea of there being a body of knowledge that can unravel and explain the fundamentals of what makes people the way they are and be able to access and possess that knowledge to understand themselves, and others in turn. The quotes above also hint at other interrelated ambitions and understandings that will become clearer later, of being able to use psychological knowledge to manage oneself and others.

Like findings from other studies investigating what draws people around the world to study psychology, other major motives described by the Nepali students for choosing to study psychology, included a desire to resolve personal psychological distress (Murphy & Halgin, 1995): "I thought if I study psychology, I could make myself happy and would be fresh mentally" (STUD-2) and a desire to help others (Farber, Manevich, Metzger, & Saypol, 2005; Orlinsky, Rønnestad, & Collaborative Research Network of the Society for Psychotherapy Research, 2005): "I felt it was a form of helping other people" (STUD-20). Another interviewee pinpointed the source of his interest in psychology in the fact that his mother was living with depression and wanted to learn how to care for her (STUD-24). Again, these ambitions of "making oneself happy" and to help others with their own suffering by gaining psychological knowledge reveals an understanding, and hope, that studying psychology can provide one with tools to heal oneself and others from suffering.

Whereas these two motives, resolving one's personal psychological distress and a desire to help others were separate for some students, for others, it was their own experience of living with mental ill health that inspired them to want to help others. One of the interviewees explained that he had first started suffering from depression when he was thirteen: he had long periods of sadness, fatigue, loss of appetite and difficulties concentrating at school. He said those years were the darkest time of his life and that he needed help but did not know where to go and spent years in isolation with little support or understanding from friends or family. As opposed to experiences of Anglo-Australian psychology undergraduate students, who draw inspiration or motivation to become a psychologist from positive or negative experiences with a helping professional (Huynh & Rhodes, 2011), it was the absence of any interaction with a source of support that inspired the Nepali student to want to help others going through similar experiences. "I want to rebuild the lives of mental health patients who have been abandoned", he said. This close link between a personal "psychological wound" and a drive to choose a career in a "helping profession" has been widely documented and encapsulated in the archetypal image of the "wounded healer" (cf. Conti-O'Hare, 2002; Kirmayer, 2003; Jung, 2014). Within the "helping professions", there is a unique argument accorded to the "healing professions" – for shamanism and contemporary medicine and psychotherapy alike – that it is the healer's relationship to their own illness or affliction which forms the very basis of their authority and effectiveness as healers (Kirmayer, 2003). As Kirmayer (2003, p. 250) has suggested: "there is an intuitive logic in the notion that someone who has been afflicted and survived possesses intimate knowledge of the nature of illness and its cure". The students used this same "intuitive logic" in their thinking about their journey to self-understanding and their subsequent ability for understanding others:

> "First of all, I wanted to understand about myself, to gain a deeper understanding of my feelings, thinking and behaviour. After gaining knowledge and understanding about myself I thought it would be easier to better understand others as well." (STUD-18).

The notion that one's own transformative journey is at the very basis of one's effectiveness and authority in guiding others through their transformative process is interesting to keep in mind as the students describe the transformations they noticed and valued in their selves and in the ways they reconceptualise their futures and their lives over the course of their studies.

Valuing psychology education for what it does to selves

Over the course of their studies, irrespective of whether their initial motives were more self or other oriented, the students learnt and experienced the importance of applying psychological theory and knowledge to themselves: "I have learnt that I can apply all of the learning on myself" (STUD-4); "the knowledge can be applied in day-to-day life" (STUD-18). Rather than emphasising the usefulness of specific technical, analytical, or theoretical skills psychological education had provided them with, the value the students saw in their education was narrated in the ways in which such type of knowledge had changed the way they related to themselves and others, and how good they felt about this new way of being.

Autonomous and self-reliant selves

A student who chose to study psychology because he was seeking ways to heal himself said that gaining psychological knowledge had been a "huge asset" and a "big benefit" in his life. He explained that whereas before he would have a panic attack and felt like he was dying, after learning about panic attacks, he manages to control himself by becoming aware of what was happening and knowing that it would pass. This student said his studies had "made him good again", that he had the feeling of having "gained control" and that he had learnt how to "be happy by myself" (STUD-2). In this case, having psychology knowledge and learning about the existence, nature and process of panic attacks meant the student now knew how to manage this experience and self-care. This, in turn, gave him a sense of control over his life, and happiness. The sense of self that this student derived from applying psychology knowledge to his life and that he deeply valued was that of an autonomous and self-reliant self – responsible for his own happiness and capable of caring for himself.

It was not only the students who had begun their studies with an explicit goal of seeking ways to self-heal that noticed changes in their lives after applying psychology knowledge to their daily lives. Other students also deemed the knowledge and skills useful, helpful, and important for how it changed selves and for how it transformed ways of being in the world into better selves and better ways of being. Over the course of their studies, all selves became objects to be improved on – an understanding that, as Li (2007) has suggested, also resonates loudly within broader development discourses. For one student, her studies had taught her "how to stay positive and accepting" (STUD-4). She explains that psychological education made her realise: "yes, things happen in life, but I must adapt and move on" (STUD-4). She felt that her studies had provided her with the tools she needed to remain positive and resilient no matter what happens in her life, making her feel more self-confident: "a kind of self-confidence has built up in me" (STUD-4). Other ways of being the students highlighted as important lessons were how best to communicate and interact with others: "I have learnt to communicate differently, be more empathetic, patient and how to encourage others" (STUD-14). Thus, the students were pleased with their individual transformations enabled by psychological knowledge – they had become autonomous, self-reliant, and confident selves capable of self-regulating in ways that allowed them to be in control and optimise their life experience and their interactions with others. This new way of being – of relating to oneself and others – was intrinsically of value. However, it was also valuable to many because of how they believed it groomed them to be successful in the job market and doing a future job well: "my studies will help me mentally and emotionally for doing my future job well" (STUD-11), whether that was within or outside of the field of psychology.

The next section takes a closer look at how the students spoke about their present psychology-educated selves in relation to their past "uneducated" selves and others in their society, to shed more light on how the students constitute themselves as particular kinds of persons vis a vis others by virtue of being psychology educated in contemporary Nepal.

Legitimising claims to a modern subjecthood

Education has often been seen as a means of social differentiation and economic and social upward mobility in Nepal (Tiwari, Shidiq, & Balcázar, 2016) and elsewhere (Froerer & Portisch, 2012). In this case, education in psychology offered a new way the urban young could distinguish themselves from others and make claims of modernity. Having access to psychological knowledge was to have access to a "new" kind of knowledge – one that only very few people in their society had, and therefore something that distinguished them from the psychology uneducated majority.

The students recalled ideas and images that they had about psychologists or psychology before beginning their studies. They remembered imagining a psychologist as being either a doctor or as someone possessing supernatural powers akin to those of shamans or astrologers such as being able to know another person's inner world and secrets by "reading the mind" directly, "just by looking", or by "reading bodies" and inferring emotional states. In speaking about these recollections, the aspiring psychologists were quick in distancing their present – and modern – selves from others in their society and from their past selves. When recalling these images and ideas, they labelled them as being "misconceptions", "stereotypes" and "myths", and lamented the fact that those ideas still prevail in Nepali society. To illustrate what they believed to be the current unreadiness of Nepali society to value psychology knowledge, students stated what they perceived to be generalised negative attitudes with regards to mental ill health, misapprehensions of psychology as a discipline, and lopsided priorities. In their own words, they put it like this:

> "People have deep rooted stigma about mental illness despite about 50% of the population suffering from it at any point in their life. So, people are hiding the illness inside them. I see a bright future if we can generate awareness regarding mental illness among people." (STUD-11).
>
> "People haven't understood the balance that is required between mind, body, and health to live a perfect and peaceful life. We have the tendency of giving importance to material life instead […] People are conservative about spending financially on their mental health and have not given importance to mental health in comparison to the allopathic and even cosmetics and entertainment." (STUD-18).
>
> "I think only us as psychology students have really understood what psychology is actually about. If you ask outside, like even when you talk to BBA [bachelor's in business administration] students, it is the same as before. They believe that once psychology is studied, people have like…that they will know everything about others. Even my friends ask me to tell them about how they are. They are like…you study psychology, so tell me, how am I? So, these things even exist today." (STUD-24).

The contrasting of their knowledge with that of the majority of others in their society who, in their view, have little or no knowledge about psychology, illustrates their desire to align themselves with modern, scientific ways of thinking. By acquiring this knowledge, the students set their selves as modern subjects who can navigate the complexities of modern life, and who can claim a certain level of authority and expertise. This knowledge also positions them as agents of change in their communities. In this way, the acquisition of new knowledge is seen as a key strategy for promoting individual and social progress, and as a necessary condition for achieving modernity in the contemporary world. It provides them with a tangible avenue for societal transformation, offering a clear path toward shaping their communities.

In sum, the above has elucidated how psychology education – through the process of subjectivation – encouraged the students to adopt a modern self that puts emphasis on individuality and to distance themselves from others in their society in their unique psychological expertise. In the following, I shed light on the responsibilities awakened by this sense of self in disseminating their new knowledge and in actively creating a different social and professional future.

Self-masters and the responsibility to create a different social and professional future

Despite the pervasive stigma, ignorance or backwardness the students perceived to prevail in their society, they were hopeful of a different future where people were more educated (and psychology educated in particular), and their expertise would be better understood and valued: "People don't have much knowledge about the psychology here in Nepal, but it is changing." (STUD-25). They believed, and speculated, that the scope of their degrees was slowly increasing, especially since the 2015 earthquakes aftermath, which they thought had brought about change – although transient – in the general public's understanding and moral value towards mental health and psychology experts. In fact, the students' own trust in the value of psychology knowledge was validated to them in market terms in the 2015 earthquake aftermath when they witnessed psychology skilled people being momentarily in high demand in development and humanitarian agencies – one of the most coveted employment spaces for young educated people in Nepal. Although ephemeral, this validation from the global development and humanitarian apparatus of the value of their expertise was important.

> "After the earthquake there were many advertisements appearing for vacancies for psychologists and counsellors. And the news and media helped expand the positive image of psychologists that provided counselling to those who were suffering." (STUD-7).

Some students, and members of their social network, began to think that becoming a psychologist would make for a good career in the future and believed that having a psychology degree would facilitate getting a job with NGO/INGOs.

> "I had studied psychology as a major subject in bachelor levels and there was demand for psychologists after I completed my bachelor level. There were not enough psychologists to help the people after the 2015 earthquake. Also, my teacher inspired me that psychology had good scope and that it would be a good career as a psychologist in the future." (STUD-7).

> "My uncle told me that the ones with knowledge in psychology had priority in NGOs and INGOs, so I started the masters." (STUD-20).

In addition to having witnessed the possibility of NGO and INGOs hiring psychology-skilled people in large numbers, the students had the impression that, in the post-earthquake period, more people in their country had become "aware" about the existence of mental health issues and had begun to understand, trust and value psychology knowledge and expertise (as described in chapter 6). However, they also noted that any of the hopeful changes brought about by the post-earthquake context with regards to the mental health system in their country had been short-lasting because they relied on foreign funds that "came and vanished" (STUD-16). Whilst they were disappointed about the short-lasting nature of the changes they saw after the earthquakes (also discussed in chapter 4), they had faith in a different future. Their faith was not passive in nature nor only a faith they cultivated in the tools offered by the discipline of psychology for self and others. The aspiring students believed it was their responsibility, as psychology educated individuals, to widen the scope of the discipline and to create their own job opportunities, and achieve wider social transformation with hard-work and entrepreneurship. Entrepreneurship is not only an evident ideal that follows an understanding of self that is autonomous and responsible for one's life outcomes, but also provides an element of hope for those who perceive themselves as being marginal to the development discourses. By creating their own businesses and opportunities, they believed they could contribute to the development of their society and empower others to do the same.

> "It is our responsibility to work in the progress of psychology in Nepal. We need to do it slowly and steadily." (STUD-18).

> "I think the scope is that which needs to be created by us. Personally, I think I have to make the scope. It is in our hands, like we have studied the locus of control and there is an internal locus of control, and exactly that is in my hand and if I wish I can do it, but I need to do hard work." (STUD-19).

> "We need to work hard to make a field for ourselves." (STUD-6).

The future they envisaged, thus, was a future that needed to be actively created by them. The faith they had in a different future was based on the faith they put in ideals of hard-work and entrepreneurship and reflected their belief that individuals have a "locus of control" and therefore can take control of their own lives and shape their own destinies. The adherence to the understanding promoted by psychology knowledge – of individuals having an internal locus of control and therefore always having control over their actions and outcomes – is suggestively in agreement with an entrepreneurial selfhood. In some students, there was almost an element of evangelism, a sentiment akin to wanting or needing to "spread the light". This sense of wanting to share knowledge and make others "aware" is also very common in development discourse and logic.

> "On knowing more about mental health, and exploring more of it, I found that everyone needs this." (STUD-6)

> "Psychology is new for here and it is most needed so that people can understand themselves and people around them and for well-being." (STUD-8)

The students came to an understanding that psychology knowledge was not only beneficial for self and others, but needed. Going back to the notion of effectiveness and authority in guiding others through their transformative processes after one has undergone successfully through theirs, most of the students imagined a new professional future for themselves as psychology experts, guiding and supporting others in their own self-transformations. In the words of one of the interviewees: "I want to establish my own clinic and be the change agent of society in helping people" (STUD- 22).

Together, these interviews illustrate how the students are exploring new avenues for comprehending the self and are developing an independent and self-sufficient self-concept, while also perceiving the self as a modern self – one that needs to be enhanced and improved on and views psychological knowledge as a technology and tool for accomplishing it. This modern self resonates with the "entrepreneurial self" (Bröckling, 2016) promoted in market-oriented societies – that is, a type of self that thinks of themselves as entrepreneurs of their own lives, treating their selves and their personal projects as a business enterprise. Indeed, as many scholars have suggested, using a Foucaudian interpretation, a unique aspect of neoliberalism is how it informs entirely new ways of relating to the self and how it constitutes new kinds of subjects (Rose, 1999; Foucault, Davidson, & Burchell, 2008; Roy, 2022). I suggest that psychology educated individuals might feel compelled to shape their own futures in response to market-oriented forces, encouraging them to become masters of their own destinies as promoted by the ideal of the "entrepreneurial self" (Bröckling, 2016). In the following, I continue this analysis by exploring the educational and professional histories of three psychology educated individuals: Kamala, Sadik and Amina, who are further down their career path than the masters' students and are working in mental health in Kathmandu. Kamala, Sadik and Amina engage in active entrepreneurship and promote psychological knowledge as a tool for living a good life, to be modern, to advance professionally by selling this knowledge as a service (as Kamala and Sadik describe) as well as a tool to uplift and transform society, particularly in challenging gender norms (as Amina elaborates).

The social role of psychology knowledge – a tool for a modern society

Kamala and Sadik: Promoting modern solutions for modern youths

Kamala and Sadik are both highly passionate about psychology. It was, in fact, at a psychology related seminar in Kathmandu in 2012 that they first met. Now, they are married and continuously support each other, both in their personal lives and in the development of their professional careers. They both belong to a particular demographic that is not front-lined in development projects: they are from Kathmandu, belong to high caste groups, and had a private high-school education. Indeed, people like them are often agents of development rather than subjects of it. They are also the active entrepreneurs that the masters' students interviewed aspired to become in the next stage of their professional lives.

In 2015, right after their bachelor's degree, Kamala and Sadik founded the first entirely youth-led and youth-oriented NGO working in, and promoting, the field of psychology in Nepal. The NGO was their dearest project among many other efforts they put in their attempts to promote mental health and craft their professional selves, portfolios, and lives. I first met Kamala and Sadik in 2017, when they were in their late twenties, and finishing up their Clinical Psychology master's degrees at Tribhuvan University.

In the following, I recount their educational and professional narratives, in which they speak about certain sacrifices as well as a great deal of effort, investment and goodwill they put into crafting their professional selves with entrepreneurial acumen. Throughout, they reflect on the fact that now, after years of personal investments, sacrifices and relentless efforts, they are no longer the employees wanted by their local formal job marketplace. Their story illustrates the tensions the educated middle-class youth face between the imperatives of becoming an "entrepreneurial self" (Bröckling, 2016) and the need to remain embedded within society's slower changing values and modes of operating.

*

Sadik's interest in psychology began when he was about fourteen years old, in class nine, before he even knew the subject existed. He explains that he was fascinated by Sherlock Holmes and wanted to know how to become like him, "I was thinking which subject was more relevant for this kind of things, and found psychology because it has a direct link to human behaviour." After gaining some more information about the discipline online, he decided that he wanted to work in the field of psychology. In Kamala's case, she says she "always loved talking to people" and that people used to be her "favourite subject" but was also unaware about a field in which one could support others "just by talking". Both narrate going against their respective family's wishes when they finally chose to study psychology rather than a subject that would lead them to becoming a medical professional or an engineer – the common aspirations of middle-class parents for their children in Nepal (Mikesell, 2006). Kamala explains,

> "My father wanted me to be in the medical field, he wanted me to study medicine or dentistry or something like that, but I really did not like studying science. […] I remember my father even took me to the admissions for dentistry, but I had bombed chemistry in high school, which was a good escape because I needed to have passed chemistry."

Kamala knew her father was disappointed in her choice but found "a good escape" for not having to meet her father and society's expectations by not having the necessary grades, and therefore not having the option to get into medicine or a medical-related field. Sadik, on the other hand, having always excelled academically had no justifiable escape. So, when Sadik prioritised his own interests over his family's, choosing to study humanities in his plus two (intermediate level of education) instead of science, it created a significant conflict with his family. He tells me:

> "My family was very angry with me. Especially my father. He did not talk to me properly for two years because of that."

Sadik sacrificed kinship harmony to follow his interest in psychology. After finishing his plus two, his interest in the discipline grew even stronger and wanted to explore more but says he felt unsatisfied in Nepal. Like many young middle-class educated people in Kathmandu do (Acharya, 2012), he began looking into options for studying abroad. He was thinking about moving to Australia when he met Kamala and decided to do his bachelors' degree in psychology in Bangalore (Karnataka, India) instead, staying closer to home and being able to see Kamala more often. Kamala and Sadik cultivated their relationship at a distance and fostered in each other the desire and confidence to be able to "do something together in psychology" in Nepal. Using psychology knowledge as a tool, they wanted to build something together and work for the change and betterment of their own country rather than try to escape from it.

Kamala and Sadik began their entrepreneurial journey creating a joint blog. Their goal was to educate and inspire their peers about their beloved discipline. The name of the blog was a combination of the words "psychology" and "science". They explained to me that the name came from a sense of disappointment with the fact that in Nepal psychology was taught within humanities and social science faculties and institutes rather than scientific ones. They had aspirations both for psychology as a discipline, and for their country. They wanted psychology to be formally recognised as a legitimate science, and for it to be accompanied by the reverence and influence that typically accompany scientific disciplines, and they wanted Nepal to be a modern society where psychology had a respected status as a scientific pursuit. In a similar way that Adams (1998) noticed with medical professionals, here the psychology professionals were also advocating for the elevation of science as the foundational tenet shaping the very essence of modern Nepal, perhaps to make a departure from entrenched traditions and superstitious beliefs. In their blog, they wrote about a wide array of psychology related topics. Later, they made use of Sadik's holiday breaks, when he would be back in Kathmandu, to put into practice some of their knowledge and provided free school programs. At first, Kamala tells me, they offered and gave school programs in schools that they "knew from earlier", or in which they had contacts from "friends of friends", their relatives or close affiliations. She explains their motivations for doing these school programs and what they offered to the schools as follows:

> "We wanted exposure, we wanted to execute certain learning and we also wanted to enhance our knowledge in psychology. So, we used to call schools and say we are wanting to do stress and emotion management programs or something like that, and would you be able to give us one hour or two."

Although they call their activities "programs", initially, they did not follow any structured curriculum. They shared any content they felt would be relevant, and fun, for their audience. At these schools, thus, Kamala and Sadik were not only psychology experts but also content creators. The write-up of one of their early school engagements published on their blog provides a picture of what it was they taught. They state that they spoke about "transitions and identity crisis in teenagers", "the bad trap of drugs due to the stress, anxiety and peer pressure in that age group", "the increasing suicidal rate among teens", "the need of motivation for students and how to keep motivated", "the importance of positive thinking", "six important steps to improve life" and that they shared skills "to make students capable of self-help when they have some mild psychological problems". In addition to providing information, they combined their teaching with the sharing of psychological tests such as the WAT (word association test), relaxation techniques like meditation, and referral information in case anyone felt the need to seek professional support. The school pupils were therefore exposed to a general picture of the challenges people of their age group experience (e.g. identity struggles, drug use and abuse, an increasing suicide rate), were provided with explanations for these challenges based on Kamala and Sadik's knowledge of the human psyche and given advice and techniques on how one should live to live well. Kamala and Sadik taught the school pupils that to live well one could use certain techniques to improve and optimise their selves: for instance, by meditating, by not losing motivation with their studies and by thinking positively. In so doing, Kamala and Sadik positioned themselves as "experts" and professional selves, imparting a lesson that those who are psychology educated, like them, know the science and technology behind the secret of – instead of the wisdom perhaps – to living well.

In both Kamala's and Sadik's narratives, as was the case for many of the masters' students interviewed, their experiences in the aftermath of the 2015 surfaced as a turning point with regards to their own understanding about the importance of mental health and of their expertise. Kamala explains,

> "Initially, I did many projects around psychology out of pure enthusiasm for the subject and people. I just used to love the work, so I did that, and wanted to share it. But after

> the earthquake, Sadik and I did some programs. For example, we put up a small tent and wrote '*hami saunchau*' (we listen), and I saw how much people used to cry when we were in the tent. People used to come and used to cry for things they do not have, for the people they had lost, and that was the trigger. That was the first time I realised this can be very helpful. After the earthquake, my realisation was that talking about fear and anxiety is needed as much as talking about physical pain. That encouraged me to reach out to more people and talk about mental health."

In the earthquake aftermath Kamala and Sadik acted as "barefoot therapists" (Atif et al., 2016) setting up their own temporary shelter, relying on basic soft skills they had learnt about in class such as listening and probing and their good will to provide support to vulnerable others. The experiences they had listening to people that had been affected by the earthquake changed the way they related to their work, their skills, and their selves. Kamala explains how the mental health support they provided to people post-earthquake concurrently made manifest to her the usefulness of psychology skills, the need people have to talk openly about challenging emotions and the role she could play in promoting mental health. The work they informally carried out and the positive effects they believed they had in the lives of others fueled their confidence in the discipline they had chosen to study, in the worthiness of the skills they had developed and could develop further, and in their self-worth as professionals. For Kamala, for instance, drawing out the commensurability between physical and mental pain seemed to propel her efforts in the field of mental health even further and increase her confidence in the value of her chosen expertise. Indeed, although Kamala did not explicitly put it like this, if caring for mental pain is as important as caring for physical pain, Kamala had in fact fulfilled her father's expectation – she was, after all, working in a medical-related field.

Coupled with this increased confidence in the value of their expertise and their self-worth as professionals, Kamala and Sadik felt they were increasingly faced with an external demand for professionalisation. Kamala explains that, at first, they provided psychology-related programs to institutions that would invite them to do so, or for people that welcomed the free support. However, they were increasingly often faced by people asking what organisation they were representing. Kamala and Sadik would explain that they had "an open group" but that they were not an official organisation. That was not always enough, "people wanted that attachment, they wanted the recognition from an organisation". This is resonant with what Craig (2012b) has also written about processes of professionalisation of *amchi* (tibetan healers) in Nepal, and the drive for state recognition and support of their practices to legitimise their work and grant it authority. Kamala and Sadik faced similar questions when they started broadening their reach, contacting schools where they had no social affiliations to rely on. The conundrum they faced was that, although they knew they needed an institutional affiliation to continue carrying out and expanding their programs, they did not want to volunteer for some other organisation and "do what other people wanted us to do". They wanted to work independently and decided to create their own NGO, using entrepreneurship as a problem solving method (Sarasvathy & Venkataraman, 2011). Attesting to their entrepreneurial mindset, Kamala tells me,

> "We wanted to execute our ideas and plans, and we thought organisations would not give us that opportunity for us to execute our ideas, so we thought why not register the

> organisation. So, I guess we started our NGO because we did not have any platforms to go and say we want to do this and this and we want you to trust us.”

In 2015, therefore, Kamala and Sadik founded their youth-led and youth-oriented NGO working on the promotion of mental health and the discipline of psychology among the Nepali youths. They saw the area of mental health and psychology promotion for (and among) the urban young as an important need and niche that they needed to, wanted to, and could, fulfil – combining social activist motives with entrepreneurial means. Kamala explains that, before their NGO, there were no youth organisations working on the social issue of mental health, and that although there were a handful of “bigger” mental health dedicated NGOs before 2015, they felt there was a big disconnect between the work they were doing and the impact they had on Nepali youths, as well as a disconnect between the organisations' understanding of what psychology knowledge is good for, and their own. For Kamala, the work other organisations did was to do with mental disorders and interventions, which is not what they believed young middle-class Nepalis were interested in. Young Nepalis, in her opinion are interested in:

> “everyday stressors or relationships between their parents and them, relationship between them and their teachers, and maybe how to get motivated in everyday life.[…] And yes, youths are more interested in mental health disorders nowadays, as depression is becoming more fashion [sic]…but the work done by those organisations does not cover the youth.”

For Kamala, the important missing piece from other NGOs’ work is a focus on mental health promotion: “there was no one developing podcasts or doing much awareness programs or posting information on Facebook and Twitter”. She views other NGOs as being sustained by, and therefore influenced by, external funding that is generally restricted to programs targeting very specific kinds of populations (rural or semi-urban) experiencing particular social issues – issues she believes are different from those faced by the urban young. “They used to just do programs in the field” she says. Whilst she believes the “bigger” NGOs are “doing good work” and views them as being part and parcel of the efforts to promote mental health in Nepal, she also says they “cannot just rely on them”. This resonates with the “entrepreneurial self” described by Bröckling (2016, p. 20) where “people regard themselves increasingly as entrepreneurs of their own lives, electing to assume responsibility for themselves rather than making others responsible for them”. Her critique towards other efforts in mental health was not restricted to the limitations in the type of programs and the scope of other organisations, but to the limited dedication and sense of ownership with which she believes some of the people working at other NGOs operate. She explains it like this:

> “When I talk to people who are in these bigger organisations, they say, ‘that is out of the scope of our project’ or ‘it is not in our scope of our program’ and I find it a little difficult to digest that fact because how can mental health not be the scope of the project, right? And so, the project finishes and that is the end of their program.”

In saying that she finds it “difficult to digest” when people draw a line under their responsibilities with regards to mental health at the scope of a specific project and that they “cannot just rely” on other mental health NGOs, she differentiates their deep dedication to the cause with that of others and takes it upon herself, as a personal duty for the wider public, to work on mental health promotion. Rose (1996, p. 12) argued that in liberal and democratic regimes, the government of others has always been linked to a certain way in which free individuals are enjoined to govern themselves as subjects simultaneously of liberty and of responsibility. Indeed, Kamala and Sadik took it into their own hands to create a platform they felt was missing for the youth that addressed a social issue they believed was neglected by other institutions and youth organisations, and that focused on a segment of the population left untargeted by others. They envisioned their NGO as a platform that not only trusted the young, psychology educated, socially aware and passionate people to directly work on the promotion of mental health in their country but where mental health and the discipline of psychology could be promoted in a way that is relevant to young Nepalis. Kamala and Sadik are certain about the important impact the new generations can have on promoting mental health and well-being in their country, "we should reach the mass(es) through young people". They believe that young "psychology enthusiasts", like themselves, are more genuinely motivated to work on promotion than other NGOs, and that young people have a very powerful and far-reaching influence on their peer's interests and beliefs. Kamala says:

> "Young people should work on the promotion side because of the reach of the network. Young people are always with their peers and influenced by them. So, if you talk about mental health and I am a friend of yours then I will be interested in learning about that issue as well or start believing that that issue is necessary".

Engaging the young, Kamala believes, means tapping into an extensive and powerful network of social influence through which to promulgate the promotion of mental health. Sadik explains that over the years, they went from being an amateur organisation to a more professional one, with their own office and counselling room. When they founded their NGO, they invited and welcomed other "psychology enthusiasts" such as recent graduates and psychology-interested youths, to be part of, and involved with the network: as board or executive members, interns, volunteers, or as general members; creating a network of psychology interested youths. Sadik became officially the founder and president of the organisation, Kamala the founder, executive director, and vice-president. Building on their pre-NGO experiences, Kamala and Sadik continued providing "school mental health programs" – this time, being able to state their organisation's affiliation with their NGO, and as Kamala says, "being more serious and professional about our work". They also produced a weekly radio program – "the first of its kind" in the field of mental health, monthly podcasts and newsletters; they held monthly psychology related discussions and kept their blog going. They maintain an active online presence on social media and facilitate, organise and/or conduct workshops, trainings and awareness programs in schools, colleges, and youth groups. A few workshop titles listed on their website – created as part of their crafting of professional selves – include many personal and professional development coaching-style events such as: "Be the professional you", "Research and proposal writing", "Psychology and Mental Health Celebrated", "How to study better?", "Motivational interviewing", "Psychological, Emotional, Social and Health Education at schools", and "Art Therapy Techniques". Thus, Kamala, Sadik and other members of the NGO design, facilitate or give trainings to others, teaching them how to optimise themselves with a view to enhancing skills that are marketable.

In addition to their voluntary work with their NGO and their studies, both Kamala and Sadik build their professional lives by getting involved in different organisations as interns, carrying out independent research projects, teaching psychology courses in colleges and providing counselling sessions to private clients. In recognition of her work, Kamala has been awarded a few awards such as the Women Achievers Award, the Global Peace Women Young Leader Award by Global Peace Women International and has been frequently invited on TV programs, and features in local newspapers, to talk about mental health and/or her professional career within the field. More recently, Kamala became the head of programs for a private counselling online business, a psychology lecturer at university level and is pursuing a part-time PhD. Yet despite their efforts, and the formal recognition from media outlets and awards, Kamala explains how now that she and Sadik "have to earn our bread and butter", they get rejected from jobs at other mental health dedicated NGOs that they are certain to be overqualified for. "I think they see us as competition", Sadik explains, while Kamala worries she might have limited her future professional opportunities because of her work with their NGO.

After years of relentless efforts crafting their professional selves through voluntary work and the creation of their own NGO, they have their job applications rejected by other mental health NGOs and development organisations. Kamala and Sadik's story illustrates the tensions young people face between the promises of the modern ideal and the need to remain embedded within society's – slower in changing – modes of operating. Whilst Kamala and Sadik invest heavily in their education and skills development, and embody ideals of innovation and creativity, the local job market does not immediately recognise the value of these skills, making it difficult for them to garner support and acceptance for their non-conventional career path and challenging for them to find suitable employment despite their qualifications. This is an argument that I develop further in the next section where I narrate Amina's entrepreneurial path and the struggles she faces in her continued efforts to shape a future society that is liberated from deeply rooted traditional gender roles.

Amina and her "life project" of "social construction"

In talking about her family and her experience growing up in Kathmandu, Amina describes her mother as being the most powerful person in the household and the family member with the most "traditional ways of thinking". In a household where Amina felt "unnecessary" traditions were not only being forced upon her but also making her mother anxious and unhappy, she explains how she grew to become the "black sheep" in her family and a "strong" woman who challenges Nepali society's gender expectations and social norms with how she lives her life and the work she does.

Amina describes herself as being an early entrepreneur in the field of mental health in Nepal. She began her therapeutic business in 2006, in her early twenties, before having formal qualifications to do so, and continues to be today one of very few Nepali practising psychotherapists in the country. Now in her mid-thirties, after more than a decade of practical experience and a collection of psychology related degrees and qualifications, she describes herself as being courageous and proud, “especially in a society and country like Nepal”. This sense of pride, I came to understand in conversation with her, was not only derived from the way she lives her life, as a modern woman in what she considers a still predominant traditional Nepali society, nor solely from her business and profession as a therapist. In fact, her sense of pride was derived from the fact that she saw the way she lives her personal life as reflecting what she attempts to help others accomplish as a therapist, and that having psychology knowledge enabled her to make claims of being a particular type of self: a modern self.

As a young girl, Amina resented having to be involved in household religious functions such as *pujas* and *shhradhha.* Growing up, she tells me, she would sometimes say she was menstruating, using the belief that menstruating women become “impure” and should not be involved in sacred affairs, to escape having to be involved in religious events. She also resisted other social norms she felt were unduly imposed on her for the only reason of her being a woman such as learning how to cook. Later in life, she did not resent the traditions themselves so much as the effects she believed her mother’s sense of responsibility to uphold these traditions had on her mother’s own happiness and, consequently, on the way she raised her three daughters. Amina believes her inner child’s yearning for seeing her mother being happy has, in some powerful way, shaped her professional and life agenda. Today, she describes her life as a “project” and her “life project” as being one of “social construction”, which I unpack through analysis of her narrative below. Central to her life and her project are psychology knowledge and therapeutic skill. Amina does not only make sense of her own life and narrate her life in psychology terms, but it is also through her therapeutic practice that she tries to shape a future society into one that is liberated from traditional gender roles.

Therapy for “social construction”

Amina sets herself very much apart from other mental health professionals who believe problems lie within the chemistry or brain of a person and who rely on medicine for a cure. She writes about the philosophy that drives her work on her website, and states: “we are driven by the philosophy that every individual is normal but may be troubled by some abnormal psychological difficulties”, and continues, “the visible issues of an individual actually have deeper roots somewhere else. You can relate it to the tip of an iceberg that has enormous structure hidden below. With the help of psychotherapeutic approaches, we dig into the roots/causes of such problems and terminate them permanently”. The biggest problem, she tells me, is often that clients are not aware of the underlying issues causing their suffering and blame themselves for feeling sad and anxious.

> “The problem is that people think it is their own fault. They name it depression, anxiety, or any… and it is not that. And otherwise, they blame their mother-in-law, or husband […] they think ‘I’m suffering’ and that they are weak, ‘I am depressed…’ and they think it is their fault. They feel guilty about what is happening but when they understand the reason, it is different”.

As a therapist, Amina supports her clients in becoming aware of underlying reasons for their suffering and considers her work a success if she manages to make her clients understand that their suffering is not their fault and that they are not to be blamed. She shares a case example of a woman she worked with:

> “She did her masters from the UK, Nepali woman, 42 years old, and what happened? After the earthquake, she came to see me with restlessness. She told me that her mother-in-law was not the best person and had done many wrong things to her. So, she had cursed her internally. And during the earthquake, her mother in law’s house collapsed, fully damaged. Everyone was fine, only the house was damaged. And she felt that because she had cursed, that happened to the entire house. Her thoughts were ‘you have done wrong to me, so now wrong will happen to you’ and it was completely secret, she had not told anyone, not even her husband but the guilt was eating her inside.”

Through therapy, Amina tells me, this woman became aware of a wider structure that was causing her suffering and understood that she was not to be blamed for her reactions and was “finally able to breathe and relax”. The wider structure underlying this woman’s suffering, Amina believes, is the same structure that she is convinced, after many years of working with clients in Kathmandu, underlies a lot of her clients’ suffering: the gender role in traditional Nepali society, and what she terms, women’s “dysfunctional guilt”. According to Amina, both women and men are raised in ways that inform their “social constructs” with regards to their roles in society according to their gender and suffer in different ways because of these constructs. However, she believes women in particular suffer from “dysfunctional guilt” when they experience the impossibility of meeting their own expectations with regards to their duties as a married woman and as a daughter-in-law in Nepal.

> “Right after marriage girls start getting that sense of guilt. They start thinking, should I cook, should I cook longer hours, should I wake up early in the morning, should I do this. That kind of guilt automatically comes. […] Girls see a lot of their mother’s side when they are a child. So now [later in life] she has to be a good wife, a good daughter-in-law in her mind, which is the construct she has from when she was a child and when she saw her grandmother or mother in that growing age. So, she then thinks that a daughter in law should be a certain way – that idealised daughter in law. So, the reason they are suffering is that they are not being the idealised daughter in law but in their mind they have to be. They are in conflict with themselves. That conflict creates dysfunctional guilt.”

This “automatic” and “dysfunctional” guilt that comes after marriage for a woman, Amina believes, can be explained by Nepal’s traditional society and its prescriptive roles according to gender – which connects with the gendered roles depicted in the theatrical performance showcased during the conference in the previous chapter (cf. Chapter 6). “In our culture…” she tells me, “I am not married to a man, I’m married to a home. So, if anyone comes in that place, that person must do the same, according to the role. It is all about the role. It is not about the person, the personality, not likes and dislikes of the person”. She makes a difference between functional and dysfunctional guilt: “If you feel guilty about something that you have done wrong and you take charge and try to solve, and learn, it is your functional guilt. For instance, if I do something wrong and I feel guilty and next time I try to do differently… that’s functional. But if I feel guilty about the system that made us the way we are, I don't have to feel guilty, and that guilt is dysfunctional".

Amina's in-laws had already died by the time she married her husband which meant her living arrangements differed from what she says is expected of a married woman in Nepal which is that the woman moves into the husband's home with her in-laws. Instead, Amina lives with her husband, their son, and her own mother. Even though her living conditions are different than for the majority of women in Nepal, Amina is convinced that "traditional" gender roles underlie a lot of the suffering she witnesses in her consultation room.

> "It is so common to have women come to me saying that they are depressed, that they are in their forties or fifties, saying that they have lost their whole life in caring for others, not thinking about themselves at all. Feeling like they have no identity. A real existential crisis. For example, if I wanted to raise my child differently, I would not be able to. And in my case, it is my mother, so it is okay for me… but if it were my in-laws, it would be different. And if I raise my voice, obviously my mom gets angry, but it is *my* [my emphasis] mom, so again, it is okay, but many women are with their in-laws and it is different. Women do not only suffer with their husband but with the mother of their husband… the main patriarch of the family. Women go abroad if they can mainly for this reason, not other than that, unemployment, or that…because they just want to live freely. And if they come to Nepal and stay with family again the situation is the same as fifty years ago. Mothers have not changed. In any house, women must like to cook, and she gets depressed because she does not mind meaning. Women do not have a place in their family because it is understood that when you get married, you go to a different home. So, it is not their home. And when they go to their husband's house they are seen as from a different home and must prove themselves and they are always excluded. For the woman, then, where is her place?".

Therapy, and especially therapy with married women, in her view, does not only support the woman in how she experiences her personal life. Amina believes therapy also helps the client's relationship with others, and can transform families as a whole. Furthermore, she believes that when therapy is beneficial for a woman, it can lead to wider intergenerational social transformation.

> "If you can support women, they can raise their children differently, and if they can raise their children differently, then automatically society changes. If I can support even one or two women…they can raise their children differently and that already makes a big difference."

Amina understands the gender roles that are causing so much suffering as social norms that are continuously being reproduced by individuals (both women and men) that were not only raised with what she labels as "traditional social constructs" around gender roles but by individuals who growing up also witnessed their own mother's guilt in never being able to fulfil her own social constructs. Thus, she believes that if women, through therapy, can become aware of the harm their own "social constructs" have caused them, these women may be able not only to free themselves from their own suffering but also raise their children in a way that will free the next generation from feeling guilty for not adhering to traditional social norms, ultimately allowing the space for gender role norms to change. Amina views her therapeutic practice as being a medium through which she may support, over time, social reform, or in her own words “social construction”. But these changes and the intergenerational struggles they cause also have their psychological costs, as all my interviewees show. Furthermore, psychology knowledge and psychology skills are not only important for Amina because they allow her to shape other people but have also become central to the way in which she speaks and theorises about her own life.

Psychology knowledge enabling a (guilt-free) modern self

“And what was it that motivated you?” I ask Amina, inquiring about her motivations not only to study psychology but to start her own therapeutic business, and dedicate her life to change society.

> “My experience with my mom maybe… that feeling of why she always had to bring all those unnecessary traditions and being anxious, and treating her children in a stressful way, you know. It was not healthy. So, she is my inspiration, my motivation for that. You know, every child wants their mothers to be happy. It matters. The mother is the world for the child. So, if I can make my mom happy, then my whole world is happy, and I could not do that in my childhood, so I try with other mothers”.

In rationalising her therapeutic calling and goals as being motivated by her childhood experiences and her inner child’s unfulfilled yearnings of seeing her mother living a relaxed and happy life, Amina uses psychology language and logic to narrate and theorise about her own life. Indeed, Amina talks about psychology knowledge and her therapeutic work as being “a part of her” and describes her job as “not feeling like work” and it being “a real and deep passion”. Conversely, she speaks about her own life as being an ongoing “project” and often uses her own life and her journey of ever-increasing self-awareness and self-acceptance to illustrate what she attempts to help others accomplish as a therapist, collapsing her personal and professional goals as well as her goals with those that others ought to have.

> “I myself have struggled a lot. I am from the same society, you know. I had the same construct. Because in my case, my husband is very supportive, but I used to feel that ‘my god, what kind of wife am I’ […] like sometimes when he does dishes, I feel ‘oh my god, what am I doing’”.

Amina felt like a “black sheep” in her family because she did not want to accept certain “traditional ways of thinking”, but says she also realises she used to think “like society”, and at times, still does. The way she knows certain “social constructs” are still ingrained in her is that she notices her own feelings or thoughts of guilt that arise when she or her husband behave in ways that clash with traditional gender roles, especially with regards to household chores. Amina traces the origins of the feelings of guilt she still feels from time to time to the fact that she was raised by a “traditional mom” who she often saw feeling anxious and stressed about having to uphold traditions. Although she occasionally feels a sense of guilt when she sees her husband, for instance, doing the dishes, her ability to notice these thoughts and feelings and her understanding of wider social structures that are making her feel the way she does is what makes her different from the majority of people in her society and what allows her to be able to choose how to live, and break free from traditional ways of thinking. She attributes her self-awareness skills and her “deep understanding” of how social norms impacts on an individual’s psyche to having psychological knowledge and an established therapeutic practice,

> “I was the same, just thinking like society and then I started studying therapies and already started psychology. And I started learning skills and practising skills, and I applied it to myself. It is so important to apply to oneself. So, I started to internalise things. From my core, I would inquire ‘Why do I do this like this’, that is why I understood things in depth”.

Amina believes that her psychological skills have enabled her not to give in to occasional feelings of guilt and not to conform to behaving in traditionally prescribed ways. In being aware of her thoughts and cognisant of their origins, Amina says she can free herself from unnecessary guilt and choose to live a “healthy”, “happy” and modern life that is not dictated by traditional gender roles. She also says that it is “because of that deep understanding” that she can now raise her son differently. She considers herself fortunate to have found in psychology techniques to enhance awareness, freedom, and self-direction, and wants to support others in doing the same, through therapy.

Conclusion

This chapter explored how formal psychology degree education shapes self-identity among young middle-class urban individuals in Kathmandu. While I do not assert that psychology education singularly determines these students’ identities, through twenty five master’s student interviews, I showed how this higher education pathway significantly transformed their understanding of self. The students articulated being drawn to pursuing a psychology degree for its promise of providing knowledge through which they could understand themselves and others. They valued how their education changed the ways they understood and related to themselves and others, describing how they became more self-aware, confident and capable of managing their own well-being. The 2015 earthquake proved pivotal in validating their degree choice, as they witnessed psychology-trained individuals being momentarily in high demand by development agencies.

The narratives of three psychology graduates revealed how this educational transformation manifested after the completion of their degrees. After graduating, Kamala and Sadik found themselves crafting professional identities through entrepreneurial means, founding Nepal’s first youth-led mental health NGO while facing institutional resistance – despite their psychology qualifications, established NGOs rejected their job applications, viewing them as competition. Amina’s account showed how her psychology training enabled her to challenge traditional gender roles, using her therapeutic practice informed by her degree to address dysfunctional guilt among women. She applied the knowledge from her psychology education to analyse her own journal and help others transform.

Together, these accounts demonstrated how a psychology degree education promotes a modern notion of selfhood emphasising individual autonomy and continuous self-improvement. This, I argued, aligns with characteristics of the “entrepreneurial self” that Bröckling describes – subjects that are awakened, have self-initiative and feel self-responsibility. However, I also showed that, as both current students and graduates discovered, embodying this entrepreneurial self meant navigating significant tensions between their modern aspirations and Nepal’s slower-changing social structures. Their experiences highlight the ongoing challenges faced by entrepreneurial selves in “being different differently” (Bröckling, 2016, p. 198).

Chapter 8. Conclusion

In the introduction of this thesis, I laid out my intention to offer my friend Rupa, and others, a broader perspective of the implications of the 2015 earthquakes in Nepal. Although my main objective was to undertake an ethnographic study of the mental health system in the post-earthquake context, my research has ended up reaching towards further understanding of the shifting landscape of aspirations and possibilities for social change in the country. This thesis provides ethnographic evidence of the effects, implications, and the complexities surrounding the implementation of humanitarian, development and global mental health policies in Nepal. In so doing, it challenges simplistic narratives of aid dependency and emphasises the agency of mental health actors in navigating shifting norms of international aid and in shaping the mental health system. Furthermore, this thesis reflects on the role of mental health actors in contemporary nation building and contributes to our understanding of modern Nepal. As a whole, this thesis evidences the continuous negotiation of tensions arising between aspirations – encompassing policy, aid norms, and modernity – and lived realities experienced in practice.

Following the 2015 earthquakes in Nepal, there was a surge of new funds and projects aimed at providing MHPSS to those affected by the disaster. Simultaneously, there arose a sense of hope for the potential to enhance the country's healthcare system for the longer-term. The post-earthquake context also attracted the attention of ethnographers seeking to track the implementation of the humanitarian aid response in the immediate aftermath (Seale-Feldman, 2020) and wanting to study the short-term impact of newly introduced mental health efforts in earthquake-affected communities in rural Nepal (Chase, 2020). More broadly, these scholars reflected on wider questions on the role of ethnography in post-disaster settings. On one hand, Seale-Feldman (2020) reflects on the possibilities and impossibilities of field research in emergency settings. And, Chase (2020), on the other hand, suggests we eschew theory-driven critiques of global mental health and advocates instead for the need for densely "peopled" ethnographic accounts (Chase, 2020). While I concur with the need for, and difficulties around, ethnographic engagement in post-disaster settings and my research shares common ground with the work of these researchers, specifically in my efforts to contextualise Nepal's mental health system within broader historical narratives (Seale-Feldman, 2019) and my data on brokerage and translation of mental health policies (Chase, 2020), the different time frame of my fieldwork offered me a different vantage point. In studying the mental health system across multiple sites two years after the 2015 earthquakes, this thesis builds on the previous studies and offers insights into the juncture of time when mental health actors and institutions had to renegotiate their roles and responsibilities to ensure the continuous availability of mental health resources and care.

Based primarily in Kathmandu, this study explores the question of who is mediating mental health efforts in post-earthquake and federal Nepal, and why. Although each part of this thesis addressed three avenues of inquiry, the answers to these are threaded throughout the thesis as a whole and extend beyond its delineated divisions. The three research questions guiding each part were:

1. How has mental health emerged over time as an object of care in Nepal? What does the present state of mental health care tell us about the object of care, and how does it mirror prevailing social and economic influences?

2. How do mental health brokers and translators navigate, stabilise and normalise constantly shifting aid norms and projects? What is at stake in doing this, and how do these norms and projects intersect with their local ambitions and agendas?

3. In post-earthquake Nepal, how do individuals with varying gender and socioeconomic positions engage with and transform psychological knowledge, and what are the impacts on both individual identities and broader social change?

These research questions evolved from my initial research design. When I began, my focus was primarily on mapping mental health services and studying the immediate effects of the humanitarian response on Nepal's mental health system. However, conducting fieldwork in 2017, two years after the earthquake, provided an unexpected analytical advantage. The distance from the immediate post-disaster period revealed that the earthquake's impact on Nepal's mental health system was more profound and complex than initially anticipated. Rather than simply observing the direct effects of humanitarian intervention, I found myself witnessing how the earthquake had triggered deeper transformations in how mental health care was conceived, delivered, and integrated into broader social processes. This realisation led me to shift my focus to examining how different actors within the system – from institutions to individuals – were actively engaged in reshaping mental health care in Nepal. The evolved questions reflect this broader understanding: they examine how mental health emerged as an object of care, how institutional actors navigate changing aid requirements, and how individuals across different social positions engage with psychological knowledge within the system. These questions, while different from my initial focus, better captured the ongoing processes of change I observed in Nepal's mental health system during this crucial period of transition.

In the following, I address each set of questions by drawing upon the ethnographic material presented in this thesis.

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To answer my first research question, regarding how mental health has emerged over time as an object of care, I historically traced mental health as an object of care from pre-1990 to the post-earthquake period, with a particular focus on the period following the 1990's economic liberalisation (chapter 2). In doing so, I showed how the object of care transformed alongside each wave of political and economic transformation. First, in the pre-1990 period, mental health care was provided through diverse healing practices (including dhami-jhakris, matas, gurus and Ayurvedic and Tibetan doctors) alongside early biomedical psychiatric services focused solely on medication and electroconvulsive therapy at facilities like Bir Hospital. Then, following democratisation and economic liberalisation (1990-1996) mental health became an object of care shaped primarily by the dramatic expansion of NGOs – with registered organisations increasing from 350 in 1989 to 5,787 in 1997 (Shrestha, 2006) – that introduced psychosocial components for specific “victim” groups. During the civil war period (1996-2006), mental health became defined by trauma and PTSD concerns, with new organisations like TPO and CMC-N providing “psychosocial interventions” for conflict-affected populations and refugees. In the post-conflict period (2006-2015), mental health as an object of care became integrated into global development priorities following the 2007 Lancet series, emphasising evidence-based interventions and health system strengthening approaches. And finally, in the post-2015 earthquake and federal context that I studied (2017-2018), mental health as an object of care appeared to be operating within a market-oriented system that attracted significant international funding under “Building Back Better” frameworks. Through this historical analysis, I showed that mental health emerged in different ways over time and is therefore a contested object of care, with transformations strongly influenced by the socio-economic and political context. More fundamentally, this historical tracing revealed that the contestation is not simply about different approaches competing, but about the fundamental nature of what mental health IS being repeatedly redefined. The very ontology of mental health – what it is as a thing requiring care – gets reconstituted in each period: from a medical condition requiring hospital treatment to a social problem requiring NGO intervention to a trauma response requiring specialised care to a market commodity requiring competitive delivery.

Having traced how mental health emerged over time as an object of care in Nepal and drawing from the insights from Chapter 2, I then turned, in Chapter 3, to answer the question “what does the present state of mental health care tell us about the object of care, and how does it mirror prevailing social and economic influences?”. My choice to present the ethnographic material as fragments rather than a unified narrative itself began to answer this question – this methodological approach reflected how Nepal’s mental health system resists unified representation because it operates through fragmentation and competition rather than integration. The ethnographic fragments from my 2017-2018 fieldwork revealed that the state of mental health care during this period was characterised by fundamental fragmentation, evidenced by how mental health care was constituted as entirely different objects across sites - as rapid biomedical intervention requiring quick medication fixes in Dr. Bhargavi’s 2-5minute consultations, as social support and community building during CNMH’s leisurely tea-sharing home visits with Maya’s family, as systematic collaborative care involving trained teams at the regional hospital, and as long-term containment at the private rehabilitation center despite stated aims of community reintegration. I showed that this fragmented state of mental health care revealed that mental health as an object of care is not a unified or stable entity but rather gets contextually determined by institutional settings, with different actors actively constituting it as different kinds of objects requiring different responses. I argued that this fragmented state appeared to mirror the prevailing social and economic influences of the neoliberal reforms detailed in Chapter 2, creating a therapeutic marketplace. I suggested that market competition drove institutional divisions, illustrated when during the World Suicide Prevention Day march – despite its stated goal of unity – quickly fragmented into separate organisational banners as each group asserted distinct professional identities. In addition to institutional divisions, I also showed how business logic has increasingly entered mental health care directly, evident in Pretvan’s online platform that critiqued NGOs as “black holes for money” while emphasising “financial incentives” as superior motivators. Finally, I suggested that this fragmented state of the mental health care I observed in 2017-2018 was not a failure of system integration but appeared to be the successful outcome of 30+ years of market-oriented reforms that positioned mental health as something to be delivered through competition rather than coordination.

Then, to answer my second research question regarding how mental health brokers and translators navigate, stabilise, and normalise constantly shifting aid norms and projects, Part II specifically employed brokerage and translation as key analytical concepts to examined the active work required to make two key contemporary aid norms – “country ownership” (chapter 4) and “evidence-based practice” (chapter 5) – function in Nepal’s mental health system. Through detailed ethnographic analysis, I revealed mechanisms through which mental health actors operated as brokers and translators, mediating between global aid frameworks and local implementation realities and how they enacted evolving aid norms.

First, I showed that mental health actors navigate constantly evolving aid norms through intensive performative labour that stages adherence to these norms regardless of underlying implementation realities. Chapter 4’s ethnographic account of the “historical” mental health training demonstrated this mechanism clearly – NGO staff orchestrated complex behind-the-scenes logistics (transporting medicines, managing ceremony logistics, providing infrastructure) while carefully staging the appearance that local government was leading mental health reform. The interruption of actual training time for ceremonial purposes revealed how displaying compliance with “country ownership” norms took precedence over substantive capacity building, yet all actors contributed to maintaining interpretations of the event as reflecting government ownership.

Then chapter 5 revealed how the norm of “evidence-based practice” is embedded through creating structural dependencies where evidence-based research engagement becomes the mandatory condition for accessing resources and maintaining legitimacy. This was evident in the case of CNMH, which had a different epistemic orientation and were later compelled to participate in evidence-based research frameworks for survival. CNMH engaged with university partnerships and the MRC grant despite Anna’s recognition that the grant’s “scale and approach did not match the vision or values of CNMH” because “the resources CNMH would receive from the grant would cover the operational costs of the organisation for some time”.

Taken together, these two chapters elucidated that what is at stake in brokering and translation evolving aid norms and projects is who gets to define what legitimate mental health care is and who has the power and resources to implement it, with each norm serving distinct but complementary functions in this definitional process. Chapter 4 revealed that performing “country ownership” establishes the legitimacy and recognition necessary for mental health to be considered as an object of state care. The “historical” mental health training ceremony was significant because it positioned mental health within “the development lexicon and framework of the 'Naya Nepal' state” rather than remaining solely in the NGO charity domain. For mental health advocates who had long been marginalised, achieving “public recognition of those who were enabling mental health efforts” through government ceremonial endorsement was crucial for establishing professional legitimacy. The stakes involved transforming mental health from a charity issue into a legitimate governance responsibility, creating the foundation for future resource allocation and policy development. Chapter 5 demonstrated that performing "evidence-based practice" directly determines which specific models of mental health care receive resources and policy influence within that legitimated domain. TPO Nepal's successful enactment of evidence-based norms enabled them to embed their preferred "psychosocial counseling" approach into national standards through government training modules and treatment protocols. Meanwhile, organisations like CNMH, despite providing care, remained peripheral to policy conversations - as Anna noted, Dhriti was "a lonely voice" at the Ministry of Health compared to advocates aligned with evidence-based medical models.

Throughout these two chapters, I also addressed the question of how these norms interested with local ambitions. For the "country ownership" norm, Chapter 4 showed how it intersected with local ambitions by creating a convergence mechanism where diverse actors pursued distinct goals while appearing to serve a shared nationalist project, operating through the alignment of professional legitimacy aspirations with state capacity discourse, organisational survival strategies with embedded partnership frameworks, and political capital accumulation with ceremonial ownership performances. For psychiatric professionals like Kanchan, Rikesh and Ganesh, country ownership provided a framework for expanding professional influence while also serving national interests, as evidenced by Kanchan's description of the training as being "historical", which reinforced NGO centrality by positioning the state's request for the training as validation of their indispensable technical expertise needed for knowledge transfer. NGO organisations leveraged country ownership performances to secure long-term positioning within state systems rather than being displaced, with the intensive behind-the-scenes work from transporting medicines to coordinating ceremonies demonstrating how they embedded themselves deeper into state infrastructure while appearing to "hand over" control, as shown by Naya's extension of the NeighborNurture project where demonstrating government buy-in became the metric for donor satisfaction. I suggested that local government officials may have used country ownership ceremonies to build legitimacy in the new federal system. In this case, the convergence of agendas created an apparent mutual enablement that maintained existing power asymmetries, where country ownership became a shared fiction serving everyone's immediate interests. Chapter 5 evidenced how the norm of "evidence-based practice" intersected with local ambitions by making a specific type of research engagement the pathway to achieving personal professional goals. Anna's ambition to establish CNMH as a legitimate alternative to medical models required strategic adoption of evidence-based language and documentation, as she recognised that having "evidence" could give her social approach credibility in policy discussions, leading her to hope that student research could be "pulled together" to advocate for holistic mental health care approaches. Dhriti's ambition to be taken seriously as a mental health advocate became dependent on research partnerships that provided documentation to transform her from "a lonely voice" at the Ministry of Health into someone with evidence-backed arguments for why mental health care needs broader understanding beyond medical models. TPO Nepal staff's ambition to institutionalise psychosocial counseling as legitimate mental health care aligned perfectly with evidence-based requirements, enabling them to use RCT evidence to embed their preferred community counsellor model into government training modules and treatment protocols. These intersections revealed how evidence-based practice operates as both an enabling and constraining force, determining whose mental health visions can access resources and policy influence while compelling even philosophically opposed organisations to strategically engage with research frameworks for organisational survival.

Finally, my third research question asked how individuals with varying gender and socioeconomic positions engage with and transform psychological knowledge, and what are the impacts on both individual identities and broader social change. The ethnographic evidence revealed differentiated processes of engagement where individuals' social positioning—particularly their gender, class and educational status—fundamentally shaped how they engaged with psychological knowledge and the resulting impacts.

Regarding engagement processes, urban, educated actors demonstrated active selection and transformation of psychological concepts, while those with less institutional power engaged primarily as subjects of psychoeducational interventions. Chapter 6 showed how Dr. Rajendra positioned himself as expert authority while radio callers remained subjects of intervention, and how urban trainers created hybrid knowledge forms by embedding psychological concepts within Christian service ideologies for rural farming communities. The forum theatre evidence demonstrated knowledge transformation through constructed expert consensus among urban middle-class professionals, while rural populations were positioned as recipients of mental health advice. Chapter 7 revealed more active transformation among psychology students and graduates, who appropriated Western concepts for personal optimisation and professional identity construction. The impacts on individual identities varied accordingly. Chapter 6's psychoeducational activities aimed to shape understandings of distress and promote help-seeking behaviors, employing "confessional technologies" and positioning some as community mental health monitors. Chapter 7 showed psychology students developing "autonomous" and "entrepreneurial" identities while graduates like Amina used psychological frameworks to legitimise challenging traditional gender roles. Regarding broader social change, the evidence presented revealed both emerging transformations and institutional constraints. I suggested that psychoeducational activities have introduced particular mental health discourses into the public sphere and increased the visibility of psychological expertise. During my research, psychology graduates were creating new professional spaces like youth-oriented NGOs and therapeutic practices addressing specifically Nepali concerns such as gender role conflicts. However, I also showed how these changes are co-existing with significant institutional and societal resistance. Thus, while the circulation of psychological knowledge is generating new forms of professional practice and public discourse, existing power structures during my fieldwork period continued to constrain more systematic transformation of Nepal's mental health landscape.

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In addressing these three research questions, this thesis demonstrated how Nepal's mental health system operated as a dynamic ecosystem shaped by multiple forces, actors, and processes. Through its three parts, it revealed different dimensions of how this system evolved and functioned. Part I established the fundamental characteristics of the system, showing it to be marked by fragmentation and plurality. As demonstrated in chapter 3, the system encompassed diverse understandings of mental health, multiple care providers, and varied approaches to treatment. I argued that this configuration reflected how mental health had emerged as a contested object of care within a system shaped by market-oriented economic forces that drove competition and market dynamics. Importantly, chapter 2 revealed that this fragmented and competitive nature of the system was not arbitrary but rather an outcome of historical tensions between different political shifts, aid regimes, and evolving aspirational discourses and practices. Part II examined how different actors worked to maintain and transform the system through key aid norms. Through analysis of "country ownership" (chapter 4) and "evidence-based practice" (chapter 5), I showed how the system adapted to changing global health imperatives. The chapters revealed how both state and non-state actors became mutually dependent in performing these norms, thereby securing the system's continued operation and funding. This was particularly evident in how NGOs with different epistemic frameworks had to navigate evidence-based requirements to maintain their position within the system. Part III demonstrated how the system both shaped and was shaped by broader processes of social transformation. By examining how different actors engaged with psychological knowledge within the system, these chapters revealed its role in mediating between global frameworks and local aspirations for modernity. Chapter 6 showed how mental health professionals used the system as a platform for "Nepalising" psychological knowledge, while chapter 7 revealed how the system enabled new professional identities while also constraining them within existing social structures. Together, these analyses showed how Nepal's mental health system served as a crucial site where global health frameworks, local aspirations, and social transformation intersected. The system emerged not just as a healthcare delivery structure, but as a dynamic space where multiple actors negotiated between international aid norms, professional aspirations, and visions of modern Nepal.

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